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

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SC Court of Appeals

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.

AMENDED RECORD ON APPEAL

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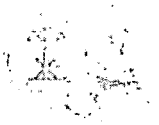

Orangeburg Common Pleas

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

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> 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.

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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

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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

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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, [redacted] ("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

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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.

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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.

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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

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IMPORTANT NOTICE - READ THIS INFORMATION

NOTICE OF ELECTRONIC FILING [NEF]

A filing has been submitted to the court RE: 2015CP3801234

Official File Stamp:	10-25-2019 11:43:21 AM
Court:	CIRCUIT COURT Common Pleas Orangeburg
Case Caption:	Tekayah Hamilton , plaintiff, et al VS Regional Medical Center , defendant, et al
Document(s) Submitted:	Order/Other Order/Other
Filed by or on behalf of:	Edgar Dickson

This notice was automatically generated by the Court's auto-notification system.

The following people were served electronically:

Joseph Reza Shakibanasab for Regional Medical Center
Virginia Watson Williams
Michael C. Tanner for Regional Medical Center
David Reynolds Williams
Jonathan F Krell for Tekayah Hamilton

The following people have not been served electronically by the Court. Therefore, they must be served by traditional means:

Robert Lee M, Jr.

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG)
)
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen,) CIVIL ACTION COVERSHEET
Plaintiff(s))
) 2015-CP - 38- 01334
vs.)
)
Regional Medical Center and Jamie Downing, RN,)
Defendant(s))

Submitted By: Jonathan F. Krell
Address: PO Box 399 – Charleston, SC 29402

SC Bar #: 16691
Telephone #: 843-723-7491
Fax #: 843-577-4179
Other:
E-mail: jonathan@uricchio.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

FILED FOR RECORD
ORANGEBURG, S.C.
NOV 04 2015
CLERK OF COURT

DOCKETING INFORMATION (*Check all that apply*)

**If Action is Judgment/Settlement do not complete*

X JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
X This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts
☐ Constructions (100)
☐ Debt Collection (110)
☐ General (130)
☐ Breach of Contract (140)
☐ Fraud/Bad Faith (150)
☐ Failure to Deliver/ Warranty (160)
☐ Employment Discrim (170)
☐ Employment (180)
☐ Other (199)

Torts - Professional Malpractice
☐ Dental Malpractice (200)
☐ Legal Malpractice (210)
X Medical Malpractice (220)
Previous Notice of Intent Case # 20___-NI-_____
☐ Notice/ File Med Mal (230)
☐ Other (299)

Torts - Personal Injury
☐ Conversion (310)
☐ Motor Vehicle Accident (320)
☐ Premises Liability (330)
☐ Products Liability (340)
☐ Personal Injury (350)
☐ Wrongful Death (360)
☐ Assault/Battery (370)
☐ Slander/Libel (380)
☐ Other (399)

Real Property
☐ Claim & Delivery (400)
☐ Condemnation (410)
☐ Foreclosure (420)
☐ Mechanic's Lien (430)
☐ Partition (440)
☐ Possession (450)
☐ Building Code Violation (460)
☐ Other (499)

Inmate Petitions
☐ PCR (500)
☐ Mandamus (520)
☐ Habeas Corpus (530)
☐ Other (599)

Administrative Law/Relief
☐ Reinstate Drv License (800)
☐ Judicial Review (810)
☐ Relief (820)
☐ Permanent Injunction (830)
☐ Forfeiture-Petition (840)
☐ Forfeiture—Consent Order (850)
☐ Other (899)

Judgments/Settlements
☐ Death Settlement (700)
☐ Foreign Judgment (710)
☐ Magistrate's Judgment (720)
☐ Minor Settlement (730)
☐ Transcript Judgment (740)
☐ Lis Pendens (750)
☐ Transfer of Structured Settlement Payment Rights Application (760)
☐ Confession of Judgment (770)
☐ Petition for Workers Compensation Settlement Approval (780)
☐ Other (799)

Appeals
☐ Arbitration (900)
☐ Magistrate-Civil (910)
☐ Magistrate-Criminal (920)
☐ Municipal (930)
☐ Probate Court (940)
☐ SCDOT (950)
☐ Worker's Comp (960)
☐ Zoning Board (970)
☐ Public Service Comm. (990)
☐ Employment Security Comm (991)
☐ Other (999)

Special/Complex /Other
☐ Environmental (600)
☐ Automobile Arb. (610)
☐ Medical (620)
☐ Other (699)
☐ Sexual Predator (510)
☐ Pharmaceuticals (630)
☐ Unfair Trade Practices (640)
☐ Out-of State Depositions (650)
☐ Motion to Quash Subpoena in an Out-of-County Action (660)
☐ Pre-Suit Discovery (670)

Submitting Party Signature: _____ Date: 11/3/15

SCCA / 234 (06/2015)

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FOR MANDATED ADR COUNTIES ONLY

Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Clarendon, Colleton, Darlington, Dorchester, Florence, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Lee, Lexington, Marion, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Union, Williamsburg, and York

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.

2. The initial ADR conference must be held within 300 days after the filing of the action.

3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)

4. Cases are exempt from ADR only upon the following grounds:

   a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;

   b. Requests for temporary relief;

   c. Appeals

   d. Post Conviction relief matters;

   e. Contempt of Court proceedings;

   f. Forfeiture proceedings brought by governmental entities;

   g. Mortgage foreclosures; and

   h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.

5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.

6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: **You must comply with the Supreme Court Rules regarding ADR. Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of Eighteen, Plaintiffs, vs. Regional Medical Center and Jamie Downing, RN, Defendants.	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT CASE NO.: 2015-CP-38-01635 **SUMMONS**

FILED FOR RECORD
ORANGEBURG, S.C.
CLERK
2015 NOV -7 P 4:29
CLERK OF COURT
ORANGEBURG, S.C.

TO THE DEFENDANT ABOVE-NAMED:

A lawsuit has been filed against you.

Within 30 days after service of this summons on you (not counting the day you received it), you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the South Carolina Rules of Civil Procedure. The answer or motion must be served on the plaintiff's attorneys, at the addresses shown below. If you fail to do so, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

URICCHIO HOWE KRELL JACOBSON
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ATTORNEYS FOR PLAINTIFF

CLERK OF COURT
ORANGEBURG, S.C.

September ____, 2015
Charleston, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of Eighteen, Plaintiffs, vs. Regional Medical Center and Jamie Downing, RN, Defendants.	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT CASE NO.: 2015-CP-38-01334 COMPLAINT Jury Trial Requested

FILED FOR RECORD
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2015 OCT -7 P 4:27
CLERK OF COURT
ORANGEBURG

Plaintiffs, by and through undersigned counsel, brings this action against Defendants based on the allegations set forth below.

AS A PRELIMINARY MATTER

Plaintiffs attach the affidavit and CV of Monica Stobbs, RN, BSN, to this complaint and incorporate by reference herein.

PARTIES

1. Plaintiffs are citizens and residents of Orangeburg County, South Carolina.

2. Upon information and belief, Defendant Regional Medical Center ("Regional") is an agency, within the meaning of the South Carolina Tort Claims Act (S.C. Code Ann. § 15-78-10, *et seq.*) of the State of South Carolina. Regional operates a hospital and other facilities by staffed physicians, nurses and other health care providers and technicians in Orangeburg County, South Carolina.

3. Upon information and belief, Defendant Jamie Downing, RN, is a citizen and resident of Orangeburg County, South Carolina.

JURISDICTION and VENUE

4. The Court has subject-matter jurisdiction and personal jurisdiction over Defendants and venue is proper in Orangeburg County, South Carolina.

FACTS

5. At all times relevant to the allegations contained in this Complaint, Defendant Regional engaged on its staff as employees, physicians, residents, interns, specialists, nurses and other personnel, and was operated by and through its agents and/or employees, acting within the course and scope of their employment.

6. Defendant Regional, by and through its agents and/or employees, and Defendant Downing, in their treatment of Plaintiff, were required to exercise and use that degree of skill and care ordinarily used under the same or similar circumstances by members similarly situated within the medical profession.

7. Defendant Regional is liable for the acts of its agents and/or employees acting within the course and scope of their employment under the theory of *respondeat superior*.

8. At all times pertinent hereto, Defendant Regional and Defendant Downing were under a duty to provide competent medical treatment, within generally accepted standards of care.

9. On October 25, 2014, Plaintiff, a minor, was admitted to Defendant Regional for treatment of neo-natal fever.

10. At the time of his admission, the minor Plaintiff was one (1) month old. Upon admission, it was discovered that he had a fever of 102.6, but all other symptoms were negative. Additionally, there was no past medical history contributing to the admission.

11. 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 at this time.

12. The Ampicillin IV began at approximately 11:30 PM on October 25, 2014. The medical record neglects to document the site and condition of the administration.

13. On October 26, 2014 at approximately 7:17 AM, Claforan IV is administered in the site of the administration is not noted.

14. On that same date at 11:22 AM ampicillin is administered and the site and condition of the administration is not noted.

15. Later that day, at approximately 3:52 PM Claforan is administered and the condition of the site is not noted.

16. At 10:55 PM on the same date, ampicillin is administered, but the condition and site of the administration is not noted in the record.

17. One minute later, Claforan is administered and the condition of the site is not noted.

18. On October 27, 2014 at 4:34 AM ampicillin is administered and the condition of the site of the administration is not noted.

19. On October 27, 2014 11:40 AM ampicillin is once again administered and condition of the site is not noted.

20. On October 27, 2014 at 4:08 PM Claforan is administered and the record is devoid of any mention of the site or condition of the IV administration.

21. On October 27, 2014 at 5:48 PM ampicillin is administered and the note fails to document the condition or site of the IV administration.

22. On October 27, 2014 at 11 PM, Defendant Downing, RN, initiated an IV antibiotic via peripheral IV and the record is silent on IV location, site appearance and/or if blood return was obtained from the IV prior to administration of the drug.

23. October 27, 2014 at 11:08 AM ampicillin is administered and the record is yet again devoid of any notation of the condition or site of IV.

24. On October 28, 2014 at 4:04 AM a peripheral IV assessment grid fails to document the evaluation of blood return prior to infusion of antibiotic.

25. On October 28, 2014 at 4:27 AM ampicillin was administered and the order was to infuse over 20 minutes. The location of the administration and condition of the site is not mentioned in the record and there is no evaluation of blood return prior to the administration.

26. On October 28, 2014 at 4:49 AM there is a medical note that is silent on the evaluation of the IV site and/or of the IV infiltrate.

27. On October 28, 2014 at 4:50 AM the patient is noted as being "fussy". The IV antibiotics were discontinued, the IV dressing was removed and the minor Plaintiff's hand was puffy with bruising. Additionally there was swelling to the fingers and the peripheral IV was removed. Additionally a warm compress was applied.

28. October 28, 2014 at 5:17 AM, the site condition was noted to have edema and pain. An infiltration score of one was noted. It was noted again that the minor Plaintiff was "fussy".

29. October 28, 2014 at 7:30 AM and assessment of the site was completed and it was noted that the right-hand was swollen with a darkened area to the top of the hand.

30. October 28, 2014 at 7:48 AM on a skin abnormality grid the right-hand was noted to have discoloration and blisters.

31. That as a result of the breach of Defendans duty of professional care, Plaintiffs have, are and will in the future continue to suffer from the following, including but not limited to: pain and suffering; permanent scarring and impairment; loss of enjoyment of life; medical expenses and emotional distress

FOR A FIRST CAUSE OF ACTION
(Medical Negligence)

32. Plaintiff incorporates all allegations of paragraphs above into this cause of action as if set forth verbatim.

33. Defendant Regional, by and through its agents and/or employees, and Defendant Downing, owed Plaintiff a duty of care to use that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances.

34. 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 the 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.

All of which were the direct and proximate cause of Plaintiff's injuries and emotional trauma, all in violation of the statutes and laws of the State of South Carolina, combining and concurring.

35. That as a result of the negligence, carelessness, willfulness, wantonness, and recklessness of Defendants, Plaintiffs have been injured and damaged. Plaintiffs have, are and will in the future continue to suffer from the following, including but not limited to: pain and suffering; permanent scarring and impairment; loss of enjoyment of life; medical expenses and emotional distress - all to their injury and damage in an amount of actual and punitive damages to be determined at the trial of this action.

WHEREFORE, Plaintiffs request that judgment be entered against Defendants on all causes of action and that Plaintiffs be awarded: actual damages; punitive damages; a trial by jury

as to all causes of action properly triable; the costs of this action; and such other and further relief as the Court may deem just and proper.

URICCHIO HOWE KRELL JACOBSON TOPOREK THEOS & KEITH, P.A.

Jonathan F. Krell
PO Box 399
Charleston, SC 29402
Tel.: (843) 723-7491; Fax: (843) 577-4179

Williams & Williams

David R. Williams
1281 Russell Street (29115)
PO Box 1084
Orangeburg, SC 29116
ATTORNEYS FOR PLAINTIFF

September 30, 2015
Charleston, South Carolina

STATE FO SOUTH CAROLINA
COUNTY OF ORANGEBURG

) IN THE COURT OF COMMON PLEAS
) 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

FILED FOR RECORD
VIRGINIA B. CLARK
CLERK OF COURT
ORANGEBURG, SC
15 OCT -5 P 4:26

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.

PLAINTIFF'S EXHIBIT 12

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.

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS 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, Plaintiffs, -vs- The Regional Medical Center and Jamie Downing, RN, Defendant.	)	2015-CP-38-01234 **ANSWER OF THE DEFENDANTS**

Defendant, The Regional Medical Center (hereinafter TRMC) and its employee, Jamie Downing, R.N., improperly named, by and through the undersigned, hereby answers the Complaint of plaintiffs as follows:

1. Defendant denies all allegations contained in the Complaint unless specifically admitted, qualified or explained.

2. Defendant lacks sufficient information to admit or deny the allegations contained in paragraph 1 of the Complaint, and therefore denies same.

3. Defendant admits the allegations contained in paragraph 2 of the Complaint insofar as defendant admits that it is a government healthcare facility.

4. Defendant denies the allegations contained in paragraph 3 and 4 of the Complaint.

5. The allegations contained in paragraphs 5, 6, 7, and 8 of the Complaint contain legal conclusions to which no response is required.

6. The defendant would crave reference to plaintiff's medical records as to the allegations

contained in paragraphs 9, 10, and 11 of the Complaint. Defendant denies a deviation from the standard of care by its employees.

7. As to the allegations contained in paragraphs 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30 of the Complaint, defendant would crave reference to the entire EMR and denies a deviation from the standard of care by its employees.

8. Defendant denies the allegations contained in paragraphs 31, 23, 33, 34, and 35 of the Complaint and demands strict proof thereof.

FOR A SECOND DEFENSE

9. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 8 of this Answer as if realleged herein verbatim.

10. Defendants, who are employees of TRMC, assert it is a governmental entity as contemplated by the South Carolina Tort Claims Act, and it hereby asserts all defenses afforded it by the South Carolina Tort Claims Act, §15-78-10, et seq., Code of Laws of South Carolina, whether or not specifically or separately pleaded herein, including §15-78-60 and all subparts.

MT #2

FOR A THIRD DEFENSE

11. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 11 of this Answer as if realleged herein verbatim.

12. Defendant asserts it is entitled to an Order of this Court limiting plaintiffs' recovery, if any, to those actual damages set forth in §15-78-120, Code of Laws of South Carolina, and asserts that it is not liable to plaintiff for punitive damages, exemplary damages, or pre-judgment interest.

FOR A FOURTH DEFENSE

13. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 12 of this Answer as if realleged herein verbatim.

14. Defendant asserts that all times relevant to the Complaint, its physicians, nursing staff, and non-professional employees were in compliance with the applicable standard of care and defendant asserts its employees did not deviate at any time from the standard of care and the treatment of plaintiff. Defendant further asserts that all supervision, staffing, training and medical equipment available to staff fully conformed to and was in full compliance with the applicable standard of care. Therefore, plaintiff is barred from recovery against the defendant TRMC for the allegations contained in the Complaint.

FOR A FIFTH DEFENSE

15. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 14 of this Answer as if realleged herein verbatim.

16. Defendant asserts that plaintiff's alleged injuries were caused solely by a natural disease process, and, therefore, defendant TRMC is not liable to plaintiff in any fashion.

FOR A SIXTH DEFENSE

17. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 16 of this Answer as if realleged herein verbatim.

18. Defendant asserts that any injuries and damages of the plaintiff, which are expressly denied, were not proximately caused by any action or inaction of the defendants.

FOR A SEVENTH DEFENSE

19. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 18 of this Answer as if realleged herein verbatim.

20. Defendant asserts that any injuries and damages of the plaintiff, which are expressly denied, were proximately caused by the acts of a third party.

FOR AN EIGHTH DEFENSE

21. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 20 of this Answer as if realleged herein verbatim.

22. The Defendant asserts, upon information and belief, that the pendant state claims in this action are governed by the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et. seq., which governs the terms and conditions under which sovereign immunity is abrogated and reserved unto governmental entities and political subdivisions of the state. Pursuant to § 15-78-120 (a) (1), the plaintiff, if entitled to any damages, which Defendant specifically denies, is limited to a maximum of $600,000.00. The Defendant is informed and believes that they are entitled to an Order of this Court striking all reference to damages being construed to be over the amount of $600,000.00. Plaintiff is also not entitled to punitive or exemplary damages pursuant to § 15-78-120 (b).

FOR A NINTH DEFENSE

23. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 22 of this Answer as if realleged herein verbatim.

24. Defendant asserts that to the extent the minor suffered a compensable injury from a course of medical treatment that was in any way negligent, that Plaintiff was at least equally negligent as Defendant TRMC and as such is barred from recovery under the doctrine of comparative negligence.

FOR A TENTH DEFENSE

25. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 25 of this Answer as if realleged herein verbatim.

26. Defendant asserts it is not liable for any conduct constituting the exercise of judgement or discretion, pursuant to §15-78-60(5) Code of Laws of South Carolina.

FOR AN ELEVENTH DEFENSE

27. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 27 of this Answer as if realleged herein verbatim.

28. Plaintiff is barred from recovery for the responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity pursuant to S. C. Code Ann. §15-78-60 (25).

FOR A TWELFTH DEFENSE

29. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 28 of this Answer as if realleged herein verbatim.

30. The proper party, pursuant to the S. C. Tort Claims Act, is The Regional Medical Center which should be substituted as the party defendant, Jamie Downing, R.N., pursuant to S. C. Code Ann. §15-78-70.

WHEREFORE, the defendant requests the Court inquire into these matters herein, dismiss plaintiff's complaint with prejudice and with costs, and grant such other and further relief as the Court may deem just and proper.

MICHAEL C. TANNER, L. L.C.

By: _____

Michael C. Tanner
P.O. Box 1061, 392 Second St.
Bamberg, S.C. 29003
(803) 245-9153
Fax: (803) 245-9154
Attorney for TRMC

Bamberg, S.C.
November 24, 2015

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. The Regional Medical Center, et al, case number 15-CP-38-1234, hereby certify that I have served the foregoing Answer, by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Jonathan F. Krell, Esquire
PO Box 399
Charleston SC 29402

MICHAEL C. TANNER, L.L.C.

By: _____

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

Bamberg, S.C.

November 24, 2015

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of Eighteen, Plaintiffs, vs. Regional Medical Center and Jamie Downing, RN, Defendants.	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT CASE NO.: 2015-CP-38-01234 **PLAINTIFF'S RESPONSES TO DEFENDANT'S REQUEST TO ADMIT**

TO: MICHAEL C. TANNER, ESQUIRE, ATTORNEY FOR DEENDANTS ABOVE-NAMED:

The Plaintiff, by and through the undersigned counsel, hereby responds to the Defendant's Request to Admit, as follows:

1. Admit the value of the amount in controversy in this action is less than $100,000.00.

   RESPONSE: Deny.

2. Admit the value and amount in controversy in this action is greater than $100,000.00.

   RESPONSE: Admit.

3. Admit the value of Plaintiff's actual damages exceeds $100,000.00.

   RESPONSE: Admit.

Signature Page to Follow

URICCHIO HOWE KRELL JACOBSON
TOPOREK THEOS & KRELL P.A

Jonathan F. Krell
PO Box 399
Charleston, SC 29402
Tel.: (843) 723-7491; Fax: (843) 577-4179

December 14, 2015
Charleston, South Carolina

On December 14, 2015, I served Defendants through their attorney, Michael C. Tanner, Esquire, Plaintiff's Responses to Defendant's Request to Admit to the following address:

Michael Tanner, Esquire
P.O. Box 1061
Bamberg, SC 29003

Attorney for Defendants

Debi M. Carrier
Paralegal to Jonathan F. Krell

STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG)

TAKAYAH HAMILTON, INDIVIDUALLY AND AS PARENT AND GUARDIAN AD LITEM FOR ROBERT LEE M., JR., A MINOR CHILD UNDER THE AGE OF EIGHTEEN,	TRANSCRIPT OF RECORD
PLAINTIFF,	
VS.	
REGIONAL MEDICAL CENTER AND JAMIE DOWNING, RN,	2015-CP-38-1234
DEFENDANTS.	

May 7th, 2018
Orangeburg, South Carolina

B E F O R E:

THE HONORABLE EDGAR W. DICKSON, Judge; and a jury.

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

JONATHAN KRELL
ESQ.
Attorney for the Plaintiff

MICHAEL C. TANNER
ESQ.
Attorney for the Defendant

HILDA JORDAN
Circuit Court Reporter

Transcribed by Pamela E. Green, Circuit Court Reporter

PROCEEDINGS

THE COURT: All right. I, I wanted to get some of the motions out of the way, and some bookkeeping stuff out of the way. I don't know if anybody's gonna show up for the roster meeting since this is the only trial, but I just want to make sure.

I was looking over, before we get started on this, I only have eight witnesses in this case.

Is that correct?

I got Ms. Hamilton. I don't -- Mrs. Middleton, Doctor DeVito.

Who -- what does he -- what is his specialty?

MR. KRELL: He's a plastic surgeon, Your Honor---

THE COURT: As is---

MR. KRELL: ---from Charleston.

THE COURT: ---Doctor Davis?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: DeVito's our expert plastic surgeon, and Doctor Davis is defense experts.

MR. TANNER: He did the IV actually.

THE COURT: Yeah. Yeah.

MR. KRELL: Maybe he's not their expert.

THE COURT: Huh?

MR. KRELL: Maybe I misspoke. He's not their expert. I'm sorry.

THE COURT: Okay. And then Ms. Stobbs is your nursing expert --

MR. KRELL: Yes, sir.

THE COURT: -- that I've got to do a motion with.

Ms. Downing is the nurse that put in the---

MR. TANNER: Yes, sir.

THE COURT: And Ms. Hurley is who?

MR. TANNER: She's my expert, Your Honor.

THE COURT: She's---

MR. TANNER: Oh, nursing expert.

THE COURT: Okay. All right. All right. Let me just make sure I'm -- because it's gonna -- and, Mr. Tanner, looking over the record, there isn't no question that the injury occurred due to this inflation issue.

Is that correct?

MR. TANNER: Infiltration, yes, sir.

THE COURT: Infiltration.

MR. TANNER: Yes, sir.

THE COURT: Infiltration.

MR. TANNER: I-N-F-I-L---

THE COURT: Yeah. No, I got it written down.

MR. TANNER: Okay.

THE COURT: I just don't know how to pronounce it.

MR. TANNER: There's another word, extravagation, that actually technically is what happened because of the fluids used, but they're sort of synonymous.

THE COURT: Uh-huh. (Affirmative).

Okay. And you're not claiming that there was any other cause for this other than this infiltration, right?

MR. TANNER: Right. It's an inherent risk of, of the IV.

THE COURT: Right.

MR. TANNER: Yes, sir.

THE COURT: Right.

I, I understand their -- your position is it's an inherent risk. Their position was they were grossly negligent. I just want to make sure---

MR. TANNER: Right.

THE COURT: ---that's what we're talking about, right?

MR. TANNER: Correct.

THE COURT: Okay. All right.

Okay. Okay. I got the -- they're a couple of different motions that y'all wanted me to go over or do.

There were issues about Ms. Downing. Wanted to go into some issues about whether or not she could -- they were gonna be any statements early on about the fact she's never been -- ever had any problems.

MR. TANNER: Yeah, we just wanted to bring up and make

sure that there's -- the fact that she's never been sued before, maybe had a claim brought against her, to show that she's issued the proper care in this case. We just would move any, any evidence like that would be excluded.

THE COURT: Yeah. I mean I, I don't know that, unless you get into -- unless, unless you get into her character, I, I don't know that that's what---

MR. TANNER: Yeah, I know. I, I mean I think it's an improper question---

THE COURT: Okay.

MR. TANNER: ---and I had no intention of getting into that. That was in our---

THE COURT: Okay.

MR. TANNER: ---return. So unless they sort of get into it and open the door, I'm not gonna ask her that.

THE COURT: Right.

Now, the only -- you know, one of the issues is gonna come up. We might talk about it now. Is -- there is that -- Mr., Mr. Krell, you had asked about -- there were still some -- the even record---

MR. KRELL: Yes, sir, that's --.

THE COURT: You wanted that to come in?

MR. KRELL: We haven't even seen it, but---

THE COURT: Well---

MR. KRELL: ---not only -- we provided a privilege log.

THE COURT: Right.

MR. KRELL: They've objected to it. We wanted to argue that we wanted to at least take a look at it to see what, to see what's in there.

THE COURT: Well, I got it.

Okay.

MR. KRELL: Okay.

THE COURT: You don't want it, but you can argue it.

Go ahead and argue it if you want to.

MR. KRELL: Your Honor, I'm -- if you -- I don't believe -- I don't want to see it.

THE COURT: Okay.

MR. KRELL: I'll withdraw that motion.

THE COURT: Okay. All right. And -- but, but let me, let me just tell you, they -- I, I think I -- number one, I think it's protected anyway. So we'll have that to -- understand that.

But, number two, I've looked at it, and I don't think you want to -- their conclusion to come out.

Okay. And, and y'all can talk about it. I'm not trying, I'm not trying to hit y'all too early in the morning, and we can come back to this. I'll let y'all talk about it some other time.

MR. KRELL: A hush has descended over the courtroom.

(Pause.)

MR. KRELL: Let's move on, Judge.

MR. TANNER: We'll, we'll skip it for now.

THE COURT: Okay. All right.

All right. There was -- Mr. Tanner, I think there was or I don't know who. I can't remember. I got them listed here.

One -- I got the doctors being driven out of the practice.

MR. TANNER: Yeah, I mean, again, I -- in my -- I think that's an improper question, and I have no intention to ask it.

THE COURT: I didn't think you did, but I just wanted to make sure.

Okay. The -- let's get to Ms. Stobbs, whether or not she is qualified to be an expert. I have read the deposition.

Mr. Krell, anything you want to tell me about how you want her to be qualified?

MR. KRELL: Well, Your Honor, I think she's got extensive knowledge of nursing. She's got extensive experience in monitoring and administering IVs, and the general administration and the general monitoring is basically the same for a pediatric versus an adult. And if they want to argue that it goes to her credibility, that's fine, but clearly she's qualified as a nurse.

THE COURT: As a, as a nurse?

MR. KRELL: Yes, sir.

THE COURT: Okay. That's right.

MR. KRELL: As a nursing expert in the general field of IV infiltration.

THE COURT: Nursing 101. I believe.

MR. KRELL: That's what they call it. That's, that's---

THE COURT: That's what she called it.

MR. KRELL: It's popped up many times in these depositions.

THE COURT: All right.

MR. TANNER: Negligent -- respectfully, Your Honor, if they were qualifying her as a nurse, that's one thing. But I think what they're actually trying do is qualifying her as a pediatric nurse or a nurse familiar with pediatric IVs. She's never practiced pediatric nursing.

THE COURT: No, I -- I've read it. I've gone through it. She's never done it. She's never done---

MR. TANNER: You know, the, the -- sort of the -- I guess the big case on this is the Batello versus Vicura case where an orthopedist was attempting to give podiatry opinions, and obviously the podiatry -- he's a, he's a physician, but yet he wasn't familiar with the standard of care.

Ms. Stobbs testified numerous times in her deposition that she didn't review any of the literature. She hadn't done it. If the sole purpose of an expert is to educate the jury, respectfully she's lacking in that area because she hasn't -- again, she hasn't started an IV. She hasn't monitored an IV. She's not familiar with the literature.

Categorically, a lot of what she does say is, is just flat out wrong and obviously refuted by the literature and we've cited that in our memorandum. I think we might of been gone before Ms. Hilda was going.

We good?

THE COURT REPORTER: We're good. Go ahead.

MR. TANNER: So, I don't think she's gonna be able to aid the jury because, frankly, I'm just as qualified, if not more than her, because I've at least read the articles. She's, she's neither started, monitored, nor read the articles. So, so, I don't -- I'm not sure how, under the rules, she's going to assist the jury as an expert because she has no basis on which to testify.

THE COURT: Well, if she's -- and I, and I understand cause I, I -- I've, I've read your cross-examination -- well, your questioning of her knowledge of, of dealing with children. But as far as her qualifications for nursing care, you know, I think she qualifies as a, as a nursing care expert.

Now, you're gonna get to make all the hay you want to---

MR. TANNER: Yes, sir.

THE COURT: ---off that -- other than that. But I, I -- I'll qualify her for nursing care, but that's, that's it. Not neonatal or anything like that.

MR. KRELL: I mean that's fine, Your Honor. I appreciate it.

THE COURT: All right. Let's see.

Oh, had, had y'all got the photographs?

MR. KRELL: I didn't mark anything until we made all these rulings. I've got stickers on everything, but I just kept them all blank until we --

THE COURT: Okay.

MR. KRELL: -- kind of figured all this out through trial.

THE COURT: I, I saw four pictures.

Do y'all -- you've got it?

MR. KRELL: Yes, sir.

THE COURT: Are they marked?

MR. KRELL: I don't have them marked. I've got two photographs, Your Honor.

THE COURT: Aren't there four, four photographs?

MR. KRELL: I may of sent four. I know I've got three. One, one, Your Honor, and I've got smaller ones. Here are

the small ones if you want it. These are the three, Your Honor, that we want---

THE COURT: Well, can you -- let me, let me hold the ones that, that I can hold if you don't mind --

MR. KRELL: Okay.

THE COURT: -- if you don't mind.

Which are the three that you want---

MR. KRELL: I mean I've just got to fill them out, Your Honor.

THE COURT: Yeah. Okay.

MR. KRELL: This was the first one.

THE COURT: Yeah, just get them -- put them down there. I want to get -- at least put an identifying number on them.

MR. KRELL: Okay.

THE COURT: So, on the record, they'll know what I'm talking about.

(Pause.)

THE COURT REPORTER: One, two, three for ID, Judge.

THE COURT: All right. And -- okay. All right. All right. Yes, ma'am, I want you to look at those if you don't mind.

(Pause.)

THE COURT: Okay. And those -- and, and, and just for the record, we've got three photographs that are identified as Plaintiff's 1, 2, and 3 just for purposes of

identification, and you've got those three blown-up?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: And I'll show them to---

THE COURT: No, no, no.

MR. KRELL: If Michael wants to --.

THE COURT: Okay. All right. Plaintiff's, Plaintiff's marked for Exhibit 1 is a picture of the minor Plaintiff's hand showing the open wound.

Is that correct, Mr. Krell?

MR. KRELL: Yes, sir.

THE COURT: Okay. And you -- you're gonna have somebody who can identify that all three of these are true and accurate reflections?

MR. KRELL: I believe Ms. Hamilton will be able to do that.

THE COURT: Huh?

MR. KRELL: Ms. Hamilton, the---

THE COURT: Okay.

MR. KRELL: ---child's mother.

THE COURT: All right. All right. And, Mr., Mr. Tanner, your objection?

MR. TANNER: Is, is cited in our memo that we sent you last week. Obviously there's -- they're, they're inflammatory. They're sort of graphic. There's no scale on

them. The child's hand is obviously no where near the dimensions that it is on those photos.

I suspect, on the blowup, it's probably gonna look even bigger and greater. We're talking about a 30 day old infant at the time that this event happened. And, and without any reference to scale and reference to depth in, in what all happened, is -- all it's gonna do is just arouse the prejudice of, of the jury.

Certainly, number two, is a photograph after her scar, which sort of looks like the photograph that was done in the independent medical examination. But certainly one in three, again both of those are sort of enlarged to show well beyond what the child's hand would look like at the time. It's impossible -- it's gonna be impossible -- I think it's gonna be impossible for the jury to differentiate that from how small the child's hand was, and truly how small this wound was at the time. And, and there's just no probative value of sort of these open flesh wounds, and, and any probative value I think is -- clearly goes over any sort of -- the prejudice is way, is way greater to the hospital than any probative value that they have.

If the child's gonna testify, it's -- certainly they can identify him. So, it's not like they need the photographs to identify who it is, and, again, it's just not -- without any scale, without anything, it's really not

representative of, of what happened here.

THE COURT: Yeah, just for---

MR. KRELL: Your Honor?

Your Honor, I, I believe that in one of the photographs, if not both, I -- we chose those specifically out of all the ones you saw because there's a adult hand in the picture. I don't know what he's talking about with scale, but one of them has an, an adult hand that it's in the photograph. That's why we---

THE COURT: One, one and two have an adult hand, and, and three has part of an adult hand, and it -- and three is a little bit blurry. I mean---

MR. KRELL: Yeah, it's---

THE COURT: I mean---

MR. KRELL: But, Your Honor, that's what it looked like.

THE COURT: No, I, I---

MR. KRELL: You know, and so he wants to kind of have his cake and eat it too. He, he doesn't -- he says it's prejudicial, but that's what it looked like.

THE COURT: No, and, and I understand, and, and you don't need to really go into any more---

MR. KRELL: Yes, sir.

THE COURT: ---argument. I -- you know, here's the way I look at it is I've got three pictures. I don't think I --

whereas I guess it would be handy having a, a ruler in there, I, I don't think that any of the jurors are not gonna have some idea of, of the size of a child's hand, and I think, I think most of the jurors are gonna be familiar with what -- to me, what you're looking at is just the, the size of the injury in relation to the size of the hand.

And if I've got somebody that says it's a true and accurate copy of it, and we're not doing too many of them, actually I was worried that they may be trying to put in many more pictures of this. But I think this is a representative sample. I think, if somebody testifies it's true and accurate reflection of the child's condition, then I'm, I'm gonna let it in.

I'm gonna note your objection for the record, sir.

MR. TANNER: Thank you, sir.

THE COURT: Okay. All right. And, and so, when we go about putting it in, if you'd just remind me---

MR. TANNER: Yes, sir.

THE COURT: ---of your objection.

All right. The -- there were four or five statements that Ms. Hamilton makes that seem to be reflective of -- I, I don't know who actually spoke them.

Are you intending to get into that area of testimony?

Particularly, Mr. Krell, the way I look at it, and, and you can, you can -- we can argue it as you want to. But Ms.

Hamilton's gonna be able to testify as to what happened to the child. I don't think there's any issue from the Defendant that, that the infiltration is because of this. Nobody else put it in.

There's no testimony that Mrs. Hamilton messed with it, is there?

MR. KRELL: No, sir.

THE COURT: I mean it's just a matter of whether or not the nurse did. So, I'm really -- my general thoughts is, is there's no reason to muddy the record, and here's the gentleman right now.

Is that Mr. Ham --[redacted]

UNIDENTIFIED SPEAKER: Uh-huh. (Affirmative).

MR. KRELL: That's R.J.

THE COURT: All right. Glad to have him here.

Now, he's not gonna -- how, how are y'all gonna handle him being here during---

MR. KRELL: I thought we'd introduce him to the jury, show the jury his scar maybe at the beginning, and then Ms. Hamilton's sister's here to take him back---

THE COURT: How's that---

MR. KRELL: ---to school and then maybe, at the end of the case, we'll get him back.

MR. TANNER: That's fine with me, Judge.

THE COURT: Okay. All right. Okay. Let's -- that,

that way he'll be here and -- but I, I really just didn't think he'd be good to be in here for the whole trial.

MR. KRELL: No, sir.

THE COURT: Okay. Anyway, my, my thought is that just messes the record up. I don't---

MR. KRELL: We'll stay away---

THE COURT: You tell me.

MR. KRELL: We'll stay away from it.

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

Is that everything?

Y'all look through there.

(Pause.)

THE COURT: On conformed -- informed consent issue.

Okay. I think -- go ahead. You --.

MR. KRELL: Your Honor, I've, I've been through the records. I haven't seen the documents yet. So, if there's anything in there we just would move to exclude. But -- that there's any --.

THE COURT: Well, I'd, I'd like for you to look at it so we can---

MR. KRELL: Yes, sir.

THE COURT: ---and then we can discuss it before we get into any argument about that.

MR. KRELL: Okay.

THE COURT: Okay. All right.

MR. KRELL: Unless, of course, Mr. Tanner consents to it, it's not coming in---

MR. TANNER: No.

MR. KRELL: It's been -- I don't know.

THE COURT: I mean I, I---

MR. TANNER: I mean it's, it's part -- again, it's part of our defense that's, that's part and parcel of an IV is an infiltration. So, I, I certainly can't consent to it, and there's gonna be replete testimony from the nursing experts. In fact, even Plaintiff's expert concede -- I think she calls it a potential risk of the procedure. But it's, but it's clearly a risk. So, it's an inherent risk in every IV.

So, I can't defend the case without that.

MR. KRELL: I'll take a look, Your Honor.

THE COURT: Okay. All right. Y'all look at that.

Now, I -- let's see. The, the, the voir dire. Oh, the -- oh, voir dire I got in my hand. Terrible place for it to be.

All right. Have y'all looked over each other's voir dire?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: We looked at it.

THE COURT: Mr. Tanner, have you had an opportunity to look over it?

MR. TANNER: I'm, I'm trying to put my hands on Mr. Krells, Your Honor.

THE COURT: Okay.

MR. TANNER: Your Honor, I think one thing. I do see Ms. Shuler's here. So, we probably need to ask if anybody -- add---

THE COURT: Oh yeah.

MR. TANNER: Add her name to it since she's gonna be sitting here through the trial.

THE COURT: All right. Yeah.

(Pause.)

MR. TANNER: I, I don't have a problem with theirs, Judge. I, I notice Mrs., Mrs. Williams is here, and certainly welcome to have her. But I think I had left her off my voir dire cause I didn't realize she was participating. So, I just want her name on there, and anyone asked if they're clients of hers.

THE COURT: Okay. And, and, Mr. Krell, something that I wasn't doing but I -- when I first started getting on the bench is, just so you'll know, is what I normally do is have you introduce your client, the other attorneys, tell something about your firm and like that. Before I start asking if anybody---

MR. KRELL: Sure.

THE COURT: ---in the jury, you know, has been

represented by, you know, you -- that kind of stuff.

MR. KRELL: Okay. Will do.

THE COURT: But I usually let you do that and let Mr. Tanner---

MR. TANNER: Sure.

THE COURT: ---introduce everybody at his table as well.

MR. KRELL: Okay. I'll go through all the members of our firm.

THE COURT: Huh?

MR. KRELL: I'll go through all the members of our firm. I don't know how---

THE COURT: I, I, I don't know that I'm gonna require you to do, do that.

Mr. Tanner, you have any problem with me not naming everybody in Mr. Krell's firm?

MR. TANNER: No, sir.

THE COURT: Okay. But you, you do need to at least tell them the names.

MR. KRELL: I'll tell them the name. I'll tell them to make sure that I work with my dad.

THE COURT: Okay.

MR. KRELL: He's the only living one on the name met -- on the name letterhead, Your Honor.

THE COURT: Is he really?

MR. KRELL: It's Uricchio Howe and Krell, but Mr. Uricchio and Mr. Howe have been gone for a little while.

THE COURT: Oh, I did not -- you know, I'm sorry. I did not realize that.

(Pause.)

THE COURT: Anything else that y'all believe we need to go over?

Well, let -- going back to the voir dire, let me just mention, Mr. Tanner, Number 10, on yours.

MR. TANNER: Yes, sir, I think that was -- there was some talk, you know, within the last year or so, with the transformation of the hospital, there was some talk in the community that the hospital might be sold, and, and that was sort of geared at that. But if you're uncomfortable with that, I'm---

THE COURT: I am.

MR. TANNER: It's not gonna be the hill I'm gonna die on.

THE COURT: Okay.

MR. TANNER: I'll withdraw that.

THE COURT: All right. Thank you, sir.

All right. Anything else, gentlemen, or lady, that y'all think y'all -- I should go into?

MR. KRELL: I can't -- I think we've agreed on a lot of the things we might want to have---

THE COURT: Yeah. Now, if y'all want to go ahead and let's mark the exhibits now so we can move along. That'd be great. Hilda would appreciate it. I would too.

And, Hilda, here's 1, 2, and 3, and they're gonna be in over, over---

THE COURT REPORTER: Mr. Tanner's objection.

THE COURT: All right.

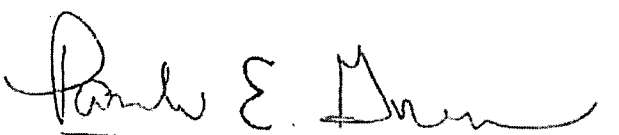
* * *END OF REQUESTED TRANSCRIPT OF RECORD* * *

CERTIFICATE

I, Pamela E. Green, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Orangeburg County, South Carolina, on the 7th day of May, 2018.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

December 22nd, 2020



PAMELA E. GREEN, Court Reporter

2015-CP-38-01234

Tekayah Hamilton, individually and as Parent Guardian Ad Litem for Robert Lee M. Jr.,

Plaintiff,

v.

The Regional Medical Center,

Defendant.

Transcript of Record

May 7 - 9, 2018
Orangeburg, South Carolina

B E F O R E:

The Honorable Edgar W. Dickson, Judge

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

David Williams, Esquire
Jenny Williams, Esquire
Jonathan Krell, Esquire
Attorneys for the Plaintiff

Michael Tanner, Esquire
Attorney for the Defendant

Hilda M. Jordan, CVR-M
Circuit Court Reporter

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EXHIBITS:

FOR THE STATE:

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(Court in session May 7, 2018 at 11:15 a.m.)

THE COURT: All right. Ladies and gentlemen, we're getting ready now to pick a jury in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for [redacted] -- and that's -- it's [redacted] -- right?

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. -- Jr., a minor under the age of eighteen. They are the plaintiffs. The defendant in this case is The Regional Medical Center.

The plaintiffs are represented by Mr. Krell and Mr. Williams. And one of y'all -- I need for y'all to introduce -- yeah, Mr. Krell.

MR. KRELL: Thank you, Your Honor.

THE COURT: Yes, sir.

MR. KRELL: I'm Johnny Krell. I'm from Charleston. I practice law in Charleston with my father, at the Law Firm of Uricchio, Howe & Krell. I have the pleasure of representing Ms. Tekayah Hamilton and her son, [redacted] who I believe most of y'all saw earlier. Sitting beside me is David Williams. You may see his wife, too. Virginia Williams, Jenny Williams, who practice locally at the Law Firm of Williams and Williams. Thank you.

THE COURT: All right. And Ms. Hamilton, could I

MR. KRELL: Yes. I think Your Honor, we've agreed to enter in the photos in? Excuse me, not the photos, the medical chart?

MR. TANNER: Correct.

MR. KRELL: We've agreed to enter the wound care chart?

MR. TANNER: We've agreed policies and procedures -- to the key pieces of evidence and I'll get the photos into evidence.

THE COURT: Okay. All right.

MR. TANNER: And I think we've also talked about earlier about a stipulation. Obviously, they brought this case a personal tort claims act. I think clearly the Court can take judicial notice The Regional Medical Center is a government hospital owned by Orangeburg and Calhoun County, so I ask you to take judicial notice of that fact. I think Mr. Krell's in agreement to that.

THE COURT: Okay.

(Off the record discussion)

MR. KRELL: Your Honor, I know in reviewing Mr. Tanner's charge that the standard -- is gross negligence standard.

MR. TANNER: That's what the law is.

MR. KRELL: And, you know, we have researched Fletcher (sp) verse MUSC. I've got the case, Your Honor, I

can pass up, wherein the standard is just a heightened standard of, breach of a standard of care for a doctor. I think it would transfer to a nurse. There is not a gross negligence standard in this case. It would just be the typical med mal standard that you hold a doctor or a nurse to.

THE COURT: Well, if y'all would give me the case law.

MR. TANNER: And I don't disagree, but if you want, I won't bring that up in my opening if that's what y'all are asking?

MR. KRELL: Yeah. Sure.

MR. TANNER: I don't have a problem with that.

THE COURT: Okay.

MR. WILLIAMS: We just think it's a better thing, Judge to address as we're prepared --

THE COURT: No, no. I'll agree. I'd like to see the case law so I know how we're going to address it at that time, okay?

Okay. Anything else we need to address.

MR. WILLIAMS: Nothing.

MR. TANNER: No, sir.

THE COURT: All right. We'll thank y'all. If y'all will be back here at 1:30, we'll get started.

(Court in recess for lunch break at

12:15 p.m.)

(Plaintiff's Exhibit No. 1, photo, was marked for ID.)

(Plaintiff's Exhibit No. 2, photo, was marked for ID.)

(Plaintiff's Exhibit No. 3, photo, was marked for ID.)

(Plaintiff's Exhibit No. 4, medical records, was marked for ID.)

(Plaintiff's Exhibit No. 5, intravenous therapy manual, was marked for ID.)

(Plaintiff's Exhibit No. 6, office visit records, was marked for ID.)

(Plaintiff's Exhibit No. 7, medical bills, was marked for ID.)

(Plaintiff's Exhibit No. 8, Dr. DeVito office notes, was marked for ID.)

(Defendant's Exhibit No. 1, Davis letter, was marked for ID.)

(Defendant's Exhibit No. 2, Hand photo, was marked for ID.)

(Court in session after lunch break at 1:30 p.m.)

THE COURT: All right. And Mr. Love was sitting in the right place. Juror No. 106 is our Foreman, okay?

(Court's Exhibit No. 1, note selecting Juror No. 106, John Love as foreperson.)

THE COURT: All right.

Is the plaintiff ready?

MR. KRELL: We are ready and we've got some housekeeping matters that I think we have agreed to.

THE COURT: Oh, okay.

MR. KRELL: And we've agreed to Exhibits 4, 5, and 6, which was -- 4 is the medical chart from The Regional Medical Center; 5, is the policies and procedures; and, 6 is the wound care records that'll come into evidence.

MR. TANNER: That's correct. That is correct.

THE COURT: What was the last thing?

MR. KRELL: No. 6 was the wound care records, from the follow-up care from the initial admission.

THE COURT: Okay. And 4, 5 and 6 are in without objection.

MR. KRELL: Yes, sir.

COURT REPORTER: So that would be 1 through 6 in without objection?

MR. KRELL: If Michael would have agreed to those pictures. I'd appreciate it, but --

THE COURT: I think the pictures are in over his objection.

MR. TANNER: Correct.

COURT REPORTER: All right.

THE COURT: Based on my ruling earlier, okay? Okay.

MR. KRELL: So they're in Your Honor?

THE COURT: Yeah. They're in, assuming someone testifies it's a true and accurate reflection of the way that they looked at the time.

MR. KRELL: Yes, sir.

THE COURT: Yeah, which I anticipate that, but --

MR. KRELL: Yes, sir.

THE COURT: Okay.

(Plaintiff's Exhibit No. 1, photo, was marked and entered)

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

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

(Plaintiff's Exhibit No. 4, medical records from TRMC, was marked and entered)

(Plaintiff's Exhibit No. 5, intravenous therapy manual, was marked and entered)

(Plaintiff's Exhibit No. 6, office visit records, was marked and entered)

(Off the record discussion between the Court and the bailiff)

THE COURT: No, no. You go ahead and put the alternate that's going to sit with the jury is Ms. Guillard, okay?

THE BAILIFF: Okay. Thank you.

THE COURT: Okay. All right.

All right. Y'all ready for me to bring the jury in?

MR. TANNER: Yes, sir.

THE COURT: You ready?

MR. KRELL: Yes, Your Honor.

THE COURT: Yeah, bring the jury on in, please?

THE BAILIFF: Yes, Your Honor.

(Jury in at 1:40 p.m.)

THE COURT: Congratulations.

FOREMAN: We look forward to it.

THE COURT: All right. Ladies and gentlemen, I hope y'all had a good lunch. We're going to get ready to start the trial now. I always sometime worry about my opening remarks when we start the trial right after lunch because they're not as entertaining as the attorneys remarks are going to be, but y'all need to pay attention to them just as if I was one of the attorneys in this case.

The first thing that's going to happen is that the attorney for the plaintiff, that's the person who brought this lawsuit, will make an opening statement, which will be followed by a similar statement by the attorney for the

defendant. These opening statements are not arguments. The arguments will come at the conclusion of the trial. The purpose of the opening statements is to give the parties

You know -- we haven't sworn them, have we.

THE CLERK: No.

THE COURT: No, we got to do this right. Remember, I told y'all I get a head of myself sometimes? This is one of those times I'm ready to get going. Y'all have got to be sworn in as jurors before we start this case. So I need for y'all to stand, raise your right hand and the clerk's going to swear you in.

(The jury was duly sworn)

THE COURT: Thank y'all. Y'all may sit down. Now, don't forget anything I've said already. I'm going to pick up where I left off, okay?

The arguments will come at the conclusion of the case. The purpose of the opening statements is for each party to outline their claims or defenses and the evidence they intend to present in support of those claims or defenses. Following the opening statements, each side will present its evidence with the plaintiff once again going first. Evidence may take many forms. It may be testimony, documents, models, photographs or the like. Please pay close attention to all of the evidence presented by each party.

You, the jury, are the sole finders of the facts in this case and no one else is permitted to weigh the evidence and render a verdict upon it, except you. After all of the evidence has been presented, the attorneys will make their closing arguments. Unlike these opening statements, these final remarks are truly arguments, that is, each side will emphasize certain portions of the evidence and try to persuade you to agree with their version of the facts. Keep in mind that the opening statements as well as the closing arguments of the attorney are not evidence in this case. Give the attorneys your undivided attention, but keep in mind that what they say is not evidence.

After the arguments are finished, I will explain the law which you are to apply in this case. You will then retire to the jury room to consider the facts and the law. Once you have done so, you'll return a verdict in favor of one side or the other.

During the course of the trial, the plaintiff has the burden of proving her claims and must meet that burden by proving those claims by the greater weight or preponderance of the evidence. What we mean by the greater weight of evidence can be illustrated by imagining a traditional set of scales. And y'all have all seen those. Lady Justice holding the scales, they're evenly balanced. When the case begins, the scales are even. After all of the evidence has

been presented if the scales remain evenly balanced or if they should tip even slightly in favor of the defendant, then the plaintiff will have failed to meet her burden of proof and your verdict would be for the defendant. On the other hand, if the scales should tip even slightly in favor of the plaintiff, then she will have met her burden of proof and your verdict should be for the plaintiff.

As I mentioned earlier, although I am the only person who can tell you what the law is, you are the only ones who can determine the facts. I do not have the right to indicate how I might feel about the evidence presented. Excuse me. I do not have the right to indicate how I might feel about any of the facts.

Throughout the trial, it is my intention to act impartially toward each party. It is also my duty to rule on the admissibility of evidence. There are certain rules that both sides must obey in presenting evidence. These rules have a definite purpose. They ensure that the information you received is the most trustworthy and reliable evidence available. An objection is a procedure that is used for an attorney to call a possible violation of these rules to my attention. For this reason, you should not hold an attorney's objection against him or his client, nor should you conclude from my ruling on the objection, that I favor one side over the other.

I remind you to pay close attention to all of the evidence presented to you. It is you, the jury, who will determine the facts in this case. As a result, you will have to evaluate the credibility, and that simply means the believability, of each witness who testifies. After doing so, you will be prepared to render a just and fair verdict in this case.

All right. Now, Mr. Williams, you're going to give the opening statement?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: All right.

MR. WILLIAMS: May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S OPENING STATEMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, Mr. Foreperson, my name is David Williams. I'm an attorney here in Orangeburg. I practice at the law firm of Williams and Williams. There are seven attorneys at our law firm. Our law firm was started by my granddad, the late Marshall Williams and my dad, Charles Williams, and my mother the late Karen Williams. My dad still practices with me, my brother Charlie, who's appearing to be hiding behind the pole, he practices with me. My wife is an attorney, Jenny, who is seated with us here today. And we also have Senator Hutto

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MR. WILLIAMS: May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S OPENING STATEMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, Mr. Foreperson, my name is David Williams. I'm an attorney here in Orangeburg. I practice at the law firm of Williams and Williams. There are seven attorneys at our law firm. Our law firm was started by my granddad, the late Marshall Williams and my dad, Charles Williams, and my mother the late Karen Williams. My dad still practices with me, my brother Charlie, who's appearing to be hiding behind the pole, he practices with me. My wife is an attorney, Jenny, who is seated with us here today. And we also have Senator Hutto

and Senator Hutto's son, Skyler. We have Russ Blanchard. It's occasionally our opportunity to work with other attorneys. In this case, I get work with my friend Johnny Krell who you met earlier.

We have the privilege of representing Ms. Hamilton, Tekayah Hamilton and her son, [redacted] who we refer to as R.J. They have a claim that they're here before you and you're our jury. What does it mean to be a jury? I would tell you that jury service is probably second to only one thing, that's service in the armed forces, okay? There is nothing more important to our democracy than having the ability to have a group of our peers, a group of people from our community, make the decision what's right and what's wrong.

You're going to hear a lot of things that are going to be presented. You're going to hear witnesses that are going to present different pieces of evidence. Your job as a jury is to determine what are the facts. You heard the Judge say he's going to tell you about the law, but you can pick -- you can determine what are the facts, and how do I apply these facts to the law that he told me.

What you've got to understand is burden of proof. You know, I think everybody wants to think, by what we've seen on TV, where we hear these criminal cases. This isn't criminal court. We're in civil court and like the Judge

said, it's just Lady Justice with even scales and whoever tips it slightly their way wins. And it's our burden to tip it slightly our way.

I like to reference it like a football, because I know football and I feel like most people understand football. It's like playing football except we're receiving the ball on the fifty yard line. We don't have to score a touchdown. We just have to keep the nose of that football ever so slightly beyond the fifty yard line.

What happened in this case? What brings us before you today? You're going to hear my client, Ms. Hamilton. She's going to present how she had a one-month old at the time of this incident. That one-month old had a one hundred and two degree fever. At a hundred and two degree fever, she did what any mother would do, seek medical care. She came to The Regional Medical Center in hopes that they would help her do two things; one, monitor him; and, two help him reduce that fever. Help her reduce that fever.

Unfortunately, what you're going to hear about is poor R.J. came in with a fever, but left permanently disfigured. You're going to hear how that happened. You're going to hear the rules that apply, and you get to decide whether someone broke the rules. You're going to hear someone tell about the different rules they want to -- exist, that maybe you don't see on paper. It's your job to make that

determination. It's our job to make the allegations, but it's your job to make the determination. And I want you to hear and listen to this lovely woman tell you about what happened. I want you to hear our experts. I want you to listen to what they say. And at the end, I think it's going to be clear to you. I think you're going to understand what happened.

Now, what do we want you to do about this? It's easy -- you've heard -- I guess, somebody asked do you have a problem making a monetary award on a case. We'll we're not in criminal court. Nobody's going to jail. There's no way we can cause anybody any kind of -- anything other than put a dollar figure on it. That's what we're here today to do.

Well, why do you have mother and then the three-year-old today that you saw in the courtroom who you'll see again. Well, mother's got to bring both of their claims. Mother's claims is for one thing, right? The cost associated with her child's care. And that cost is not only the cost that she had due to the initial care, but up until the child's eighteen, up until this child's out of the house. You're going to hear what benefit there is to try to make this disfigurement less and you're going to hear recommendations. The ultimate victim in this case, R.J. R.J.'s the one who's wearing this disfigurement the rest of his life. R.J.'s the one that was in pain. R.J. was the

one that suffered. R.J. is going to be asking, through his mother, through us, for pain and suffering, for loss of enjoyment of life, for value for this permanent disfigurement. I think the hardest thing about our job is trying to explain what that is. And often, you know, it's easy to put medical bills in front of you. It's easy to talk about what experience has happened. It's hard to tell you how to think about the experience going forward. And as I thought about it, you know, it's easy to think about myself. You know, what -- I think everybody's got something they're self-conscious about, something that they notice about themselves. Mine's my front two teeth. My brother over there chased me around -- I was wearing socks as a little boy and I slipped and I chipped out ninety percent of those front two teeth. And you can look at them and you might say they don't look like a big deal to you, but it's been a big deal for me my entire life. I initially -- the feeling of having something foreign in your mouth every day. Then it became -- now, as I get older, I find myself brushing my teeth with baking soda trying to keep the other teeth to match the front two teeth. I do remember in college, I went -- you probably think this is the least of my problems being where I was, but I was at a dance and they had black lights. And I'll never forget my date looked at me, what's wrong with your teeth. Oh, these two glow.

These two fake teeth they don't glow. They looked very odd and I felt that. And I'll use another example. I've got a friend Paul. Paul's got a disfigured hand. It's his right hand. Paul is in his fifties. Still to this day, you see Paul in a picture, his hand is in that pocket. You see him and he's behind somebody else. You don't see Paul expose that hand in those photographs. You don't see Paul eager to come up and shake your hand, how you doing? I'm Paul. He doesn't. If you go and introduce yourself he's going to shake your hand, but you can tell he's self-conscious. I don't know what happened to Paul's hand. I know that it happened when he was too young to remember. But what's different, we know what happened to R.J.'s hand and we know who caused it.

So we're going to be talking a lot about how do you put a dollar figure on that in this case? And I want you to think about that. This case is going to be pretty short. We think we'll be finished with this case today but for one witness tomorrow. That doesn't mean that it's not a serious case. I ask that you listen to us, you listen to all of our evidence. At the end of the day, that football is going to be well past that fifty yard line. Thank y'all for being here. Thank you for your service.

THE COURT: Thank you, Mr. Williams.

Mr. Tanner?

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

MR. TANNER: We're going to set up the easel, Your Honor.

THE COURT: Okay.

(Mr. Tanner sets up easel)

MR. TANNER: Can y'all see that?

DEFENSE'S OPENING STATEMENT

BY MR. TANNER:

Thank y'all for being here. Again, my name is Michael Tanner, I'm a lawyer from Bamberg. I represent The Regional Medical Center. It's been my privilege to represent the hospital. It's been my privilege for years to represent the hospital. Again, with me is Ms. Glenda Shuler. She's a director at the hospital, Joseph Shakibanasab, a lawyer in my office.

I know that -- I feel certain that there is somewhere else that all thirteen of you now would most rather be, whether that be work, whether that be with your family, but this is the most important time for you to be here with us because you are the finders of fact. You are the jury of the facts in this case, as the Judge has explained to you. This case, again, as Mr. Williams said involves a child, [redacted], and his mother, Ms. Tekayah Hamilton. Ms. Hamilton back, when he was thirty days old,

noticed that he woke up with a fever of a hundred and two point six, an acute onset fever. As Mr. Williams said she did an admirable thing, which most parents would do, she took him to the doctor. She took him to the doctor over at Santee Urgent Care. They realized the severity of his fever, the potential medical issues associated with that fever, and they arranged for what's called a direct admission into the hospital, The Regional Medical Center, which is owned by the citizens of Orangeburg and Calhoun County. It's been the only hospital here for years. And [redacted], again that day was thirty days old. He was admitted under Dr. Megan Bolton. And Dr. Bolton admitted [redacted] for potential sepsis.

In this case you're going to hear a number of medical terms you may or may not know. You may or may not have any foundation, but what sepsis is, is sepsis is a potentially fatal medical condition that starts from an infection, and then when the body responds to fight that infection, it can produce different bacteria and basically the body almost cannibalizes itself. So it is a serious, serious disease. Sepsis has really emerged, you'll hear evidence in the last ten years -- people, physicians, practitioner's have a better understanding of what it is. But it's not something that you want to wait around and confirm a diagnosis.

So what Dr. Bolton did that night on October 25th,

2014, is she recognized the seriousness of this potential sepsis and she ordered treatment. And that treatment plan consisted of IV antibiotic medicine, what the literature called -- and you'll hear witness testify -- empiric antibiotics. And what that is, is that's a broad range of antibiotics that fight multiple diseases. The way that you diagnose ultimately sepsis is by blood tests. And so those tests take time for those cultures to grow out. So rather than wait a couple of days to see does he have sepsis or not, you start treating that condition. Obviously, being [redacted] young age, you treat him with IV antibiotics. He's not old enough to swallow medication. He can't take pills. That is the best and most direct route to treat that infection, and that is what Dr. Bolton did. And this case essentially ranges from October 25th through the night of October 27th. [redacted] has these medicines -- infusion. You'll hear testimony from witnesses about pediatric IV's and the maintenance and monitoring of pediatric IV's. But basically, you can almost fast forward ahead to October 27th, 2014, the night shift, 7:00 p.m. at night to 7:00 a.m. in the morning. And that was when nurse Jamie Downing comes in. And you will hear evidence from the jury, and as you see it here what Nurse Downing did initially was assess the IV. Again, that may be a foreign concept to a number of you, but based on what you do as

she's documented, you'll hear evidence that she assesses that. She noticed that the IV is in the right hand. She checks the condition of the site. There's no complications. It's not draining, infiltration score. You're going to hear the word infiltration a number of times in this case. And the infiltration score at the beginning of her shift is zero. She assess the dressing and the activity. The dressing is dry and intact. It's a transparent bandage. The flow and patency. No complications. Again, patency is an important medical term that you're going to hear about. That is how the IV is flowing. You're going to hear a number of witnesses testify to flushing the IV. That is to make sure that you can get medicine through that IV. You're going to hear that a number of times and it's important to note when this assessment was done, there was no complications. And then you're going to hear about what equipment she used and that's an extension set.

Obviously, [redacted] Jr. being a very, very small child at that time, had very small hands. Again, you're going to hear witnesses testimony that it was a 24 gauge needle that was put into his hand and then the extension set ran from that hand and the medicine was infused through a syringe pump. You're going to hear witnesses testify that at the hospital -- and not just Orangeburg, most hospitals -- you want to assess your

patient's IV approximately every hour. You're not always going to be an hour. Sometimes, you're going to be a little bit longer. In a perfect world, it would always be an hour, but that's not the world we live in. People have other patients. People have other things going on in the hospital. But basically, what you're going to see is you're going to see that throughout this period of time, these hourly assessments were being done. And they're being done starting, again, at 19:44 and all throughout the evening and into the next morning and at 4:04 in the morning, it was about time for ampicillin to be given. Nurse Downing again -- you're going to hear evidence -- assessed his IV, infiltration score zero. You're going to hear a number of witnesses testify about literature and what the literature said. Basically of nurses, they testify based on their knowledge, their training and their experience, things they learned in school, things they learn in practice and then things that other people, other professionals write about to show what the best practices are. And you're going to hear that an infiltration score of zero, that is the score that you want. Phlebitis score, zero. Phlebitis is another type complication you can have from IV's. You're going to hear when that medicine was administered, shortly thereafter at 4:27, Nurse Downing would reassess the IV, but she didn't document it again. And I'm not going to stand up here and

tell you that she did. Because the reality is you cannot possibly document everything you do. But she assessed it at 4:04. And she could not have given his medication unless she assessed it again at 4:27. It's going to be up for you to evaluate her credibility. She's going to be here tomorrow. She's going to testify and y'all will be able to hear her.

You're going to hear from a number of other witnesses as to what Mr. [redacted] happened when he had an IV infiltration. And one of those witnesses is a lady. Today, Ms. Monica Stobbs, who's present in court. I anticipate she's going to testify here shortly before y'all. And she is going to testify regarding if IV and IV medication administration. Nurse Stobbs, interestingly enough, never practiced pediatric medicine. She's not going to be able to get up there and tell you with her hand on the Bible that she's ever started an IV for a pediatric patient. She's not going to be able to get up there and tell you that she's ever -- has any personal experience monitoring an IV ???. And she's going to tell you -- when I took her deposition what she told me is that she didn't review any of this literature that says these are things that you look for. These are the things to expect. Nurse Stobbs, you're going to hear a lot again about that size of that needle, that 24 gauge needle. And Nurse Stobbs is going to tell you, I

suspect, like she told me numerous times, that you have to get a blood return with that needle. You're going to hear a number of witnesses testify there that's going to tell you that that is simply not true. The literature says you can't always get blood return.

Remember what we were talking about earlier, flow and patency, that is not the accurate method to determine if that IV is flowing properly. And I think the reason why you're going to hear that from Ms. Stobbs is because, again, she hasn't practiced pediatric nursing. You're going to hear from Jamie Downing.

You're going to hear from my expert, who both have done that and who both practice in that. So you're going to be able to, again, evaluate what they tell you. They're going to evaluate what the literature tells you, and then y'all can make an informed decision. Again, [redacted], he did suffer an infiltration. Again, I think if Ms. Stobbs would have read some of those literature, she would know the following things, again, talk about the 24 gauge needle. But she would also know that the data showed that an IV infiltration can occur between twenty-three and seventy-eight percent of the time with an IV, that it is an inherent risk of everyone getting an IV, that you may have an infiltration. The reality is, [redacted] had one. He received treatment in

the hospital for wound center. He was discharged on October 30th. Thankfully, those blood cultures grew out negative. He did not have sepsis. He left the hospital. He left the hospital with his mother. He has had additional wound treatment at TRMC wound center for a short period of time in 2015. And then he saw a plastic surgeon, Dr. DeVito in Charleston. Dr. DeVito saw him twice in 2015, in February of that year and then in March of that year. And, again, R.J. has a scar. You're going to see pictures of that. I'm sure he'll probably get up and show it to you. And Dr. DeVito, you're going to hear him testify that there were steroid injections that R.J. could have had that would have potentially flattened that scar, reduced it a little bit at a time. For whatever reason, he hasn't had those. You're going to hear from another doctor via deposition testimony, Dr. Davis, who the Court appointed as an independent medical examiner. You're going to hear that Dr. Davis conducted his own independent exam of the child in March of this year and issued a report. And that report showed that R.J. has a well-healed scar. He, again, could benefit from steroid injections. You're going to hear him testify under oath that if he'd had those injections, the scar probably today would be not as thick, wouldn't be as flat. Potentially, there is a surgery that he may have, but no one can say whether or not that surgery would ultimately fix the scar.

Most likely, he's probably just going to have the scar. But thankfully what Dr. Davis is going to testify that you'll hear, that he doesn't have any functional limitations. He's a young child. He can write his name. He can draw. He can throw a ball. He can catch a ball. He can play the piano. He can do the things that normal children can do. And it's not anticipated he is going to have any functional limitations in the future. He can make a fist. There's no tendon rod deformities. He can use his fingers as they are, although, again, he has the scar. No one's disputing that he doesn't have a scar. But what we are disputing is that the nursing staff and The Regional Medical Center are the cause of that scar.

And at the end of the case as Mr. Williams said, he's going to stand up here and ask y'all for money. I'm going to stand up here and I'm going to ask you to return a verdict in favor of The Regional Medical Center. I don't have the burden of proof. I don't have to put a single witness up there. The plaintiff has the burden of proof. I ask you to listen to all of the evidence, take your time and render a true verdict, which I feel at the end of the case will be for the hospital. Thank you.

THE COURT: Thank you, Mr. Tanner.

Is plaintiff ready to call it's first witness?

MR. WILLIAMS: Yes, sir, Your Honor, we'd call

Monica Stobbs.

THE COURT: Okay. Ms. Stobbs.

Ms. Stobbs, if you'd come right up there. And I'm going to let you put that heavy thing down first.

THE WITNESS: All right.

THE COURT: All right. And then if you'd put your left hand on the Bible.

THE WITNESS: (Complies)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

THE COURT: And the clerk's going to swear you in.

(WHEREUPON, Monica Stobbs, was duly sworn)

THE COURT: Okay. Ms. Stobbs, you're going to need to speak louder, more loudly than that. If we need to pull the chair up or -- I'm sure you can talk louder?

THE WITNESS: My name is Monica Stobbs.

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

All right. Mr. Krell.

MR. KRELL: May it please the Court, Your Honor.

THE COURT: Yes, sir.

MONICA STOBBS - DIRECT EXAMINATION

BY MR. KRELL:

Q Good afternoon. How do you do?

A Good, thank you.

Q Tell us, what you do for a living?

A I've been a nurse for over thirty years for -- until 2015, I practiced actively in a hospital. For twenty-one years I worked at Massachusetts General Hospital in Boston, which is Harvard's Hospital. It's the number one hospital in the country. Prior to that, I worked at Cornell Medical Center in New York City. That's typically rated the number -- in the top ten hospitals in the country. I practice trauma surgery at Massachusetts General Hospital. Primary care, that would be -- one of the components was IV therapy. I was certified in IV therapy at Massachusetts General Hospital as well.

Q Where did you grow up?

A I grew up in southern Illinois. Right outside of St. Louis, Missouri.

Q Where did you go to college?

A I went to Creighton University in Omaha, Nebraska.

Q And did you do a nursing degree at Creighton or --

A Yes. I got a four-year nursing degree at Creighton University, a bachelors of science.

Q And how many IVs do you think you've administered over your career as a nurse?

A Thousands. The primary care for the patients that I have managed has involved IV therapy.

MR. KRELL: At this point, I'm going to introduce

Ms. Stobbs as an expert in nursing.

THE COURT: You said an expert in nursing?

MR. KRELL: Nursing.

THE COURT: Okay.

MR. TANNER: Subject to my prior objection if you'd note that for the record, Your Honor.

THE COURT: All right.

Ladies and gentlemen of the jury she has been qualified as an expert in nursing. And I just tell you a little something. Normally, a person cannot give opinion testimony. Normally, when a person testifies, they must testify as to what they either saw, heard or sensed by smell or something of that nature. However, there is an exception when someone is qualified because of education or experience. They are permitted to give their opinions in certain areas if the Court qualifies them that way. This witness has been qualified in the area of nursing care and may give an opinion in that area. It is evidence for you to use in any way that you see fit.

All right. You may continue.

MR. KRELL: Thank you, Your Honor.

THE COURT: Thank you.

BY MR. KRELL:

Q Have you had a chance to review documents regarding R.J.?

A Yes, I have.

Q All right. Tell the jury what documents you've reviewed in this matter?

A In J.R.'s -- you want me to go through the documents individually?

Q List them for us. Just tell us what you went through.

A I was provided the hospital record for R.J.'s hospitalization where he incurred getting a burn injury from an IV infiltrate. I also have reviewed a subsequent record for evaluation of that hand injury by a plastic surgeon. And I've also reviewed four different literature -- articles that were provided by the defense attorney on IV management. I've reviewed depositions of Nurse Downing and Nurse Craft, which are the two -- which are two -- Nurse Downing was the nurse that administered the IV antibiotic to this baby. And Nurse Craft was the nurse that was on duty just prior Nurse Downing taking over the care of the baby.

Q And were you here to -- Mr. Tanner's opening arguments, did you hear that?

A Yes, I did.

Q And Mr. Tanner spoke about the fact that you never administered an IV to a child; is that correct?

A He did say that. The four articles that he provided to us -- well, first of all, I had never given an IV antibiotic or IV medication to a baby. But the management of the IV,

the rules for management IV are exactly the same if you're a baby or if you're an adult in terms of management of a vein. It's the same safety practices that have to be put into place. And the rules are there just so that an injury to a person, whether it's a baby or an adult, doesn't occur due to improper management of that IV.

Q Thank you. And for our benefits, explain to us how you put an IV in? How do you administer the IV, the actual needle?

A So you basically, you know -- how you're putting an IV in or how you're giving medication?

Q How do you put the IV in?

A So basically, you put a tourniquet on the -- you choose the location. Whether it's an adult or a child, you have to chose the location of where you're going to put the IV. You choose the location. You have to use the antiseptic. You clean the skin. You put a tourniquet on. You clean the skin. You get the IV catheter and you insert the catheter into the vein. And once you have elicited a blood return, you see blood coming from it, you then can flush it with normal saline. And when you're flushing it, you want to watch and make sure that it's not swelling up and that it's actually in the vein and that it's patent.

Q What's a blood return?

A That's a blood return. That's right. The blood return

is what confirms that the IV is actually in the vein and that is an important finding when you place an IV.

Q Is a blood return the only item you look for when checking for patency?

A When you check for patency, it's only one item. The rules basically say that in order to make sure that the IV is patent, to make sure that it's in the vein and that the medication is going to go -- not to the surrounding tissue around where it can cause injury. The rules are that you put into place multiple different things. One is you look at the site. It's just common sense. You're going to look at the IV site and make sure that there's no redness, there's no swelling, that it looks like that there's no abnormal findings. You're going to check for a blood return. If you get a blood return, that's good. Sometimes the smaller gauge catheters do not give a blood return, but you still check for a blood return. It's one additional thing that you can do to make sure that that IV is actually in the vein. And then you flush the IV with normal saline. And while you're flushing with normal saline, you're observing to see if you have any resistance. You're observing to see if there's swelling at the site or if there's any other indication that the IV may not be in the vein.

Q Thank you. And in reviewing the records for R.J., can

you walk us through when he was admitted, and then when this incident occurred. And we can just start with when he was admitted, go through a couple records and then go to when this incident happened.

MR. KRELL: Your Honor, there's' an exhibit that we've admitted and I'd prefer --

THE COURT: You may. Yes. Go ahead.

BY MR. KRELL:

Q And here's what we've marked as Exhibit 4, which is the chart. If you could make sure that corresponds to your records and start with the first page there?

A He was basically admitted to this facility on the 25th of October with a fever. He was five weeks old at the time that he was admitted. They weren't sure of what the cause of the fever was and so he was admitted and started on IV antibiotic therapy in case he had some sort of an infection. He was administered IV antibiotics between the 25th of October when he was admitted until the 28th of October when the IV infiltrated. He had a peripheral IV that was placed in his right hand.

Q What's a peripheral IV?

A It's an IV that was placed into his right hand. It's just a short catheterizing and he was periodically given IV antibiotics.

Q And so we can give medicine through the IV. How do you

do that? Can you explain that to us?

A So, you know, again the rules for administering an IV antibiotic -- you know, a nurse's primary job is to make sure that the patients are safe. That anything that we do to them is not going to harm them. And so these are very, very simple rules that were put into place. And that is, again, before you would administer anything through an IV, you want to look at the site and see if there's any evidence of swelling. And you do this immediately before you give the drug, not twenty minutes before or twenty-three minutes before. At the time that you're administering the drug, prior to administering, at that time, you look at the site, you see if it's swollen or if it has any indication that it might be infiltrated or any indication that it may not be in the vein. Then you basically connect the -- you connect the end of the catheter to the tubing for the IV -- I'm sorry. Then you basically, you connect a syringe on the end that has normal saline in it. And you can withdraw and check for a blood return. And if you get a blood return then that would be evidence that it would be in the vein. And then prior to giving the drug, you would flush it with normal saline. And normal saline is something that if it's not in the vein it's not going to harm the area. It's likely not going to cause a burn type of injury like an antibiotic can if it's not in the vein. So you look at the site, you check

for a blood return and you flush it with normal saline prior to giving the antibiotic, and then you administer the antibiotic.

Q Let me turn your attention to the medical chart and I believe it's maybe number five on the chart in front of you or in the documents you brought, which I believe were the same. Let me turn your attention to that medical record of October the 28th, 2014 at midnight.

A Can you show me number five because that's number four?

Q Yes, ma'am.

MR. KRELL: Is that okay?

THE COURT: Yeah. Yeah.

BY MR. KRELL:

Q Does that corresponded with those documents you have.

A What was the question?

Q I'm going to turn your attention to the midnight on October 28th, 2014. Do you see that record?

A Yes.

Q And what does that record reflect?

A That record reflects that at midnight that a normal saline flush was administered through the IV.

Q And then prior to that, which would bring us back in time to 11:44 p.m. on the 27th, what was administered?

A An antibiotic.

Q Okay. Which one.

A Cefotaxime.
Q Okay. If you keep going back in time to the 11:08 note on the 27th -- do you follow me? It's right at the bottom?
A Yes.
Q What was administered?
A Ampicillin.
Q Okay. And that's actually the medication that we're talking about here today, correct?
A Yes.
Q And if you just keep going back in time, I think it'll be the next page, page six of Exhibit 4. Is the top note 8:00 on the 27th?
A Yes.
Q Okay. What was done then?
A Saline flush.
Q Okay. And then back to 5:48 p.m., what was done?
A Ampicillin.
Q All right. And then at 4:08, what was done?
A Cefotaxime
Q And that's the medication you just spoke about, right?
A Yes.
Q And what's the note right before that, the 16:07 note say?
A It says sodium chloride flush.
Q Okay. So you have a flush at 4:07 p.m.?

A Yes.
Q And then what happens?
A Then the antibiotic is given one minute later.
Q Okay. What's your opinion to a reasonable degree of nursing certainty whether or not at that time at 4:07 the saline flush was administered properly?
A It was administered properly. It was administered one minute prior to the antibiotic.
Q Okay. Now, let's turn back and go forward in time back to page five? Back to our midnight note; we have a saline flush.
A Yes.
Q Okay. And then tell the jury what happened between midnight and 4:27 a.m.?
A I don't see that there's a flush.
Q What's that?
A At midnight, there's a saline flush that's given and then at 4:27 in the morning ampicillin is given.
Q Is there a flush given?
A No.
Q And you can refer to your documents as well. But something does happen at 4:04 a.m., correct?
A At 4:04 there's a note that shows that -- it's just a basic activity check.
Q Is that when Nurse Downing checks the site supposedly?

A Right.

Q Does she check it at 4:27 a.m. when the medication is administered?

A There's no documentation of that.

Q Do you have an opinion whether or not to a reasonable degree of medical certainty whether or not that should be documented?

A It should be documented. Any medication that's given through an IV should be documented because if it's not documented, it wasn't done.

Q What's that?

A If it's not documented, it wasn't done.

Q Now, tell us a little bit more about the saline flushes. Is that just salt water or what is it?

A Saline flush is a medication basically, but it is salt water. It's comprised of sodium and -- but if you give it through an IV and the IV is infiltrated or the IV isn't in the vein, it's going to cause swelling. You'll see that. But it's not going to cause the skin to break down in a burn-like injury to the skin in the area around the IV.

Q For the purposes of the medical chart, do you have an opinion to a reasonable degree of nursing certainty whether or not the saline flush is considered a medication?

A I consider the saline flush a medication. Anything you give to someone through an IV is a medication. It needs to

to be documented.

Q And is that your opinion to a reasonable degree of medical certainty, it should be documented?

A Yes, that is my opinion to a reasonable degree of medical certainty.

Q Have you reviewed any documents in this case which support that theory as well, or that opinion?

A The literature that was provided by the defense indicates that it should be document. And the policy and procedure for the hospital says that it should be documented.

MR. KRELL: Your Honor, may I approach the witness, please.

THE COURT: You may.

BY MR. KRELL:

Q I show you Plaintiff's Exhibit 5, which I ask you to take a look at.

A This is The Regional Medical Center's policy and procedure for IV therapy.

Q Is it fair to say that's the hospital's rule book?

A Yes.

Q They've got to follow those rules?

A Yes.

Q And why do they have those rules?

A They have these rules so that harm doesn't happen to a patient around IV therapy.

Q What do those rules state about saline flushes?

A The rules state that saline flush should be given and documented.

Q Right. I'm going to let you look at page five of nine, the intravenous therapy peripheral access page.

MR. KRELL: Can y'all see this or is it better --

THE COURT: Mr. Tanner, can you see that?

BY MR. KRELL:

Q Are you at page five of nine?

A I am.

Q And at the bottom of the page, the last bullet point, if you could read what that says?

A It says flushing the INT, which is that -- with saline is to be documented on the MAR medication record.

Q Okay. And the documents that we were looking at before, I believe it was document 5 and 6, are those the MAR's?

A Yes, that's the medication record.

Q Where are the saline flushes prior to administering ampicillin documented?

A They're not documented.

Q And you said earlier if it's not documented, what?

A If it's not documented, it wasn't done.

Q You give the saline flush every time you administer -- before you administer the medication?

A Yes, that's one of the rules is you give a saline flush. That's one of the ways that you can determine whether or not the IV is patent.

Q And do you have an opinion to a reasonable degree of medication certainty whether or not the nurse and TRMC breached the standard of care by not documenting it?

A I believe that the nurse and the hospital breached the standard of care. The nurse did not document whether or not she gave the normal saline flush. There are other assessments that are required, the observation of the site, that also weren't documented. And the facility didn't implement the appropriate guidelines to make sure that the documentation was done as it should be.

Q Well, Mr. Tanner said that you can't document everything. He told that to the jury?

A I mean, it's pretty scary to think that you wouldn't document medication, you wouldn't document something with a five-week-old baby? There just are certain things that you may not document, but certainly medication in a five-week-old baby that you're giving through their vein would be something that you would document. The standard of care requires that. And if it's not documented, it wasn't done.

Q But even -- what does their rule book say about

documenting saline flushes?

A Well, the P&P book says that it needs to be documented in the medication record.

Q Let's talk about the articles that you've reviewed and talk about blood return and patency. Can you tell us what article, the first article you're reading?

A I'm going to put this stack down -- the next stack.

COURT REPORTER: You're going to lose that. I'm sorry.

MR. KRELL: Hold on a second. Hold on. Hold on.

THE COURT: Are you going to gather that back together? Are you through asking her about that?

MR. KRELL: I'm going to put it back together, Your Honor.

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

A Do you want me to start with the defense articles?

BY MR. KRELL:

Q That would be great.

A And your question was?

Q We can start with the first article.

A So the defense provided us with four different articles. The first article is called Intravenous Extravasation, the Mechanisms Management Prevention. And extravasation just means that the IV came out of the vein

and now fluid is being administered into the skin in the area around the IV. And the significance of that --

Q What year was it published?

A -- is that it can cause a burn-like injury to the area of the skin. This article is from 1993. It's twenty-five or so years old.

Q What does that article say about blood returns and patency?

A This article says that there are different measures to ensure the patency of the IV to make sure that the IV is actually in the vein. It does say that with small gauge catheters that it may not be reliable to use a blood return for ensuring -- alone, to make sure that the IV is in the vein. But there are other components, and there's one component of checking to make sure that the IV is in the vein.

Q What else in that article did you find instructive in this matter?

A It says that because IV infiltration can be a high risk, that you need to put prevention measures in place. You need make sure that you follow all of the rules in terms of evaluating the IV before giving medication through it. It says that health care providers are often cavalier in managing IV therapy because it's such a common practice.

Q What does that mean? What does cavalier mean there?

A You know, just give -- without putting all the rules into place give an IV medication. And it says that this inattention to detail can lead to an unfortunate consequence. It can result in permanent disfigurement, loss of function.

Q That's the article they gave us, right?

A Right. It says that the IV site itself should be assessed every hour and it should be assessed more frequently after you begin infusing medication through that IV.

Q How long did -- that's interesting you bring that up. How long did Nurse Downing stay with R.J. after infusing the ampicillin at 4:27 a.m.?

A In her deposition testimony she said that she typically stays with a patient for thirty seconds to one minute after beginning the administration of an IV.

Q Do you have an opinion about that to a reasonable degree of nursing certainty whether or not that is a breach of the standard of care?

A It's a breach of the standard of care. When you start that IV medication on somebody, you should stay with that patient for at least five minutes after it's started. And you need to frequently check on the patient, the IV site, during the administration of the medication.

Q On that same vein, when did Nurse Downing return to the

room after the administration of the 4:27 a.m. ampicillin?

A Well, in her deposition she said that she returned when the pump alarmed, at the end of the infusion of the medication. So she did not indicate that she went back and checked on the patient and the IV site at any point in the interim of twenty minutes that the antibiotic was infusing.

Q All right. Thank you. Anything else from the first article that is authoritative in this matter?

A Another thing that's interesting is it says -- it says here that basically the same antibiotics increase the incidence of extravasation and the potential for severe local reactions and necrosis, which is death -- tissue death. It's like a burn having gone through to the tissue in both adults and infants. So again the management of an IV is the same whether it's an adult or a child or an infant, they have the same risk of complications if the rules for managing the IV are not maintained.

Q Is that it from that article so we move to the next?

A It also says basically that once the pump is started, that the pump may continue to deliver the antibiotic even if it's extravasated outside of the vein. So, you know, that means that the pump is not going to alarm to tell the nurse down the hall somewhere that she needs to go back because the IV is out of the vein. It means that the nurse is responsible for going back periodically while that IV

Q Go ahead to the next article?
A Yes.
Q What's the title of the next article?
A The title of the next one is Assessment of an Infant with a Peripheral Device. That's from 2003.
Q That's only fifteen years old?
A That's only fifteen years old. And this basically just talks about the complication rate of IV's, and that you can incur an infiltration. Which again, as a nurse taking care of a patient, it just signals the red flag that if you're giving a medication you know that there's a potential risk for infiltration. And because of that, you have to protect the patient and you have to make sure that you evaluate the site before you give it, give the medication. You check for a blood return, and you administer a saline flush and you document those findings. So, you know, again, it just suggests that a nurse should be on notice to put those safety measures in place with a patient.
Q And so when you use the term document, what does that mean?
A In the medication record, that you gave the saline flush.
Q You mean you write it down.

A You write it down. If it's not written down, it was not done.

Q Is there anything --

A No, --

Q -- else from that article that's authoritative in this action?

A No.

Q All right. Let's go to the next article?

A This one is called infusion -- Infusion Nurses' Society, Infusion Therapies in the Clinical Practice the 2nd Edition. It's from 2001, so it's only seventeen years old.

Q Tell us what you found out there?

A I mean, this one basically says that again, because of the risk for infiltration of an IV with medication, that before, during and after you have to monitor that site. It basically says that extravasation, if the medication goes outside of the vein that it can result in sloughing of the skin, tissue necrosis. Preventative measures should be put in place to minimize that problem.

Q Do you have an opinion of what type of preventative measures should be put in place?

A Basic, simple nursing 101, whether it's a baby or an adult, the management of a vein, it's the same. And that is, again, I -- you know, I'm going to sound like a broken record, but really it is so easy. You look at the site.

Does it look like it's -- there's any signs of a problem? Does it look like it might be outside of the vein? Check for a blood return and also give a normal saline flush and document that you gave it and what the findings were.

Q Go to the next one.

A This one actually has a table that it shows. And the table basically says the IV site should be checked for patency before, during and after the administration of a vesicant, which would be like an antibiotic, the infusion of saline flush prior to administration. It says that in terms of the policies and procedures for how to monitor that IV site once you've started giving medication through it, it says that the nurse, during the administration -- there can be different ways to do it -- one, the nurse can be in constant attendance during the infusion of the vesicant. Whereas, other options would be that the patient and the site should be monitored at specific intervals during the infusion. So, again, if you're not going to stay with the patient, go back in and at least look at the IV site while it's being administered and make sure that it's not outside of the vein. And then another option would be that two licensed nurses would verify the vein patency before the administration of a vesicant. And, again, a vesicant would be a fluid that could cause a burn or an injury to the tissue if it gets outside of the vein. It also says that

basically vesicants -- that the hand -- and, again, in this baby that's where the IV was. It was in the right hand. It says that the hand should be avoided for vesicant administrations because of the tendons and the nerves could be destroyed if the vesicant extravasates the vein. So, you know, it even says here that the hand was a poor choice for the IV.

Q Is there anything in that article that talks about blood return and patency with blood return? Should it be used to determine patency?

A It say that the blood return in a small-veined IV, it may not be -- may not always be an accurate indicator of whether or not it's in the vein. But it doesn't say you shouldn't do -- check for a blood return. It's just one more measure that you can put into place. It's very simple, very easy to make sure that the IV is actually in the correct location.

Q Is that the article that has a footnote? Is that footnote 49? I don't have the document in front of me?

A I don't know.

Q Well, if you might take a look, is there a footnote on the end of the sentence?

A A picture of a hand?

Q No, that's not it. Let's go on to the next article. What's the title of the next article?

A This is the last article and this one was Intravenous Therapy in Children.

Q What's the date of publication on that?

A I couldn't find a date of publication.

Q Can you tell us what you found in that article?

A This one talks about frequent assessments during the administration of an IV, of a IV medication. On the first page it says that the basic principals of safe administration of IV fluids using medications are the same regardless of the patient's age. So whether a patient is a baby or an adult, this article says that the safety principals are exactly the same.

Q Does that article talk anything about blood return?

A I don't know if this one talks about blood return.

Q We've reviewed those four articles that tell us --

A I just want to say too that this, you know, again talks about, again, what I said, a vein is a vein whether it's an adult or a child. And, again, on page five seventy-nine it begins with the selection of the IV site and the different practices around it are exactly the same whether it's an adult or a child. So -- and it says, you know, that -- to provide the treatment with the maximum amount of safety. It says that a peripheral IV -- the sites for a peripheral IV are discussed for adults, but the same principals apply to a pediatric patient.

Q Does that article address blood returns?
A It may.
Q Do you have any notes that would reflect that? You want to just move on to the next article?
A I don't have it in my notes to reflect that.
Q And there's another article that I provided you?
A Yes.
Q Okay. What's the title of that article?
A The title of this article -- and this would be 2014 and the injury to this child occurred in 2014. So it would be the same relevant time frame, not twenty-five years earlier. But this is 2014. It's Policies and Procedures from Fusion Nursing of the Pediatric Patient. And this is from the Fusion Nurses' Society.
Q That's one of the articles that defense counsel also provided was from the Infusion Nurses' Society, too, correct?
A Yes.
Q And what does this article state on page one hundred about flushing?
A It says slowly aspirate until brisk blood return is obtained. It said flushing is performed prior to each infusion --
Q Uh-huh?
A -- after each infusion. So you give the flush before

and you give the flush after.

Q In this article that is number seven on page one hundred, what does it state?

A It says slowly aspirate until brisk blood return is obtained.

Q Well, what does aspirate mean?

A Pull back. You're withdrawing the syringe to see if there's a blood return.

Q Blood return is just one of the steps ???.

A It's just one of the steps.

Q Do you have an opinion to a reasonable degree of nursing certainty whether or not a saline flush was given to R.J. prior to the ampicillin that was given at 4:27 a.m. on October 28th, 2014?

A There's no documentation --

MR. TANNER: Objection, Your Honor.

THE COURT: Hold on for one second.

MR. TANNER: It's been asked and answered multiple times.

THE WITNESS: That's a --

THE COURT: Wait, just one second. Just one second.

MR. KRELL: Hold on. Hold on.

THE COURT: I'm going to note your objection. I'm going to let her answer it but this will be last time she

answers it, okay?

MR. KRELL: Yes, sir.

THE COURT: Okay. Go ahead.

A There's no documentation that a flush was given before the ampicillin was administered.

BY MR. KRELL:

Q Ms. Stobbs, what's the effect of an infiltration of a medication like ampicillin?

A What happened to this child. It can cause a burn-like injury to the skin in the area. So in this case the IV infiltrated in the baby's right hand and within a short period of time the skin on the back of the hand was like a burn. It basically came off, left him with a scar.

Q Thank you. Please answer any questions defense counsel has.

THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

MONICA STOBBS - CROSS-EXAMINATION

BY MR. TANNER:

Q Ms. Stobbs, again, I think you've been a registered nurse since 1983; is that right?

A Yes.

Q That's more than twenty-five years ago, right?
A It'd be closer to over thirty.
Q So all of these articles were available to you to read early-on in your nursing career, correct?
A Correct.
Q But you weren't familiar with any of these articles until we provided them to you, correct?
A Correct.
Q I think you started out at St. Louis University Hospital; is that right?
A Yes.
Q And that's in Missouri?
A Yes.
Q Were you ever pediatric advanced life certified as a nurse?
A I was adult certified as adult ACLS.
Q ACLS. But that's different that PALS, Correct? P-A-L-S?
A Correct.
Q And you were never certified in that, were you?
A No.
Q And, again, when you were at St. Louis University Hospital did you ever take care of a pediatric patient?
A No.
Q And you never administered an IV to pediatric patient

there, did you?
A No.
Q And you never monitored and assessed a pediatric IV did you?
A No.
Q In fact, you have no experience at St. Louis University Hospital regarding any pediatric nursing, correct?
A Correct.
Q All right. But yet you're going to sit here and you're going to tell the jury that a vein is a vein; correct?
A Well, articles you've provided me with say that.
Q They say other things don't they?
A Well, you've asked me do they say a vein is a vein; essentially they do. They said that the safety practices around it are the same, whether it's an adult or the child.
Q All right, Ms. Stobbs. Thank you. Let's turn to Intravenous Therapy in Children, that you point out to the jury was provided by my office. Tell me when you have that?
A Which one?
Q Intravenous Therapy in Children. And I believe it's page five sixty-two.
A Yes, I have it.
Q Would you look at five sixty-two?
A Yeah. I'm on five sixty-two.
Q You see the heading that says vessel size, in bold?

A Yes.
Q Read that for the jury, please?
A It says the size of venous and arterial vessels in the infant and child are smaller than those in the adult. Although the vessels are anatomically positioned in the same location throughout life, there's sometimes thread-like characteristics and tendency to hide, making difficult to locate in a young patient.
Q Let me stop you there. I think you forgot a word. You see where it says the size of vessels and arterial vessels in the infant and child are obviously smaller?
A Oh, yes. It does. Obviously smaller than those in the adult.
Q So that says that a vein is not a vein, correct?
A It says that a vein is a vein. It's not saying that children don't have veins or babies don't have veins. It's saying that they're smaller in size.
Q So even though this article that's twenty-something years old says that they're obviously smaller and pediatric veins are sometimes thread-like in characteristics, you're going to sit here and tell the jury that a vein is a vein is a vein?
A Absolutely.
Q Okay.
A And this same article also talks about that the same

[illegible] from adult and the child [illegible] around IV therapy.

Q And you're getting paid to come testify on behalf of Ms. Hamilton, correct?

A Yes, I am.

Q And I think you hold yourself out as an expert witness, correct?

A I sorry. I don't understand that question.

Q Do you advertise your services?

A I don't advertise my services as a nurse expert, no.

Q Do you have a website?

A I have a website, yes.

Q Does your website talk about how to win.

A I do general medical consulting.

Q Yes, ma'am. If you could answer my question --

A My question is I do not advertise myself specifically as a nurse expert.

Q You have a website?

A I have a website for general consulting, general medical consulting that I do with attorneys.

Q And your website talks about how you help them win, doesn't it? Doesn't it Ms. Stobbs? Either it does or it doesn't?

A Well, it does. Whether it's defense or the plaintiff's side. It doesn't matter because the medical records speak

for themselves. The facts in the medical records are what determine whether right or wrong was done. It is not which side gets -- which side I'm working for, because I may review a case and say I don't think there's a case.

MR. TANNER: Your Honor, I'd move to strike that soliloquy she gave as non-response to my question. My question was just whether her website asked if she wins.

THE COURT: Ms. Stobbs, if you would just respond to the questions. If it's a yes or no question and you believe you need to further explain it, I'll allow you to do that, but you just need to say yes or no and then respond, okay?

THE WITNESS: Okay. Yes.

BY MR. TANNER:

Q And after that you went to Washington University Medical Center, correct?

A (Witness pauses)

Q In your nursing practice? We're talking about your nursing practice?

A No, I went to Cornell University in New York City.

Q Well, you were at St. Louis University Hospital in 1983?

A Yes.

Q And 1985, right?

A Correct.

Q And then you're at Washington University Medical Center from 1988 to 1989, correct?

A Sir, do you see when I started New York Cornell Medical Center?

Q Well, you have 1990. Were you working at two places at once?

A I went from St. Louis University to Cornell University Medical Center. When I was at Cornell University Medical Center, I did a short interim where I still maintained my position at Cornell in New York City and went to Washington University, which is in St. Louis, because they had the -- at that time the only physician that was doing successful heart and lung transplants on patients, so I wanted to have the opportunity to work with those kinds of patients.

Q Okay. And the medical issues in this case have nothing to do with heart and lung surgery, correct?

A Correct.

Q Okay. And again, according to your CV, you were at Washington University Medical Center as a per diem nurse in 1988 and 1989, correct?

A Correct.

Q All right. And didn't provide any pediatric experience there, did you?

A No.

Q All right. And never started a pediatric IV at the

A No.

Q And never assessed and monitored pediatric [illegible]; correct?

A No.

Q All right. And I just think you just the jury that you were at Cornell. And I heard you say earlier how you were there and their reputation. Again, at Cornell, did you ever practice pediatric nursing?

A No.

Q Did you ever start a pediatric IV at Cornell?

A No.

Q Did you ever maintain a pediatric IV?

A No.

Q And after that, is that when you moved to Boston?

A Yes.

Q Okay. And you were at Massachusetts General Hospital, right?

A Yes.

Q And you worked in trauma surgery and orthopaedics?

A Yes.

Q Again, no peds experience?

A No.

Q Never would have started a pediatric IV up in Boston?

A No.

Q Never would have assessed a pediatric patient for an IV?

A No.

Q And then you moved to South Carolina in 2012; is that right?

A Yes.

Q All right. And you worked at the Medical University for a short period of time?

A Yes.

Q All right. And, again, at MUSC you didn't work in peds, did you?

A No.

Q Never started a pediatric IV?

A No.

Q You never monitored or maintained a pediatric IV, did you?

A No.

Q And as you sit here today, you have never one time in your thirty-something year career monitored or started a pediatric IV, correct?

A Correct.

Q You talk a lot about a 24 gauge needle and blood return. You remember that in your deposition?

A Yes.

Q Okay. And you recall you were deposed in March of this

year?
A Yes.
Q And how much are you getting paid an hour to come testify here?
A Two hundred dollars an hour.
Q And up to this point in time, have you billed over, in excess of five thousand dollars?
A It's possible.
Q Have you billed over seventy-five hundred dollars?
A I don't know.
Q You don't know as you sit here today how many hours you have devoted to this case?
A I don't know the exact number.
Q Okay. And, again, in your -- all your time in this case, you didn't research any literature at all, did you Nurse Stobbs?
A No.
Q All right. But despite all your years of clinical practice at all these prestigious facilities, you didn't do any research on pediatric IV, either initiating or maintaining, correct?
A Management of an IV is the same whether it's in a baby or an adult in terms of the safety practices.
Q That's your story and you're sticking to it?
A It's not my story. It's the standard of care and it's

the truth.

Q Would you agreed that inherent risks of every IV is an infiltration?

A It is potential risk, a potential risk, which is why we have to put into place the appropriate safety measures to make sure that that doesn't -- you can minimize that event.

Q Are you telling the jury that there's a difference between a risk and a potential risk?

A I'm saying that when -- it's a potential risk. If you have an IV put in, then there's a potential risk of IV infiltration.

Q I'm sorry. I guess I just don't understand your answer. Are you telling the jury that there's a difference between a risk and a potential risk?

A Potential risk to me is the exact same thing. It is a potential risk that may occur in an IV infiltrate if you have an IV and getting medication through it.

Q So is it the same thing? I'm just having a hard time. Is it the same thing as a risk?

A Potential risk is one and the same. A potential risk is one and the same thing.

Q So a potential risk and a risk are one and the same thing?

A That's correct.

Q All right. You saw where Nurse Downing came on, on the

evening of October 27th, 2014?
A (Witness pauses)
Q You saw that from reviewing the chart?
A Yes.
Q You saw where she assessed the child?
A Yes.
Q Okay. And part of that assessment is to assess the IV site of the child?
A Correct.
Q And she documented that, correct?
A Yes.
Q She documented that a IV was in the right hand, correct?
A Yes.
Q She documented that it was an over the needle catheter, right?
A Yes.
Q And the catheter is that straw-like part of the catheter where the needle -- the needle starts the catheter, right?
A Yes.
Q And the catheter is actually a straw-like part that the IV tubing hooks up and that's how the medication is administered?
A Yes.

Q And she documented that in the record is right?
A Yes.
Q She documented the site condition, correct?
A Yes.
Q And she documented that there was no complications with that site condition, correct?
A Four hours prior to the administration of the ampicillin; that's correct.
Q Okay. Well, we're still talking about 19:44, okay? Let's talk about 19:44. That's what my questions were, okay?
A Uh-huh. (Affirmative response)
Q And that's a yes?
A Yes.
Q She documented that the site condition, there was no complications at 19:44, correct?
A Correct.
Q And she documented the infiltration score was zero, correct?
A Correct.
Q And that's in the infusion society materials that we provided, correct?
A Yes.
Q And that's also in the infusion materials that plaintiff provided, correct?

A Yes.
Q And that is an optimal score, is it not?
A Yes.
Q That is no signs or symptoms of infiltration, correct?
A Correct.
Q And also she documented a phlebitis score of zero, correct?
A Correct.
Q And that is also optimal score, is it not?
A Yes.
Q And that is no sign and symptoms of phlebitis on that IV, correct?
A Correct.
Q She documented the dressing, did she not?
A Yes.
Q She documented that it was dry and in tact with a clear bandage, correct?
A Yes.
Q That bandage is so she can see through and you can see that catheter, correct?
A Yes.
Q She documented the flow of the patency, that there was no complications, correct?
A Yes.
Q She documented the extension set that was used, did she

not?
A Yes.
Q And so before she's administered any medication, she has assessed that IV, has she not?
A Yes.
Q And she has documented that in the chart, has she not?
A She's -- this is not around the time of medication. At the time of 4:27 when the medication was given, those documented findings don't exist. What you asked me, yes, that's correct, prior to the time of the administration.
Q And Ms. Stobbs, I certainly appreciate your answer. I was asking you again that 19:44, that's 7:44. We're not talking about 4:27. That wasn't my question. My question was she's documented at 19:44 all of that in the chart, correct?
A At 7:44 p.m. the night before the administration of ampicillin, that is correct.
Q And then she assess the IV again at 20:54, correct?
A At 8:54 p.m. the night before, she does document those findings.
Q And it's also documented an infiltration score of zero, correct?
A Yes.
Q It's documented a phlebitis score of zero, correct?
A Yes.

Q At either 7:44 or 20:54, she doesn't document any signs of redness, does she?
A No.
Q She doesn't document any signs of swelling, does she?
A No.
Q And all of that again is in the chart, correct?
A Yes.
Q Okay. And, again, that's before the medicine is administered, correct?
A Yes.
Q All right. She does another IV assessment at 22:05, correct?
A Correct.
Q And if you see that the policy here, it talks about protocols for flushing and assessing. You want to assess that IV or flush that IV rather, a minimum of every four hours or after the administration of the medication, correct?
A Correct.
Q Or as needed, correct?
A Correct.
Q That's what PRN means? That's Latin for as needed?
A Yes.
Q So, again, at 20:54 Nurse Downing hasn't administered any medication yet, has she?

A Correct.

Q Okay. And yet she's accessed the IV. And you want to assess the IV approximately every hour, correct?

A Correct.

Q That's what the literature says, correct?

A Yes.

Q All right. And she's done it, has she not?

A Yes.

Q And she's documented that, correct?

A Up to this point.

Q Her next assessment, I believe, is timed at 22:05. Have you reviewed that?

A Yes.

Q Okay. Any documentation of infiltration score being anything other than zero?

A No.

Q Phlebitis score documented at zero, correct?

A Correct.

Q And she again didn't document any signs of redness on the IV, correct?

A Correct.

Q She didn't document any signs of swelling on the IV, correct?

A Correct.

Q Now, to do all of this, she actually had to be in the

[redacted]

A Yes.

Q The IV that's in his right hand? She just can't just chart this from the desk, can she?

A I guess she could, but I would hope she would document what she saw.

Q Okay. And is there anything in the record that shows she didn't document other than what she saw?

A No.

Q She assesses the IV again at 23:23, correct?

A Yes.

Q Infiltration score again of zero?

A Yes.

Q Your optimal score. Phlebitis score is zero?

A Yes.

Q No documentation of any signs of redness, correct?

A Correct.

Q No documentation of any swelling in the IV?

A Correct.

Q Do you have an opinion on whether that documentation complied with the standard of care to a reasonable degree of nursing certainty?

A Up to that point, it complied with the standard of care.

Q All right. She comes back and assess the IV again at

12:37, correct?
A Correct.
Q Infiltration score is documented at zero?
A Yes.
Q Phlebitis score is documented at zero?
A Yes.
Q Any redness documented?
A No.
Q Any swelling documented?
A No.
Q What time is her next assessment?
A Her next assessment is at 4:04 in the morning.
Q Okay. Do you have there in front of you TRMC --
MR. TANNER: I beg the Court's indulgence.
BY MR. TANNER:
Q All right. Nurse Stobbs, we were talking about the 00:37 IV assessment, right?
A I'm sorry, what?
Q What was the last -- did we talk about 00 -- 12:37, correct?
A Yes.
Q And the next assessment, I think you said was at 4:00?
A I see 4:04, but, no, there was one at 2:44 activities and daily living.
Q There was also one at 1:00, wasn't there Nurse Stobbs?

A [illegible] I see 1:41.

Q All right. [illegible]

time.

A Okay. So 11:23 --

Q You see right there where it says performed on 10/28, 1:00 eastern time, Jamie Lee Downing?

A On one seventy-nine?

Q Yes, ma'am.

A Are we on the same page?

Q I believe so. Let me show you. On 10/28, 1:00, Jamie Downing?

A No, mine is a different --

Q Well, where's Plaintiff's Exhibit 1?

THE COURT: I believe it's --

MR. KRELL: It's on the Exhibit table.

BY MR. TANNER:

Q I thought you had that.

THE COURT: I think it's over there. I think -- isn't it 4?

MR. KRELL: Yes, sir.

MR. TANNER: I'm sorry.

BY MR. TANNER:

Q Plaintiff's 4. Go to page one seventy? Here it is.

A Okay.

Q All right. Do you see that IV assessment at 1:00 a.m.?

[illegible]

MR. TANNER: [illegible]

BY MR. TANNER:

Q Performed on 10/28, 1:00 a.m., Jamie Downing?

A Okay. There's another time above it of 2:49?

Q Yes, ma'am. But it says performed on 10/28, 1:00 a.m., correct?

A Yes.

Q All right. IV assessment, infiltration score zero -- and this goes on to one eighty, so if you want to flip to that page?

A Yes.

Q Infiltration score zero, phlebitis zero, correct?

A Correct.

Q And then there's another assessment at 2:42, correct?

A Yes.

Q IV activity assess, infiltration score zero, phlebitis score zero, correct?

A Yes.

Q And then the next one is at 4:04, right?

A Yes.

Q So there was actually two in between 12:37 and 4:04, right?

A So their policies and procedures says every sixty minutes. So 1:00 a.m. until 2:42 would be almost two hours

in between.

Q I'd be an hour and forty-two minutes, right?

A Correct, not sixty minutes.

Q I'm not -

A And then the next one is 4:04, which would be again, close to one hour and fifteen minutes, not what the policy and procedure of the hospital is, every sixty minutes.

Q Yes, ma'am. And you're not going to sit here under oath and tell the jury that you do everything, if it says one hour, that you've always for thirty-three years done exactly the one hour, are you?

A When it comes to safety management of an IV, absolutely. The rule is every sixty minutes and that needs to be followed.

Q You were talking earlier about the four-hour flushes, correct?

A (Witness pauses)

Q When Mr. Krell was asking you questions?

A Yes, that in addition to the flush that's given, that should be given prior to an antibiotic.

Q Those flushes that you talk about, those are the four-hour flushes from this policy, correct?

A (Witness pauses)

Q From this policy that says it's to have IMT flush with one milliliter saline on insertion, after administration or

a minimum of every four hours, correct?

A Correct.

Q And those are the flushes that populate in the medical record, correct?

A Those flushes populate. But in addition the flushes around an antibiotic will populate as well, which is why there's a flush at 4:45 in the morning after the ampicillin is started, but it probably, more likely than not, was intended to be the flush given prior that medication.

Q You've never used the Cerner System, correct?

A No.

Q And that's the system of record keeping at The Regional Medical Center, correct?

A There are a variety of types of electronic records. Essentially, they work in general in the same way.

Q And Ms. Stobbs, again, you can explain whatever you want to the jury, but if you could just answer my question first?

A I have not worked with that particular electronic system, no.

Q You read Nurse Downing's deposition, did you not?

A I did read Nurse Downing's deposition.

Q And you read in her deposition that it's her custom, habit and practice to inspect the IV site prior to administering a medication, correct?

A Mr. Downing was a nurse for one month, so what her practice and procedure was, I don't find credible.

Q And, again, Ms. Stobbe, if you could just answer my question?

A That is what she said.

Q And you read that, right?

A I read that.

Q All right. And she was under oath just like you were, right?

A Correct.

Q She's under oath like you are today?

A Yes.

Q To tell the truth, right?

A (No response)

Q And what she's documented in the assessment records is what she had done prior to that time, correct?

A Yes.

Q And that's what she documented, right?

A Yes.

Q And you truly believe that the management of a vein is a vein whether it's an adult or a pediatric patient?

A That's what the articles that -- I do believe that. And the articles that you provided me with say that.

Q And we talked about a few of them. I think Mr. Krell provided -- I think he was asking you some questions about

the policies and procedures for infusing nursing in a pediatric patient, do you recall that?

A Yes.

Q Do you have those hand?

A Which one? The on you provided or the one Mr. Krell

Q The one Mr. Krell provided?

A May I have his article?

Q Okay? Do you have a Preface?

A Yes.

Q You want to turn to that, please?

A Okay.

Q Would you read the first sentence in the second paragraph on that page?

A It says children are not just little adults and are physiologically different.

Q It's pretty clear that the Infusing Nursing Society shows that there's a difference between adults and children, correct, Nurse Stobbs?

A Not in their veins or in the management of an IV. It says that physiologically, meaning their body size may be different. Physiologically does not mean that their vein would be different. The location is the same place. The practice principles around management of IV therapy, this does not talk about that. This basically is just saying that physiologically, meaning size-wise, maybe, you know,

different rate of growth, those kinds of things may be different.

Q Are you going to tell the jury that physiologically as stated by the Infusion Nurses Society deals with everything else different between an infant, a child, and an adult, but not the size of the veins? Is that what you're telling these people?

A That is what I'm saying. Things that would be different would be doses of medication, obviously based on size. The vein is going to be in the same place of a baby as it's going to be in an adult. And the management for IV therapy in terms of safety practices and what the rules are, it's exactly the same.

Q Well, we just talked earlier when I started asking you questions that they're not in the same place, correct? And that we talked about on five sixty-two?

A (Witness pauses)

Q It says vessel size, there are sometimes thread-like characteristics and tendency to hide them making them difficult to locate in the young patient, Anatomic and Physiologic Differences in Children. I didn't write the book.

A That same article references in other places that the management of an IV is the same in an adult as it is in the child. And I can show you those places if you'd like me to.

Q Children present a wide variety of physical characteristics differing from those in adults, correct?

A Correct.

Q That's what all through this text wrote, correct?

A Correct.

Q But you've testified as authoritative in the field of nursing, correct?

A Correct. It also says if the site's a peripheral IV --

MR. TANNER: Your Honor, again, she's not responsive --

THE WITNESS: Okay.

THE COURT: I guarantee you Mr. Krell is going to ask you that question, okay?

THE WITNESS: Okay.

THE COURT: Okay.

BY MR. TANNER:

Q Nurse Stobbs, again, if you turn back to policies and procedures for infusing nursing in patient? And I'm on page one twenty-five this time.

A All right.

Q Let me know when you're there, please, ma'am?

A I'm on page one twenty-five.

Q You see at the top of the page infiltration and extravasation?

A Yes.

Q Do you agree that IV and vein can be used synonymously?
A Yes.
Q And extravasation depends on the type of fluid; is that correct? A vesicant versus a non-vesicant?
A No. It refers to fluid not going into the vein. It refers to fluid coming out of the vein, regardless of whether it's a vesicant or whether it's plain old normal saline or whatever it is.
Q So you're going to tell the jury that the difference between vesicant and non-vesicant doesn't have to do with IV medication?
A There are different types of fluids that you can administer IV. You can administer a vesicant, which if it goes outside of the vein can cause a burn-like injury to the tissue in that area. You have non-vesicants like normal saline for instance, the normal saline flush, which if those go outside of your vein may not cause that type of an injury.
Q You see that box up there that says considerations for the pediatric patient?
A Yes.
Q And that says vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity, correct?

A Yes.

Q And, again, [redacted], was admitted for a work up of sepsis, correct?

A Yes.

Q You would agree with me that sepsis could be fatal if untreated, correct?

A It could be.

Q And it's a serious medical condition?

A It is.

Q Larger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult. You see that?

A Yes.

Q And you disagree with that statement, don't you?

A I do disagree with that. There are other articles that show that an IV infiltrate can be noticed immediately. When you have fluid that's leaking out of the vein into the area around it, you will see swelling particularly, the back of the hand doesn't have fat on it that would hide it as an IV would be if it was, for instance, placed in the arms and in different locations.

Q Nurse Stobbs, how many texts have you written on infusing nursing for pediatric patients?

A None.

Q You would agree with me the Infusion Nurses' Society is

far more credible than you, correct?

A Yes.

Q And despite the fact that they say larger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult, you're saying -- you're telling this jury in Orangeburg County that they're somehow wrong?

A I'm saying that's what this article says, but there would be other articles that may say something different.

Q Well, do you have those other articles?

A No.

Q So you don't have them here to share with the jury in Orangeburg County?

A I know that from thirty years of practice, over thirty years of practice with an IV infiltrate on the back of the hand, which is an area that doesn't have any fat, you will notice swelling in that area if it's -- fluid is being delivered outside of the vein.

Q But the article that we do have to share with the jury in Orangeburg County says that it's difficult to recognize, correct?

A That is what this article says.

Q And that is what -- this was materials provided by the plaintiff, correct?

A Correct.

Q You see under precautions it says [illegible]

A Yes.

Q You use the smallest gauge and length catheter to accommodate the prescribed therapy?

A Yes.

Q Avoid placing catheter in areas of flexion. You see that?

A Yes.

Q That's why you don't want to put it in the elbow, right?

A Or the hand.

Q Does it say don't put it in the hand in there?

A It says areas of flexion. It doesn't say elbow. You mentioned that so I mentioned the hand, which is where it was in this baby because, obviously, the hand flexes. So that would be another area of flexion.

Q You see on one twenty-seven where it says extravasation as vesicant solutions?

A Yes.

Q Remember we just talked about that?

A Correct.

Q In your deposition -- and that was under oath, correct?

A Yes.

Q You testified that you had no opinions that Nurse Downing intentionally tried to hurt this child, correct?

[illegible]

A Correct.

MR. KREIL: Your Honor, I'm going to object. I think he needs to show her the question if he's going to talk to her about her deposition.

THE COURT: Yeah.

MR. KREIL: At least he didn't impeach her with it, but I mean --

THE COURT: You can just ask her the question straight out.

MR. TANNER: Okay. And I think she answered it, but I'm happy to ask it again.

THE COURT: Yes, sir.

BY MR. TANNER:

Q You have no opinions that Nurse Downing did anything intentionally to hurt this child, correct?

A Correct.

Q You want to flip over to page one twenty-six in policies and procedures for infusing nursing of the pediatric patient? You see the bullets?

A Yes.

Q All right. The second bullet says small-gauge catheters -- you see that?

A Yes.

Q And then in parenthesis, 24 gauge or smaller. See that?

A Right.

Q And that was the catheter that was used for this patient, correct?

A Yeah.

Q May not provide a positive blood return. See that?

A Yes.

Q Especially in neo-nates, correct?

A Uh-huh, correct.

Q And he would have been considered a neo-nate, correct?

A Correct.

Q Use additional parameters such as flushing, evidence of pain, swelling or edema to determine patency, correct?

A Yeah. So you can't use a blood return to check alone. It should be used in conjunction with other measures to provide, make sure that the IV's in the correct place. And it says may not provide a positive blood return.

Q But you've never tried to get a blood return with a 24 gauge needle on a pediatric patient, correct?

A I've gotten blood returns from a 24 gauge needle in an adult.

MR. TANNER: Your Honor, you know, she again --

THE COURT: If you would just answer that question

please ma'am.

THE WITNESS: Not in a pediatric patient.

THE COURT: Thank you, ma'am.

Q So you don't know if it would collapse the vein do you, Nurse Stobbs?

A I don't believe that it would collapse the veins.

Q But you've never done it?

A No.

Q Okay. And all the literature says that is not an accurate method to determine catheter patency, correct?

A Alone, in and of -- by itself, that is correct.

Q Okay. At your deposition you went on and on about how it was the most important thing, correct?

A In my deposition I said that it was one measure. One of the measures. You can't unbundle those measures.

Q Okay.

MR. KRELL: Your Honor, I need to object. I mean, if he wants to ask her the question then --

THE COURT: I think Mr. Krell wants you without any reference to deposition just ask the question. And then if she doesn't answer that way, you can refer to it, okay?

MR. TANNER: Yes, sir.

THE COURT: Okay. Thank you.

BY MR. TANNER:

Q The medication was administered at 4:27, correct?

A Correct.
Q And Nurse Downing's note is at 4:50 regarding this event, correct?
A Correct
Q And you've reviewed that note, correct?
A Yes.
Q And that talks about the catheter being intact?
A Yes.
Q All right. She did document some swelling?
A Yes.
Q She had a discussion with Ms. Hamilton about what she found?
A Yes.
Q She got the charge nurse in, correct?
A Yes.
Q They called the physician?
A She got the charge nurse in because she was a brand new nurse and had never seen an IV infiltrate from ampicillin?

THE COURT: Ms. Stobbs, you know, if you would answer the question, then you can explain it, okay?

THE WITNESS: Oh, okay.

THE COURT: That's all we need you to do.

THE WITNESS: Okay.

THE COURT: Okay?

THE WITNESS: Sorry.

BY MR. TANNER:

Q Nurse Downing called the doctor, correct?

A Correct.

Q The IV was discontinued, correct?

A Correct.

Q The doctor made an order for a warm compress to be placed on the hand, correct?

A Correct.

Q At that time, there was no noted redness to the hand, correct?

A Well, the skin fell off the hand practically within the next couple of hours, but no.

Q Is there anything noted at that time at 4:50 about redness to the hand?

A What page are you on. It says 04:50 patient fussy, hand puffy, bruising, swelling, IV was removed.

Q And my question again, anything about any redness?

A No.

Q Do you agree with the literature when it says the infiltration rate is approximately twenty-three to seventy-eight percent?

A I don't know what the -- I agree that I've read that in the literature that you've provided.

Q Do you have any articles to dispute that?

A No.

Q And infiltration is the most commonly identified complication of IV therapy, correct?

A According to the literature that you provided, yes.

Q Do you have any literature to dispute that to the jury?

A No.

Q Does the literature reflect that identifying an infiltration may be difficult even for the experienced clinician?

A Yes.

Q Now, Nurse Stobbs, I think you've testified earlier that you've started thousands of IVs right?

A Correct.

Q Have you ever had an IV infiltrate?

A Yes.

Q How many times?

A I don't know how many times.

Q I presume it was more than one?

A I would say more than one.

Q I presume it was more than ten?

A I don't know.

Q Have nurses at facilities you've worked with had IVs infiltrate?

A Yes.

Q Were you negligent when the IV infiltrated?

A No, because I caught it early-on.

Q Were the nurses [illegible] the IV infiltrated?

A No.

Q Do you agree with this statement IV infiltration may be a potential risk of having an IV?

A It's a potential risk, yes.

Q Do you agree with the fact that it happens isn't necessarily negligence?

A If the appropriate safety measures are put in place to ensure that it was in the correct location and it infiltrates, it is a risk of the procedure.

Q But you would agree that the fact that it happens is not necessarily negligence, correct?

A Correct.

Q And those are your words from your deposition, correct?

A Correct.

MR. TANNER: Nothing further, Your Honor.

THE COURT: Thank you.

Mr. Krell.

(Mr. Krell reviews notes)

THE COURT: And Mr. Krell, I know you've got questions that you need to ask, but if you don't mind, I think the jury would like to take a break.

MR. KRELL: Yes, sir.

THE COURT: Do you mind if we take a --

MR. KRELL: No, sir.

THE COURT: Okay. All right.

Ladies and gentlemen, we're going to take about a ten-minute break, let y'all get up, stretch your legs, go to the restroom if you need to. Remember what I told you earlier on is you cannot talk about any of the testimony that you've heard so far, okay? If y'all will go back in there. I'll get y'all back out in ten minutes, okay?

(Jury out at 3:22 p.m.)

THE COURT: Ms. Stobbs, you are not trapped in that chair, okay?

THE WITNESS: Okay.

THE COURT: But you cannot talk to anybody about your testimony.

THE WITNESS: Okay.

THE COURT: You can get up. You can go to the restroom. If you need to, you know, look through your notes and kind of go through, you can do that. But you can't talk to anybody about your testimony, okay?

THE WITNESS: All right. Okay.

THE COURT: All right. But I know you need to stretch your probably legs after sitting --

THE WITNESS: Thank you.

THE COURT: Yes, ma'am.

THE WITNESS: Appreciate it.

at 3:22 p.m.)

(Court in session after short break at 3:45 p.m.)

THE COURT: Mr. Krell, your redirect is going to be limited to his cross, even though I know that like this, but I just wanted to -- you know.

And your recross is going to be limited to his redirect, okay?

MR. KRELL: Yes, sir. They're fussing at me to be short so --

THE COURT: Huh?

MR. KRELL: They're fussing at me to be short so it should be.

THE COURT: When has an attorney ever listened to another attorney.

MR. KRELL: I'm going to try.

THE COURT: All right. Are y'all ready to bring the jury back in? You ready?

MR. KRELL: Yes, sir.

THE COURT: You ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. Yeah, bring them back in please?

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you.

MR. KRELL: Sir?

THE COURT: Oh, no. I was just wondering what is this? Is this that still --

MR. KRELL: It's my exhibit with the policies and procedures.

THE COURT: Oh, okay. Oh, I thought it was still the same thing. Okay. All right.

All right. And Nurse Stobbs you haven't talked to anybody about your testimony, have you?

THE WITNESS: No.

THE COURT: Okay. Thank you.

(Off record discussion)

(Jury in at 3:45 p.m.)

THE COURT: All right. Ladies and gentlemen, we're going to continue with the examination of Nurse Stobbs, okay?

Mr. Krell.

MR. KRELL: Thank you, Your Honor.

THE COURT: Yes, sir.

MONICA STOBBS - REDIRECT EXAMINATION

BY MR. KRELL:

Q Briefly, Ms. Stobbs, let me turn your attention to the Assessment of an Infant with Peripheral Intravenous Device article, please?

[illegible] Exhibit [illegible]

Q [illegible] the [illegible] the [illegible]

[illegible]?

Q Yes, it is?

A And what is the title? Assessment -- I've got it.

Q How many pages is that document?

A It looks like about two, three pages.

Q Okay.

A Two and a half.

Q Were you provided any footnotes?

A No.

Q If you would, please read the third paragraph on the first page -- the first sentence, please?

A On the first page?

Q Yes?

A The existing clinical research studies --

Q The one above it?

A The one above it. Precise complication rates are difficult to determine because of significant inter-facility variations in reporting. A lack of consistent definitions for complications and reports focused on select complications.

Q Thank you. And then if you go down to where the paragraph that starts infiltration is the most commonly identified -- do you see the note?

A Yes, sir.

Q And that talks about twenty three to seventy-eight percent. That's of reported incidents. That's not when you go to the hospital and get an IV you're going to infiltrate twenty-three to seventy-eight percent of the time. That's just of the reported infiltrations?

A Correct.

Q Okay. So you don't go into the hospital and expect seventy-eight percent of your patients be infiltrated?

A No. But as a nurse you're aware that it is a potential complication. It can happen commonly. And because of that, you have to put the proper rules in place.

Q And that's what this case is about. It's about monitoring and flushing, correct?

A Right.

Q And you're supposed to flush this IV on R.J. each time before a medication is given?

A Yes. To make sure that it's in the vein.

Q And you're supposed to document it?

A You have to document it. If it wasn't documented, it wasn't done.

Q And in this case was it done?

A It wasn't documented and it wasn't done. I do not believe that it was done.

Q Thank you.

THE COURT: Anything?

MR. TANNER: Nothing on recross, Your Honor.

THE COURT: Thank you, ma'am. You may step down. Are you ready to call your next witness, Mr. Krell?

MR. KRELL: Tekayah Hamilton.

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

MS. HAMILTON: Okay.

THE COURT: Okay.

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

THE COURT: Any objection?

MR. TANNER: No objection, Your Honor.

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

THE WITNESS: Yes, I do. Thank you.

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

THE WITNESS: Thank you.

THE COURT: Thank you.

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

THE WITNESS: (Complies)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

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

THE WITNESS: Okay.

(WHEREUPON, Tekayah Hamilton was s

duly sworn)

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

THE WITNESS: Yes, sir.

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

TEKAYAH HAMILTON - DIRECT EXAMINATION

BY MR. KRELL:

Q Tekayah, where are you from?

A Santee.

Q And did you go to school in Santee?

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

Q What year did you graduate?

A In 2003.

Q And do you currently work?

A Yes, sir, I do.

Q All right. And what do you do?

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

Q How long have you done that?

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

Q All right. And do you have any children?

A Yes, sir.

Q And how many children do you have?
A I have six.
Q Okay. And you have a child named Robert?
A Yes, sir.
Q And what does he go by?
A R.J.
Q How old is R.J.?
A He's three.
Q And was R.J. in court earlier today?
A Yes, sir.
Q And did you have to take R.J. after about -- with him being thirty days old at the time to the hospital here in Orangeburg?
A Yes, sir, I did.
Q Tell us what happened?
A He was running a fever off and on that day. And I took him to the Santee Health Clinic and they admitted -- they admitted him into The Regional Medical Center. And upon arriving they checked us in and everything, and then they took us in the other room and put the IV in and brung back.
Q And that was on the 25th of October of 2014?
A Yes, sir.
Q And how did he do during his stay in the hospital?
A He was okay. He was off and on. The fever was still running off and on and he was whining and crying.

Q Were you with him the whole time?
A Yes, sir. I was.
Q Any complications prior to October the 28th, 2014?
A No, sir.
Q On the afternoon of October the 27th, 2014 -- you've heard Nurse Stobbs testify to Mr. Tanner's question, that the nurse had checked his site and it look all right, correct?
A Yes, sir.
Q That's his IV site? Where it has an infiltration score, as you've heard of zero, correct?
A Yes, sir.
Q All right. And you heard the phlebitis score was zero, correct?
A Yes, sir.
Q Now, bring us to and put us in the room, if you can, at 4:27 approximately on the 28th. Tell us what happened?
A Okay. He was laying in the bed and he was crying, like really crying. I mean, it wasn't not like just crying. And when the nurse finally came back -- the IV beeped and when she did not came, I first pressed the button, the beep on the bed. And when she finally came, she said she was down the hall. And she finally came and she check him and she changed the IV thing and she left out. Then she came back with another lady and they was talking and she say they was

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

Q Do you need a tissue?

A Thank you.

Q You need a glass of water?

A (Witness pauses)

Q You want a little water?

A No, sir. I'm fine.

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

A Okay.

Q We'll go at your pace.

A Okay.
Q Up until 4:27 that morning, R.J. was okay?
A Yes, sir.
Q He's administered the medication at 4:27, correct?
A Yes, sir.
Q The medication goes through, correct?
A Yes, sir.

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

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

MR. KRELL: Yes, sir.

BY MR. KRELL:
Q What happens after the medicine completes?
A The machine went off and it buzzed a couple of times. I can't remember exactly how many minutes apart was it, that it just kept going off. She said she was down the hall so she can't hear it, but I did call up there twice and she finally came back and she checked it. And then that's when she left, came back and get another nurse, and they told me they was going to call the doctor then.
Q And after they removed the dressing, what did his hand look like?
A His whole hand was just swell up and on top was a big black scar and it was a bubble. It was like a big lump

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

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

THE COURT: Sure.

BY MR. KRELL:

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

A Yeah. And it had puss.

Q What's that?

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

Q Whose hand is this?

A R.J.

Q And do you know who took that photograph?

A His daddy took it.

Q Okay. His daddy took it?

A Uh-huh. (Affirmative response)

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

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

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

MR. TANNER: Thank you, Your Honor.

MR. KRELL: Thank you, Your Honor.

(Plaintiff's Exhibit No. 1, photo, was marked and entered previously)

BY MR. KRELL:

Q And if you could describe that document as well?

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

Q Whose hand is that?

A It's R.J.'s.

Q And who took the photograph?

A His dad.

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

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

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

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

MR. TANNER: Thank you, Your Honor.

THE COURT: Okay.

BY MR. KRELL:

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

A Yes, sir. He was fine.

Q And does this accurately depict what his hand looked

like following 4:50 a.m.?
A Yes, sir.
Q These are all with infiltration scores of zero earlier in the day, right?
A Yes, sir.
Q And that would be Plaintiff's 3. Does that accurately reflect how R.J. looked?
A Yes, sir.
Q And when was that taken?
A I think it was that picture right there because it bust the following day, so it'd be like the 29th.
Q Now, as a result of those injuries did R.J. have follow-up care?
A At the wound center, yeah.
Q And did he have about fifteen visits?
A Yes, sir.
Q And when he went to see the wound care specialists, what would they do to the wound?
A They unwrap it and they'll clean it and --
Q They clean it, right?
A Yes, sir.
Q And when they clean it they get in there, right?
A Yes, sir.
Q And how did that make R.J. feel?
A He cried every time.

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

THE COURT: Well --.

MR. TANNER: If he rephrases it, possibly.

THE COURT: Well, he --

BY MR. KRELL:

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

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

A He cried.

BY MR. KRELL:

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

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

Q And they did that fifteen times?

A Yes, sir.

Q On different occasions?

A Yes, sir.

Q I show you another photograph we've marked.

THE COURT: This will be 2?

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

THE COURT: Okay.

MR. KRELL: But we just marked them out of

chronological order. Excuse me.

THE COURT: I think that the --

MR. TANNER: I thought --

THE COURT: Huh?

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

MR. KRELL: It is. I just --

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

MR. KRELL: 2.

MR. TANNER: 2, right?

THE COURT: 2.

COURT REPORTER: That's in.

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

BY MR. KRELL:

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

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

Q And whose hand is that?

A R.J.'s.

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

THE COURT: Okay.

MR. TANNER: Same objection as my --

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

MR. KRELL: Thank you, Your Honor.

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

BY MR. KRELL:

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

A The right hand.

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

A His right hand.

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

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

Q How old is he?

A Three.

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

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

Q Is he able to go in the sun?

A Sir?

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

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

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

THE COURT: At his hand now?

MR. KRELL: Yes. I'm sorry.

THE COURT: Any objection, Mr. Tanner?

MR. TANNER: No, sir.

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

[redacted], brought into the courtroom)

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

hand first or do you want the --

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

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

MR. TANNER: Yes, sir.

THE COURT: Okay. All right.

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

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

BY MR. KRELL:

Q Tekayah, is this R.J.?

A Yes, sir.

(Mr. Krell present[redacted], to the jury)

MR. KRELL: Thank you, Your Honor.

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

JURY: (Affirmative response)

THE COURT: You could see his hand?

JURY: (Affirmative response)

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

[redacted], taken out of the courtroom)

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

MR. KRELL: No, sir.

THE COURT: Huh?

MR. KRELL: No, sir.

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

MR. TANNER: Yes, sir. Just briefly.

THE COURT: Yes, sir.

TEKAYAH HAMILTON - CROSS-EXAMINATION

BY MR. TANNER:

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

A Yes, sir.

Q And are y'all married?

A No, sir.

Q R.J. has rickets disease as well?

A Yes, sir.

Q Can you explain to the jury what that is?

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

Q Does he have to get medical treatment for that?

A He's just on vitamin D.

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

A Yes, sir.

Q Okay. A couple of different doctors, right?
A Yes, sir.
Q And you take him from --- you live in Eutawville; is that right? Holly Hill?
A No, sir. I live in Santee.
Q I'm sorry. Santee. You take him to Santee and Charleston to see the doctors at MUSC?
A Yes, sir.
Q And that's been going on since, what, 2016?
A Yes, sir.
Q Okay. And he sees a couple of different doctors at MUSC, right?
A He sees two different doctors.
Q Okay. Dr. Dawes, does he still see Dr. Dawes?
A No, he's gotten released.from Dr. Dawes.
Q Okay. Does he Dr. Paulo?
A Yes, sir.
Q And there was a while there that you were taking him to Charleston about every month for the rickets; is that right?
A Yes, sir.
Q You understand that R.J. first came to the hospital from Santee because of possibility of sepsis, right?
A No, I did not know what his diagnosis was at first because nobody knew. They said they was still running test.
Q Did they explain to you that they were giving him IV

because there was a potential that he could have sepsis?
A They didn't say sepsis. They say because he could have some kind of viral infection.
Q Have you looked at R.J.'s medical records?
A No, sir. I haven't.
Q You do recall him spiking a fever of almost a hundred and three degrees?
A Yes, sir.
Q And do you recall talking to Dr. Bolton in the hospital once you got to Orangeburg from Santee?
A Yes, sir.
Q And she told you that they were going to do an IV and you would have consented for the IV, correct?
A Yes, sir.
Q All right. And they started those IV medications around October the 25th; is that right?
A Yes, sir.
Q And he was discharged from the hospital on October 30th, right?
A Yes, sir.
Q Do you recall this picture being taken?
A I can't remember that date. That was after all the visits from the wound center.
Q Okay. And that would have been in Orangeburg?
A Yes, sir.

Q And he was, in fact, released from the Wound Center, right?
A Yes, sir.
Q Didn't have to have any operation or anything like that, right?
A No, sir.
Q And who is Dr. Peter DeVito?
A He's a plastic surgeon.
Q Okay. Where is Dr. DeVito?
A He's located in North Charleston.
Q And did someone refer you to Dr. DeVito?
A Yes, sir.
Q Okay. And did you see Dr. DeVito on February 2nd of 2015?
A Yes, sir.
Q And it was Mr. Krell, your lawyer, that referred you to the doctor, right?
A Yes, sir.
Q None of the doctors at the wound center told you to go see Dr. DeVito, did they?
A After they released him they say nothing else they could have done. So --
Q And Dr. DeVito saw [redacted] again on March 2nd, 2015, right?
A Yes, sir.

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

A Yes, sir.

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

A Yes, sir.

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

A No, sir.

Q Did he have any steroid injections in 2016?

A No, sir.

Q Did he have any steroid injections in 2017?

A No, sir.

Q Even though that would help his scar?

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

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

A Yes, sir.
Q Did you trust what Dr. DeVito was telling you?
A I did.
Q Okay. And he thought that the steroid injections would be of benefit to your son, right?
A Yes, sir.
Q And you want your son -- you want his scar heal, don't you, Ms. Hamilton?
A Yes, sir.
Q Your son saw Dr. Davis in March 2018 in Columbia. Do you remember Dr. Davis?
A Yes, sir.
Q And Dr. Davis was appointed by this Court to do an independent medical examination; do you recall that?
A Yes, sir.
Q Okay. And you took him up there and Dr. Davis saw R.J., right?
A Yes, sir.
Q Okay. And you had an opportunity to speak to Dr. Davis?
A Yes, sir.
Q Okay. And Dr. Davis issued a report; is that right?
A Yes, sir.
Q And that report, I believe, was dated March 28th, 2018; is that right?

A Yes, sir.
Q And Dr. Davis noted in his report that R.J. had a well-healed scar, right?
A I'm not sure what his report said.
Q All right. Do you remember Dr. Davis telling you at the time that R.J. -- when he saw him that R.J. denied pain, burning or itching with his scar?
A R.J. explain to him everything that was bothering him because he can talk.
Q So if Dr. Davis noted that R.J. when he saw him denied pain, burning and itching, that would be accurate of what R.J. told Dr. Davis?
A He didn't deny it. Because when he asked him if it itched and then Dr. Davis asked who scratch it for you. He said I tell my mama to scratch it like I tell my mama to scratch my back. So, no, R.J. didn't deny it because R.J. the one who brought up the subject about his hand hurting and itching.
Q All right. So it's your testimony that Dr. Davis didn't accurately put that in his report?
A I'm not sure what he put in his report because I didn't read his report. I'm telling you what happened when I was there and what happened.
Q Okay. Do you remember Dr. Davis doing some muscle test to R.J.?

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

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

A It's my testimony.

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

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

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

A Yes, sir.

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

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

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

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

A No.

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

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

Q You think -- I'm sorry.

A I can't --

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

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

Q Because you were going to Charleston --

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

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

A Not where Dr. Dawes office is.

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

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

Q So the Charleston metropolitan area?
A Right.
Q Do you think the appointment was from three years ago in 2015?
A I'm not sure. I can't say yes or no. I can't remember.
Q It just seems a little odd to me that you don't see Dr. DeVito for three years. You see a different doctor that the Court appoints in Columbia that tells you --
A It's not odd because like I said I missed an appointment with Dr. DeVito and I explained to Mr. Johnson -- I spoke with Mr. Johnson probably twice about that, but I was also staying in touch with Ms. Debbie and let her know what was going on. And she understood that I had to get that straight and make sure he stay on his medicine.
Q Okay. But R.J.'s not on any medicine for his hand, right?
A No.
Q So the reason you went back to the Dr. DeVito just a few weeks ago wasn't because you got Dr. Davis' report?
A I'm pretty sure it wasn't because it's not like he said this and that. He was just doing a follow-up appointment.
Q Even though you didn't have any appointments with Dr. DeVito in 2017?
THE COURT: Mr. Tanner, we've gone over this

enough.

BY MR. TANNER:

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

A No.

Q Okay. Thank you, Ms. Hamilton.

THE COURT: Anything on redirect?

MR. KRELL: Yes, sir.

THE COURT: Okay. Limited to his cross again.

TEKAYAH HAMILTON - REDIRECT EXAMINATION

BY MR. KRELL:

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

A No.

Q Maybe when he gets older?

A Correct.

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

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

Q Do you know how Dr. Davis got involved?

A No, sir.

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

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

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

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

Q We agreed to it, right?

A Yes, sir.

Q Thank you.

THE COURT: Anything on recross?

MR. TANNER: Just briefly.

TEKAYAH HAMILTON - RECROSS EXAMINATION

BY MR. TANNER:

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

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

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

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

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

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

Q When you saw -- I'm sorry.

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

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

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

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

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

Q Okay. Thank you, Ms. Hamilton.

A Uh-huh.

THE COURT: All right.

MR. KRELL: Nothing further from Ms. Hamilton.

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

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

would be Dr. DeVito.

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

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

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

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

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

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

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

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

MR. TANNER: No, sir.

THE COURT: Okay. All right.

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

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

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

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

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

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

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

THE COURT: Are we ready?

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

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

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

THE COURT: Okay.

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

time.

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

MR. TANNER: My expert, Nurse Hurley.

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

MR. KRELL: Yes, sir.

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

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

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

MR. KRELL: That's fine.

THE COURT: Will that be all right?

MR. KRELL: That's perfect.

THE COURT: Okay. All right.

(Off record discussion)

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

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

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

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

testimony out of order, okay?

MR. WILLIAMS: Okay.

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

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

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

THE COURT: Okay.

Okay. Plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Defense ready?

MR. TANNER: Yes, sir.

(Off record discussion)

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

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you, ma'am.

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

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

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

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

THE COURT: Okay. Come on down.

MR. SHAKIBANASAB: (Complies)

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

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

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

MR. SHAKIBANASAB: (Complies)

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

MR. SHAKIBANASAB: Yes.

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

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

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

THE COURT: All right.

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

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

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

A Yes, we are.

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

A Yes.

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

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

Q And what is your profession?

A Plastic surgery.

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

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

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

A It was in Atlanta.

Q And how long is a general surgery residency?

A Five years.

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

A Yes, sir.

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

A Yes.

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

A Yes.
Q Explain to the jury, what's significant about being the chief surgical resident?
A Residency is -- you're a doctor when you graduate from medical school, but you're a doctor in the book sense only. And so the way residency programs in the United States work is graduated responsibilities starting from internship all the way through until you graduate. Your final year you can be elevated to the level of chief resident. The chief resident really is somebody, although supervised, more distantly supervised. You're sort of running your own clinic at that point with mild supervision so that you can learn to make those choices properly for patients.
Q And that would have been done something you have done at the Atlanta Medical Center your final year?
A Yes.
Q All right. And then you mentioned that you had a fellowship after your general surgical residency?
A I did.
Q And was that at the medical university?
A In Charleston, yes.
Q And that was in plastic and reconstructive surgery?
A Correct.
Q And that's a two-year program?
A It is.

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

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

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

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

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

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

fellowship.

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

A Nose.

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

A I did.

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

A Just under two years, yeah.

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

A Correct.

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

A I am.

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

A Yes.

Q Any partners in your practice?

A No.

Q And your licensed to practice medicine in South Carolina?

A I am.
Q And are you currently licensed to practice medicine in any other state?
A No.
Q And have you previously been licensed to practice medicine in any other states?
A Yes, I was licensed in Georgia as part of the residency.
Q And then when you moved back to South Carolina, you let that license lapse?
A I did.
Q All right. And are you board certified?
A Yes.
Q In what specialty?
A Plastic and reconstructive surgery.
Q Explain to the jury what it means to be board certified in those fields?
A So there are only -- The American Board of Medical Specialties, ABMS, defines which specialties are qualifying for certification. And then each one of those specialities has their own requirements once they are a member of the American Board of Medical Specialities. And for plastic surgery in the United States, you have to -- in my area you had to be fully -- already fully trained in one of the three disciplines prior to going. You had to be fully trained in

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

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

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

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

A Ten years.

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

A Every ten years.

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

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

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

A Yes.

Q And are those terms synonymous and basically differing

with a solution involved?
A Yes, I think that again those are interchangeable. People would have used them probably, slightly, you know, they would use for the same purposes.
Q And have you also in your medical career provided assessment and treatment to patients that have had scaring?
A Yes.
Q And treated scaring on their hands?
A Yes.
Q All right. And you were court ordered in this case to perform an independent medical examination on [redacted], correct?
A Yes.
Q Did you prepare such an examination?
A I did.
Q And that was at what time in this year, do you know?
A I think it was -- it was in March of this year, I think.
Q And did you issue a report?
A I did.
Q And that report is dated March 28th, 2018?
A Yes.
Q All right. And that would have been the report you did after your examination of [redacted]?
A Correct.

Q All right.

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

THE COURT: Any objection?

MR. KRELL: No, sir.

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

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

Okay. Thank you.

MR. TANNER: Thank you, Your Honor.

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

A No.

Q Let me sort of explain this, what the records indicate and I have a series of questions for you. When you saw Mr. [redacted], was his mother present?

A Yes.

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

A No.

Q Did she tell you that when he was approximately thirty

[illegible]

[illegible]

[illegible]

A No.

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

A No.

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

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

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

A Yes.

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

A Ask me that again?

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

A Yes.

Q Answer?

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

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

A Until isolating the particular bacteria, yes.
Q Okay. And what is your understanding of claforan and ampicillin, are those considered broad-spectrum antibiotics?
A Well, yes. They are different and yet they would cover the majority of the infectious disease.
Q And is the use of IV administered antibiotics for a potentially septic patient an appropriate method to administer antibiotics?
A Yes.
Q And does the placement of an IV have known potential complications?
A Yes.
Q And can you explain to the jury what the potential complications in an IV would be?
A Well, so even though minimally invasive, an IV is anything that breaks the skin, it's somewhat invasive. And so to be able to present a patient with either fluids or medications in a liquid form, that is non-internal, you have to cannulate the blood vessel and we would rather that be a venous blood vessel. And venous blood vessels are sometimes difficult to find and/or fragile.
Q Doctor, I believe you testified in your discovery deposition that you have treated patients who have either an infiltration or extravasation in your residency?
A Yes.

Q All right. And is that similar to what [redacted], suffered?

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

Q Okay. And you testified you prepared a report?

A Yes.

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

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

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

MR. SHAKIBANASAB: Oh, pardon me.

THE COURT: Could you reread it?

MR. SHAKIBANASAB: May I start?

THE COURT: Yeah.

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

Q And that would be the nature of your examination?

A Yes.

Q All right. What sort of testing did you perform on [redacted]?

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

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

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

Q And you performed those various and sundry tests with [redacted]?

A I did.

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

A Yes.

Q Do you have a copy there in front of you?
A I do.
Q Can you tell me your findings from your independent medical exam, please, Dr. Davis?
A Well, so he was approximately three years old and the dorsal or the back side of his hand had scar tissue. And that area of the scar tissue is between his wrist and his -- what the public would call knuckles. But the metacarpophalangeal joint, the scar tissue was an area that was not consistently one thing. Some areas were thin. Some areas were thick. Also there were portions of the scar tissue that were not the same color as the rest of the back of the hand. Some areas were darker than the parts of the back of the hand. Some areas were lighter in color.
Q Let me stop you there for a second?
A Yes.
Q Real quick. Did you make any comment in your examination about whether [redacted] scar was healed or not healed?
A So based on a conversation that I had with his mother, really about whether or not there have been any break-down to the tissue after the initial healing and time since initial healing, and on my exam I was able to determine that he had, what we would call a well-healed or a mature scar that should be stable from this day forward.

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

A Yes.

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

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

MR. KRELL: That's wrong.

MR. TANNER: Deficits.

A Deficits to any of those.

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

A I did.

Q And what was his response?

A He denied any pain.

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

A I did.

Q And what was his response?

A He did not have any burning.

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

A I did.

Q And what was his response?

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

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

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

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

Q And what was your finding as to [redacted]?

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

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

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

Q And --

A But a part of the exam.

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

A Right. So the hand generally moves in multiple

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

Q And did you find any impairment of tendon functionality?

A I did not.

Q And presuming that [redacted] doesn't have any injury to his hand with respect to him, do you have an opinion on whether or not he would have normal functionality throughout the rest of his life?

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

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

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

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

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

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

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

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

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

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

Q All right. And did you recommend some possible treatment options for [redacted], as a result of this?

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

Q All right. What were those techniques.

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

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

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

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

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

Q And that would be under general anesthesia?

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

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

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

A Yes.

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

A I do.

Q And what would that cost be?

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

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

A And steroid -- and steroid injections, yes.

Q And that would include the anesthesia component as well?

A Yes.

Q All right.

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

MR. KRELL: No objection.

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

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

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

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

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

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

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

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

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

A Yes.

Q And what would your opinion be?

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

Q And if Dr. DeVito would have implemented the steroid regime, do you have an opinion on whether or no[redacted] scar would be softer?

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

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

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

Q At this stage if[redacted] doesn't avail himself to any of those treatment options, do you have an opinion to a reasonable degree of medical certainly on whether or not the scar will get better or worse?

A I do have an opinion.

Q And what would that be, sir?

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

Q It should sort of remain the same?

A Correct.

Q All right. And as a part of your examination, did you take photographs of [redacted]?

A I did.

Q All right. I'll pass this photograph to you. Did that photograph accurately and truly represent the condition of [redacted] hand when you performed the IME.

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

Q And you, yourself, took the picture?

A I did.

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

A No.

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

A Yes.

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

MR. KRELL: No objection, Your Honor.

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

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

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

degree of medical certainty and most probably whether [redacted], will be able to throw a ball?

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

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

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

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

A No.

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

A No.

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

A No.

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

A I saw no functional --

MR. TANNER: Deficits.

A -- deficits.

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

A No reason.

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

A He should be able to drive.

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

football?

A I see no reason that he couldn't.

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

A None that I can tell.

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

A Yes.

Q Thank you for time, sir.

THE COURT: Have you got --

(Cross examination read by Mr. Krell)

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

A Yes.

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

A Yes.

Q And how can it?

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

Q All right.

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

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

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

A Right.

Q On someone, correct?

A Yes.

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

A Yes.

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

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

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

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

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

A Well, at least three. Yeah.

Q At least three?
A Yeah.
Q And he's still having problems?
A That's --- yes, she's informed me of that?
Q Yeah?
A Yeah.
Q And having -- wanting it scratched or having it itch, that's a symptom of scaring --
A It can be?
Q Correct?
A Yeah.
Q How about in this case, do you have an opinion?
A Well, you would -- anybody who has a thick scar tissue that tells you that they itch, you would believe that that is related to the thickness of the scar tissue.
Q And in this case for R.J., do you have an opinion regarding --
A Well, he does have some thick scar tissue. I don't have an opinion about how he felt about it because he did not answer me when I asked him does it itch?
Q But mom, mom did?
A Mom did.
Q And he is a child of tender age?
A Right, yes.
Q So?

A Yes.
Q Okay. And the mom did say that he wants her to scratch it?
A Correct. Correct.
Q Okay. That's what's in your report, correct?
A Correct.
Q And that's Exhibit 1 to your testimony, correct?
A Yes.
Q Okay. We also have a note from Exhibit 1 that the scar felt tight. Did that come out during your direct exam?
A I don't know if came out during the exam, but --
Q I don't know either. You, during your direct examination?
A During my physical findings he told me during all those functionality tests that I gave him that it sometimes felt tight.
Q What does that mean to you as a doctor?
A Well, I -- the way I would interpret that personally -- and he obviously is three, he did not -- he was not as fluid in his discussion. But the human body is sort of fluid until there is an injury and then it is less fluid. And so I would not be -- it would not be a surprise to me if somebody with scaring felt tight, less fluid.
Q And he was able to describe it in such a way that you interpreted that it felt tight, the scar?

A Right, yes.
Q And that tightness is certainly related to the infiltration, correct?
A Well, it would be believable that it was due to the scar tissue.
Q You believe it, correct?
A Yes.
Q Okay. And that's given to a reasonable degree of medical certainty?
A Yes.
Q Okay. Now, with all the treatment you've described, the steroid treatment, getting a three-year-old to take steroid treatments are going to be very difficult, correct?
A Well, you would not want to make it scary to them. And, yes, so I think anything that has to be -- we're giving somebody a shot at that age --
Q Uh-huh.
A -- it is --
Q Wouldn't you agree with --
A -- intimidating.
Q Sorry. Wouldn't you agree with me that in this case that giving R.J. steroid shots is not going to have -- would not be an easy thing to do?
A I would totally agree with you that it's not easy.
Q Right?

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

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

A That's right.

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

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

Q Right.

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

Q Uh-huh. (Affirmative response)

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

Q Right.

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

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

year-old child?

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

Q Benadryl is a medication for itching, right?

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

Q Okay.

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

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

A Yes, right.

Q You also said you can physically hold him down?

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

Q Okay.

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

Q Uh-huh. (Affirmative response)

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

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

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

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

A And then you inject.

Q And then you inject?

A Yeah.

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

A Well, only into the thick areas.

Q Okay.

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

Q Is that the --

A It's not --

Q -- thickness or --

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

Q So he would just need to have one stitch?

A Probably so, based on the size of his hand, yes.
Q All right. Now, you also talked about surgery, correct?
A Yes.
Q That he probably needs?
A Well, so it's not -- it's more about not need, it's the wrong word, but --
Q Uh-huh. (Affirmative response)
A -- if a person comes to me and would like to improve the look of the scar and not, you know, like we said before not necessarily that there's a functional problem, but the look of it.
Q Uh-huh. (Affirmative response)
A Then we only have a couple of options available. Whether or not you do stuff externally or remove the scar through an excision.
Q And if you do either technique, the steroids or the scar revision, R.J.'s still going to have a scar there for the remainder of his life, correct?
A Yes.
Q And that's -- you have an opinion that he'll have a permanent scar for the remainder of his life, correct?
A I'm of the opinion that he --
Q And what --
A -- will have --

Q What -

A -- a permanent scar.

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

A Yes.

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

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

Q All right.

A But he would definitely have the scar still.

Q No more questions.

MR. TANNER: Nothing further from this witness.

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

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

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

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

(Court in session May 8, 2018 at 9:00 a.m.)

THE COURT: Are y'all ready?

MR. KRELL: Yes, sir, Your Honor.

THE COURT: Okay.

MR. KRELL: We just have one matter to take up. Michael and I spoke and the life expectancy of this child -- he's three years old. From the date of trial forward would be 73.76 years and we'd ask that you take judicial notice of that.

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

MR. KRELL: In the charge?

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

LAW CLERK: .76.

THE COURT: Yeah. Okay.

Anything else?

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

THE COURT: Okay. Let me just tell y'all what my expectation is. My expectation is we're going to finish up with witnesses this morning and we're going to do the -- it'll go to the jury some time this afternoon.

MR. KRELL: Nothing from the plaintiff on that.

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

MR. KRELL: Yes, sir.

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

MR. KRELL: Yes, sir. Thank you.

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

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you, ma'am.

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

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

And is plaintiff ready to call its next witness?

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

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

THE WITNESS: Yes, sir.

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

THE WITNESS: (Complies)

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

PETER DEVITO - DIRECT EXAMINATION

BY MR. KRELL:

Q Good morning, doctor?

A Good morning.

Q What do you do for a living?

A I'm a plastic and reconstructive surgeon.

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

A Almost fifty years.

Q Where did you go to college?

A I graduated from Princeton University. Medical school was Duke University, and I did my internship in general surgery at Yale. And I was one of the two plastic surgery professors at the medical university and ran the residency during the 70s. And I went into private practice in 1980 and was chief of plastic surgery at Roper Hospital for fourteen years. And I've been chief at St. Francis Hospital. Those are the two biggest hospitals in Charleston, over twenty-five years now. I'm a senior advisor to the South Carolina Society of Plastic Surgeons.

Q Do you typically treat patients with scars?

A All the time. My whole life.

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

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

Q Cancer in children?

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

Q Over the course of your --

A Pardon?

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

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

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

A Yes, sir.

Q Regarding surgery, plastic surgery on patients' hands?

A Well, I wrote the emergency room manual sections on

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

Q You teach as well or you did teach?

A I still do.

Q Oh, you do?

A Yes.

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

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

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

A Dr. Donen Davis, right.

Q He did rotation with you?

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

Q All right.

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

MR. TANNER: No objection, Your Honor.

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

All right. He's your witness.

MR. KRELL: Thank you, Your Honor.

BY MR. KRELL:

Q Dr. DeVito, did you see [redacted]

A I did.
Q Did I set up an independent medical exam with you?
A I believe so.
Q And were you paid for that?
A Yes. We charged the standard fees of the Charleston County Medical Society. We adhere to that suggestion of medical legal fee schedules for reports and appearances and testimonies and --
Q So isn't -- the fee is five hundred dollars. Does that seem about right?
A I believe that's what it is now. I don't keep up with it. The office up front just deals with that.
Q In your chart you have it where it reflects that the independent medical exam fee is five hundred dollars? If you could --
A It's probably in here somewhere, Mr. Krell. I don't have the bills.
Q Okay.
A The only thing I have are the notes that I dictated but there's probably a bill summary. Here it is. It is. Yes. 1/26/15, charged five hundred dollars, credit five hundred dollars, Attorney Krell.
Q And when did you see R.J. for this independent exam?
A When did I see him the first time?
Q Yes, sir.

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

Q How was he doing at that time?

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

Q What's a keloid?

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

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

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

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

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

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

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

A Sure. (Witness steps down)

BY MR. KRELL:

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

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

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

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

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

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

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

photograph?

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

Q Is that painful?

A The whole nature of the wound is painful.

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

A Thank you. (Witness takes stand)

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

A This is the February 2nd note?

Q Yes, sir?

A Yes, sir.

Q You said there was also hypertrophic scarring bordering

on keloid formation?

A Yes, sir.

Q What did you next find?

A Let's see here.

Q You talked about steroid injections?

A Yes, sir?

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

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

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

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

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

Q It's painful?

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

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

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

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

Q Well, what are you recommendations?

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

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

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

A Yes.

Q And how was he doing then?

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

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

A Both. Both.

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

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

A No. Very understandable.

Q Let me show you --

A it's a dilemma.

Q A painful dilemma?

A Yes.

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

A (Witness steps down)

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

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

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

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

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

Q How about if you did scar revision surgery?

A There's always a scar.

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

A (Witness takes stand)

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

A Yes, sir.

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

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

Q Okay. Was the scar symptomatic at that time?

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

Q What do you mean withdraw?

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

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

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

BY MR. KRELL:

Q What does your note reflect?

A I don't know.

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

BY MR. KRELL:

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

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

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

Q And you recommend surgery?

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

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

A Well, yes. There's pain.

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

A Yes, sir.

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

A Yes, sir.

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

THE COURT: That's plaintiff's 6?

MR. KRELL: 6, Your Honor.

BY MR. KRELL:

Q You've had a chance to review those?

A Yes, sir.

Q Do those seem reasonable and necessary?

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

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

A Yes, sir.

Q Is that the bill associated with the wound care?

A Yes, sir.

Q Does that seem reasonable and necessary?

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

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

MR. TANNER: No objection.

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

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

BY MR. KRELL:

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

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

Q Right?

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

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

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

Q Is there more procedures?

A It could be.

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

A Yes. Yes, sir.

Q Okay. And then how about the associated costs,

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

A Yes, sir.

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

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

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

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

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

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

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

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

A Yes, sir.

Q Does that accurately reflect your visit in this matter?

A Yeah. This is my initial office note.

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

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

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

MR. TANNER: No objection.

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

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

BY MR. KRELL:

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

THE COURT: Mr. Tanner.

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

PETER DEVITO - CROSS-EXAMINATION

BY MR. TANNER:

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

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

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

A Yes, sir.

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

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

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

A No.

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

A No.

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

A No, sir.

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

A No, sir.

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

A No.

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

A It was thick and it was similar.

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

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

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

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

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

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

MR. TANNER: 2, yes, sir.

THE COURT: Okay.

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

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

THE WITNESS: Thank you.

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

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

BY MR. TANNER:

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

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

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

A Yes, sir.

Q Okay.

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

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

THE WITNESS: I'm sorry.

THE JUROR: Okay.

THE COURT: Okay. All right.

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

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

Q Okay.

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

MR. TANNER: 1.

COURT REPORTER: Thank you so much.

MR. TANNER: Yes, ma'am.

BY MR. TANNER:

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

A No, I took no pictures.

Q But you did an independent medical exam?

A Yes.

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

A Yes, sir.

Q And that would be the same picture?

A Yes, sir.

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

A No.

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

A I don't know when it was scheduled.

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

A Correct.

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

A I saw it.

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

A Yes.

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

A No.

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

A Yes.

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

A Yes, sir.

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

A With the derma jet?
Q Yes, sir.
A The derma jet is as painful as a needle. It's just that it's not a needle. It's injecting the cortisone under high pressure and it helps the physician to get the medication into the scar itself, rather than to try to do it with a needle and syringe.
Q Yes, sir. You had mentioned when Mr. Krell was asking you questions though if the child at age three, almost four, come in and see you in the white coat, he can be upset. And so my question is if you'd done this when he was four months old, presumably he wouldn't have had that same apprehension, right?
A Oh, no. He could still have apprehension because the derma jet treatments are painful. And, you know, I did it. I gave him the pain and he'd see the white coat and the white coat, pain -- it's emotional scaring that --
Q Well, but almost four years later he might not remember it, correct?
A No.
Q You would agree that it --
A He would remember it.
Q -- that it was your recommendation back in February of 2015 to have steroid injections, correct?
A Yes. And I still do.

Q And then would have been your recommendation to Ms. Hamilton?
A To treat the scar, yes.
Q You thought that would benefit her son, right?
A Yes.
Q And to date he hasn't had any injections?
A No, not yet.
Q And when he came back in March you again recommended him to have the steroid injections, correct?
A Yes, sir.
Q And you felt at that time that it would benefit, benefit the child?
A Yes, sir.
Q And you mentioned earlier the jell, the sheeting. And that was what Dr. Davis recommended from his report that you read, right?
A Yes, sir.
Q I don't see anything in your report that he has any loss of functionality, correct?
A I really didn't examine him about that. He wouldn't even let me touch the wound. So I suspect he has some limitation, utilization of that hand compared to a child who doesn't have a hand that's injured like that.
Q But you don't have anything in your report --
A But I don't have anything in my report about it.

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

A I don't believe so.

Q Thank you, sir. No further questions.

THE COURT: Anything on redirect limited to his cross.

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

THE COURT: Any problems with that?

MR. TANNER: No objection.

THE COURT: Thank you, Dr. DeVito.

THE WITNESS: Thank you, Your Honor.

THE COURT: Yes, sir.

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

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

THE COURT: Okay.

(Off record discussion)

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

THE COURT: All right.

Do you know what --

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

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

A I don't believe so.

Q Thank you, sir. No further questions.

THE COURT: Anything on redirect limited to his cross.

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

THE COURT: Any problems with that?

MR. TANNER: No objection.

THE COURT: Thank you, Dr. DeVito.

THE WITNESS: Thank you, Your Honor.

THE COURT: Yes, sir.

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

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

THE COURT: Okay.

(Off record discussion)

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

THE COURT: All right.

Do you know what --

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

-- if he'll refresh my recollection.

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

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

(Off record discussion between counsel)

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

THE COURT: Okay. All right.

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

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

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

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

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

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

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

THE COURT: All right.

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

THE COURT: Who's going to speak?

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

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

THE COURT: All right.

Mr. Tanner, anything else?

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

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

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

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

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

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

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

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

(No response from counsel)

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

(Court at ease)

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

MR. WILLIAMS: Yes, sir.

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

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

THE COURT: Yes, sir.

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

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

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

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

All right. Y'all ready?

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

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

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

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

MR. WILLIAMS: That's fine.

THE COURT: That's fine. Okay.

Bring the jury on in.

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you.

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

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

Yes, sir.

MR. WILLIAMS: May it please the Court.

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

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: Thank you, Your Honor.

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

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

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

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

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

Yes, sir.

MR. WILLIAMS: May it please the Court.

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

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: Thank you, Your Honor.

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

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

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

Thank you.

THE COURT: Thank you, sir?

Any other witnesses on behalf of the plaintiff.

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

THE COURT: Okay.

Where's Ms. Downing.

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

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

THE COURT: Do you know where she is?

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

THE COURT: Yeah. Go ahead.

MR. TANNER: (Exits courtroom)

(Court at ease)

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

THE COURT: Sure.

(Court at ease)

THE COURT: Mr. Shakibanasab?

MR. SHAKIBANASAB: Yes, sir.

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

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

MR. SHAKIBANASAB: (Exits courtroom)

(Court at ease)

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

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

MR. WILLIAMS: Sure.

THE COURT: Y'all work it out.

MR. WILLIAMS: (Exits the courtroom)

(Court at ease)

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

(Counsel enters courtroom)

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

THE COURT: Oh, okay.

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

(Court at ease)

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

got to --

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

THE BAILIFF: Take them back out --

THE COURT: Yeah. Yeah.

THE BAILIFF: Okay.

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

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

(Court at ease)

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

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

THE BAILIFF: (Affirmative response)

(Court at ease)

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

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

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

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

THE WITNESS: (Complies)

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

THE WITNESS: Yes.

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

THE WITNESS: Uh-huh. (Affirmative response)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

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

(WHEREUPON, Jamie Downing, was duly sworn)

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

JAMIE DOWNING - DIRECT EXAMINATION

BY MR. WILLIAMS:

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

A I recently relocated to Greensboro, North Carolina.

Q Okay. And are you still a nurse?

A I am.

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

A Yes. Vaguely.

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

had begun working full time shortly before that?

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

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

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

BY MR. WILLIAMS:

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

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

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

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

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

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

shift on the floor for six to eight weeks.

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

A Yes, that's correct.

Q And you started in August?

A Yes.

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

A That sounds about right.

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

A I think it was the end of October.

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

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

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

A I'd only been there for a few months, so that sounds about accurate, yes.

Q And during your two-week training, were you given policies and procedures?

A So for the first two weeks it would have been hospital-base training, that is the time you review all the hospital policies.

Q And when you did your six to eight week training with

another nurse, you went specifically through the policies and procedures?

A You specifically care for patients on the floor, and learn the policies in the two weeks prior and implement that into your care of the patient. So you're giving direct patient care.

Q So you would expect during that training that they would show you all the policies and procedures?

MR. TANNER: Object, Your Honor. Improper form.

BY MR. WILLIAMS:

Q Did you review all the policies and procedures?

A Yes.

Q Did you have a nurse tell you how to interpret the policies and procedures?

A So the way a hospital policies and procedures are written, they're not -- there's not room for interpretation. They are direct instructions on the way you should perform a procedure.

Q Okay. So there's no room for interpretation as you read it as whatever it reads, correct?

A Correct. That is the policy of the hospital.

Q Whether it's an infant or an adult are you told to assess the IV the same way?

A So IV assessment, I don't believe -- it's not a full step by step policy. There are recommendations on when IV's

should be assessed, who they should be assessed on, how frequently. But a true nursing assessment of an IV is something that is more for the nursing school, practiced through nursing school and done through the nursing practice. It's not something that is step-by-step taught through a policy. It's something you repetitively do throughout your nursing practice and training.

Q Sure. But my question is, in your assessment, is there anything different from with infant as opposed to an adult in the assessment of the IV site?

A Yes. Pediatric IV's are very different than adult IV's. With pediatrics, your patients are very small and very mobile, so one factor their veins are very small, they're very mobile. They're very fragile. So in assessing a pediatric IV's you're going to do a more frequent assessment and you're also going to be more understanding of how this patient's probably going to move more. They don't understand what they're doing. Obviously, a baby, pulling at his IV is not intentional or pulling at a site isn't intentional. So you're very aware of that when assessing a pediatric IV, whereas you might have adult patient who's lucid, their veins are more stable. Their veins are bigger. They're able to use bigger catheters, we call them. That's the part of the IV that stays in the vein. So it's very different assessing an adult and a pediatric patient.

Q Tell me, what are the steps to assess an IV site?

A So to assess an IV sited means to check it. So to assess an IV, kind of eyes, feel, kind of going through everything. So you're first is going to look at the patient. Where is the IV site? So I know with [redacted] it was in his hand. So you're first going to look at that hand. If this is the first time you're coming onto the shift, you're going to do a very thorough assessment, say this is where it is. This is the way it looked when I first saw it. And your assessment throughout the night are going to be kind of based off of that. So you're going to look at the position of the IV. There are little (inaudible) at the bottom of an IV, so especially pediatrics there's a little tiny triangle. So a way to see if it's in the same position is to look at that triangle. And you kind of want it pointed in the same spot. There's going to be a clear dressing over it. You want to make sure that dressing is intact. That there no -- any fluid or anything that looks, other than normal. So you want to make sure that dressing is intact. There's specifically extra tape in a pediatric IV that's going to be moving a lot, and you want to make sure that tape is still there and that it's secure. You're also going to see if there's anything stabilizing it. So a lot of times pediatrics they will have an arm board. So that will cushion, that stabilizes the arm

and the hand to keep it straight. So you want to make sure an IV -- it's like a little straw that goes into another little straw and it's very flexible. So sometimes you need to hold that in the same position. So that's what you're going to do when you're looking at it. If there's any tubing hooked up to it, you want to make it's intact, there's nothing changed or abnormal about that IV tubing. You're going to look at it and touch it. You want to feel the top of it and feel around it. It should be consistent with the patient's other extremities. So if this hand was soft and smooth and warm, then it should be soft and smooth and warm. You're going to feel for any kind of swelling, any temperature changes. You're going to keep looking at it, touching. And then you're going to check for something called PEC, so making sure that straw is open so that we're able to flush fluid in and out of it. So you would clean the site and then flush it with normal saline, which is like salt water. So a small amount, about a millimeter, of normal saline just making sure that IV is flowing the way it's supposed to. And so that's going to kind of give you an idea. And you're still going to keep touching and feeling the site as you're flushing it to notice for any changes since that would indicate that the catheter isn't where it's supposed to be. So if you notice any sign and if it's cool to the touch, that means you're touching fluid,

you're not touching skin. So you continuously monitor that while assessing the IV. And if all that's good and it looks like it did the first time you saw it, you're not seeing any additional discomfort from the patient, sometimes that salt water can be a little irritating, so you kind of have to assess that, especially in a pediatric patient who can't talk to you. So it can be a little irritating the first time you do it, if the patient initially kind of (inaudible) you'd flush it a little bit more and a lot of times they kind of calm down a little bit after that first irritation because it is salt, so it can be a little irritating, so. You're probably doing a lot of things. You're looking, you're touching, you're feeling, you're seeing, you're flushing. Sometimes those pediatric IVs, especially in the hand, they can become kinked. So sometimes it takes a little manipulating, maybe even to tape the hand a little bit more on the arm board, open that straw back up. And so it's just kind of a give as you go. And you just kind of have to keep reassessing. But that first, initial assessment, you're really going to have a good idea of where that placement is so then throughout the night you can continue to look at that same placement for reference in your assessment.

Q Ms. Downing, you had a rather lengthy explanation. Can you tell me any of those steps you don't do for an adult?

A So you would do it with an adult. So you typically wouldn't have an arm board with an adult patient if the were lucid. The thing to take out of it with pediatrics is that it is much --

MR. WILLIAMS: Your Honor, at this point I'd ask you to instruct her to answer the question yes, no or at least allow me to treat her as a hostile witness.

MR. TANNER: I think she's trying to answer his question.

THE COURT: Well, I think you were asking her to differentiate -- the difference and I thought she was explaining that. What was she doing --

MR. WILLIAMS: Well, she's talking about an arm board. I've asked her about what's different in the assessment of the IV site and what -- I think she's admitted that there's nothing really different about the assessment of the IV site --

THE COURT: Well, I don't know --

MR. TANNER: Because he interrupted her before we could hear her answer.

THE COURT: Well, you just hold on. Ms. Downing. It is Downing, right?

THE WITNESS: It is.

THE COURT: Okay. Ms. Downing. I'm sorry. When Mr. Williams is asking you the question, if you would just

address that specific area. And right now he's asking you about assessments. So if there is a different way that you assess adults rather than children in putting in the IV, that's what -- if you would just address that.

THE WITNESS: Absolutely.

THE COURT: Okay.

THE WITNESS: Sorry.

A It's just that it's a little complicated in talking about adults and pediatrics. So adults, you would check an arm board if you an arm board. You don't typically have one, which is why I mentioned it. Also before administering a medication you have to for a check for blood return in an adult patient. You're not able to do that in pediatrics because for risk of collapsing the vein or compromising the site. You wouldn't do that with a pediatric patient like you could do with an adult if you're about to give medication. You could assess a patient differently for pain. And as an adult, you can ask them if they feel tender at the site. Yo can't do that with pediatrics. I think it more comes down to being able assess a pediatric patient versus an adult rather than specific things you do.

BY MR. WILLIAMS:

Q Sure. But you touch and feel both an adult or a child's hand?

A Yes.

Q You check for potency?
A Patency?
Q Patency, excuse me?
A Yes. Making sure the IV is flowing well.
Q And do you clean the site?
A Yes.
Q And you always flush before you administer the antibiotic?
A You would always flush an IV before administering any medication.
Q So you always flush at least four hours?
A Yes. And that's the hospital policy. It's either you would flush with the normal saline of if they were getting a medication, it's just making sure the IV is being used every four hours to maintain the site.
Q Okay. So is the administration of the ampicillin a suitable flush?
A So that's kind of a tricky question. So it would meet the hospital policy that you would need to use the IV every four hours, but you would need to flush it prior to giving the medication to assess the site. So that's kind of considered part of the entire procedure.
Q And you're required to note that you flushed the site is that right?
A So flushing a site is part of your assessment so it's

not -- as -- that is not in the Cerner (sp) data base for that flush to be documented. The four-hour flushes do task, so everything comes up with a flow sheet. So there is no way -- so assessing the IV is part of the procedure of giving the medication, so there is not a specific spot to say, yes, this amount of saline was flushed prior to giving the medication because that's -- it's just part of the procedure.

Q Before the time of the incident that we're here today about, had you noted that you flushed the IV before administering ampicillin.

A No. So like I said there's no task or flow sheet that pops up for me to document that information in the charting system.

Q So The Regional Medical Center mandates in their procedure manual that you're to document when you flush, but there's no way for you to document it?

A Okay. The Regional Medical Center policy documents that the IV is flushed every four hours. And that is done through the medical administration record. So the flushes are documented every four hours and they're automatically populate and the medications populate on there as well. So that's where that would be documented. When you're doing a medication and flushing it, -- There's no way to give the medication without flushing the IV first, so it's considered

part of that procedure.

Q Does your policy and protocol indicate that you're to flush prior to administering medication?

A I'm sorry, that I don't know it -- memorized off the top of my head.

Q Okay. And does your policy and procedure number twelve say that flushing the INT with the saline is to be documented on the D mark?

A (Witness pauses)

Q At the very bottom?

A Yes. So this section of the policy is referring to INT flushes that are used, those every four-hour flushes if you're not giving a medication. The INT policy protocol for flushing above says to instill the saline flush and doesn't mention documenting. So here at the bottom it's just talking about whether just flushing the IV and you're not actually giving a medication with it, just that that's documented in the MAR, (sp) that's something to be given every four hours.

Q So earlier you said there's no room for interpreting these policies; is that right?

A Right. This is written and you follow these policies.

Q And that policy says flushing the INT with saline is to be documented on the MAR; is that right?

A Yes, absolutely for when you are just giving a flush

and not giving a medication.

Q Okay. Does it say that in that policy?

A As a nurse interpreting this policy, as someone who has managed multiple IV's, yes. This is what it means to a nurse.

Q As a nurse who's managed multiple IV's for two weeks, three weeks?

A So that's not a correct statement. So as a nurse, you're in nursing school for two and a half years. I did multiple IVs. This is not the first time I've ever managed an IV.

Q Okay. But do you agree that nothing in the policies and procedures says anything other than it's to be documented on the MAR every time you do a flush?

MR. TANNER: Objection, Your Honor. It's been asked and answered at least two or three times.

THE COURT: Well, I'll let her finish answering that. Thank you.

A Yes. So I understand the spot -- It's in a different section of the policy. It's not referring to when you're administering a medication. This is specifically referencing when you're just flushing an IV, to give the flushing. It's not associated with a medication. So this is saying the saline must be documented in the MAR for these four-hour flushes as they are the only thing I see given at

the time. If you're also doing that medication, it's going to be in the MAR, so you are going to see that flush or something being given to that IV every four hours. So this is just making sure if you're just flushing the IV to meet this policy, that it is documented in the MAR. If you're giving medication, it's documented into the electronical medical record as well. So it is included in a different aspect, a different spot in this policy. This section doesn't refer to that.

Q Okay. Can you explain to the jury what a vesicant is?

A So a vesicant is a solution that can be irritating to the veins.

Q If it doesn't make its way into the veins what can it do?

A Well, it can go under the skin and it can cause burning.

Q So it burns, right?

A Yes.

Q Would it be more appropriate to document when you flush in preparation for a medication that burns as opposed to just randomly flushing?

A No, because it's our policy as a nurse to always flush before any medications. It's consistent throughout your practice. It's not necessary to document on one medication versus another if you're going to do it for everything.

Q So it's your testimony you never documented that you flushed prior to administering the medication?

A No.

Q Is that a no that that's not a correct statement?

A No. It's a correct statement, I can't -- There is no reason to do it. I can't say it never got -- happened because there was a flush that was populating at the same time, but I never physically documented a note that said, IV flush prior to administering medication because your assessment is there.

Q You had never seen an infiltration before [redacted] is that right?

A That's an incorrect statement. I'd seen an IV infiltration before. I'd never seen an IV infiltration with ampicillin before.

Q Okay. Did you testify in your deposition that you'd never seen an infiltration before?

A No, I said I'd never seen an IV infiltrated with ampicillin before.

MR. WILLIAMS: I beg the Court's indulgence for one second.

THE COURT: Sure.

BY MR. WILLIAMS:

Q All right. So you've never seen a burn like this before; is that right?

A I never had. And I actually never saw [redacted] in person after the event.

Q How many infiltrations had you seen prior to this incident?

A I couldn't give you an exact number. I would say over ten, probably closer to twenty.

Q So twenty. Over what period of time?

A Since starting nursing school so probably about two and a half years.

Q Okay. And in this case, why did you get the charge nurse?

A Because I had never seen an infiltration of the ampicillin before and I knew it was a vesicant. I also saw a small discoloration that looked like bruising and I'd never seen that with an infiltration before. I knew that the catheter had to be removed, but I wanted to make sure that we were following -- in compliance with the hospital policy and I was doing everything that needed to be done.

Q Tell me, what's the reason for the need to keep accurate medical records?

A So accurate medical records is like taking a picture of a hospital stay. They conform to document what was done and for further treatment. So, you know, like what medications people receive, if that treatment worked or not, how the patients responded to that medication. It's important for

the long-term care of patients and treatment in the future.

Q And if the record says you did something, would you want people to assume that you did it?

A Could you rephrase your question?

Q Sure. If the record says you did something, what does that mean in your mind?

A Well, it obviously that you documented it and you did it.

Q Okay. If a record doesn't say you did something, how do you interpret that?

A It'd would be different to say that Jamie did not do this versus it not being in the chart. And so there are some things as a nurse you chart by exception. So it's very important to keep as well as thorough medical records, accurate medical records, also concise medical records, so if a patient's readmitted to the hospital seeking treatment later, they're able to look at these medical records and find the information they're looking for. So you want to make sure you're including information that is helpful for that and that you don't need to be redundant and include the same thing over and over again. Because when you're trying to find that abnormal information, that changing pertinent information, you want it to be easily accessible for the better treatment of the patient.

Q Have you ever documented that you failed to flush an

IV?

A No, because I never would have given a medication without flushing an IV.

Q Okay. And if you remembered to document that you didn't flush it, you would just flush it, right?

A There's no way to go back, if that makes sense. There's no way to say I didn't flush an IV. I'm going to go do it now. It's part of your medication policy and procedure in my practice as a nurse. You wouldn't give a medication without first flushing the IV.

Q Do you remember flushing the IV before administering this ampicillin?

A I don't specifically remember the morning. I remember afterwards, day. But I know my practice as a nurse and I know that I flushed that IV. I don't think the medication really would have infused with the extension flaps and the tubing that's used at The Regional Medical Center if that IV hadn't been flushed.

Q Okay. But sitting here today you can't tell the jury that you remember flushing this IV?

A That's correct. It was about four years ago and I don't specifically remember flushing the IV. But that is my practice as a nurse and the procedure you have ingrained in you in nursing school. And as a pediatric nurse, you care for your patient. So knowingly not flushing the IV, it

makes no sense. It makes no sense not to do that.

Q Do you agree that the vesicant, the ampicillin, the medicine that causes the skin to burn, that you administered was what caused this injury?

A Yes.

Q And sitting here today do you know what happened, other than the vesicant, the burning medication, went somewhere other than where it was supposed to go?

A No. There is no way to really know why the medication after starting to infuse then did not go inside the vein. There's no way -- the IV could kink. The IV could move. The medication could irritate the vein. There could then be a tear in the vein. There are just so many things that can happen with a pediatric IV in a very short period of time. There's no way to say why this medication, after the initial assessment went where it wasn't supposed to go.

Q Okay. It didn't go to the vein; is that right?

A So it initially did. The burn indicates, the infiltration indicates at some point during the infusion the (inaudible) was no longer where it was supposed to be.

Q Okay. Are you aware of the nurses' practice act?

A Yes.

Q What does its rule?

A So I'm not familiar with the specific wording but the gist of it, and each state has their own nursing practice

act is to provide safe care for your patients and the way they recommend to do that in North Carolina. Not North Carolina, sorry. South Carolina.

Q Does it say your duty is to do no harm?

A I believe that.

Q Are you familiar with Mr. Tanner's articles, the policies and procedures from Infusion Nursing for Pediatric Patients?

MR. TANNER: Your Honor, I would object. They're not my articles. I didn't offer them.

THE COURT: All right. Okay.

A I think --

THE COURT: Wait a minute.

THE WITNESS: Oh, sorry.

THE COURT: No, I was just --

THE WITNESS: Okay.

THE COURT: -- I will note your objection that they're not your articles. So if you'd just refer to what they were?

MR. WILLIAMS: Sure.

BY MR. WILLIAMS:

Q Are you aware of the articles Mr. Tanner provided such as Assessment of an Infant with Peripheral Intravenous Device?

A I had a chance to look them last week, but I haven't

read the entire article.

Q At the time of this treatment of [redacted], you hadn't read that article?

A No, I hadn't.

Q Okay. Have you read the one Intravenous Extravasation Mechanisms Management and Prevention?

A No, I haven't.

Q Have you read the one Infusion Therapy of the Infusion Nurse's Society?

A No, I haven't.

Q Okay. Sitting here today, have you read those?

A No, I haven't. So reviewing the texts of articles aren't necessarily common practice. I'm sure we'll be having an expert in the field in reviewing literature or doing quality improvement, different settings it would be appropriate to review those articles. Typical nursing practice you're review the policies of the hospital, you have your information you've learned in nursing school how to practice as a nurse, and training and that's the real source of information for IV management.

Q Sure. And sitting here today you have some different certifications that you didn't have at the time you were treating [redacted] is that right?

A Right. I'm a certified pediatric nurse and certified nurse educator.

Q And at the time of this incident -- that didn't happen until you went and worked at MUSC; is that right?

A No. It's not associated with the hospital that you work at. It's the number of hours and the amount of training and studying you've done to take the exam. So I haven't taken the exam yet, no.

Q And you did that once you left The Regional Medical Center?

A Right. And it's a certification that is -- I wanted to be a pediatric nurse. I wanted to be a pediatric nurse my whole life.

Q And sitting here today just to be clear with the jury, you weren't certified as a pediatric nurse at the time you treated [redacted] is that right?

A No, not certified but I had multiple hours of training as a pediatric nurse.

Q Tell us about this computer system, would it prompt you indicate to whether you flushed the IV?

A No. As we discussed before there's no flow sheet associated with the medication administration for flushing an IV.

Q Okay. So explain -- is it my understanding the IV wasn't patent at 4:45?

A So I think you're referring to the flush that was charted against. So at that point, I believe in that

patient that started right around 4:27 off the top of my head, that that patient ran for about twenty minutes. When those task you have kind of a window of administering those medications, obviously it wouldn't be appropriate to give an IV flush for a medication that's already infusing. At that point, that infusion was done you would give that flush after finishing the medication. The IV was infiltrated and it would not be appropriate to flush the IV out knowing we had a bad site.

Q Sure. Is it fair to say the record indicates that the IV wasn't patent at 4:45?

A That is not what that documentation says, no. It says that it's not appropriate to give that flush at that time. The assessment later, I think that was documented at 4:50, documented that the IV wasn't patent.

Q Okay. The 4:45 number, where would that have come from the record?

A So when there's -- when an IV order is placed by a physician, there's saline flushes automatically tasked every four hours. So whenever the IV is initially ordered the saline flushes associated and kind of just a set that's the physician orders. So they would automatically be happening every four hours. So that is that task. So it technically could have been charted against because you already flushed the medication when giving, using this IV or it could be

charted after. But it just automatically tasks regardless of what else is ordered or going on with the patient.

Q And I earlier asked you if the computer system automatically prompted tasks and you would flush?

A It didn't. So that was not a task. That was prior to the medication. That was a task I was tasking every four hours. That was not associated with the medication.

Q But again, the computer system prompted that task, correct?

A It did. It was for every four hours flush but it was after the medication was administered.

Q And that occurred at 4:45, correct?

A Correct. That's the time that it tasked.

Q And you started this medication twenty minutes prior; is that right?

A I believe that was 4:27.

Q Okay. So the medication would have run until 4:47; is that right?

A Yes.

Q Okay. And you didn't enter the room until 4:50; is that right?

A No, I would have went in as soon as the alarm sounded. It's documented -- you do the best you can as charting real time. Obviously, at the moment the more pressing circumstance would be to assess the patent and follow proper

procedures for removing an IV. The 4:50 documentation would have been documented after, honestly. So I, as a nurse, probably rounded three minutes. And I'll be honest in that. But it -- at the more pressing time I was caring for the patient at 4:47 or it would have been removed (inaudible).

Q You agree that the mother was paging you, trying to get you into the room?

A I do not recall that. There are multiple nurses on the floor at a time. You're not always sitting at the nursing desk but pretty commonly there's someone is and someone would have gone in there. From my memory, mom was holding the child when I went back in there kind of going back forth with everything you would expect. A new mom with a new baby in a hospital for a couple of days. But if I had been paged in there earlier, someone would have been in there whether it was a nurse or a nursing assistant, or a charge nurse, another nurse if I was with a patient would have been in there.

Q Do you recall going in there and the baby's screaming and the mother's upset?

MR. TANNER: Your Honor, he's -- I haven't objected every time, but he leading the witness again. He's chosen to call her on his case and he's got to ask open-ended front questions.

THE COURT: If you'd just ask her what she

remembers about the mother.

BY MR. WILLIAMS:

Q Well, what do you remember about the mother?

A Yes, I remember her. And I really in my heart remember mom being agitated and just exhausted. I remember talking to mom, explaining kind of what infiltration is and why we're removing it and why we're putting a compress on it, that we're going to call the doctor, but we're not going to restart the IV and that was mom's question, as well. There was not frequent calling or paging. Someone would have been in there. I remember going in there talking with her about the IV, calling the charge nurse as for removing. Mom very receptive to all the information we were giving her and just kind of going over what this means and that we're going to call the doctor and that this is what this is going to look like. So that is what I remember.

Q Okay. You'd been in the room starting this IV medication and you stayed in there for about thirty seconds?

A So, I can't tell you exactly how long I was in there. It was long enough to start the medication, I watched the patient, watched the pump, do some documentation on the computer and step out. So I would think it was anywhere from thirty seconds to a minute to a minute and a half.

Q Okay. And you weren't here to hear mother's testimony

about what she recalled, were you?

A No, I wasn't here.

Q You just got here a short time ago?

A Yes.

Q Okay. Did R.J. do anything to cause this?

A No.

Q Did Ms. Hamilton do anything to cause this?

A No. IV infiltration is a known risk of IV therapy. Nobody did anything to make this happen.

Q Is it my understanding that this site went from a zero to this?

A So a zero describes an IV that is -- I'm assuming you're referring to the infiltration and phlebitis score, which is used in the assessment of the IV. So that is used to assess the IV properly throughout. That's kind of a quick way to say no there's no inflammation, no there's no swelling. There's no sign that this IV is not working properly. So when starting an IV and IV's working well and being used, it's going to be a zero. So it's always going to start at a zero. So, yes. So any sign, like you just discussed about the vesicant. So what happened when a vesicant is -- extravasation, but basically it is an infiltration of a vesicant. So this vesicant goes outside of the vein and under the skin. The initial presentation is going to be the same as just a normal fluid. So it's --

it's swollen. It's cool to the touch. There might be some discoloration. There might be a knot. There was like small bruising and the medication is localized. So the longer this medication sits there, it's going to change, which is why we frequently assess these IVs and we assess these site and document them. So, yes. The initial presentation was mild swelling with a dark spot that's been noted. But it changes because of the medication that can burn. So an assessment every thirty minutes is probably going to be different than the one that was done previously before it. So it did start at a zero, the IV was flushing well. It was patent. It was able to be used. It was everything you need an IV to do until it's not and then you notice this swelling and that's when it's removed, but things change progressively, yes.

Q What is the scale of the infiltration score?

A I would need to see it. So it's on the bottom of the flow sheet in Cerner. I think it's a zero to five, infiltration and phlebitis, which refers to how the irritation of a vein. And it has different kind of categories. I think a one is swelling less than one inch. There is specific criteria that's used that's available to you every time you're rating the site.

Q So it's a zero to five. And it was a zero. It went from a zero to this; is that right? A simple yes or no is

what I'm asking?

A Right. But it's not a simple yes or no question because it progressively changes, it doesn't go from zero to that, no. It takes hours and it takes time.

Q In the amount of time from when you administered this medication, it went from a zero to this; is that right?

A That is not correct. I did not see his hand that way.

Q So you didn't monitor his hand before administering the medication?

A Yeah, I did monitor his hand before administering the medication. This picture was taken, I'm not sure when, but hours following the administration -- the medication was administered around 4:27. The IV was removed right around 4:50 and then my shift was over at 7:00. So I would've assessed the IV up until reports to the next nurse, which was around 6:45. So the IV continued to change because he still had his medication. That was there.

Q Maybe I should ask, did it go from a zero to this?

A So my --

Q Or --

A No. The IV site that I had was documented in the chart. It was mild swelling with a dark spot. A compress was applied and that is the way it looked when I left from my shift.

Q Okay. Is what caused this a five plus this or where is

this on the chart?

A So five plus, it's hard without actually seeing the grid. It is the same injury. It is not that there would be subsequent injury. And the amount of medication went under the skin that damaged tissue and that takes some time. So the IV site changed throughout the next couple of hours and was monitored. So it did start at a zero. I couldn't tell you what a five looks like without seeing a chart.

Q But when you administered the medication it's your position it was a zero. But once you gave this medication it continued to do damage to cause this?

A So when I initially assessed the IV, it was a zero. So it was flushing well. It was a good IV site. The medication was given. After medication was given in the IV site, as that was assessed, there was a small -- It was, I think mild inflamation is the word I used. And it had a score of a one and a one and that was documented. The IV was removed and then it was documented throughout the next shift, would be another nurse documenting -- would have been assessing of the IV site, of how it changed. So it's the same medication. There's no way to really know what the extent is going to be throughout monitoring and assessing. So it didn't go from zero to this on my shift. I think that this would take time.

Q But [redacted] didn't do anything wrong, correct?

MR. TANNER: Objection, Your Honor. He's asked and answered this multiple times.

THE COURT: She's already said he didn't.

MR. WILLIAMS: Okay.

BY MR. WILLIAMS:

Q And this medication required a flush before you gave it?

A It did.

Q But you don't specifically remember giving that flush?

A So I remember many a times giving -- I do not remember this specific morning, no. I remember many times administering an IV medication via syringe pump and in my practice as a nurse. Like I said, I do not think that -- without flushing it first and the medication would have never been given, so common practice as a nurse.

MR. WILLIAMS: Nothing further, Your Honor.

THE COURT: Okay.

Anything on cross?

MR. TANNER: Can we have just a comfort break for a couple of minutes?

THE COURT: Okay. That probably wouldn't bother anybody, I don't think. All right.

Ladies and gentlemen, we're going to take like a five-minute comfort break. And then we'll get y'all back in here, okay? Remember, you cannot talk about any of the

testimony you've heard so far. Thank you.

(Jury out at 11:46 a.m.)

THE COURT: You can stand up.

THE WITNESS: Can I stand? All right.

THE COURT: No, no, you did good. You can stand up. You can stand up. But you don't go anywhere -- wait one second before you go anywhere, okay?

THE WITNESS: Okay.

THE COURT: All right. Ms. Downing you're not trapped to the chair. You can get up and walk around.

THE WITNESS: Okay.

THE COURT: But you can't talk to anybody about your testimony.

THE WITNESS: Got it.

THE COURT: If you need to go to the restroom to do something like that --

THE WITNESS: Okay.

THE COURT: -- you can do that but you just can't talk to anybody. Okay.

THE WITNESS: Okay.

THE COURT: All right. Stretch your legs if you need to.

THE WITNESS: I do.

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

THE WITNESS: Thank you.

THE COURT: Yes, ma'am.

(Court in recess for a short break at 11:46 a.m.)

(Court in session after short break at 11:53 a.m.)

THE COURT: Is the plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Is the Defense ready?

MR. TANNER: Yes, sir.

THE COURT: If the jury's ready, bring them on out.

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay.

Mr. Tanner, about how long is your -- is --

MR. TANNER: I'm not going to have a very long examination of Nurse Downing.

THE COURT: Well, yeah. But how about Nurse Hurley?

MR. TANNER: Hurley? I don't know, about forty-five minutes, an hour.

THE COURT: That'd be your direct?

MR. TANNER: I would think she could be done everything in an hour.

THE COURT: Oh, okay. Okay. All right. Okay. All right.

(Jury in at 11:53 a.m.)

THE COURT: All right. Ladies and gentlemen, we're going to continue with the examination of Ms. Downing.

Mr. Tanner.

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

THE COURT: Yes, sir.

JAMIE DOWNING - CROSS-EXAMINATION

BY MR. TANNER:

Q Thank you Nurse Downing, I appreciate you coming back from Greensboro today to be with us. You were explaining to the jury -- Mr. Williams was asking you about this blowup, which I can't remember which Exhibit this is, but this isn't the way the child's hand looked during your shift was it?

A No.

Q Okay. I'm going to show you this picture right here of a healing wound. That's not what it looked like during your shift, is it?

A No. You can see that there's tissue that's healing there. So that would have been --

Q This would have been --

A -- significantly later.

Q -- significantly later in the healing process, correct?

A Yeah.

Q Where were you born, Nurse Downing?

A I was born in (inaudible) Massachusetts.
Q Okay. But where did you grow up?
A I kind of grew up all of the place. lived in Massachusetts for a while. I lived outside of Fayetteville, North Carolina for a while. I finished High School right outside of Savannah. I went to college in Athens, Georgia. Then Charleston. And several months ago I moved to Greensboro, North Carolina.
Q Okay. So you went to high school and spent your formative years in Georgia?
A Yes.
Q Okay. And did you always want to be a nurse?
A I did. So I like many young women. I always want to care for people. That's kind of where you're rooted, and then I good in both math and science so you're edged towards medicine. But I was able to volunteer with a couple of groups in high school, specifically, I was able to volunteer with the Low Country Down Syndrome Society. There's a teacher of mine who was on the board and had a child with down syndrome and was able to attend their events, and there was a bunch of games and interactive participations for the kids to be there and all of their families were there. So walking around and seeing the impact that having this whole community together, but I think that's really what lead me towards nursing versus doing research with science or doing

medicine, because I felt like as a nurse you really got to spend time with families. And you get to educate them and really create impact in the community of families and follow them long-term. And so that's kind of what lead me to nursing. It was always kind of in the back of my head, but really lead me towards pediatric nursing, the idea of working with families.

Q Okay. And does the practice of pediatric nursing have something called PALS?

A It does. PALS is the life saving support during a pediatric emergency.

Q And that's a certification you have?

A That is a certification I hold. So I am a certified pediatric nurse, like we discussed and I've got that. Which says that you are an expert in the pediatric nursing field, that you have significant hours. I think it's -- I've worked over a thousand clinical hours directly caring for pediatric patients, that you are well-versed in all therapy applications. And so different medicine, different procedures, but that you are widely-versed and It's an awful two-hundred question test that takes you three hours. It's something you keep up with, with continuing education but it's really saying that you've cleared out pediatrics and that you are an expert in that field.

Q And you've kept that certification up currently?

A Yes.
Q And you went to nursing school at Georgia Regions; is that right?
A Yes. So the school changed names a couple of times but it was the Medical College of Georgia, the Regions University is where I graduated from.
Q And that was my question. Is that the same thing that people know as the former Medical College of Georgia?
A Yes. So the curriculum has changed a little bit since I've been there. When I was there it was a five semester program. It's gone down to four. But it's the same administration and faculty.
Q Okay. You testified earlier that the cannular that's in the IV site is straw-like; is that right?
A Yes.
Q And the needle you used was a 24 gauge needle?
A Yes.
Q Let me show you something Nurse Downing. You testified earlier to an arm board. Is that what this is?
A Yes. That's an arm board that would typically be used on a types of patient.
Q And would this have been similar to the arm board used on [redacted]
A Yes.
Q And that would be placed under the hand when the IV was

started?

A Yes. And so it's soft and it allows kind of for that positioning. IVs are -- I like to use straws. When you're working with kids you try to think of things that are relatable. But an IV, cannular, which I think they have here is like a small straw. And then a vein you can kind of think of is a little baby straw. And so the arm board would provide stability to the hand, being able to straighten out that vein, obviously. A small baby can't really keep their hands straight and it helps them from bending frequently and irritating the site as well.

Q And what am I holding in my hand now, Nurse Downing?

A So that is a 24 gauge three-quarters and five-eights inch cannular from an IV start. So that yellow piece and then the actual clear small piece is the straw piece that actually stays in the vein. And the second part of that tubing is the extension so that's connected. It helps keep the pressure there so that the site doesn't come compromised with clots and things like that. It's also higher access it to get medication.

Q And is that where you would also do the flush?

A Yeah.

MR. TANNER: Judge, I just want permission -- I'd like Nurse Downing to step down and show the jury the 24 gauge needle?

THE COURT: Sure.

A (Witness steps down)

Q Now, again, if you can explain the yellow part. That is the catheter tube, correct?

A Okay. The catheter is actually this clear little piece. Earlier when I was describing a triangle, this is what I was talking about. So it would be placed on the hand there. So it would be very -- kind of telling if the vein -- if the catheter is positioned a different way. It kind of has this little trick catheter. If it was straight before and it's twisted that way, there'd be concern that it's not where you left it, and so that means that's a change. And then this would stay there. This would be secured down. But this isn't actually in the vein and as you can see, it's really quite small, which is great when you're inserting it. And it helps you feed it in without damaging the vein, but it can be kinked very easily. It also causes pressure and so over time with frequent movement, it just can bend and sometimes have a mind of its own. So you want to assess it frequently because this is -- can be ever changing, because it's not super stable. And then that is the pressured extension (inaudible). And what to make sure is that there is positive pressure. If not, you can have blood coming out the back and then that blood could clot. And so by having this extension back here, it's

making sure the pressure is positive. And so you're preventing clotting and then also it's better, comfortable -- from being exposed to infection in the hospital. But this is where you would clean, attach a small syringe that has the normal saline in it and flush. And you're always checking just kind of the integrity of this whole structure when assessing.

Q So this would be -- essentially, this would have been in [redacted] hand, correct?

A Correct.

Q And first, there would have been a needle on the other end of this, right?

A Correct.

Q And then obviously the catheter would go under the skin, correct?

A Right.

Q All right. And then the extension set you would actually take a syringe with normal saline and do your flush before you administer the medication, correct?

A Correct.

Q And that was always part of your nursing practice and habit, correct?

A Correct. There's no way to really tell if the site is open and flowing without flushing it. And so it would not be (inaudible) to give the medication without flushing it

first because you don't know if it's going to go where you want it to.

Q And you wouldn't give a medication without flushing it first anyway, right?

A No.

Q Because that's not how you were taught. That's not how you're a nurse, correct?

A Correct.

Q All right. So when you administer the flush, you would inherently -- you would be touching his arm to make sure it was still warm, right?

A Right.

Q You'd be making sure that there's no swelling, no redness?

A Correct.

Q Okay. And then you would do the flush through there with saline and then you would hook up the IV tubing?

A Right.

Q And then administer the ampicillin?

A Correct.

Q And that was 4.25 milliliter; that's correct?

A Correct.

Q All right. You can have a seat Nurse Downing.

A (Witness takes stand)

Q At no time during your treatment of R.J. was his

infiltration score anything other than a zero, correct?

A I believe I charted it after the incident, it was a one. But before that, no.

Q I'm sorry. That was a poor question. Before the medication administration, it was never charted at anything other than zero, correct?

A Correct.

Q And Mr. Williams had asked a number of questions about five. It was never documented as a five, was it?

A I haven't reviewed the whole chart as far as what other nurses documented. I do not believe so, but I know on my shift it was zero and then once we noted the inflammation had scored a one.

Q And so at no time during your treatment of [redacted], was the infiltration score a five?

A Correct.

Q Because if it was, you wouldn't have given medicine, right?

A Well, correct.

Q And likewise when we're talking about the flush and let me show you this. This would have been your 4:04 assessment?

A Correct.

Q And that would have been when you documented everything, those should be part of your hourly assessing of

the IV?

A Yes.

Q And documented no -- infiltration score of zero, phlebitis score of zero, correct?

A Correct.

Q And then again when you would have gone in there, just twenty-three minutes later, you would have reassessed the IV as we explained, correct? You would lay hands on it?

A Yes. Yes, sir, right. The tubing even connects t[redacted] what we would call an INT. So it's just saline inserted. The tubing actually, we're going to need him to have that for the medication. So you would need to go in and touch the IV, assess it, and then later hook up the medication.

Q And then that's when -- then when you would flush the IV, correct?

A Correct.

Q And then given the ampicillin.

A Yes.

Q Thank you so much, Ms. Downing or Nurse Downing for coming back here.

THE COURT: All right.

MR. WILLIAMS: I want to grab an exhibit, Judge, give me one second.

THE COURT: Take your time. I just remind you

that your redirect is going to be limited to his cross.

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: I'm just going to pull -- is it all right if I pull two documents out of this Exhibit 4?

THE COURT: As long as you put them back.

MR. WILLIAMS: I'm going to do that. It's TRMC 005 and 006.

JAMIE DOWNING - REDIRECT EXAMINATION

BY MR. WILLIAMS:

Q If you would look at those real quick?

A (Review documents)

Q Prior to this incident what was the last time that it -- you said these flushes were the four-hour flushes on there; is that right?

A Correct.

Q What was the last time you did a four-hour flush?

MR. TANNER: Your Honor, I would object. For the record, I think it was sort of outside of the scope of my cross-examination.

MR. WILLIAMS: Well, he asked her if she did a flush before administering medication.

MR. TANNER: I asked her if she had flushed before she administered, but I didn't talk about the four-hour flushes that are part of the medication --

MR. WILLIAMS: He discussed that, Your Honor.

THE COURT: Well, I'll let him ask that question, but we're going to keep it short on this, okay?

A (Reviews exhibit) So, there would be a four-hour flush at midnight, flush target and I charted it after I flushed after the Claforan, which was the other antibiotic he was getting. It tasked right after that medication was administered and so it was charted then, flushing out the IV after.

BY MR. WILLIAMS:

Q And I want to be clear for the jury at midnight is when this flush occurred here and you were supposed to do one four hours later; is that right?

A That's right. So in nursing there are --

THE COURT: If you'd just answer his question about that part.

THE WITNESS: Okay.

THE COURT: You want to repeat the question?

MR. WILLIAMS: Sure.

BY MR. WILLIAMS:

Q At midnight, you did a flush and you were supposed to do one four hours later?

A Correct, you have an window as a nurse to administer a medication.

Q And at 4:00 a.m. would be at four hours after midnight;

is that right?

A Correct.

Q And you administered the medication that caused this injury at 4:27; is that right?

A Yes.

Q And the system prompted you and said you didn't enter the four-hour flush at 4:47; is that right? Or 4:45?

A Do you have the following page with the flush on it?

Q Yes, ma'am.

THE COURT: Would that be 007?

MR. WILLIAMS: Well, I believe it's the backwards way, so that means 004. That could be wrong.

THE COURT: I have no idea.

Q Is this what you're looking for?

A That's it.

Q They're in reverse chronological order.

A Right. So the next flush was tasking at 4:45. So, yes, that was given at midnight and then the medication was given at 4:27.

Q 4:27. But the flush, the four-hour is going to happen at 4:00 a.m.; correct?

A So, it's a system based -- I can't tell you when it was supposed to be given. It's incumbent on when the physician ordered the IV. So if the physician might order the IV at 8:00 p.m. or 8:45, it would task out a forty-five minute

mark with every four hours. So I can't tell you exactly when. I would have to see the original orders.

Q And the policy doesn't say an hour limit, does it?

MR. TANNER: Your Honor, I think this is far -

THE COURT: Okay.

MR. TANNER: -- far afield from my questions.

THE COURT: And we are going beyond the cross.

MR. WILLIAMS: Okay.

THE COURT: Okay.

MR. WILLIAMS: Nothing further, Your Honor.

THE COURT: All right. Thank you.

MR. WILLIAMS: Let me put those back real quick so I --

THE WITNESS: Here --

MR. WILLIAMS: Sure. Thank you.

THE COURT: Yeah. Put those back in reverse chronological order.

Okay. All right. And anything on recross?

MR. TANNER: No, sir.

THE COURT: Nothing?

MR. TANNER: No, sir.

THE COURT: Okay. All right. You may step down. Thank you, ma'am.

MR. TANNER: Your Honor, I would ask if Ms. Downing can be excused?

THE COURT: Any objection to her being excused, Mr. Williams?

MR. WILLIAMS: No objection.

THE COURT: Okay. All right. Thank you, ma'am.

All right. Ladies and gentlemen, what we're going to do is -- as it's eating time. I don't know if it's eating time for y'all time but it is eating time for me. And the other thing is I've got to take up some matters with the attorneys outside of your present. So I'm going to let y'all go eat lunch. I'll ask y'all to again be back here at 1:30 like you were yesterday and we'll get ready to -- I'm anticipating -- so, you know, I didn't say assume, because you know what assume does to, but I'm anticipating that when we come back we've just got one more witness to do, then we'll do closing arguments and my charge to y'all. And hopefully, some time this afternoon, this case is going to go to y'all so y'all can begin your deliberations. Until that time, you cannot talk among -- very good. You cannot talk among yourselves about this and you can't do any independent investigation and you can't talk to anyone else, okay? So y'all go enjoy lunch and come back and we'll be working during the lunch hour while y'all are enjoying yourself, all right.

(Jury out at 12:10 p.m.)

THE COURT: And I guess y'all should have said

y'all rested, shouldn't you?

MR. WILLIAMS: We do, Your Honor.

THE COURT: Okay. Thanks. Don't get ahead of myself.

All right.

MR. TANNER: I have a motion.

THE COURT: All right, sir. What is your motion?

MR. TANNER: I have a motion for a directed verdict.

THE COURT: Okay.

MR. TANNER: Based on the testimony of all the witnesses, in particular, Nurse Stobbs, plaintiff's expert, I do not feel that the evidence presented to the court and the inferences reasonably derived therefrom have shown that plaintiff has prove gross negligence, which is the standard in this case, given that the hospital is a governmental healthcare facility. There was no question submitted to Nurse Stobbs about gross negligence. I asked her about if an IV infiltrated, does that mean you're negligent and she said, no. Therefore, it's sort of axiomatic that if you're not negligent you certainly can be grossly negligent. They elected to call Nurse Downing in their case in chief. She testified that she flushed the medicine before she gave it to the child. There is an absence of any and all evidence of gross negligence. Nurse Stobbs had no opinions on

y'all rested, should we say so?

MR. WILLIAMS: We do, Your Honor.

THE COURT: Okay. Thanks. Don't get ahead of myself.

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whether or not Nurse Downing had intentional conduct. Obviously, the gross negligence standard, as the Court knows, doing something intentionally that one knows not to do or the intentional not doing of an act or it is my favorite of her deposition would be the absence of slight care. And clearly all the testimony in this case by the expert, by Nurse Downing, is that she certainly did slight care. She testified at length in front of the jury about all the assessing she did. All the checking for redness, all the documentation, how she managed and monitored this IV. And they -- again, they have nothing sort of even bootstrapping together to get to that gross negligence standard. As a matter of law, I respectfully do not feel that the jury can considered this because of the tort claims definition in 15-78-6025. Clearly, this is a patient in a hospital. The hospital has a duty of due care, with supervising and monitoring. Supervising and monitoring are one in the same. And the case of Ethridge versus Richland School District One certainly leads the court that when there's only one reasonable inference the normal question of law and fact, but in this case when you only have one inference, then it becomes a matter of law for the Court. And I think respectfully, because they didn't get Nurse Stobbs to say that there's evidence of gross negligence, there is nothing for this Court to consider, other than as a

matter of law that they have not met their burden of proof and not met their burden for the jury to continue with any sort of submission of this case to the jury.

THE COURT: All right. Anything in response from the plaintiff? Whose going to --

MR. WILLIAMS: Judge, the first issue I think ir raised is Michael wanted our expert to get on the stand and make a legal conclusion to be able to bind it over to the jury's hands. I don't think that's the requirement. In fact, I think that would be a serious error to allow an expert to testify concerning the law in the case, and it's only Your Honor who can charge the jury on the law. To use a term like gross negligence is a legal conclusion. But the evidence is clear. We've got everything down to a system the first testimony that you can't interpret these rules. And then testify that she interpreted them this way. A system that said you had to do it by this time, the ignore button was pressed. There's nothing more willful, wanton and reckless than to have something that you press ignore when it tells you to do something that your policies and procedures require you to do. I could go one with the testimony, but obviously the plaintiff testified how she was pressing the call button. She was screaming. She was irate that her baby was sitting in her hands burning. And her excuse was she was in another room. I think there's nothing

more clear that this is a jury question. I think the law says that the jury gets the case to determine whether or not gross negligence -- and I don't agree with the definition of gross negligence. It doesn't have to be intentional. It can be reckless disregard, reckless disregard of policies and procedures. Reckless disregard of the information you are provided, that causes this kind of damage.

So I think we've met certainly our burden of proof to get it in the hands of the jury, but I don't concede that this is a gross negligence standard. It is a negligence standard when it involves the one claim, which is the negligent medical malpractice administration of medication. And I think the case is clear. I think the tort claim act is clear, that their immunity is waived, except for these exceptions. And sure there's some of our claims that fall under subsection 25 and have a gross negligence standard, but I think we have certainly produced a medical malpractice claim, which is separate and apart. And I think the law is clear that medical malpractice is based on negligence. And, you know, should we be a non -- a private entity, we'd be seeking punitive damages would be the only requirement to gross negligence. So I don't think that's accurate, Judge. And I would reserve the right to continue to argue that up until the time the jury charges are --

MR. TANNER: If I may reply?

THE COURT: Yes, sir.

MR. TANNER: Again, Stewart versus Richland Memorial Hospital is the law of this state. And I've yet to hear a case from the plaintiff that says that is not the law of this state. And that says that the standard is gross negligence. The standard in that case was charged to the jury of gross negligence in breaching the professional nursing standard of care. You know, again --

THE COURT: I'm aware of that. You don't need to go into that. We mentioned this yesterday. And sort of like we put on the record yesterday, you know, Nurse Stobbs mentioned a lot of different things about not noting it on the computer and not staying there five minutes and things like that. To me, that's all questions of who the jury is going to believe. And since it's a factual question that goes along with the earlier rulings of the Court -- and I'm just looking at (inaudible) versus South Carolina DJJ. It says gross negligence is a factually controlled concept whose determination best rests with the jury. And that's the way I'm going to leave it.

MR. TANNER: Yes, sir.

THE COURT: All right? And I deny your motion for a directed verdict.

MR. WILLIAMS: Could we go over one housekeeping matter, Your Honor.

THE COURT: Sure.

MR. WILLIAMS: The only issue -- because of his argument I want to be prepared, we would make a motion to prohibit his expert from making any kind of legal conclusions to the jury. I don't think she has the ability to. I think even if she was a lawyer she'd have the ability to get up and offer an opinion as to a legal conclusion.

MR. TANNER: An expert can give an opinion on ??? issues, Your Honor. I mean, it's in the rules.

THE COURT: But I think it just -- I think he's just -- you're going to phrase just in determination of whether there was negligence or not, just like you ask everything else. I'm assuming you're not going to ask.

MR. TANNER: I mean, I'd like to ask her were they grossly negligent.

THE COURT: Okay.

MR. TANNER: I mean, again, I think she can give that opinion under -- I think it's Rule 1001 on experts.

THE COURT: Something like that, yeah.

MR. TANNER: And certainly negligence and gross negligence.

THE COURT: Okay. All right. I'll think about it over lunch. As a general rule the -- you know, an expert can give an opinion as to the ultimate issue in a case, you know? So that's what the rule says, okay? Now, you know,

when we left off yesterday I said I still believe that the patient's going to be required to show gross negligence. We've talked about that. So unless y'all -- y'all are going to have to give me a case or something. Have y'all had a chance to look over the charges?

MR. WILLIAMS: Very, very briefly, Your Honor. We have a little bit to work on with regard to that.

THE COURT: Okay. All right. Well, if y'all will look them over so that we can talk about that. I also need for y'all to give me an idea of how you want the verdict form to look. I generally believe simple is best, but I don't know what y'all going to want, okay?

MR. TANNER: Yes, sir.

THE COURT: Okay. So, all right. We'll see y'all in about an hour, okay? Thank y'all.

(Court in recess for lunch at 12:31 p.m.)

(Court in session after lunch at 1:30 p.m.)

THE COURT: One of the last things that happened right before we left is we were talking about the expert talking about the ultimate issue in a case. And I said that yes, they can address the ultimate issue in the case. But Mr. Tanner, you mentioned something to me that you wanted to ask her whether or not she was grossly negligent.

MR. TANNER: Yes, sir. And I had asked the plaintiff's expert. You know, we talked about, just colloquialism, about in an infiltration that doesn't mean you're negligent. And so it's my intention to ask my expert was she negligent, and then was she grossly negligent.

THE COURT: Okay. And, you know, obviously I was not -- you're asking negligence in some kind of non-legal sense of negligence. See, here's my problem, okay? And I didn't -- your nurse is going to testify to the standard of care of nursing in a pediatric situation, I assume?

MR. TANNER: Correct.

THE COURT: Okay. And so when you're asking her questions like that, you're going to ask her did she deviate at all from the standard of care?

MR. TANNER: Yes, sir.

THE COURT: Did she even slightly deviate from the standard of care? Did she do anything wrong whatsoever that you can think of in reviewing the records.

MR. TANNER: Yes, sir.

THE COURT: Right?

MR. TANNER: Yes, sir.

THE COURT: Okay. She's not going to be qualified, I don't think -- I mean, she doesn't have -- and, of course, she's not a lawyer, right?

MR. TANNER: No, sir. And other than that's how

we've always done it is the only reason I know how to tell you.

THE COURT: Okay.

MR. TANNER: I got your ruling. I'm being respectful of your ruling. I'm not arguing with you about that. The only thing I wanted to do is in recognizing your ruling, I think I need to proffer that just in case we needed to go up --

THE COURT: And I want you to do that. And actually, you know, when you asked those questions the plaintiff didn't objection, you know. And I, quite frankly, was, you know, just --

MR. TANNER: Doing other judicial matters, right?

THE COURT: Well, no. I was listening but I -- you know how -- you know how in the Bible it says it's more than just hearing, it's listening or something like that or listening or hearing. I never can figure that out, which shows you how well I do with my Bible reading. But I don't think -- if he asked a question like that, I think you can get into it on redirect. But as far as direct, I think you go over everything, that she didn't do anything wrong and don't do that. Because I think you can ask whether or not she was negligent without asking that.

MR. TANNER: Like I said, whether or not I could properly do it before, I just did it. I would always ask

did they breach the standard of care? Were they grossly negligent. So I'll just ask the negligence questions on the proffer. That way, it's not heard.

THE COURT: Yeah. If you don't mind just to protect the record that way.

MR. TANNER: Yes, sir.

THE COURT: But I think -- my own take on it is the jury is going to listen more, did she do anything wrong? Did she break anything -- negligence is a --

MR. TANNER: Foreign concept?

THE COURT: Yeah. Uh-huh. Okay? All right. So are the plaintiff's ready to go?

MR. WILLIAMS: Yes, sir.

THE COURT: Defendant ready to go?

MR. TANNER: Yes, sir.

THE COURT: Okay. Yes, ma'am. Is the jury ready?

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay. Bring them on in.

THE BAILIFF: Yes, sir.

THE COURT: Yes, ma'am.

And, Mr. Tanner, thank you for being so accommodating, you know.

MR. TANNER: Glad to help you, Judge.

THE COURT: A Judge needs all the help he can get. Okay. You said you think it'll take about an hour, an hour

and fifteen altogether? Okay. Well, we'll find out.

Who's doing cross?

MR. KRELL: I am.

THE COURT: Okay. He's been quicker than Mr. Williams, I've noticed.

MR. WILLIAMS: Yeah, I'm slow.

(Jury in at 1:39 p.m.)

THE COURT: All right. Ladies and gentlemen, we're getting down to the defendant's part of the case, okay?

And so, Mr. Tanner, are you ready to call your first witness?

MR. TANNER: Yes, Judge Dickson. Thank you.

THE COURT: Yes, sir.

MR. TANNER: I call Cindy Hurley at this time.

THE COURT: All right. Ms. Hurley, you can put that down before we swear you in, okay?

THE WITNESS: Yes, sir.

THE COURT: Put your -- yeah, you've been watching them.

THE WITNESS: I have.

THE COURT: Oh, good. Good.

All right. Yes, sir.

(WHEREUPON, Cindy Hurley was sworn to tell the truth.)

CINDY HURLEY - DIRECT EXAMINATION

BY MR. TANNER:

Q Good afternoon, Cindy. Thank you for being here.

A You're welcome.

Q Can you please tell the jury where you live?

A I live in Lexington, South Carolina.

Q And where were you born, Ms. Hurley?

A I was born in Columbia.

Q And what is your occupation?

A I'm a registered nurse.

Q Tell the jury about your educational background?

A Well, I graduated from high school in Columbia at Cardinal Newman. I went to the University of South Carolina, graduated thirty-nine years ago yesterday from the nursing program.

Q Congratulations.

A Thank you. Since then, I've worked.

Q As a registered nurse?

A As a registered nurse.

Q And after you graduate from the University of South Carolina, did you take the nursing boards?

A I did.

Q Did you pass them?

A I did.

Q Do you have a nursing license?

A I do.
Q Have you had a nursing license since you graduated?
A I have.
Q Have you started an IV on a pediatric patient, such as R.J.?
A I have started IVs on children.
Q Do you have an estimate of how many times you've started --
A A hundred. More.
Q Have you monitored an IV and managed an IV on a pediatric patient?
A Yes, a lot more. Hundreds of times.
Q Okay. And have you -- in doing that, have you assessed a IV on a pediatric patient, such as R.J.?
A Yes.
Q Any idea how many times you've assessed those IV's?
A Hundreds.
Q Okay. And have you also practiced clinical pediatric nursing?
A Yes.
Q And where did you have that clinical pediatric nursing practice?
A Initially, of course, in school. We go through pediatric rotations and I really got my first basic pediatric nursing when I was working for a general surgeon.

I was a first assistant and we lived in Laurens County, so the hospital, we did -- we didn't ship many babies. We would take care of them there. So multiple times.

Q Did you have other clinical pediatric experience outside of Laurens?

A Yes. When I left Laurens, I went to Lexington Medical Center and I worked there for thirteen years. I started out in what they call the staff pool. And I would go to work in the mornings and they would tell me which floor and where I was going to work that day. It might have been ICU or pulmonary or pediatric, oncology, even the ER, just wherever they needed me, that's where I worked.

Q Okay.

MR. TANNER: Your Honor, at this time, I'd offer Nurse Hurley as an expert in pediatric IV management.

MR. WILLIAMS: No objection.

THE COURT: All right. Ladies and gentlemen, Ms. Hurley has been identified as an expert in pediatric IV management. You remember yesterday I gave you the conditions about expert opinions. This will apply to her as well as it applied earlier witnesses, okay?

All right.

BY MR. TANNER:

Q Nurse Hurley, you were provided some materials in this case?

A I was.
Q And what material were you provided?
A I was provided with a portion of a the medical records from Orangeburg Regional.
Q And were you provided with other materials?
A Yes. Depositions. You want to know each one?
Q If it's easy. If not, we'll get to them --
A Ms. Middleton, Ms. Craft --
Q Nurse Downing?
A Nurse Downing.
Q Nurse Stobbs?
A Nurse Stobbs.
Q All right. And you were present in the courtroom when Nurse Downing testified --
A I was.
Q And you have reviewed the hospital record from The Regional Medical Center from October, the admission from October 25th through October 30th, 2014?
A Yes, sir.
Q Explain to the jury what the reason -- what was the purpose of that admission?
A The baby was admitted through the emergency room, came in with a high fever. I think it was a hundred and two point six. And we worry about babies that are that young. I think he was a week and two days old when his mom brought

him in there sick.

Q I'm sure we could spend hours talking about the rest of the days.

A Right.

Q I know the jury probably doesn't want to hear that. Why don't we just move ahead to October 27th; is that fair?

A Okay. That's fair.

Q Can you tell me, can you tell the jury what shift Nurse Downing would have been working on October 27th, 2014?

A Ms. Downing was working the 7:00 p.m. shift to 7:00 a.m. shift, which would have been the 27th into the morning of the 28th.

Q And when a nurse works nights, that's typical for younger nurse?

A Yes. It's typical for all of us.

Q And when a nurse works nights, do they just show up at 7:00 and leave at 7:00?

A No, sir.

Q What would have been her process?

A Well, in fact, in preparation for this, I actually went through and made notes of every time that Ms. Downing took care of that baby during that twelve-hour shift.

Q Okay. What's the first thing that a nurse does when they come on the floor or the unit regarding their patients. What is that called?

A It's called a shift report or sidebar.
Q And can you explain to the jury how that works?
A Yes. A previous nurse who's had that baby for twelve hours tells the nurse -- both are together and they actually round together. They go and see each patient. R.J. wouldn't have been the only patient that Ms. Downing had. She, I think, in -- I'm not sure how -- I wasn't here for all the testimony, but during depositions I think they could have had three to five patients a piece.
Q Yes, ma'am.
A So anyhow, she did that with five different nurses. But in this case, she started around 6:45, got report.
Q Okay. And what would that report consist of?
A It would consist on how the baby had done that day. What his vital signs were. If there were any lab work that morning, they would have gone over that. Any new orders the doctors might have written that day, multiple things. And the main thing is they would have actually gone to the bedside for a lot of this report. And at that time, they actually assessed the IV together.
Q I'm sorry. I was looking for that IV assessment. When would the first time have been that she would have assessed the IV?
A at around 7:44.
Q And in military time what is that?

A Well, I actually, because I wanted military time confuses me sometimes even after forty years. So what I've done is I've made it in normal time, if that's okay?

Q Yes, ma'am?

A Okay. So 6:45 at night was the shift report and then at 7:30 she did her nurse note. The first IV check was at 7:44.

Q Okay. And is this TRMC 00183 and 184, is this a copy of that IV assessment?

A Yes, sir. It is.

Q I'm going to set the easel up and we can show the jury this. All right. And so this would have been done -- it's time at 19:44, right?

A Right.

Q And, again, in military time that's 7:44?

A Correct.

Q So about an hour really after she got the report, correct?

A Right.

Q And explain to the jury what the IV assessment entails? And if you want to come down and show the jury on the form, whatever is easiest for you --

MR. TANNER: -- with the Judge's permission. :06

A Okay. (Witness steps down) All right. Let's set at quarter 'till 8:00 she does her IV check when she goes in

and she does all of that that she was talking about. She looks at it, she touches it. She probably compares it even to the other hand. And she marks that there's no complications that she can see. There's no drainage there, which drainage would be more than, say, infection. It would be more like you would wonder if maybe some of the IV fluid was leaking out. That would be what -- that would be that. And then the infiltration score, there was no signs of infiltration. There was no swelling, no redness. The phlebitis score also was zero. There's wasn't any -- no blood, no swelling, no indications that there were problems up above the IV. The IV dressing, it was dry. It was intact. And, again, I think she told you about how the dressings are clear so you can see all the way down. And there -- let's see. And she actually charted there was that little extension set on there that she showed you that hooks directly to the IV. So at quarter 'till 8:00 it was great.

BY MR. TANNER:

Q Okay. All right. And if you want to carefully get back on the stand?

A All right. Yeah, I think I might be real careful.

(Witness takes stand)

Q And when was the next time that Nurse Downing would have had an interaction assessment for R.J.?

A At 8:44 the vital signs were done also. And then at

8:50 she confirmed those vital signs. And what that means is the nursing assistant or the nursing tech does the vital signs, but then it's up to the R.N. to make sure that she agrees with those and sometimes we even recheck them. But she agreed with the vital signs so that was at ten minutes 'till 9:00.

Q And what would her next interaction with R.J. have been?

A All right. At 9:19 she gave a flush. And a flush, of course, she explained which is that little tiny bit of water or saline, salt water, that you push through the vein to make sure it's still open.

Q And what time would that be in military time?

A That was 9:19 p.m. so that would have been 21:19 military.

Q And is that one of the four-hour flushes or is that a flush for the administration of medication?

A That was a four-hour flush, but we need to back up to 8:00.

Q Yes, ma'am. Go back to 8:00.

A 8:00 there was a flush on the MAR and I hope y'all understand MAR is the medication records, so if I say that again. Let's see. So she didn't give the flush at 8:00. And the reason she didn't give that dose at 8:00 was because the nurse on the previous shift had given an antibiotic. So

that flush was given before that antibiotic. It was given after the antibiotic. So at 8:00 it really didn't make any sense at all to go flush it again. So then again at 9:19 she gave the flush. So within that four-hour parameter, per the hospital policy and procedure, and I'm sure that we'll get to that too. But the hospital states that every four hours that IVs have to be checked or flushed. And, again, that's for infants, babies. In an adult, I think it's every four to eight hours when they flush. So that is a difference in children.

Q So is there a difference from a nursing perspective in treating children and adults?

A Oh, that is -- there's just so much difference. I mean, babies are not children. Children are not adults. It's all different. Your equipment's smaller. You've got smaller stethoscopes, you've got smaller EKG pads. Everything's little and dainty and lots different.

Q You've read Nurse Stobbs deposition, correct?

A Yes.

Q And where she says -- testified in her deposition and testified in front of the jury, that a vein is a vein is a vein, I believe is what she said. Do you have an opinion to a reasonable degree of nursing certainty, more probable than not on the accuracy of that statement?

A I do. Okay.

Q Can you tell the jury what that is?
A I will. When you look at a baby or a child, we know they have everything we have. They have a brain, they have a heart, kidney, lungs. They have -- we all know that. They have veins and arteries just like we do and they're in exactly the same place, but it also makes sense that they're not near mature as ours are. So when you start to assess a baby for an IV, there is definitely a skill. There's a skill there. You don't always -- you can't see them. Most of the time, sometimes it's very difficult to feel them. So you do little tricks like warming up the hand to make them pop up. And we all know that from dishwater.
Q And are veins on a child, a thirty-day-old child and an adult, are they similar?
A They're similar because we all have them, but babies are -- just like they're tiny, their veins are very tiny, very fragile, very frail. So when you're inserting an IV you have to be very careful that you don't go through the vein or actually into tissue that you don't want to go into. It's definitely a skill.
Q And is that because the literature reflects that children's veins are small and thread-like compared to adults?
A Yes. And -- yeah.
Q I mean, I didn't mean to interrupt you there.

A No.
Q Go ahead and tell me again what Nurse Downing did after that point in time?
A Okay. So she gave that four-hour flush at 9:19. And at 10:05 she went in and she did another IV check, just like that one. So that means she's been at work since 6:45 and she's already checked -- and we're up to 10:05. And she's already checked that IV once and flushed it. She's checked it and flushed it twice. And that's a little over two hours.
Q All right. And what did she do after that point in time?
A After that time, she checked the baby at 11:00 and he was sleeping in his mom's arms, I believe.
Q Okay. And did she chart that in her notes?
A She did.
Q Now, let me show you her notes. It keeps walking off on me. And this is TRMC 0036.
A Right.
Q Is this called a narrative note?
A Yes.
Q And you testified earlier she would have gotten a report from Susan Craft, right? And that's at 18:45?
A Right.
Q And then at 19:30 patient resting in mother's arms?

A Right.
Q No signs of distress or discomfort?
A Right.
Q Initial assessment complete, vitals stable. Is that what you were talking about earlier, the vital signs?
A Right.
Q Lung sounds clear bilaterally? Explain to the jury what that means?
A You just -- well, first of all the baby's been admitted for sepsis. So we don't know if it's a possible urinary tract infection, pneumonia, anything. I believe mama had Strep B when the baby was born, which is not uncommon at all. So the doctor in the ER has figured all of that in. So that's why we did the lumbar check or the hospital did the lumbar check and the chest x-ray. And, of course, the lumbar check came back in a day or two and it was fine. The chest x-ray was fine. But the reason we listen to the lungs is to make sure that there's nothing, no rattling, good air sounds.
Q All right. And she also reports she had an interaction with Ms. Hamilton. Writes, his mother states he has been drinking well.
A Right.
Q And voiding per patient normal?
A Right.

Q And that says, PIV to R hand flushing well, dressing dry and intact. What does that mean?
A Peripheral IV.
Q That's the IV to his right hand?
A Right hand.
Q And what does it mean when a nurse charts that it's flushing well?
A That it is -- well, that it's open.
Q Okay. And that goes to the patency of the IV?
A That's right.
Q I'm sorry. What time did we leave off?
A Let's see. All right. We got to 11:08.
Q Okay. What happened at 11:08 p.m.?
A 11:08, you brought the nurses narrative in here --
Q Yes, ma'am.
A -- but with that narrative, there's also -- when the nurse comes on at the beginning of the shift, there has to be an admission history physical. It's not a hospital rule, it is a national or a joint commission rule which so -- and I just want to say that her admission history and physical is incredible. I mean, it is -- it's awesome. She -- you can sometimes look at new nurses and they're just on it.
Q And you -- what are some of the information contained in her --
A Oh, my goodness.

Q initial history and physical?
A Skin color normal for ethnicity. Skin description, dry, warm. Heart and lungs are normal. Just relaxed, no crying. Breathing is relaxed. Arms and legs are relaxed. I mean, just -- it's a head to toe assessment. That's what we do when we go in. And this sets the pace for the rest of the shift.
Q Okay. So is that -- if you will, is that your baseline?
A This is your baseline. This is your baseline.
Q All right. And likewise when she documents if that entry at 19:30 at 7:30 that the peripheral IV in the right hand is flushing well --
A That's right.
Q -- is that a baseline?
A That's right.
Q All right. What else did you review of Nurse Downing's care and treatment of this patient?
A All right. So 11:08 she got the ampicillin. So that would have meant that at -- of course, we go back to 9:19, she had flushed it, okay? So about two hours later she starts -- she gives an another antibiotic ampicillin. So she would have gone in there with all of her little supplies like she showed you and -- well, no, she didn't do that part. And she would flush it again because she's giving an

antibiotic. You've got to flush it before and you've got to flush it after. So it got flushed again.

Q Okay. And so she'd given that antibiotic at that point in time?

A Yes.

Q And what was Nurse Downing's next interaction with the patient?

A At 11:23 she went in to check the IV again, which would have been another one of these checks.

Q And that would have been -- in military time, that would have been 23:23; is that correct?

A That's correct.

Q And that is listed right here on TRMC 181 and spills over into 182?

A Correct.

Q All right. And she would have again assessed for signs of infiltration; is that right?

A Correct.

Q And that is a zero?

A That's right.

Q And explain to the jury the significance of that score?

A That there's absolutely no problems with the IV. She did everything we've already talked about and it was still good.

Q And then it says phlebitis score, zero?

A No problems with the IV.
Q And, again, you've reviewed the policy and you heard her testimony. Is that what you're looking for since you're not infusing medicine continuously?
A Correct.
Q And so you always want to document the infiltration score and the phlebitis score?
A Correct.
Q And what was Nurse Downing's next interaction?
A Okay. So at 11:44 she went in again. Now, she's already given the ampicillin so she flushed before and she flushed after. Now a few minutes or several minutes later, twenty, thirty minutes later, she goes in to get another IV. So again, she flushes the IV, puts the medicine on a pump. And babies, little babies, you have to have them on a pump. And I believe this was a syringe pump. And then she would have flushed it afterwards. So that's two more flushes.
Q Okay. And what did she do after that point in time?
A Vital signs at 11:59 p.m.
Q Okay. And were those vital signs normal?
A Yes, they were.
Q And what did she do -- are we now close to midnight?
A We're at midnight.
Q We're at midnight. All right. And what did Nurse Downing do for R.J. at midnight?

A Well, on the MAR there was an order for the flush, which we know is the every four-hour flush that shows up on that medication record. Because as long as you have an IV, the policy said that IV has to be flushed at least every four hours. So with that, that feeds into the MAR, but she didn't do it.

Q Okay. What did she do?

A She didn't do it because she had just flushed it after she gave Claforan at quarter 'till 12.

Q Okay. And what time did she perform that flush?

A She performed that flush at 1:04 a.m., but that was after another IV check at 12:37.

Q 00:37?

A Yes, sir.

Q Let me see if we have that one. Yes, ma'am. Here we go. It's on TRMC 188. So again noted an infiltration score of zero?

A Yes.

Q Noted a phlebitis score of zero?

A Yes.

Q It says child was sleeping. Any signs and symptoms of any IV complications documented?

A No, sir.

Q What did Nurse Downing do after that assessment?

A The next time she did, I guess, a room check and she

noted that the baby was sleeping.

Q And is that part of your periodic nursing rounding?

A Yes, sir.

Q Now, each time -- there are things that nurses do that they don't -- is all, each and every ounce of care that a nurse provides, is that documented in the chart?

A No, sir. There isn't a way to do that.

Q Okay. All right. Go on. Thank you, Ms. Hurley.

A All right. So now we're at 2:41.

Q Yes, ma'am?

A And it's another IV check. She goes in and does another one of these right here.

Q Okay. And she did another one at 1:00, as well, I believe, correct?

A Yeah.

Q Okay.

A 1:04 a.m. That's the one that she didn't get at midnight because -- I think we talked about it. She'd just given the medicine.

Q All right. And what did she do after that point in time?

A Let's see. We talked about the IV check at 2:41. At 2:43 vital signs.

Q And how were those vital signs?

A They were okay too.

Q All right. And so that's another interaction between her and the baby?
A Well, probably with her and the baby, it would have been between 2:43 and 2:49 because at 2:43 the nursing assistant took the vital signs and then at 2:49 Ms. Downing confirmed them.
Q Okay. And so again at that 2:30 she made a note in nursing charts, correct?
A Right.
Q Patient asleep, no signs of distress. Will continue to monitor?
A That's right.
Q Okay. All right. And what was her next interaction?
A Let's see. 4:04 a.m. she did another IV check.
Q All right. And is that the IV assessment right there?
A Yes, sir.
Q Okay. And, again, would that be as a part of her monitoring and condition of the IV?
A Yes, sir.
Q And, again, that shows infiltration score of zero, phlebitis score of zero?
A Yes.
Q And that was at 4:04 a.m., correct?
A Correct.
Q All right. What was her next interaction with the

family?

A She went in to hang ampicillin.

Q All right. And that is --

A At 4:27.

Q And we've heard ampicillin is a vesicant, correct?

A Correct.

Q All right. And the difference between a vesicant and a non-vesicant, could you explain that to the jury?

A Well, a vesicant is something, in lay terms, that can just actually cause damage. There are like salt water like we're made out of and things like D5W. If you go in the hospital and you have surgery they hang stuff that isn't near as erosive as the medicines.

Q All right. And she would have assessed the IV at 4:04?

A She assessed the IV at 4:04.

Q And the ampicillin was administered at 4:27?

A That's right. So there she would have given -- of course, you would expect her to have given two flushes. But she hung the ampicillin at 4:27, so she flushed it before. But when she went back, of course, the IV had infiltrated. So there would have been no flush at all after that.

Q And that was the flush, I believe, Mr. Williams was asking about this time at 4:45; is that right?

A Right. But, again, that -- and that's the flush that would have been the every four-hour flush.

Q And again, that's where Nurse Downing documented not appropriate at this time?
A Right. And, of course, it wasn't.
Q And the reason why -- what was the reason why it wasn't appropriate at that time?
A Because there were signs of complications. There were signs that the IV was infiltrated. You're certainly not going to push anything else through there.
Q And, in fact, most likely the IV had been removed around that time as well?
A Her documentation -- I don't think it was removed until, let's see, 5:17. But in her deposition we know why. She saw it. She assessed it. She knew it wasn't right. She hadn't seen anything like it before. So she went and got her charge nurse, which is exactly what she was supposed to do.
Q Do you have an opinion to a reasonable degree of nursing certainty, more probable than not, that that was an appropriate course of action for her to take?
A Oh, it was. Certainly.
Q All right. And then you see in the record where Nurse Downing had a discussion with Ms. Middleton about the infiltration?
A I did.
Q And that was -- I think she timed that note at 4:50.

And you were here when she testified. You try to be exact but you can't exactly be exact, right?

A You can't.

Q Okay.

A The computer's not -- it has no mercy on you. You might have done something thirty minutes before but when you go to document it, it's going to document what time you're there.

Q So she's got it 4:50 IV antibiotics DC. Explain to the jury what that means?

A She stopped the -- She stopped the syringe pump from infusing any more ampicillin into the baby.

Q Okay. IV dressing removed. Hand puffy with bruising. And you heard Nurse Downing tell the jury about that, correct?

A Yes.

Q Mild swelling to the fingers. PIV removed. What does that mean?

A Peripheral IV removed.

Q So probably around 4:50 is when that would have been taken out, right?

A Right.

Q Catheter intact. Explain to the jury what that means?

A Well, when she showed you the little catheter you -- as soon as you pull the catheter or you see the catheter, you

always look at it to make sure all the pieces are there. It's only one piece but you want to make sure that there's been no damage to it, that it's all there.

Q And this is the catheter that Nurse Downing told us about, right?

A That's right.

Q You want to come down and show the jury what you mean?

THE COURT: Carefully.

THE WITNESS: I'll watch that.

A (Witness steps down) All right. Let's see. Yeah, she's got -- this is the little catheter that would have been in the baby. And you can see because it's so flimsy and so soft -- and the bigger IVs like for us, they're bigger and the holes are bigger. There was actually fluid given through that. I mean, you wouldn't -- it's not very big but it can go through there. But, yeah --

BY MR. TANNER:

Q So that the catheter tip when she says it's intact --

A Right.

Q -- it would look like it is now?

A Exactly. I mean, honestly sometimes you can pull out an IV and you will see where there's some damage to it. But, of course, there wasn't with that one.

Q But it's much more flexible and pliable than a catheter for an adult?

A Oh, yeah. Yeah. We're not allowed to put those in -- well, I've got to backtrack just a little bit. In the critical care setting, we don't even have those on the floor, 24 gauge, because in an emergency you couldn't get the drugs through it that you need to get through. So we're not even allowed to use them, just some children.

Q And so it was certainly proper to use a small catheter like that on a child?

A I don't think you'd use anything different unless it was a central line or something.

Q Okay. And when she explained to Ms. Hamilton infiltration, do you have an opinion on if that was appropriate nursing care?

A Oh, I think it was great. I mean nurses aren't -- nurses aren't just nurses, we're teachers and social workers and preachers.

Q And then after that 4:50 they called the physician as well?

A Yes, sir. And that was -- got that there.

Q And she's got -- entered that in the chart.

A And she did.

Q What was her next interaction with R.J. and his mom?

A Okay. Let's see. 5:16 -- well, of course, they took vital signs in between -- when this was going on.

Q Yes, ma'am.

A Also, there were two or three people in the room with that baby for about, oh, gosh, thirty, forty-five minutes at least. 5:16 she confirmed the vital signs. And then at 5:17 she removed the IV. And like she said in her nurses notes. It might -- these are a minute or two different. It could have been flip-flopped, but she removed the IV.

Q And then she would have reassessed R.J. around, I believe 6:00; is that right?.

A She did. She went back in at 6:00 and he was asleep in his mama's arms, I think.

Q And then she subsequently later reported off to the on-coming nurse?

A Right. Did vital signs again at 6:22. 6:26 she confirmed them. And at 6:45 she gave shift report.

Q Okay. All right. And do you have an opinion to a reasonable degree of nursing certainty, most probably whether or not Nurse Downing's care and treatment of R.J. that night met the standard of care?

A It exceeded the standard of care.

Q And, again, you testified that you heard Nurse Stobbs -- you read her deposition, rather?

A Yes.

Q And on this catheter this is a 24 gauge needle right?

A Correct.

Q You saw where Nurse Stobbs testified numerous times in

a deposition for the jury about getting blood return on a 24 gauge needle. Are you familiar with that?

A Yes, sir.

Q Can you get blood return on a 24 gauge needle?

A We're taught not to even try. When --

Q I'm sorry. Why is that?

A Well, first of all, we see how flimsy it is. And if you hook a syringe to the end of it and there's any resistance at all, it's going to not only flatten the catheter, but it can also suck that tiny little vein down too and occlude it. So then nothing's going to go through and you do damage to the vein.

Q What does the literature say on whether or not a nurse can get blood return in a pediatric patient of a 24 gauge needle?

A When I started doing this case I used my education, my training, and my experience. But then when Ms. Stobbs kept saying about the blood return, I -- you know, you begin to second guess yourself. Everything I've read has indicated that you never -- you just don't do it. You just don't try to aspirate blood for two reasons. Number one, just what I just told you. You can damage the vein. You can damage the catheter. You can just damage. And it also -- even if you get the blood return, some of the literature says that it may not be from the vein. That it may be sucking that blood

from like around the catheter. So it's a false -- it's a false test. So they tell you not to do it.

Q Would another difference between adults and children be that on an adult patient a larger bore needle you can get blood return --

A Oh, yeah. In the critical care setting we like to put in nothing smaller than a 20. And we really like 18s. And it seems crazy but the lower the number, like 18, the bigger the catheter; 18 is huge, 24 is little. We like 18 in our patients that are on -- in ICU and post -- or progressive care because we can get that emergency medicine in quick and we can give blood. You can't give blood through a 24 catheter. If R.J. had needed blood, they would have had to have put in a central line or another kind of venous access.

Q Let me show you a part of Plaintiff's Exhibit 4. It's TRMC 006. And I'll direct you to that 16:07 flush of Nurse Craft. Again, do you have an opinion on whether or not that is a four-hour flush?

A You talking about the 16:07? Tell me again. I'm sorry. I was looking at mine.

Q I believe it's at 16:07?

A Yeah, 16:07.

Q Okay. What is your opinion of that flush?

A That was, I'm sure, a four-hour flush, but just happened to be at the same time that Nurse Craft was hanging

her Claforan. So instead of that -- that flush would have fit right into the schedule, but it's usually not that simple.

Q Okay. And then, again follow four-hour increments thereafter?

A Yeah, every four hours. She got a -- R.J. got a flush every four hours up until the time they deseated, plus all those in between.

Q Okay. Do you have an opinion to a reasonable degree of nursing certainty, more probable than not if the assessment that nurse downing did at 4:04, that last documented assessment before the ampicillin was administered, met the standard of care?

A It certainly met the standard of care.

Q Okay. And have you been qualified in this state before as an expert witness?

A Yes.

Q More than once?

A Yes.

Q Okay. Regarding your review of the literature -- and I think you've talked about some of the research you've done.

A Right.

Q Can you give the jury other -- explain to them how we're also different, peds and adults are different?

A I can. And their words are a lot better than mine

anyway. First of all, I think it's important, the very first page, very first paragraph, the potential for complications is always present in the patient receiving IV therapy.

Q And what are you referring from, Nurse Hurley?

A Infusion --

Q Infusion Nurses' Society, Infusion Therapy. Okay?

A Okay. So then, let's see. This is one that I was glad to see because it made me think I had not missed anything. Checking for a blood return or a back flow of blood is not a reliable method for determining the absence of an infiltration. A blood return may not present -- be present when small veins are used because they may not permit blood flow around the cannula.

Q All right. And I think as Nurse Stobbs testified, she said that those articles are older. Surely, those would have been in place well before 2014, correct?

A Right. And they've been teaching you about charting by exception. The reason these articles are old and there aren't any new ones, I would like to --

Q Do you have an opinion on that?

A I do.

Q Would you like to share it with the jury?

A Things haven't changed and you can't reinvent the wheel. I mean -- all the --

Q In IVs -- I'm sorry.
A Sorry. In every one of the articles that I looked at, they all say the same every one of them. And they range from 2001, I think to 1997, and -- yeah.
Q So certainly since Ms. Stobbs has been as a nurse. I think she's testified she's been a nurse over thirty years?
A It hasn't change.
Q Okay. All right. Do you have an opinion to a reasonable degree of nursing certainty whether or now Nurse Downing's flushing met the standard of care?
A It actually was above the standard. It only says that the IV has to be flushed every four hours. But that baby got seven -- I want to check it --
Q Yes, ma'am.
A -- well, seven flushes, I think in twelve hours. Seven flushes.
Q All right. And do you have an opinion to a reasonable degree of nursing certainty if Nurse Downing's actions met the policy expectation of The Regional Medical Center in regard to managing a patient?
A They actually exceeded them.
Q Okay.
A And let's see. (Reviews records) Sorry for the delay.
Q Take your time.
A Oh, okay. And this is why I say she exceeded it. Of

course, we've already talked about what policies and procedures are and how we're supposed to follow them. And let me just reiterate this too. These policies and procedures are going to be essentially the same as any hospital in South Carolina, North Carolina, all across the United States. And the reason is they're -- all the hospitals have to be accredited and they all have to meet the same standards. We actually expect the same care from anywhere we go, whether it's Orangeburg, Providence, the Mayo Clinic, that should be the quality of care. Okay. And this is how I say she exceeds it. Okay. This baby was getting -- of course, we already know, about seven flushes. She did it every four hours. But where she went through about every hour and did an IV check that we've gone through and talked about, she only had to do that -- let me read the policy. The phlebitis and infiltration scale is to be utilized to address IV site conditions a minimum of once per shift. That's all she had to do.

Q So wait a minute. Does that policy say she only needed it one time --

A Once a shift.

Q -- in twelve hours?

A Yes. Once a shift. That is the policy.

Q And how many times did she assess that IV.

A I'm going to have to count.

Q I'm sorry?
A That's all right. (Reviews document)
Q Well, I can show you. Is that easier for you? We did the 19:44, right?
A There you go.
Q We did 20:54?
A Yeah.
Q We did 22:05, 23:23, 00:37, 1:00 in the morning, 2:42, and 4:04, correct?
A That's correct.
Q And, again, according to policy she only needed to do one of those?
A One.
Q What does the literature say about IV complications?
A IV complications can be -- well, first of all, let's say local, like just right at the IV site. Sometimes they can cause problems all over the body, serious problems. On the hand, well, y'all know as much as I do now. We know swelling. We know leaking at the site. We know bruising or ecchymosis, phlebitis, those are the local things.
Q Okay. And are there other type of complications as well?
A There are serious complications. There's -- first of all pulmonary embolus, which is a blood clot that is throughout the body and goes into the lungs. An air

embolus, an air embolus is when somebody inadvertently gets air somehow into the venous system, serious, serious problems and those are catastrophic.

Q And I'm sure the other lawyers will show you these pictures when it's their turn. Do you have an opinion on whether or not the child's hand would have looked like that when Nurse Downing was caring and treating for this child?

A Oh, no. That's a healing wound there.

THE COURT: And that's Plaintiff's 3, I believe.

COURT REPORTER: You'll have to look at the little picture.

MR. TANNER: I'm sorry.

THE COURT: I'm pretty sure it's Plaintiff's 3. I have a fairly good memory for it. So we'll take -- unless y'all want to correct it we'll stay with 3, okay? I can call it up, okay? That's 1.

BY MR. TANNER:

Q What about Plaintiff's 1, would R.J.'s hand have looked like that before Nurse Downing -- I'm sorry. That's upside down.

A No, that's a healing wound.

Q I apologize.

A And what I would like, I'm not sure if anybody's interested or not. But actually, this picture would have been before the one you showed me first.

Q Okay.

A And the reason being, all that yellow stuff right there. He was getting mist therapy and that was to get all of that stuff off of it because that was preventing it to heal so that's why the mist therapy.

Q So this picture is actually after --

A That's correct.

Q -- and this would be more --

A Yes.

Q -- healing process?

A Yeah. See, it's already -- it's healing there. Yes.

Q All right. Any review of the documentation show that the phlebitis score prior to the infiltration on the night of October 27th was anything other than zero?

A No.

Q All right.

MR. TANNER: I beg the Court's indulgence.

THE COURT: Okay.

BY MR. TANNER:

Q Just a few more questions for you, Ms. Hurley, and then I'll let you go. Do you have an opinion to a reasonable degree of nursing certainty, most probably whether The Regional Medical Center acting through it's nurses, including Nurse Downing, complied with the standard of care in the care and treatment of [redacted]

A I do.
Q And what is that opinion?
A I think that Ms. Downing, who's a reflection of the hospital, did an outstanding job taking care of this baby.
Q Thank you very much for your time. Please answer any questions that Mr. Williams or Mr. Krell have for you.
A All right.

THE COURT: Mr. Krell, is she yours?

MR. KRELL: Yes, sir.

THE COURT: Okay. Mr. Krell, she's your witness.

MR. KRELL: Thank you.

THE COURT: Yes, sir.

CINDY HURLEY - CROSS-EXAMINATION

BY MR. KRELL:
Q Good afternoon?
A Good afternoon.
Q That baby is healing is your testimony, correct?
A Yes, sir.
Q Did that baby go into the hospital with any wounds to his hand?
A No.
Q When it left the hospital did it have any wounds to its hand?
A Yes, but we don't know what they looked like.
Q You don't know what what looked like?

A We don't know what his hand looked like when he left. I haven't seen any of those pictures. I'm can assure you -

Q You agree that's his hand. Is that normal?

A I do. It's a normal healing wound.

Q That's a normal hand?

A It's a normal healing wound. The wound is healing exactly like they expect it to.

Q What's the number one rule of nursing? Is it to do no harm?

A Certainly.

Q You talked about literature. When did you review some literature?

A After my deposition the other day.

Q That was about a month ago?

A I think it was a week ago, wasn't it to? Two weeks ago?

Q A week ago? And what did you review?

A I reviewed the article -- let's see. The Infusion Nurses' Society Infusion Therapy.

Q Okay.

A Intravenous Therapy in Children.

Q All right.

A Assessment of an Infant with a Peripheral IV, and Intravenous Extravasation Mechanisms Management and Prevention.

Q And the last one you mentioned is the article that you cited for blood return, correct? Checking for blood return?
A No, sir. That was the first one.
Q Okay. That's the - tell me which one it is.
A The Infusion Nurses' Society.
Q And what does that say?
A You want me to read it again?
Q Yeah. I'm a little confused.
A Checking for blood return or back-flow 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 around -- they may permit blood around the cannula.
Q What's your opinion regarding how often the IV site should be checked?
A Every hour to hour and a half.
Q Is that what you testified to in your deposition?
A Well, I got confused there. You had me kind of nervous.
Q I did?
A Yeah. And I said the time was wrong. But when I looked at it, she was in there -- you had me thinking she wasn't -- I was wrong. But she was in there every hour to hour and a half.
MR. KRELL: Your Honor, may I --

THE COURT: You may.

MR. KRELL: May I explain to the jury what I'm doing now.

THE COURT: Yeah. And you can ask her what she said during the deposition. You might not need to even open it.

MR. KRELL: I'd like to.

THE COURT: Okay. Okay. Go ahead.

MR. TANNER: This is a transcript of the deposition I took of Ms. Hurley a couple weeks ago.

BY MR. KRELL:

Q Let me hand you this, Ms. Hurley. And I know you've got a lot of stuff. Would you like me to move any of this.

A This is my deposition? Oh, okay. I got you.

Q All right. I had you confused, right?

A You had me way confused.

Q Okay. Let's turn to page 72 in your deposition?

A Okay.

Q I think that's the right page. Excuse me. Page 71.

A Okay.

Q All right. And at line 20 I asked, So what's your opinion regarding how often a site should be checked? What was your answer?

A I said every hour to two hours and then I said an hour and a half.

Q Okay. What's the standard of the hospital for checking the site?

A Ever hour. I -- every hour. Every hour.

Q Every hour?

A Every hour, I think.

Q Okay. You think?

A Well, why don't we just make sure. I'd rather make sure. All right. If IV fluids are going and that would be -- we talked about in my deposition the buretrol, if the patient had a continuous IV, in adults it would be a bag and in a baby it would be a container with a smaller than that cup. Then you would check it every hour. And the reason you check it every hour is because you want to make sure it's not being infiltrated.

Q I'm looking at page six of nine, intravenous therapy, item thirteen. Is that what you're looking at?

A Yes.

Q This says, and correct me if I'm wrong, IV site is to be checked hourly and prn with appropriate documentation, correct?

A Correct. But that's because they're talking about IV fluids are going in that baby continuously. And this baby didn't have that. The only time he got medicine was every four to six hours, which would have been his ampicillin and his Claforan.

Q At the time of your deposition you had no idea about that, correct?
A I tried to explain that. We were -- we were not -- okay. Yes, we tried. I tried to explain that, that she was right. But then I got all confused.
Q I mean, you'd do anything to say this nurse was right; isn't that true?
MR. TANNER: Objection, Your Honor.
A You know --
THE COURT: Wait a minute.
A No, sir. That's not true.
THE COURT: Wait. Wait. You don't even need to respond. He doesn't need to ask it, okay? Thank you.
BY MR. KRELL:
Q You would -- in your deposition you actually said that these rules and these policies and procedures is the rule book of the hospital, correct?
A It's the rule book of health care, sir. I want to say something just so I can --
Q If you could just answer the question --
A I did answer the question.
Q I don't think you did.
THE COURT: Right now the only thing you can do is answer his question.
THE WITNESS: Is answer the question?

THE COURT: Yes, ma'am.

THE WITNESS: Okay.

THE COURT: I assure you that Mr. Tanner will follow-up. Okay.

THE WITNESS: Okay. Thank you.

THE COURT: Okay.

A Okay. I'm back.

MR. KRELL:

Q From where? Where are you back from?

MR. TANNER: Your Honor.

THE COURT: All right. Mr. Krell. That's okay. Just ask the questions. Just like she gets to answer them, you get to ask them.

BY MR. KRELL:

Q Is it appropriate to call the policies and procedures the rule book of the hospital?

A It certainly is. Yes, sir.

Q Is it appropriate for nurses to interpret these rules?

A Yes, sir.

Q They can interpret them in how they see fit?

A Well, they interpret them the correct way, I'm sure.

Q Okay. We've talked about this rule, and you can quote it. You've got the policies in front of you?

A Right.

Q Page five of nine?

A Right.
Q Flushing the INT with saline is to be documented on the MAR?
A Correct.
Q Was that done?
A Yes, sir, it was. Every four hours.
Q Was it done every time it was flushed?
A No, sir.
Q How do we know that?
A It's actually not protocol.
Q It's not protocol?
A No, sir, it's not.
Q Okay. Why does it say it on that document?
A It says on this document that it's to be documented every four hours and it was. And that's automatically -- like Nurse Downing was explaining to you, it goes automatically into the medication records so that they make sure that their IV gets flushed every four hours in case -- because a lot of times people don't have medicines.
Q Now, on the medical records it's done -- on the MAR, it's done every four hours?
A Yes, sir.
Q Now, when was the last flush prior to the administration of the ampicillin at 4:27 a.m.?
A (Witness pauses)

Q And I'm happy to provide you --
A I got it. All right. I'm looking for -- all right. 4:27?
Q Yes, ma'am.
A The patient got the ampicillin. She got one flush.
Q When?
A At 4:27.
Q Is it documented?
A No, sir. And it won't ever be documented. It's not protocol. When you give an IV medication it is part of the process. You get your supplies and you go in and you always flush it. You give your medicine and you always flush it again. That is just the way it is.
Q Prior to 4:27 when was the previous flush?
A The previous flush was at 1:04 a.m.
Q All right. Now, the way I read the record it looks to say at midnight. Does that say midnight on --
A Well, it didn't make much sense to give it at midnight because she had just had a flush at 11:44.
Q And so what time did she give it if it wasn't at midnight?
A At 1:04.
Q And how do you know that?
A Because she documented it.
Q Who did?

A Ms. Downing.
Q She documented it in this MAR that she gave a flush?
A At 1:04.
Q Okay. Have you read your deposition?
A Yes.
Q Do you have a copy of your deposition?
A I do.
Q Would you pull it out, please?
A Okay.
Q Would you look at line 17 and read 17 through 24, please?
A What page?
THE COURT: What page?
MR. KRELL: I'm sorry. Page 37. I apologize.
THE COURT: Page 37?
MR. KRELL: Page 37, Your Honor, lines 17 through 24 of Nurse Downing's deposition.
A Okay. 17 through 24. It's not a specific medication. It's the way MAR was set. So the IV had to be flushed at least every four hours with either saline or a medication. So it doesn't allow you to really document a flush. As a nurse you chart by exception, but to check an IV site you flush an IV, though it's not specifically in there, but that's how you assess an IV.
BY MR. KRELL:

Q You just read that it doesn't allow you to document a flush, correct?
A (Witness pauses)
Q Yes or no?
A I did.
Q You were here for Nurse Downing's testimony --
A I was.
Q -- this morning?
A Yes, sir.
Q Did you understand it?
A Yes, sir.
Q Okay. In regards to whether or not the jury's to believe your testimony based on the records or Ms. Downing's testimony based on being there, who would they be better off believing?

MR. TANNER: Objection, Your Honor. He's trying to pit the witnesses against each other.

THE COURT: Yeah. It does sound like pitting.

MR. KRELL: I'll withdraw the question.

A I will -- can I answer?
Q Sure.

THE COURT: No, ma'am.

MR. KRELL: Oh, excuse me. The Judge has to decide that.

THE COURT: No, ma'am. You cannot.

MR. KRELL:

Q Ms. Downing testified wasn't it, that that saline flush was given at midnight, didn't she? You heard her?

A I don't know. I don't know.

Q You don't know that she said it or you don't --

A No, sir. I don't know that she said it. I might have missed it if she did say it, but I'm not going to sit here and say that I heard it when I didn't hear it.

Q I show you a document that we've talked about throughout the year -- throughout the trial?

A She couldn't have. She couldn't have given it at 12:00.

THE COURT: You've already answered the question.

THE WITNESS: Okay.

BY MR. KRELL:

Q I just asked if that's what she testified to?

A And I said I didn't know. Okay.

Q All right. Tell us what that document is?

A Policies and procedures for infusion nursing of the pediatric patient.

Q All right. And who is it published by?

A (Witness pauses)

Q Is that the Nurses' Society --

A Yeah. Infusion Nurses' Society. Okay.

Q And that's the -- you quoted the Infusion Nurses'

Society document earlier. I don't think it's the same one, but the same publication, correct?

A Right.

Q Turn to page a hundred of the document I just handed you. It should be right --

A Okay.

Q All right. Do you see where it's highlighted --

A Correct.

Q -- at the bottom of the page?

A Correct.

Q All right. And it's under a section, correct, called flushing; is that correct?

A Correct.

Q Read that section for the jury from the pediatric -- it's a pediatric handbook, right? A pediatric --

A Correct.

Q It has to do with babies, right?

A Well, I don't know what I'm -- I mean, I'm not talking back or anything. I just don't know what I'm reading. This could be a twelve-year-old child or a fifteen-year-old child I'm fixing to read about, so --

Q Just go ahead --

A It says slowly aspirate until brisk blood return is obtained.

Q All right. Thanks.

A You're welcome.
Q One more question for you. How did the infiltration occur?
A There is very little way to know how that happened. There's a multitude of ways it could have happened.
Q Let's refer to your deposition when I asked you that question, okay?
A Right.
Q Let's look at page 77?
A Okay?
Q Lines 12 through 18.
THE COURT: 12 through 18?
MR. KRELL: Yes, sir.
BY MR. KRELL:
Q I ask, state, okay, how did the infiltration occur? And your answer?
A (Witness pauses)
THE COURT: That's where you read it.
A Oh, oh, I'm sorry.
BY MR. KRELL:
Q I'm sorry.
A You want me to read it.
Q I'm sorry Ms. Hurley, starting on line 13.
A Okay. Line 13.
Q I apologize?

A It's hard to say. There's a multitude of ways it can happen.

Q Okay. Do you have an opinion?

A And I said on how it was --

Q And I said how the injury happened?

A And I said, I have no idea.

Q Thank you.

MR. TANNER: Just briefly, Your Honor.

THE COURT: Are you through, Mr. Krell?

MR. KRELL: That's it.

THE COURT: Thank you.

MR. TANNER: Thank you, Judge.

THE COURT: All right. Redirect limited to his cross.

CINDY HURLEY - REDIRECT EXAMINATION

BY MR. TANNER:

Q Nurse Hurley, Mr. Krell had asked you something about the rule book, and I think you wanted to expound on that answer. Can you tell the jury what you wanted to tell them ???.

A These are rules, they're rules for all of us. But what you have to understand is that Ms. Downing did everything she was supposed to do. And I find offense because I know y'all are all well-read and you read the newspapers and as far as me doing anything to help a nurse -- the nursing

profession is the number one most honest and ethical profession there is and it has been for seventeen years. And there's not a nurse that would get up here and make up stories and tell stories. The only - and the second profession is military. So -- and I'm proud of that. So, no, I would never ever do that.

Q And just a few final questions. I'll show you what's been part of --

THE COURT: And, again, limited to his cross.

MR. TANNER: Yes, sir.

Q -- Plaintiff's Exhibit 4. He was asking you about the flush that's timed at 12:00?

A Right.

Q And I'll show you. This is page five?

A Right.

Q It says administration date and time, 10/28/2014, 0:00; is that right?

A Correct.

Q And then it says action details. Order Megan Bolton Shore 10/25/2014, 22:00. That would be the doctor's order, correct?

A That's right. From when the baby came in.

Q And then it says performed Jamie Downing R.N., Jamie D 10/28/2014 01:04, 1:04. What does -- explain to the jury what that means?

A Well, it just means that the reason she didn't give it at midnight was because the baby had an IV infusing at the time. It doesn't make much sense to go in there and --

Q And then it says verify Jamie Downing, Jamie D, 10/28/2014, 01:04?

A Right.

Q And so that's the computer time stamping when she gave that flush?

A That's right. It like I told you before. When you chart it's not like you can put things in there that didn't happen. When she wrote that she gave it. That time popped up because that's when she gave it.

Q So maybe she said she gave it at 12:00, but the record, the computer says she gave it at 1:04 a.m.

A She gave it at 1:04.

Q Thank you, Nurse Hurley.

A You're welcome.

THE COURT: Anything on recross limited to his redirect?

CINDY HURLEY - RECROSS-EXAMINATION

BY MR. KRELL:

Q Isn't it true you're getting paid two hundred dollars an hour?

A For today, yes, sir.

Q And how about before?

A A hundred dollars an hour.

MR. TANNER: Your Honor, I'd just object. This goes outside of my --

THE COURT: Well, it does. It does. But since you got to ask questions about that, I'm going to let him go even though --

MR. TANNER: Yes, sir.

THE COURT: -- but now everything else needs to be confined to his redirect.

Q So you just said that she entered it at midnight and it is at 1:04?

A No.

Q What did you say?

A It was on the MAR, the medication record to be given at 12:00.

Q Right.

A But she didn't give it until 1:04. She couldn't give it. The baby had an IV going at the time.

Q At what time? I'm sorry. I'm just confused.

A Well, let me explain.

THE WITNESS: What number was that, Mr. Tanner?

MR. TANNER: If I may, Your Honor.

THE COURT: You may?

MR. TANNER: TRMC 005.

THE WITNESS: Okay.

A I got it. This whole folder is the care that she gave that night. Everything in this --

Q Ms. Hurley.

THE COURT: Ms. Hurley. Ms. Hurley.

THE WITNESS: Sorry. I just want to --

THE COURT: I know.

THE WITNESS: I'm sorry.

THE COURT: And you have done a lot of --

THE WITNESS: I'm sorry.

THE COURT: You just need to answer his question, please, ma'am.

THE WITNESS: Okay. All right.

A So the IV -- the flush that we're talking about is the midnight flush. And the patient would have been receiving Claforan.

Q So at 12:00 when Ms. Downing testified she gave it, she just didn't know what she was doing or --

MR. TANNER: Objection, Your Honor. Mischaracterizing the testimony.

A Sir, I'm not going to answer why she said that. I don't know why she would say that.

Q But you agree she said it?

A No, I don't because I don't remember hearing it. And maybe they all did. Maybe everybody did but me.

Q All right.

A But it doesn't make -- it's not that -- she couldn't give it. There's no way.

Q Thank you very much.

A You're welcome very much.

MR. TANNER: No further questions for Nurse Hurley, Your Honor.

THE COURT: All right. May she be excused?

MR. KRELL: Yes, sir.

THE WITNESS: Thank you, sir.

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

THE WITNESS: Thank you, sir.

THE COURT: Is defense ready to call its next witness.

MR. TANNER: That is the defendant's -- we would rest our case at this time, Your Honor.

THE COURT: All right. Thank you. Appreciate it.

THE WITNESS: Thank you.

THE COURT: Thank you, ma'am. I know you've got a lot of stuff --

There's somebody's -- it's your deposition, the original deposition is right there. I just want to get it down.

COURT REPORTER: Yeah. All of our things are here.

THE COURT: Don't we need that, Mr. Krell. I'm

sorry. I think you need leave it with you if you don't mind. Thank you, sir.

(Off record discussion)

THE COURT: All right. Ladies and gentlemen, we've now heard --

Are y'all recalling anybody?

MR. KRELL: No, sir.

THE COURT: Okay. You have now heard all of the testimony in this case. There are some things I've got to take up with the attorneys. And let me tell you what my plans are, okay? It's going to take me a minute to do that. It's going to be kind of an extended break. And what my plan is is -- what we're going to do closing arguments, I'm going to charge you on the law and y'all will begin at least initially begin your deliberations late this afternoon, okay?

All right. Now, I'm going to let y'all go back in there. Remember, even though you heard all the testimony you cannot begin talking about this case until I tell you to start talking, okay? Thank y'all. Y'all doing real good. Thank you.

(Jury out at 2:52 p.m.)

THE COURT: Mr. Tanner?

MR. TANNER: Yes, sir?

THE COURT: Do you need to renew --

MR. TANNER: Actually, I need to proffer Nurse Hurley too.

THE COURT: Oh.

MR. TANNER: And I need to renew.

THE COURT: All right. Yeah, bring her back up here and we'll proffer that little bit of testimony.

(Court's Exhibit No. 3, deposition of Nurse Hurley, marked)

THE COURT: Nurse Hurley?

THE WITNESS: Yes, sir.

THE COURT: Be careful.

THE WITNESS: I'm going to be careful and I'm not going to tear anything up. I promise.

THE COURT: All right.

Ms. Hurley, go ahead and sit down.

THE WITNESS: Okay.

THE COURT: Okay. The purpose of this -- you were in here when we were talking about what you could testify and what you could not testify --

THE WITNESS: Yes, sir.

THE COURT: about? You were in here?

THE WITNESS: Yes, sir.

THE COURT: Okay. And you remember I told Mr. Tanner that since you weren't a lawyer you couldn't testify about negligence?

Q And what is that opinion?
A She absolutely was not.
Q And do you have an opinion to a reasonable degree of nursing certainty, more probable than not if TRMC as the employer of Nurse Downing was negligent?
A Absolutely not.
Q All right. And do you have an opinion to a reasonable degree of medical certainty -- nursing certainty more probable than not, if Nurse Downing was grossly negligent in her care and treatment of R.J.?
A Well, if she wasn't negligent she sure wasn't grossly negligent
Q And likewise then would you have an opinion if the hospital by and through Nurse Downing was grossly negligent in its care and treatment of [redacted]?
A My same answer, no.
Q So the hospital is not grossly negligent?
A No.

MR. TANNER: Nothing else from Ms. Hurley, Your Honor.

THE COURT: Mr. Krell, anything on cross.

THE WITNESS: Thank you.

THE COURT: Hold on. Whoa. Whoa. Whoa.

THE WITNESS: Oh, gosh.

THE COURT: Mr. Krell.

CINDY HURLEY - PROFFER CROSS-EXAMINATION

BY MR. KRELL:

Q Ms. Hurley, what's your definition of gross negligence?

A Actually causing a problem and knowing that you did it. Hurting someone intentionally.

Q Intentionally doing it?

A Uh-huh. (Affirmative response)

Q That's what gross negligence is?

A It is to me.

MR. KRELL: Thank you, Your Honor.

THE COURT: Okay.

MR. TANNER: Nothing further, Your Honor.

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

(Off record discussion)

THE COURT: All right. Gentlemen, I appreciate you having your help in the back row, you know, Mr. Krell. Thank you for having Curley, Moe and Larry behind you, helping you. But unfortunately, you know, we're here, you know, to kind of work through this.

MR. KRELL: Yes, sir.

THE COURT: Okay. My question is -- okay, what I want to do is take a short break and then we meet back in the office and we'll talk a little bit about the charges and the verdict form, okay?

MR. KRELL: Yes, sir.

THE COURT: And you can bring one of them with you.

MR. TANNER: My renewed motion for directed verdict?

THE COURT: Oh, yeah. I'm sorry.

MR. TANNER: Do you want to hear it now?

THE COURT: Yes, sir.

MR. TANNER: Your Honor, now that we're closing the defendant's case, I'll renew my motion for directed verdict. The evidence as submitted by the plaintiff and all inferences thereof is not enough to go to the jury. Specifically, the issue of gross negligence. There's been no evidentiary proof. I would ask the Court to note my prior objection for the sake of the late hour and not having to reiterate that, but it would be the same argument that I made earlier now that we're at conclusion.

THE COURT: All right. And even though I've now heard the additional testimony from your expert, from the hospital's expert, there's still issues, factual issues that I believe that the jury needs to determine. And so I am going to deny your motion for a directed verdict. Okay.

MR. TANNER: Yes, sir.

THE COURT: All right. Y'all take a quick break and then y'all meet me back there and we can talk about the verdict form and the charge, okay? Thank you.

(Court in recess for short break at 3:05 p.m.)

(In chambers charge conference)

(Court in session after short break at 3:46 p.m.)

THE COURT: Okay. All right. Is the plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Okay. Is defense ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. I'm going to put just a couple of things --

(Off record discussion)

THE COURT: All right. Mr. Williams?

MR. WILLIAMS: Yes, sir.

THE COURT: We had -- just to go back on the record. We had a conference in chambers about the charges; both the plaintiff and the defendant had -- took exception to my charges. What we have agreed to do is go ahead and do the closing arguments. I'll do my charge on the law and we'll turn the case over to the jury. And then we'll place those exceptions to the charge on the record so that it will be preserved. Is that correct, Mr. Williams?

MR. WILLIAMS: That's right, Your Honor.

THE COURT: Is that correct, Mr. Tanner?

THE WITNESS: Right.

THE COURT: But he's going to ask you about that anyway?

THE WITNESS: Okay.

THE COURT: Okay. But he's asking you that out of the presence of the jury.

THE WITNESS: Okay.

THE COURT: In case he wants to take my decision up to a higher authority, he wants to have it on the record so it'll be preserved, okay?

THE WITNESS: Yes, sir.

THE COURT: Okay. So, Mr. Tanner, she's all yours.

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

THE COURT: Yes, sir.

CINDY HURLEY - PROFFER DIRECT EXAMINATION

BY MR. TANNER:

Q Nurse Hurley --

A Yes, sir.

Q -- based on your earlier testimony do you have an opinion to a reasonable degree of nursing certainty, more probable than not, if Nurse Downing was negligent in her care and treatment of [redacted]?

A And I do.

MR. TANNER: Yes, sir.

THE COURT: So are you ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: You want to say something else?

MR. WILLIAMS: No.

THE COURT: Okay. All right.

MR. WILLIAMS: Well, I do have something to ask Mike. We'll just make sure in closing I want to --

THE COURT: Okay. Well, you want to ask him now?

MR. WILLIAMS: Sure. Michael, is it going to be a problem with this event record that's been completed, highlighted if I'm just going to read this, site to be checked hourly and prn? Is that going to be a problem or do I need to block it out with a pen or something? I'm just going to read that to them.

MR. TANNER: Yeah, I know. That's fine.

MR. WILLIAMS: Okay. To make sure.

THE COURT: Okay. All right.

If the jury's ready --

MR. WILLIAMS: So we don't want her to wait and do the jury instruction stuff now or later?

THE COURT: No, we'll do it later.

MR. WILLIAMS: Okay.

THE COURT: I want y'all to go ahead and do the arguments and like that. Let them start deliberating

because, as I told you back there, I'm not going to charge my mind

MR. WILLIAMS Got you.

THE COURT: But y'all are going to be able to get it on the record so that will be another thing that could go up and y'all can correct me on, okay?

(Off the record discussion)

THE COURT: All right. Bring the jury on in. Thank you.

THE BAILIFF: Yes, Your Honor.

(Off the record discussion)

(Jury in at 3:46 p.m.)

THE COURT: All right. Ladies and gentlemen, we are now getting down to the wire. Remember, I told you at the very first that after you hear all the testimony we'll do closing arguments, and then I'll charge you on the law? Right now we're getting ready -- what's going to happen is we're doing the closing arguments. Plaintiff will get up and make a closing argument. The defense will then get up and make a closing argument, and then the plaintiff will reply to that closing argument. After that, I will charge you on the law, okay? And then we will hopefully begin the deliberations but we won't really begin that because I've got to get some stuff on the record before we can start doing that. But, again, you cannot begin your deliberations

on this until I tell you you can start talking, okay? All right. You ready to go? All right. Mr. Williams.

MR. WILLIAMS: Yes, Your Honor. May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S CLOSING ARGUMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, I thank y'all for your patience. Y'all have been a wonderful jury, patient with everybody in this case. Like he said, it's going to be a pretty short case. Then again it's a pretty simple issue.

Our issue is did the nurse at The Regional Medical Center fail to flush? That's the case, right? That is what we're here today about. That's what we've been talking about. That's what we hired an expert to do, okay? And, you know, you've heard this, this case, you know, a football game, right? Playing the football game and you're receiving on the fifty yard line. This has turned into a kind of Carolina Clemson game where the fans are throwing bottles at the players along the way. And, you know, but the fact remains, the evidence is pretty simple. You've got an opinion, what caused it. And on the other side, you've got no opinion. I don't know. That's what everybody's saying. I don't know, okay? So if that ball's on the fifty yard line and you've got a clear opinion of what caused this is

that they didn't flush the IV that lead to this young boy's hand ending up damaged. Now, whether this is what it looked like right then and there or whether it was later, we'll talk about that. But that's not the issue. And it's easy to get distracted from the issues, right? I mean, you want to do a good job as a jury so you want to hear all the facts and understand how to apply these things. But let's not get distracted. The issue that we're here today is to talk about rules. What were the rules? You heard what the rules were. You heard what the conclusion was, that there was a willful breaking of those rules. You've heard the nurse say I'm not allowed to interpret these rules, okay? And I wanted to be as polite to her as possible. You know, I feel sorry for the nurse. You know, it's a rough spot to begin, to become a professional and here you are, you know, three times a week -- she's probably been there two weeks according to her testimony, so ten weeks, you know, she'd been in training. Her first two weeks -- within her first six days roughly, you get put in a position to deal with something like this. And I feel sorry for her. I really do. But she's not who we're talking about. We're talking about The Regional Medical Center. We're talking about how they've got this young girl trained, but she's told -- I can't interpret these rules. These rules, no room for interpretation. But then right after that she say I

interpret the rule to say this. That's a problem. That's willful, wanton, disregard to what you're told to do by --

MR. TANNER: Your Honor, I object to any characterization, willful, wanton.

THE COURT: Well, I'll note your objection on the record. Go ahead.

MR. WILLIAMS: Sure.

THE COURT: Thank you, sir.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

Yeah, it's a very -- like I told you earlier, it's a wonderful thing that we have this jury system. It's what creates this democracy where we, we make allegations against the government, okay? We can make these allegations and we have a right to be heard. The court gives us that right and you get to make the decision where the government gets to bend the rule, where they get to say well, the rules are there, but we interpret them differently.

Well, you heard their expert who came up here and said well, I said this in the deposition but you tricked me, you know. I got paid. My attorney -- the attorney for the government came and gave me new material, told me what I needed to say because what I said in my deposition wasn't what I should have said. So I'm going to come in and say well, these rules fully apply if you giving, you know, an IV

thing, you know that IV you hand up. The first sentence of this rule, it isn't just for continuous medication, the rules, continuous or intermittent. What does intermittent mean? It means not continuous. It means the occasional administering of the medication. But I didn't like that I said these applied. I didn't like that I said well, they can be interpreted. But I can come in and be held accountable for not doing the things it says do. Not flushing properly, not inspecting the IV site every hour. Her testimony was she made seven inspections over twelve hours. The site needs to be checked hourly and as needed with appropriate documentation, okay? She testified seven, that's beyond the standard of care because, you know, you only -- is once. Because I'm going to reinterpret these rules because I'm the government. Well, you know what? They don't get to reinterpret this. They don't get to say that this doesn't apply. They have to abide by the flushing with the saline. It's to be documented in the MAR. You've got to. You don't have a choice. It's supposed to be documented. But you heard the nurse, the system won't let me document it. The system that I'm required to do, The Regional Medical Center doesn't even give me the tool to do what you say I've got to do. I'm not going to interpret this, but I'm going to interpret I don't have to do that. And, you know, I'm somewhat with her. When your boss tells

you you got to do something, but then doesn't give you the ability to do it. When they tell you these are the tools you use but here, I'm going to put this tool over here so use what you got left over, okay? What that is, is that is failure to provide this patient safety that she's sworn to do, that The Regional Medical Center's sworn to do, is to do no harm. Do no harm. Had she flushed -- you heard our expert -- we wouldn't be here today if she'd flushed properly and realized that this area was infiltrated. You heard her testimony, you know, she -- to me she said, you know, that it was a zero all through this, up until this injury occurred. No, the injury didn't look like this and like this at the time that she first noticed it. But this injury came from something at the highest it's ever been on a zero to five scale was a one, okay? Nobody attempted to do anything, other than put, you know, compress on this, okay? I have a hard time believing that if a five is worst case, a zero is best case, that this is a zero at the time this drug was administered. And at the end just a one, okay?

You heard my client explain the details of what she experienced. She was teary and you know, moved me to the -- how to explain that. And I think one thing, a poor mother's sitting there begging for help with a screaming baby. A screaming baby in her lap. She's pressing the call button.

I've got my baby being burnt. I don't know what's happening. I don't know that my baby's burning right now, but I've got my baby in my arms, screaming. What do you do with that? You know, you're at the hospital and you hit the call button and you can't get anybody. You would expect when you hit that call button you're not waiting -- you certainly expect when this happens they don't make you wait until the next morning to see the doctor. Why do they make you wait until the next morning to see the actual doctor? This issue is so clear in Exhibit 4.

You're going to get this. And I'll tell you I don't know how -- there's this big stack of documents. There's really only a couple of pages that are important. But sure they want to talk about the things early on that were done to distract you from the main issue. The main issue being that the record clearly says that it was administered, the flush, at midnight. You heard the witness say it. I made a point of it. It was the last point I made with that witness that it was administered at midnight, not before, not after. In fact, the witness went on unquestioned to explain why it read what it did. She said I have an hour to enter in the record and so I entered it later. I just want to reference you the exact document, TRMC 005. It's going to be the fifth page of. And you're going to see all of these things where it says administration date and time. It's going to

say administration, date and time. It's going to say zero all the way across. You're going to see charted date and time. That should mean when she got around to entering it in the system. Charted date, time, doesn't mean that's when you did it. Administration, the pumping of the saline into that tube is when you administered. There's nothing -- this is the MAR, the medication record, okay? This is the document though that she said, okay? She's the one that did it.

If there's anybody that's going to interpret this, it should be the one that did it, and why she did what she did, not an expert that's paid to tell you. Now, what I did, especially from my colleague here, it's our duty to try to keep our cool because we don't want this -- this isn't about us. This isn't about him. This isn't about me and as frustrated as we want to get, as mad as we want to get when somebody says something we don't agree with, it's not for us. It's for y'all and these witnesses. It's for y'all to determine between the defendant and plaintiff's, okay? But you heard this witness go over this colloquy about why you should believe her, because she's the most honest profession, etcetera. Why would she say that? That's like the guy that comes to you and says I'm not behind it, but let me tell you something, okay? When you start -- if you've got to start what you're saying with I'm not lying to

you or scouts honor or, you know, I've joked with another here but one attorney got up here and says officer of this court, Your Honor, and they go ahead and explain a total lie, which was all proved out --

MR. TANNER: Your Honor, I'd object. This is outside the scope of any evidence that's been permitted about some story about a lawyer standing up here, it's improper.

MR. WILLIAMS: It's just using it as an example. I don't think it's improper but I'm happy to move on.

THE COURT: If you'd just move on please, sir?

MR. WILLIAMS: Certainly.

THE COURT: Thank you.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

She went on to say that she's telling the truth. That the nurse is wrong, but I'm right because I know what this means, not the nurse who did it. And that's a problem. If the nurse didn't know, it's a big problem. But you know what y'all need to realize is we're giving the benefit of the doubt. We didn't create the record. We didn't get to offer anything in these documents. We didn't get to make up any of these policies or procedures. This is all The Regional Medica Center's documents. They entered this. This is even assuming that they're not lying in any of their

documents. This is assuming --

MR. TANNER: Your Honor, the characterization that Mr. Williams is making, there's been zero evidence that any document ha been altered, amended, fabricated. It's completely improper.

THE COURT: And I would caution you. These are the hospital records. I heard the word lying in there. And I didn't know what that was -- what you were getting at with that.

MR. WILLIAMS: Sure.

THE COURT: But those are the hospital records and there hasn't been anything about them being different, correct?

MR. WILLIAMS: That's what I'm saying.

THE COURT: Oh, okay.

MR. WILLIAMS: We are arguing that they are, in fact --

THE COURT: Those are the records of the hospital.

MR. WILLIAMS: -- the records that are accurate.

THE COURT: Okay.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

And the important thing about that is, is that record says that these policies and procedures were violated, okay? You, our safety judge, you're the one committee designed to

protect Orangeburg County by deciding whether or not the safety rules were broken. I would argue that you need to look at it and I hope you realize that not only was it broken but it was a known rule. It was a rule that everybody testified, until the last day witness, that we are required to abide by, but then we breached that rule and we know we breached it.

You heard from Peter DeVito. You heard about these continuing issues potentially that -- this is from the teacher. This is the one who taught Mr. Davis. This is the one who wrote the rule book. He talked about the pain and he talked about the tightness of that skin. He used that explanation where he describes -- I mean, there's just nothing there to work with and how that's going to affect this child, both physically and emotionally. And you heard from Mr. Davis in his direct he said certain things. In his cross he admits it's a permanent injury. This is something this kid's going to wear the rest of his life. It isn't getting any better. There's surgeries you can do. There's things we can do to try to mitigate it, but it isn't going away. It's always going to be there. You heard that he's emotionally traumatic -- this is emotionally traumatic. The idea of injecting more medication into those sites, that's emotionally traumatic to a child. We grow up with a mother, with a dad. We, you know, parents, we swaddle our kids.

You know, that touch, that caring, that love from day one. That's what you get as a child, hopefully, okay? Mama doesn't want to go to stick her child who's already had this experience with needles, cut him open, modify it. But that doesn't mean she doesn't have a right to recover for it to do it later. But she doesn't want to do it when her child's three years old. She doesn't want to do it when her child's one, two. This child was thirty days old. Their witness thought this child was, I think, nine days old, which is not right. The child was thirty days old at the time. The child was one month old.

You heard from Cynthia that the witness -- that the nurse hadn't seen anything like an infiltration like this before. I heard it. I hope you heard it. You heard that the computer keeps accurate time. Well, if it keeps accurate time, what populated 00:00 as the time of the flush, okay? That can't be manually entered. Why is that in the medication record? You heard her say that catheter was intact. And I don't know where that example is, but it wasn't damaged. You heard all this testimony about all of the things that can happen. The tube can be bent and the needle can be crimped that can cause this problem, but she said the catheter was intact. It's not that. She doesn't know what it was. The reason she doesn't want to know what it was because it's obvious what it was, a failure to flush.

We begin with a young child that for a lengthy period of time -- and this is from their expert's witness -- this wasn't right after. Why I know this wasn't right after, because all of that had to be scraped off, get off the dead tissue. That mother had to take her child to the doctor, to wound care center, while they scraped all this stuff that's this color off, okay? I don't think anybody has to be a rocket scientists to know how painful that probably was, but that's what her child went through. This is a healed -- and healing of what she used. Healing wound. That's progress. That baby because of that progress is going to live -- and I don't have that other exhibit. I'll go get it in a second. But this one is bigger and it's not much different. But that baby's going to live with something like that for the rest of his life. He's going to be like Paul.

MR. TANNER: Your Honor, I would object to Paul. Again, it's a matter not in evidence not involving this case not before the jury.

THE COURT: I note your objection.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

He will wear this scar for the rest of his life and he's going to deal with emotional as well as the physical consequences. The physical consequence is bad, but this is the most important thing, that emotional consequence. I'm

going to ask you for a big number. I'm going to -- the defendant gets to respond but you've heard that number where sure, will admit that it's more than a hundred thousand dollars in actual damages. It's much more than that. You're going to hear about that.

This isn't just a physical injury. This isn't a minor scar. It's the emotional part that we really care about. And, you know, some people don't realize. This case has got two different lines. There's a line you're going to fill out for mama and there's a separate line you're going to fill out for baby R.J. And that money for baby R.J. is protected by this Court. That's baby R.J.'s money. So understand that and when I tell you the difference between the two, I hope you'll give us your time.

You've been so patient. Just a little bit more. Just going to look at this and you got to come to a conclusion, but I think that football is in that end zone. It only has to be an inch past it, but I think it's in the end zone. I hope you see that too. Thank you.

THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

DEFENSE'S CLOSING ARGUMENT

BY MR. TANNER:

Thank you ladies and gentlemen of the jury, obviously

going to ask you for a big number. I'm going to -- the defendant gets to respond but you've heard that number where sure, will admit that it's more than a hundred thousand dollars in actual damages. It's much more than that. You're going to hear about that.

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THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

DEFENSE'S CLOSING ARGUMENT

BY MR. TANNER:

Thank you ladies and gentlemen of the jury, obviously

we've done a lot in two days. Thank you for your service.

Like I told you before, there's certain things that are going to be in contention. One of those things is that there was an IV infiltration. No one's disputing that. None of witnesses are disputing that. Again, what I did hear Mr. Williams in his argument was talk about the standard of care. And later on, Judge Dickson's going to charge you what the law is. You are the finders of the fact. He will give you the law to apply to those facts.

I can't predict the future, but what I think he's going to charge you on is the standard of care. And what is the standard of care? It is that care in which a nurse in the same or similarly related situation should have employed. And you heard from Nurse Jamie Downing, who came here of her own free will and testified and told you what happened. You've heard from our expert, Cindy Hurley. The plaintiff wants to characterize we have an expert and we pay our expert. Somehow that's bad or nefarious, but he did the same thing. They've got Nurse Stobbs who, again when you look at the two of them -- recall how they were qualified. Nurse Stobbs was qualified as an expert in general nursing. What does that mean? Well, I'll tell you what it doesn't mean. She's never practiced clinical pediatric nursing. She's never started an IV on a child. And more importantly, the issue in this case, she's never maintained, managed and

monitored an IV. She is not qualified.

Judge Dickson will probably give you a charge on when you have experts with competing opinions.

Think for yourself. You know the good thing about our jury system is you bring in your experiences. You bring in your background. You don't leave them at the door, your common sense. And, again, y'all have paid attention this whole time, and I'm counting on you to keep paying attention throughout this process. But think about it, you have one nurse who's never been an expert before, Ms. Stobbs, who's never practiced in this area. She can't tell you what pediatric nursing is. She can't tell you what the literature is. She wants to make kind of flippant comments during my examination and during the plaintiff's examination about the age of these articles and how oh, they had to go twenty years and fifteen. She'd been a nurse for over thirty-three years and guess how many pediatric IVs she started? The same amount as me, none. But what I have done that Nurse Stobbs didn't do? I've taken the time to read the articles. You'd think your expert would read the article so you'd know what the issues are. She didn't do that. She said over and over again you can get blood return on a 24 gauge needle. Yet you heard the people that are on the front lines that practice pediatric clinical nursing and what did they say? You cannot get blood return. More

importantly, not just what they said, what does the literature say that Ms. Stobbs agreed is authoritative in that field. You cannot get blood return on an IV that small. Period. End of story. She can say all she wants that a vein is a vein is a vein. Again, y'all have common sense. Y'all have experiences. I'm sure many of you have children. You can recall onto your children. We all have different anatomy. Yes, we all have arms and legs. We all have internal organs, but they are clearly different from a pediatric patient to an adult patient. Nurse Stobbs completely dismissed that. Yet, again, all the articles, all the literature, when confronted she has to say that is what they said. Okay, again, this is not Michael Tanner writing the text book. And Ms. Stobbs wanted to argue and say she disagrees. Well, where's her textbook? She hasn't written one because again, she has never done this the first shift in her life.

Plaintiff improperly characterized how long Nurse Downing worked. She wasn't here two weeks or a few days. She testified she had been here for about three months. She started orientation in August. She was off orientation when this happened in October. She had started hundreds -- I believe she said between fifty and a hundred IVs before this had happened, which, again, is a lot more than Nurse Stobbs who, again, has started zero.

The reality is, is an IV infiltration is unfortunate. I'm not here saying that it's not. I'm not here saying that this child wasn't injured. What I am saying is Nurse Downing and the hospital did not breach the standard of care, because an IV, as the literature said, which, again, Nurse Stobbs either chose to ignore or chose not to be informed in the first place and has a lack of experience. The unfortunate reality, the data compiled is twenty-three to seventy percent of IVs will have an infiltration. Now, I don't know how you have data -- have a report without any data. So she can say that you're not reporting but you have to have a report to have the data and that is what the data is. That's what the literature said. Again, that's not me getting up here and standing and saying, I think that it's twenty-three to seventy-eight percent. That is the literature recognized in this field. She doesn't like it because it's contrary to her position, but that's the reality.

I think Judge Dickson's going to charge you on gross negligence. And that's important because gross negligence in our state is the failure to only use slight care or the intentional doing of an act in which you should not do it. You heard Nurse Downing. You heard, you saw her -- you saw everything she talked -- came in and told you that she did on her assessment. She would check the site. She would

check for swelling. She would check for signs and symptoms of infiltration. She did that numerous times. She complied with the policy. Part of the issue in this case is the plaintiff frankly completely misreads this policy. And you heard from Nurse Downing and you heard from my expert -- again, they don't like what you heard because, again, they're expert didn't bother to do her homework and read. There is a different -- in this policy if you have continuous IV versus an INT. And that's what this child had. He had an INT. He was not getting continuous fluids. Again, think about your experiences in seeing IVs and seeing things on television, you have an IV machine that's hooked up to you. In this case, all this medication was administered through a syringe pump. You heard those witnesses say that. You heard the facts of what Ms. Downing did. And I tell you, I think when you look about that you'll certainly agree that's not just slight care, that's more than slight care.

And at the end of the case I'm going to ask you to return a verdict in the hospital's favor because the plaintiff has the burden of proof. And the plaintiff has to prove that the hospital was grossly negligent. And I do not believe the evidence shows that.

Again, we haven't heard them say anything about standard of care. They want to mischaracterize the

policies. Ms. Stobbs wants to be ignorant of the literature and you can't do that. This is just as important today for the hospital as it is for Ms. Hamilton, as it is for R.J.

Again, I haven't stood here at any point during this trial and said he did not suffer an infiltration. But an infiltration, unfortunately, is an inherent risk of the policy. No one wants him to have this injury. I don't want him to have this injury.

You heard from several doctors. You heard from Dr. DeVito who, again, that there was a huge gap between 2015 and then 2018 when he rendered any treatment. Ask yourself why is that? What happened in that time? Well, Dr. Davis saw the child after the court appointed him to do an independent medical exam and said thankfully, R.J. doesn't have any functional loss of his hand. He can do the things that a normal child can do. He'll be able to do the things that a normal adult can do. But then all of a sudden, there's another trip to Dr. DeVito, three weeks before trial. Yet, there's no trips for all these years. Dr. DeVito recommended back in 2015 that these injections be undertaken. And why did he recommended that the injections be undertaken, to try to lessen the scar, to try to help R.J. and his burn wound. Dr. Davis testified to the same thing. I know it was sort of an awkward way to deliver it, reading the deposition, but that was his testimony, sworn

testimony under oath, and it was his opinion that if he had had these injections back then, the scar would have been flatter and it would have been softer, just as Dr. DeVito said. You heard Dr. DeVito say if they had done this Derma Jet it would be an improved scar by now.

We're not saying that it wouldn't have happened. What we're saying is, it's not Nurse Downing's fault that this happened because Nurse Downing did not breach the standard of care. That's what you have to remember when you get that instruction. What does the standard of care say and can they prove by a preponderance that she breached the standard of care by acting in a grossly negligent manner, which I submit to you under the law, they don't have the evidence for that.

Nurse Downing monitored his IV. She assessed his IV. She charted his IV. You're going to see -- you're going to have the records. You're going to get them all. And, again, like Mr. Williams said there's really not a whole lot of pages in the chart you have to look. But one thing is, the computer is accurate. And when you look at that Exhibit 4 and you'll see TRMC page five like Mr. Williams wanted you to see. And what did the witnesses testify that took the time to read the policies. Not Ms. Stobbs who has a website that says I help you win. She wants you to win. She doesn't want to know the truth. The truth is these flushes

that are listed on the MAR are the every four-hour flushes. Nurse Downing testified numerous times whenever she gave that medicine she flushed it. There is no other flushes in here, other than the four-hour flushes. That's the reality. They may not like it, but that's the reality. And so when this flush pops up and says 0:00, what does the computer say? Performed, Jamie Downing 1:04. That's when she did it. She can't get in the computer and manipulate. Again, Nurse Stobbs doesn't understand that. She just sees it for what it is. It's right there in the document. That is a four-hour flush. You heard Nurse Hurley say the reason why it wasn't given is because this medicine was infusing and it had to over from 23:44. It's a twenty-minute infusion. There wouldn't have been enough time for her to do that, which is why it was done at 1:04 because she had already flushed that medicine before. The catheter was intact and that's important. Just because the catheter wasn't intact doesn't mean that this IV didn't infiltrate. And the reality is no one has an explanation for why it infiltrated. IVs go bad. It's unfortunate. All of the witnesses have testified to that. But, again, they have to show that there was a breach of the standard of care and that Nurse Downing was grossly negligent when she failed to use slight care. That young woman is not a woman that's going to fail to use slight care and come from Greensboro, North Carolina and

tell you what she did. I couldn't have made her come here if I wanted to. I don't have any subpoena power outside the state. She came here voluntarily to be with you to tell her what she did. To tell her how she cared. What did she say? She volunteered in high school. She wants to be a nurse because she cares. Again, think of all her certifications and think about their expert. My witness is more qualified to be an expert. My expert is certainly more qualified to be an expert.

They could have got a true expert. Ask yourself, why don't they have a pediatric expert? Why don't they have an expert that was qualified for monitoring and managing pediatric IVs? Is it because they couldn't get one? Again, use your common sense. Think about that.

You know, I don't know what Ms. Hamilton's plans are for her son. And I suspect they're going to -- this is the last you get to hear from me. Mr. Williams gets to come up and give you another argument, but I only have this one shot. You know, Ms. Hamilton testified, and I certainly empathize for her, knowing what's happened to her child. She doesn't have any plans to have the surgery. She doesn't want to do the steroid injections, even though the doctors say that they would work. Although she had other trips to Charleston with him, ask yourself why wasn't this all sort of done at the same time.

Again, Dr. Davis and Dr. DeVito said if it would have been done earlier maybe he wouldn't have ever known it. Maybe we wouldn't be here right now. We don't know because it wasn't done. But what we do know is that Nurse Downing has come in here and testified to what she did. And she's told you that she would not administer medication without first flushing. She has not denied that. That has been her story from day one, because it's the truth. And if it's the truth supported by Cindy Hurley based on the literature, based on the fact that pediatric patients are not just merely little adults. Based on that's the unfortunate we live in is that IVs go bad and then they infiltrate. Again, there is plenty of data that shows that. And all of that shows that The Regional Medical Center and Nurse Downing were not grossly negligent and certainly administer slight care. And you've heard Nurse Hurley say care that exceeded the standard of care.

So, again, you're not going to be able to hear from me again. But I want you to take your time. Review the evidence because it's not what the lawyers are up here say. Review what you heard from those witnesses and render a verdict in favor of the hospital.

THE COURT: Thank you, Mr. Tanner.

Mr. Williams.

MR. WILLIAMS: Yes, Your Honor, may it please the

Court?

THE COURT: Yes, sir.

PLAINTIFF'S REPLY CLOSING ARGUMENT

BY MR. WILLIAMS:

Opposing counsel argues that I haven't talked about the standard of care, that I haven't talked to you about the do no harm requirement, the nurses that are -- I haven't talked to you about the rules, which his expert says, not only are these the standards here, they're standards everywhere, whatever state you're in. These rules are the standards. So not to interpret these rules, and showed you this, which says this applies to IVs, not INTs. Protocols for INT flushes. If this applies only to IVs and not INTs, I mean, I don't know how to interpret that. If that's what the government wants you to do is reinterpret that, because these only apply. That's page five on nine, one of nine, continuous or intermittent. Continuous or intermittent. I don't know how you interpret that any way different but he wants to say oh, we haven't told you what the standard of care is in this case. And our expert's just -- you know, she's just a waste of time, waste of money, waste of effort because just doesn't know what she's talking about, because she hadn't read all these manuals. Our expert said I didn't read until last week, after my deposition and I was provided them last week. The nurse, I never read those. If they're

required to know what to do is to read those, then nobody knew what to do. Not a single person in this room knew what to do. But that isn't the case.

This case is about one standard of care, really. And the one standard care is the flush. Why is the flush standard of care? Because if you did the flush, it would show where that medication is about to go. If you did the flush, you would assess the site. I know their expert said you only got to do it one shift, but the flush, the idea of the flush is if it gets outside the vein, as well as that puffiness, she said cool touch, etcetera, etcetera, but you can see right there rather than in the vein it's all right there. So I don't need to give this burning medication that I know is corrosive and it's going to heat up in that hand if I give it. And that's why that's the standard of care. And then only person who says no one can explain why. There was an expert who's been at the number one hospital in the country, then at another top-ten hospital who says it's clear, you know. There's only one cause. You didn't flush it. Didn't abide by that standard of care. The gross negligence issue, the Judge is going to charge you. But that's when you say you can't interpret these, all these things. And it clearly says that it applies to intermittent fluid. It clearly says you're to not only flush it, but document when you flush it. Then it says you're supposed to

do it a minimum of four hours and the medical record says you didn't do it? That's gross negligence.

You've heard a lot of testimony in this case. At the initial outset of this case the Judge told you, short plain statement of facts. And then he went into evidentiary and he started talking about this twenty-three to seventy-eight percent of IVs infiltrate. Twenty-three to seventy -- just understand, twenty-three to seventy-eight percent of IVs infiltrate. That's saying that two to almost eight out of ten -- two to eight out of ten people that go to that government hospital that's supposed to be the same, according to his expert, as MUSC as the Mayo Clinic, as good as Duke, Harvard, it's supposed to be just as good. That's what we're supposed to have here in Orangeburg. That's the standard of care, she said. But his interpretation, the government -- The Regional Medical Center's interpretation is the standard is oh, two to almost eight people out of ten are going to have infiltration. That isn't what this document says. That is not what this document says. And it's scary if they think that's acceptable, that that's an acceptable potential risk, because this document says infiltration is the most commonly identified complication of PIV therapy, okay? Complication. Let's first understand that. You don't expect two to eight out of ten IVs to complicate. But if they did complicate -- what this is

saying is the reported incidence is between twenty-three percent to seventy-eight percent at different hospitals. So the hospitals that report the complications from PIV treatment, of those, some of them have twenty-three percent of infiltration, some have as high as seventy-eight percent. That doesn't mean that you've got a seventy-eight percent risk of going to the hospital if you get an IV and it infiltrated and burning a hole in your hand. That doesn't -- or it infiltrated period. That's not what that says. But that's how it has been interpreted. That's how the government wants to treat you. They want to tell you that this is going to be an IV, not -- this doesn't apply to INTs because it's got to be an IV for that to apply. They want to take that and reinterpret it for y'all.

And I know, yeah, you do need to use your common sense. You're from Orangeburg. You understand Orangeburg and you certainly understand some basic -- what the attorney says and the witness says, you can't really interpret that.

And I'm sorry for getting flustered but this case is clear. This case is about R.J. And this case is about Tekayah. And they've got significant damages. And I've got terrible handwriting and I apologize but I'm going to just run through the damages of this case so you can understand. So Tekayah, I'm going to just put T.K. TRMC bills that have been submitted, four thousand six hundred and ninety-nine

dollars. Dr. DeVito -- and I understand that's assuming the care after this incident happened, right? That's the care -- we've got this additional care, six hundred thirty-five dollars. The teacher, you know, that he wants to say well, -- he charged a whopping six hundred thirty-five dollars to try to provide this woman some help. Future surgery though, you heard him say twenty-five hundred dollars is what his bill is. But at the time, which he says goes up, and this is a minimal, twelve thousand dollars for the hospital charge. A thousand twenty dollars for the injection. Mama's cost, twenty thousand eight hundred and fifty four. That's what mama's cost is associated with this. It's not going to fix it, dealing with the trauma, he'll certainly deal with it the rest of his life. He's going to deal with this emotional injury, this emotional injury is going to be something that he's going to carry with him the rest of his life. When he rips a baseball bat at T-ball, and he's going to feel that skin tight. When he goes and decides to pick up a golf club, he's going to feel that get tight. If he decides to pick up a rake and rake a yard of leaves, he's going to feel that. When he goes to shake your hand, he's going to be sticking it out there in front of everybody, okay? What is that worth? You know, and another thing I told you, you've got to think about this emotional element. That's -- that's the worst part of this whole deal. I mean,

what's it's worth the past twelve hundred eighty-nine days, how long it's been since this incident? What do you get for those days? He's got seventy-three point seventy-six year life expectancy. The Judge is taking judicial notice of his life expectancy, and he's going to charge you how to calculate something or what you can do, the tools you can do, and he's going to tell you that it's up to y'all. But seventy-three point seventy-six years is twenty-six thousand nine hundred and forty days, okay? If you were to give him a hundred dollars a day for his loss of enjoyment of life, and a hundred dollars a day for his pain and suffering the first one thousand two hundred eighty-nine dollars, that's about two hundred and sixty thousand dollars. That's a hundred twenty-eight thousand dollars -- nine hundred dollars for pain and suffering and that's a hundred and twenty-eight thousand nine hundred dollars for loss of enjoyment of life. And it's hard to conceptualize this stuff, you know. But you're the judge of the facts. You're the judge to determine what's appropriate. If you would give him fifty dollars for the rest of his life for this permanent disfigurement, that number is one point three-four seven million dollars. That's one million six hundred and four thousand eight hundred dollars. If you were to give him twenty-five dollars a day, that's six hundred and seventy-three thousand five hundred dollars for a total of

nine hundred and fifty-two -- well, scratch that. I've got the wrong page there. Do you have that total for -- yeah. You can do the math. It would be, yeah, somewhere around nine hundred and fifty. Six hundred and seventy-three plus two sixty. It would be somewhere around nine hundred and fifty thousand dollars.

This is what you can do. This is what I think you should do is put a per day value on this, for the living with the physical, the pain, the issues that's going to effect him, the loss of enjoyment of life. When he grips a baseball bat and grabs a rake, and shakes the hand, and takes a picture, this is what you get. It's only the value it is to put something -- there's some value per day. I don't know if it's twenty-five dollars; I don't know if it's fifty dollars. Mama's easy, simple. Her cost associated with this. That's her's is. But R.J., it's a separate line. It's a line that's designed to go to this court, to handle appropriately for both this -- for all of. This, scraping that dead tissue off and wearing this for the rest of his life. I appreciate you. Thank you. You've been a wonderful jury. Thank you

THE COURT: Thank you, Mr. Williams.

COURT'S CHARGE

All right. Ladies and gentlemen, you've now heard the arguments of the attorneys. It is now my turn to charge you

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THE COURT: Thank you, Mr. Williams.

COURT'S CHARGE

All right. Ladies and gentlemen, you've now heard the arguments of the attorneys. It is now my turn to charge you

on the law of this case.

The plaintiff, as Guardian ad litem and parent of [redacted]., claims that her child has been injured by the actions of the defendant, Regional Medical Center. In bringing the lawsuit plaintiff claims that the defendant should compensate her for her minor child's injuries.

You and I have certain duties to perform. As the trial judge, it is my responsibility to preside over the trial of this case and to rule on the admissibility of the evidence offered during the trial. You are to consider only the evidence before you. The testimony that has been presented from the witness stand and any exhibits, which have been made a part of the record. I have the duty to charge you on the law that is applicable in this case. It is your duty as jurors to accept and apply this law as I state it to you. If you think you have any idea of what the law is or what the law ought to be and it does not agree with what I tell you the law is, you must forget your ideas because you are sworn to accept the law and apply the law exactly as I state it to you. In every case the jury is the sole and exclusive judge of the facts. A trial Judge cannot comment on or make any statement about the facts in a case. Since you're the sole judges of the facts, do not think by anything I've said during the trial that I have an opinion about the facts.

The law does not allow me to have an opinion about the facts.

The burden of proof in this case is by a preponderance of evidence. A preponderance of evidence simply means the greater weight of the evidence. It is evidence, which, as a whole, shows that the fact sought to be proved is more likely true than not true. This can be illustrated by imagining a set of scales. That's what we talked about yesterday. Y'all will probably remember. When the case begins, the scales are even. After all of the evidence has been presented, if the scales remain even or if they tip even slightly in favor of the defendant, then the plaintiff has failed to meet her burden of proof and would not be entitled to recovery in this case. On the other hand, if the scales tip even slightly in favor of the plaintiff, the plaintiff will have met her burden of proof and you should return a verdict for the plaintiff.

The preponderance of evidence is not determined by the number of witnesses. Instead, it is determined by the greater weight of all the evidence. There are two types of evidence generally presented during a trial, direct evidence and circumstantial evidence. Direct evidence is the testimony of a person who claims to have actual knowledge of a fact, such as an eyewitness. It is evidence which immediately establishes the main fact to be proved.

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which you may either reasonably infer the truth of the fact or at least reasonably infer an increase in the probability that the fact is true. For circumstantial evidence to be sufficient to warrant the finding of a fact, the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The existence of a fact cannot be based on speculation, surmise or conjecture. The law makes absolutely no distinction between the weight or value to be given to direct or circumstantial evidence, nor is a greater degree of certainty required of circumstantial evidence than of direct evidence.

Necessarily, you must determine the credibility of the witnesses who have testified. Credibility simply means believability. It is your duty as jurors to evaluate the evidence and determine which evidence convinces you it is true. In determining the believability of witnesses who

have testified, you may believe one witness over several witnesses or several witnesses over one witness. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of the same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether the witness has an interest in the result of the trial, whether the witness is prejudiced toward either the plaintiff or the defendant. The opportunity for the witness to have seen the matters and things about which the witness may testify, and the way the witness acts on the witness stand.

The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call experts. A witness who by education and experience has become expert in some art, science or profession, may give an opinion as to the subject the witness claims to be an expert in and may also give the reasons for that opinion. You should consider any expert opinion like any other evidence and give it the weight you think it deserves. If you decide that an expert witness's opinion is not based on sufficient education or experience or if you decide that the reasons given in support of the opinion are not sound, or that the opinion is outweighed by other evidence, you may disregard the opinion

entirely. An expert witness's testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert. You do not have to accept an expert's opinion even though it is uncontradicted. The testimony of experts is to aid and assist you as jurors, not to dominate or control you in a decision of questions of facts. Their opinions and deductions from the evidence before you and their judgments and opinions do not preclude yours. You are required to decide disputed questions after comparison and consideration of all the evidence in this case. If the opinions of medical experts are relied on to establish proximate cause, the experts must state with reasonably certainty that in his or her opinion, professional opinion, the plaintiff's injuries most probably resulted from the negligence of the defendant. It is not necessary that the expert use the words most probably. It is enough for the expert to state that it is the expert's professional opinion that the defendant's negligence was most likely among the possible causes of the plaintiff's injuries. In this case there's been a conflict in the testimony of expert witnesses. To that end, you must weigh one expert's opinion against that of the other and you must consider the reasons given by one as compared with those of the other. You should consider the relative credibility and knowledge of the experts who have testified. Thereupon, you

should find in favor of that expert testimony, which, in your opinion, is entitled to the greater weight.

The plaintiff claims that the Defendant committed medical malpractice. Medical malpractice is a form of carelessness or negligence. In order to recover, the plaintiff must prove by a preponderance of evidence the standard of care, the breach of that standard of care, proximate cause and damages. The plaintiff must prove the standard of care the defendant owed in treating the plaintiff. When a nurse treats a plaintiff, 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 followed the generally accepted practices and procedures in the profession. 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 the same or similar circumstances.

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

The defendant in this case is a governmental entity as defined by State law. Therefore, they come under a special class of laws governing their liability called the torts claims act. The defendant cannot be held liable for any responsibility or duty, including but not limited to supervision, protection, control, confinement, or custody of any of their patients or clients, except when the responsibility or duty is exercised in a grossly negligent manner. Gross negligence is the intentional, conscious failure to do something which is incumbent upon one to do, or the doing of a thing intentionally that one ought not do. Negligence is the failure to exercise due care while gross negligence is the failure to exercise slight care.

To prove gross negligence the plaintiff must first

prove that the defendant owed a duty of care to the plaintiff, that they breached that duty by a negligent act or omission and that the breach was a proximate cause of damage to the plaintiff. Each of those elements must be proven by the plaintiff. To state a cause of action against the defendant, the law requires that the defendant was grossly negligent and that the gross negligence of the defendant was a proximate cause of [redacted], Jr.'s damages. The defendant's negligence must have proximately caused the plaintiff's injuries. Proximate cause is something that produces a natural chain of events, which in the end, brings about the injury. It is the direct cause of the injury.

To prove that the defendant's negligence proximately caused the plaintiff's injury, the plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the defendant's negligence. The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the defendant's negligence, The plaintiff must prove that some injury from the defendant's negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. However, the defendant cannot be held

responsible for things which could not be expected to happen. Proximate cause does not mean the only cause. The defendant's act can be a proximate cause of the plaintiff's injury if it was at least one of the direct concurring causes of that injury. The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the defendant's negligence. The plaintiff must prove that some injury from the defendant's negligence was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the defendant cannot be held responsible for things which could not be expected to happen.

Proximate cause does not mean the only cause. The defendant's act can be a proximate cause of the plaintiff's injury if it was at least one of the direct concurring causes of that injury. Proximate cause need not be established with certainty. Probability is sufficient. A bare possibility is not sufficient. You are not permitted to guess, speculate or surmise as to the proximate cause. The plaintiff must prove to you by a greater weight of the evidence that gross negligence by the defendant was a proximate cause of the injury sustained by the minor plaintiff. In considering the plaintiff's damages and

losses, the law provides that you shall assess the amount that you find to be justified by a preponderance of evidence as full and just and reasonable compensation for all of the plaintiff's damages. No more and no less. This is what the law refers to as actual and compensatory damages. Compensatory damages are not restricted to the actual loss of money or time. These damages may include mental and physical aspects of the injury, tangible and intangible, financial and otherwise. By reimbursing or compensating the plaintiff in all aspects, you are to attempt to restore the plaintiff, that is to make the plaintiff whole or as the plaintiff existed immediately prior to his injuries. The plaintiff must prove that expenses caused by the injury were necessary and reasonable.

You should consider the following elements of damage to the extent you find they were proven by a preponderance of the evidence. You should place a value on each element of the damage in accord with the evidence presented and all these amounts together to determine the amount of your verdict. I instruct you that you shall evaluate each element of damage individually. The following are various elements of damage you may consider. Medical expenses, those incurred to date and any which may be incurred in the future. Value of bodily injury and permanent impairment. The reasonable value of any bodily injury sustained

including permanent injury, significant disfigurement or significant scaring, disability or impairment and the loss of capacity to perform bodily functions or to do daily activities, past and future. The reasonable value of the plaintiff's pain, suffering, mental anguish, inconvenience, discomfort and loss of capacity for the enjoyment of life. If you decide the plaintiff is entitled to a verdict, your next step would be to decide how much money the defendant should be required to pay.

Actual damages are to compensate the plaintiff for the plaintiff's injuries or loss and to put the plaintiff as near as possible in the same position that the plaintiff was in before the incident occurred. In other words, actual damages would be the actual losses and expenses, which the plaintiff has suffered. In this case, the plaintiff alleges significant scaring as a result of the defendant's actions. You may consider as factors in making this determination the appearance, coloration, existence, size and shape of the plaintiff's scar, along with the characteristics of the surrounding skin and the remnants of the healing process and other cosmetically important matters.

A plaintiff is never entitled to recover conjectural or speculative damages. But if you find the plaintiff is entitled to a verdict for actual damages, your verdict should include an amount to cover any past, present and

future damages, which were proximately caused by the defendant. Any future damages must be reasonably certain to occur in the future as a result of the defendant's acts. Actual damages need not be proven to a mathematical certainty or be based on evidence of the precise amount of damages the plaintiff has suffered. Instead, the evidence must allow you to determine what amount of damages is fair, just and reasonable. It is proper to include in the estimate of future damages compensation for future medical expenses and pain and suffering, which will, with reasonable certainty result. Any future damages must be reasonably calculated to have resulted form the alleged injury or damages sustained in the case. Future damages must be reduced to their present cash value. Pain and suffering compensates the plaintiff for physical discomfort and the emotional response to the sensation of pain caused by the injury itself. There's no definite standard by which to compensate the plaintiff for pain and suffering. You have the authority to determine the amount, if any, to be allowed for pain and suffering using calm and reasonable judgment to ensure that the damages are just and reasonable in light of the testimony and evidence presented in this case. Loss of enjoyment of life compensates the plaintiff for limitations on the plaintiff's ability to participate in and derive pleasure from the normal activities of daily life. Mental

suffering, apprehension, shock, fright, emotional upset, humiliation and anxiety, either present or expected in the future, can properly be considered as an element of damages. The amount of damages for mental suffering cannot be exactly measured.

If you find that the defendant was permanently injured as a result of the defendant's actions, you must then decide how, if at all, that injury will effect the rest of the plaintiff's life. A person's life expectancy is determined by a life expectancy table which is a part of the laws of this state. The life expectancy table is only an estimate of the probable average remaining life -- of the life of all person's in our state of a given age. The plaintiff is a three-year-old male with a life expectancy, according to the life expectancy table, of seventy-three point seven-six years. This fact is to be considered by you along with any other facts and circumstances in evidence bearing on the plaintiff's life expectancy, including occupation, habits and health at the time of injury in deciding the amount of damages to be awarded to the plaintiff.

I have declared the law to you through these instructions to help guide you to a just and lawful verdict. Whether some of these instructions apply will depend upon what you find to be the facts. The fact that I have instructed you on various subjects in this case, including

damages, must not be taken as indicating an opinion of this Court as to what you should find to be the facts or as to which party is entitled to your verdict. Your verdict must represent the considered judgment of each juror. In order to return a verdict, it is necessary that each one of you agree. You verdict must be unanimous. All twelve of you must agree on this verdict. Your verdict cannot be based on sympathy, passion, prejudice, emotion or any other consideration not in evidence in this case. Remember, at all times you're not partisans favoring one party over the other. You are the judges of the facts and your sole interest is to seek the truth from the evidence that has been presented to you in this case.

Now, Mr. Foreman, because I'm about as tired as y'all are of sitting, I get to come down. I'm going to go over this verdict form with you. This is the verdict form. You are charged with completing this based on y'all's decisions in the jury room. This just tells you where you are. This tells you what court we're in. We're in -- as I told you, we're in Common Pleas, First Judicial Circuit. This is the case number of the case and this just tells you the parties. You notice you've got Ms. Hamilton, individually and as the guardian for R.J. The defendant in this case is The Medical Center and this verdict form. You've got a number of questions. Each one of these questions as it says, we, the

jury, by unanimous consent, have responded to the following questions. And these are the questions. Question number one, do you find that the defendant was grossly negligent? And then you'll have to check either yes or no. If you check yes, you go to question two. If you check no, you stop your deliberation. Question two, was the defendant's gross negligence a proximate cause of the plaintiff's injuries? Again, you have two choices. Yes and no. If you answer yes, you go to question three. If you answer no, stop your deliberation. Question three, please state the amount of damages, if any, sustained by the minor plaintiff, [redacted]. You are to determine only the total amount of the plaintiff's damages and enter that amount below. This is the damages to the child, okay? The next part of that question is please state the amount of damages, if any, sustained by the plaintiff Tekayah --

Did I say that right? Tekayah?

MR. WILLIAMS: Tekayah.

THE COURT: Tekayah, I'm sorry. Tekayah Hamilton, individually and as the parent and Guardian ad litem for [redacted]. That's her son, as you know. You are to determine only the total amount of the plaintiff's damages and enter that below. Okay? Do you see the line for each one of those where you fill it out when you get to that, an actual damages amount. Then, Mr. Foreman, you are

charged with signing that and dating it, okay?

MR. FOREMAN: Yes, sir.

THE COURT: All right. Now, I'm not giving you this yet.

MR. FOREMAN: Okay.

THE COURT: Okay. The reason for that is y'all know how exciting that was to listen to, me read the law. I saw y'all were excited, you know. Every now and then when I do that I misstate something, but these attorneys were paying very close attention to what I said. And I could have misstated the law to you. And if I did, I've got to correct it. So what we're going to do now is I'm going to let you go back into the jury room. The attorneys are going to tell me if I stated the law correctly or if I need to correct something. If I don't need to correct something, the verdict form and all of the exhibits are going to come back into the jury room and you can begin your deliberations. Now, if I've got to correct something, we'll bring you back out here and we'll have a few more minutes of exciting reading, okay?

MR. FOREMAN: Yes, sir.

THE COURT: Okay. I'm going to let you go back in there. Again, you cannot begin deliberating yet. We'll be with y'all in just a second, I hope.

(Jury out at 4:57 p.m.)

THE COURT: All right. Now, we'll get into the charges that -- excuse me. We'll get into the charges in a minute that we talked about in chambers that I'm not going to charge. But as to what I did charge, any exceptions?

MR. WILLIAMS: Well, they kind of go hand in hand, so I'm subject to the objections that you've already heard and rationale that you've already heard the negligent standard, you know.

THE COURT: Right. Okay

And Mr. Tanner, any changes?

MR. TANNER: No, sir.

THE COURT: Other than the exceptions.

MR. TANNER: Other than the exceptions that we discussed.

THE COURT: That we're going to come back and put on the record after?

MR. TANNER: Yes, sir.

THE COURT: Okay. If y'all wouldn't mind, if y'all would go and let's make sure we've got all the exhibits straight. And then -- and you can -- when you take it back there you can tell the alternate she can leave.

(Reconciliation of exhibits with counsel)

THE COURT: All right. Delaine, they're ready to go. If you'd take the verdict form and those exhibits and

go on back.

THE BAILIFF: Yes, sir.

THE COURT: Okay.

(Alternate juror excused at 5:00 p.m.)

(Jury deliberating at 5:00 p.m.)

THE COURT: All right. Mr. Williams, are you ready right now. You want to go ahead and put that exception on the record?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Okay.

MR. WILLIAMS: So, my problem is compounded here. The jury charge you gave the jury gave them a medical malpractice standard, which is typically, as you said, based on a negligence standard. But then it instructed the jury they have to come back with a gross negligence determination based on one exception to the waiver of immunity in the tort claim act, which would require that they make the determination that the nurse was improperly supervised. I forget what all it says, but you know what I mean.

THE COURT: Right.

MR. WILLIAMS: Subsection 25, which that potentially limits a juror from contemplating, deciding that there was a deviation from the standard of care and that that is actionable in awarding. So in addition to the

confusing instruction, I think the law is clear. It's -- administration of medicine is not an exception to the waiver of immunity under the tort claim act. Therefore, it's a medical malpractice standard based solely on negligence. And negligence is the standard, and the jury is making determination solely whether or not there was gross negligence, supervision, etcetera based on subsection 25.

THE COURT: Okay.

All right. And the reason I did not charge that is I believe that the burden of proof in this case is gross negligence when you consider the actions of a nurse in this case. And I believe the case was Stewart. Isn't it Stewart?

MR. TANNER: Yes, sir. Stewart versus Richland Memorial Hospital.

THE COURT: Yeah. Stewart versus Richland Memorial Hospital is the controlling case in that. But I have -- I want to make sure on the record that we have you objection to my charge noted in case any further work on this case -- if it goes up, okay?

MR. WILLIAMS: Thank you, Judge.

THE COURT: And Mr. Tanner, likewise --

MR. TANNER: Yes, sir. May it please the Court?

THE COURT: -- you had, I believe two lines you wanted me to include?

MR. TANNER: Yes, sir. I had asked in our proposed charges, I had a charge that says the following. I instruct you practicing nursing is an art not a science and in providing nursing care, a nurse is not required to be all knowing and all wise. That is, again, from my proposed charge, which I believe was crafted in the '90's in Columbia, Richland County specifically the number of medical malpractice lawyers and judges there.

THE COURT: Wasn't there another line as well?

MR. TANNER: There was.

THE COURT: Yes, sir.

MR. TANNER: And while a nursing mistake or error in judgment alone would not support a verdict for the plaintiff's in a malpractice suit, if the nurse fails to comply with the recognized standard of care, of nursing care, which would be exercised by a similar nurse under the same or similar circumstances, that the liability would attach to the nurse for the state where error in judgment that proximately results in injury to a patient. That would be our exceptions.

THE COURT: Yeah. Yes, sir. And as I mentioned to you I believe that my -- I'm hopeful that my standard of care charge is the general charge that we give. And whereas I do take great deference in anything that's decided in Richland County, I think that took care of that. But out of

an abundance of caution, I wanted to preserve your objection to that ruling in case you have to take the steps further, okay?

MR. TANNER: Yes, sir.

MR. WILLIAMS: Judge, thank you for a wonderful trial. You've been a great trial Judge.

THE COURT: Thank you. I do want to thank y'all. Thank y'all for working with me to get this case done, okay?

MR. WILLIAMS: Yes, sir.

THE COURT: We'll see. You know one thing I tell people whenever I run into them, is I'm lucky to practice -- I mean to be a judge in South Carolina. Because the attorneys are much a pleasure to work with. Y'all are always prepared and willing to argue and do what you're supposed to do for your client, so I'm always --

(Court in recess awaiting the verdict of the jury at 5:03 p.m.)

(Court in session at 6:10 p.m.)

THE COURT: All right. I have -- I got a -- well, it's sort of -- it's more of a request than it is a question. It says we, the jury, ask to be released for today, asking to return 5/9/2018 at 9:00 a.m. for further deliberations to finalize our decision. So, I mean, I think if they want to be released, I don't think it's going to be to anyone's advantage for us to keep them, okay?

Any thoughts on that?

MR. TANNER: I don't know because, you know, it's the fear of the unknown.

THE COURT: Oh, yeah. It is.

MR. TANNER: I mean, you know, I always worry about late deliberations because people get hungry and -- I guess for the record, I'd move for a mistrial because we don't have a verdict and --

MR. WILLIAMS: I certainly don't think a mistrial is appropriate, Your Honor. But I'd defer to the Court whether they want to ask them to continue to deliberate or if they want to recess until tomorrow.

THE COURT: Well, you know, I don't know whether they've got issues about children or anything like that. But what I was going to do is I'll bring them back in here and just ask them some questions on the record about if they would -- if they think they could do it in a little while, I'd like for them to go ahead and do it. But I've got to make sure that they don't talk among themselves, talk to anybody else, you know, that kind of --

MR. TANNER: Any research.

THE COURT: Yeah. I've just got to caution them about that and make sure they realize that I'm going to ask them about tomorrow when it comes back, okay?

MR. TANNER: Yes, sir.

THE COURT: All right.

MR. TANNER: For the record, you're denying my motion.

THE COURT: Oh, I'm sorry. Yeah. You know, you know, they haven't said they couldn't -- they've given up on it so --

MR. TANNER: Yes, sir.

THE COURT: But I'll note your motion that you --

MR. TANNER: Thank you.

THE COURT: -- and note your objection to my ruling that I'm not granting a mistrial right now. But as always, I appreciate your asking.

Yeah, if you'd bring the jury back in here?

THE BAILIFF: Yes, Your Honor.

THE COURT: I just need to talk to them for a second.

THE BAILIFF: Yes, Your Honor.

(Off record discussion)

(Jury in at 6:15 p.m.)

THE COURT: All right. I just wanted to talk to y'all a little bit, okay, before we decide anything. If I let y'all go right now, y'all know y'all can't do any independent research. Y'all can't, you know -- one or two of y'all cannot contact each other and talk about it and do anything like that. I mean, y'all's deliberation is

absolutely shut down until tomorrow at 9:00. The only thing I was curious about and I don't know how close y'all are to a decision or anything like that and you don't need to tell me that. But, you know, right now it's 6:15. I don't know whether y'all have got other things that y'all might want to do tomorrow and like that. You realize you're going to have to come back here and do that or do you think another forty-five minutes or an hour y'all come to a decision? I mean, you don't know?

MR. FOREMAN: Your Honor, to speak on behalf of the jury, most of us are pretty well stressed right.

THE COURT: Oh, okay.

MR. FOREMAN: We have -- we have made a decision. There's some processes that we would like to discuss further --

THE COURT: Okay. All right.

MR. FOREMAN: Going through the evidence. And we all kind of came to a vote, a unanimous vote of twelve, that we would like to try to get some rest tonight and come back with a clear head --

THE COURT: Okay.

MR. FOREMAN: And we all understand and we've talked about that, that no one in this jury has spoken anything of this until you told us to deliberate.

THE COURT: Okay. All right.

MR. FOREMAN: And these people have been very trustworthy in that fact. And I feel like we will continue to tomorrow morning to be able to do so.

THE COURT: The way you explained it to me, I really appreciate it. That's exactly what I wanted to hear. I'm glad that y'all understand when things kind of get to a frustration level, y'all are willing to continue to talk about this. So what I will do is, per your request, if y'all will be back in the jury room at 9:00. Now, remember y'all need to be here at 9:00 and you cannot begin your deliberations until everybody's here. Okay?

MR. FOREMAN: Yes, sir.

THE COURT: Again, let me just remind you no independent investigation. I don't know if any of y'all know each other or anything like that, you know, where you can talk. You cannot do that, okay? And if anybody tries to talk to y'all, I need to know it, okay?

MR. FOREMAN: Yes, sir.

THE COURT: So y'all go home, relax and I'll see y'all at 9:00 in the morning. Thank y'all for what y'all doing.

JURORS: Thank you.

THE COURT: I appreciate it.

(Jury out at 6:20 p.m.)

(Court's Exhibit No. 4, jury note

was marked)

THE COURT: All right. Well, I've got to say the way the foreman explained it, I thought was pretty good. So I'm not going to -- you can renew your motion if you want to and I'll continue to deny it, just if we need to do that.

MR. TANNER: I think I made it and you denied it.

THE COURT: Okay. All right.

MR. TANNER: I mean, I know that it's protected on the record.

THE COURT: Well, it is in my view. But, you know, one thing I learned is whatever I think about a case is not necessarily --

MR. TANNER: Maybe with the Court's permission, in light of what he said, I would renew my motion for a mistrial for the record at this time.

THE COURT: Okay. Right. And I will again deny it. I think -- I was glad to hear that they, you know, had apparently reached some level of frustration and felt like a night to take off would help them. So we'll see. And so y'all be back -- we'll be back at 9:00 in the morning, y'all and we'll see what happens.

MR. WILLIAMS: Thank you, Judge.

THE COURT: All right. Thank y'all.

(Court in recess May 7, 2018 at 6:25 p.m.)

(Court in session May 9, 2018 at 9:00 a.m.)

(Jury in at 9:01 a.m.)

THE COURT: Good morning, ladies and gentlemen. I hope y'all had a good evening.

MR. FOREMAN: We did. And hope you did as well, sir.

THE COURT: Yeah, I did. I did. Thank you. And I got to get up this morning and eat breakfast and not hurry and all that kind of stuff. So it worked out really well good. I hope y'all did.

Okay. Now, this morning I've got to ask y'all some questions. I want to make sure nobody talked -- y'all did not talk among yourselves last night?

MR. FOREMAN: No, sir.

THE COURT: Nobody tried to contact y'all?

MR. FOREMAN: No, sir.

THE COURT: Okay. Now, I know y'all are going to get ready to go back in there and being your deliberations. We'll go back through the exhibits and make sure we've got them all. I think the court reporter has already gone through that. So we will send those back, along with the verdict form in there so y'all can finish your deliberations. And y'all can continue on. It's a beautiful day to be in a jury room making a decision, okay?

MR. FOREMAN: Yes, sir.

THE COURT: So y'all have a good --

MR. FOREMAN: Could I ask a question? We would like to give you some questions to get you to answer on some certain items. And if we do so, we'll give you those in writing; is that correct?

THE COURT: Yes, sir. If y'all have a question -- now, I need for y'all just to understand. Sometimes, you know, when y'all have questions about a fact or something like that, most -- well, sometimes I just have to replay what the testimony was because I can't give you -- remember how I told you all along --

MR. FOREMAN: Yes, sir.

THE COURT: -- that I can't tell you anything about the facts or anything like that. So if y'all have a fact question it'll put us in a position to where y'all replay the tape or something like that. So just so y'all will be aware of that. If you have a question about the law, what I will do is I will read that portion of the charge that applies to that is normally what I do. But now it depends on what your question is.

MR. FOREMAN: Okay.

THE COURT: But if you'll write it out, we'll be glad to address it or try to address it, okay? All right, sir.

MR. FOREMAN: Thank you.

THE COURT: Y'all go on back in there and y'all begin your deliberations.

MR. FOREMAN: Thank you, sir.

THE COURT: Yes, sir.

(Jury out at 9:02 p.m.)

THE COURT: All right. Hilda's gone through the exhibits and ensured that we've got them all together. Do y'all want to review them before I take them back in there?

MR. TANNER: ???

MR. WILLIAMS: I'll take her word over our review.

THE COURT: Okay. All right. Thank you, ma'am.

THE BAILIFF: Thank you, sir.

THE COURT: You take them on.

THE BAILIFF: Yeah.

THE COURT: Yes, ma'am. Yes, ma'am. Thank you, ma'am.

THE BAILIFF: Thank you.

(Exhibits and verdict form delivered to the jury at 9:02 a.m.)

THE COURT: All right. So it's 9:02 or :03, something like that when they resume their deliberations.

(Jury resumes deliberations at 9:03 a.m.)

THE COURT: I'm anxiously awaiting questions.

(Court in recess at 9:05 a.m.)

(Court in session for verdict at 11:04 a.m.)

THE COURT: The jury's reached a verdict?

THE BAILIFF: Yes, Your Honor.

THE COURT: If you would, you know, bring them in, you know. You've told the Foreman he's going to give it to you and you're going to give it to me?

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay. All right.

THE BAILIFF: Are you ready?

THE COURT: Yeah. Yeah. Is the plaintiff ready?

MR. WILLIAMS: Yes, sir.

THE COURT: Defendant ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. All right.

(Off record discussion)

(Jury in at 11:05 a.m.)

THE COURT: All right. Mr. Foreman, has the jury reached their verdict?

MR. FOREMAN: Yes, we have, Your Honor.

THE COURT: Is that verdict unanimous?

MR. FOREMAN: Yes, sir.

THE COURT: If you wouldn't mind giving that to the bailiff, please sir?

MR. FOREMAN: Yes, sir.

THE BAILIFF: Your Honor, may I approach?

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

Y'all can sit down.

All right. Mr. Clerk if you wouldn't mind publishing the verdict please, sir?

THE CLERK: State of South Carolina, County of Orangeburg Tekayah Hamilton individually and as the parent Guardian ad litem for Robert Lee M., Jr., plaintiff versus The Regional Medical Center, defendant.

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

Do you find that the defendant was grossly negligent? Yes.

Question number two, was the defendant's gross negligence the proximate cause of the plaintiff's injuries? Yes.

Please state the amount of damages, if any, sustained by the minor plaintiff, [redacted]? One million one hundred and twenty-seven thousand two hundred and eighty dollars actual damages.

Please state the amount of damages, if any, sustained by the plaintiff, Tekayah Hamilton, individually and as parent Guardian ad litem for [redacted]? One hundred thirty-five thousand four hundred seventy-seven

dollars actual damages.

THE COURT: All right. That was signed by the foreperson and dated today.

And, again, Mr. Foreman, this is the verdict?

MR. FOREMAN: Yes, sir.

THE COURT: Okay. Any issues from the plaintiff?

MR. WILLIAMS: No, sir.

THE COURT: Anything from the --

MR. TANNER: Just for the record if you could poll the jurors individually, Your Honor, and make sure it is a unanimous verdict for the record.

THE COURT: All right. Hold on one second.

All right. Ladies and gentlemen, they've requested that I poll the jury. So when I call your name I'll ask you to stand up and I've got two questions to ask you.

(Jurors individually polled and verdict stands)

THE COURT: All right. Anything further, Mr. Tanner?

MR. TANNER: Nothing further, Your Honor.

THE COURT: Okay. All right. Ladies and gentlemen, I appreciate the way y'all paid attention during the trial and like that and gave us and the attorneys your full attention. We do appreciate that. Y'all have done a good job as jurors and I appreciate the way y'all considered

everything, told me about it and how everything was going yesterday and like that. So thank you for your service. You know, in addition to the huge amount of money that you get paid, you know, for being on the jury, you know the other good reward you may remember is you don't have to serve on a jury now for three years, okay? But now you still can if you want to. I hope y'all had a good experience. I really hope you did. So if you get an opportunity, you know, I hope y'all will consider doing that. The other thing I need to tell you is, sometimes after the trials the attorneys will contact you and ask you if you want to talk about your jury service and like that. That's a way for them to learn, you know, different things, you know, about how did -- you know, maybe just ask you questions. And you can respond but it is up to you whether or not you want to respond. If they send you a questionnaire -- I know some attorneys send questionnaires sometime. You know, they might just run into you around town. They might want to ask you a question. If you want to talk to them, you can but you do not have to talk to them. But if you do want to have some feedback back and forth, feel free to do that. The prohibition against talking about it was when you were making your deliberations and like that, not after the trial. But if you just don't want to talk about it, you don't have to, okay? But, again,

thank y'all so much for your service. I hope y'all enjoy the rest of the week. I am glad y'all were willing to serve. I really am, okay? Thank y'all. Y'all have a good day.

MR. FOREMAN: Thank y'all.

THE COURT: Thank you.

(Jury out at 11:05 a.m.)

COURT REPORTER: May I see that verdict form when you get through?

THE COURT: It's one million one hundred twenty-seven two eighty.

MR. WILLIAMS: Your Honor

THE COURT: I'm going to run copies of this for y'all, okay?

Mr. Tanner, rather than do any motions or anything like that, you've got ten days, you know, unless --

THE COURT: Do you want to hear the motion to reduce it based on the tort claims act or do you want everything in ten days.

THE COURT: Well, I mean -- I'm aware of the -- I think everybody's aware of the tort claims act. I'm giving you ten days --

MR. TANNER: Ten days.

THE COURT: There are other things that you --

MR. TANNER: Yes, sir.

THE COURT: -- may want to address.

MR. TANNER: Yes, sir.

THE COURT: So, and I --

MR. TANNER: Everything will be taken up in ten days?

THE COURT: Yeah. Yeah. That'll give you time. I mean, if I were you, I'd want time.

MR. TANNER: I appreciate that. Yes, sir.

THE COURT: Okay. All right.

MR. TANNER: Thank you, sir.

THE COURT: We're going to run copies of this so everybody will have it, okay?

Okay. All right. Thank y'all very much.

MR. TANNER: Thank you.

MR. WILLIAMS: Thank you, Your Honor.

THE COURT: Appreciate it y'all.

(Court in recess May 9, 2018 at 11:20 a.m.)

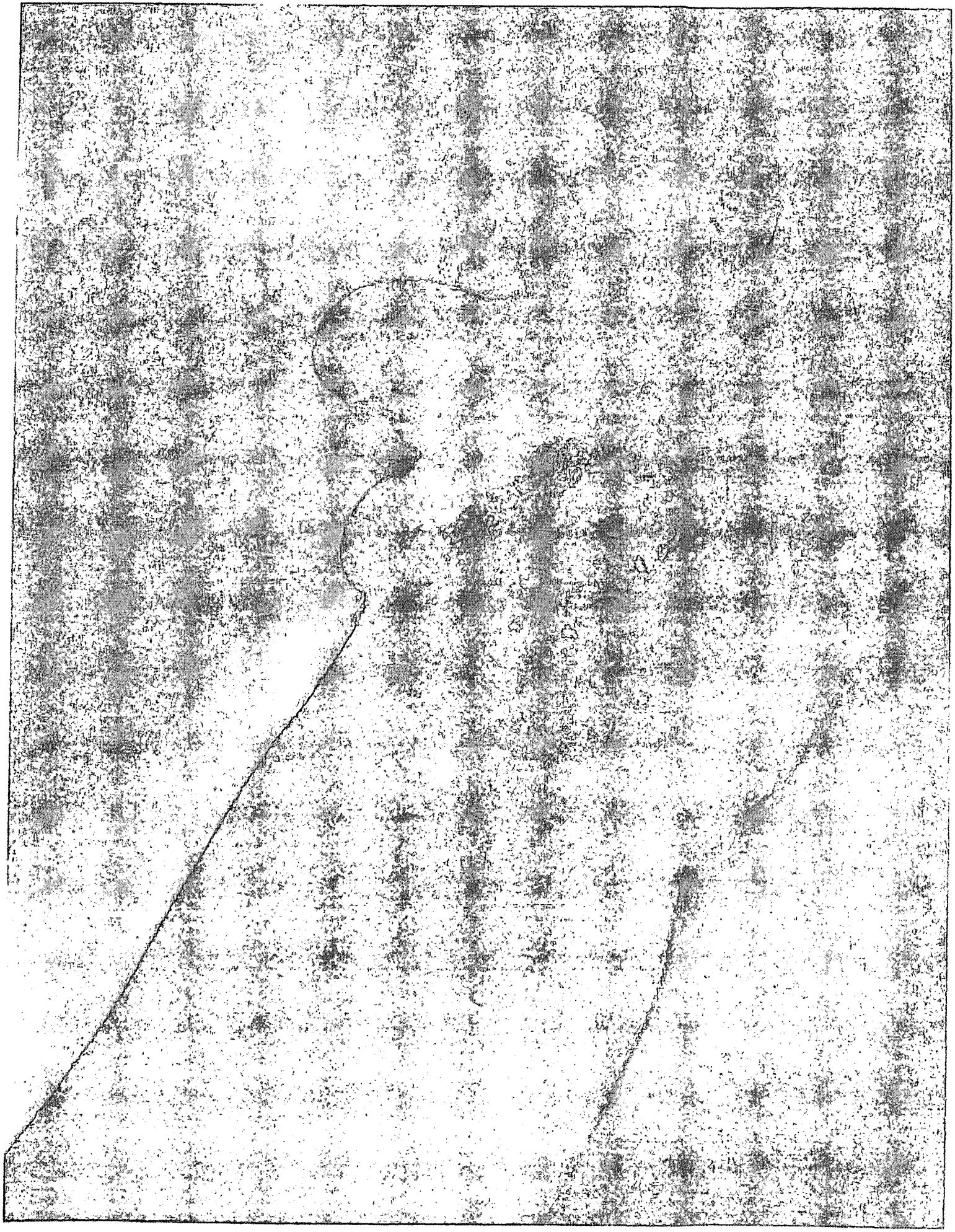
C-E-R-T-I-F-I-C-A-T-E

I, THE UNDERSIGNED HILDA M. JORDAN, CVR-M, OFFICIAL COURT REPORTER FOR THE FIRST JUDICIAL CIRCUIT OF THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE, ACCURATE AND COMPLETE TRANSCRIPT OF RECORD OF THE PROCEEDING IN THE CAPTIONED CAUSE, IN THE COURT OF COMMON PLEASE FOR ORANGEBURG COUNTY, SOUTH CAROLINA, ON THE 7 - 9 DAY OF MAY, 2018.

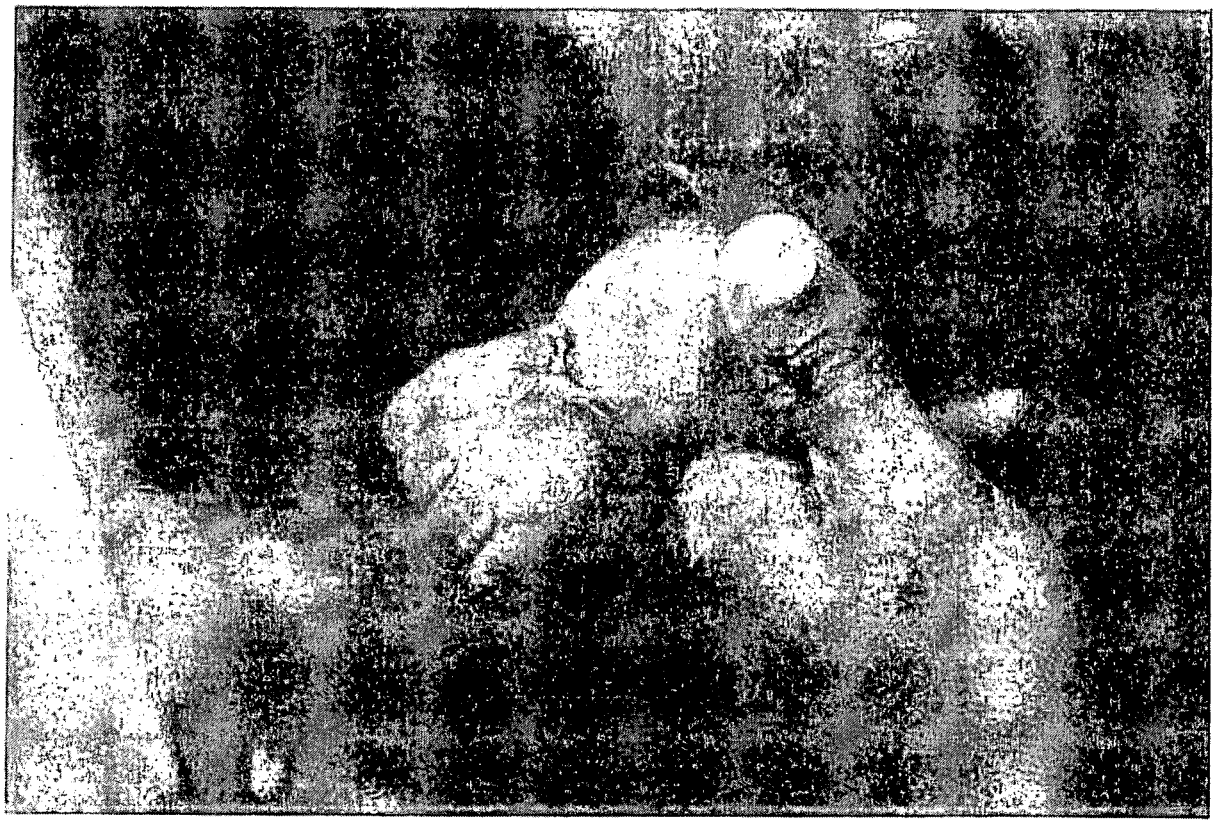
I DO FURTHER CERTIFY THAT I AM NEITHER OF KIN, COUNSEL, NOR INTEREST IN ANY PARTY HERETO.

Hilda M. Jordan, CVR-M

March 17, 2019



PLAINTIFF'S
EXHIBIT
2



+rmc
the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/29/2014 22:27
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/29/2014 22:28**
Admin Details: Auth (Verified)
PRN Response Notes: Mom states PT no longer fussing. Pt breastfeeding well. Currently sleeping; PRN Medication Effectiveness: Yes; Patient Response to Medication: No Adverse Reaction to Medication; NIPS Pain Scale: Yes; Legs NIPS: Relaxed; Arms NIPS: Relaxed; State of Arousal NIPS: Sleeping; Breathing Pattern NIPS: Relaxed; NIPS Pain Assessment Score: 0; Cry NIPS: No cry; Facial Expression NIPS: Relaxed
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Stocklin RN,Shannon M 10/29/2014 22:27; VERIFY: Stocklin RN,Shannon M 10/29/2014 22:27

Admin Date/Time: 10/29/2014 20:14
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/29/2014 20:15**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Stocklin RN,Shannon M 10/29/2014 20:15; VERIFY: Stocklin RN,Shannon M 10/29/2014 20:15
Reason for Medication: Stocklin RN,Shannon M 10/29/2014 20:15
Fever

Admin Date/Time: 10/29/2014 00:00
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/29/2014 00:00

Admin Date/Time: 10/29/2014 00:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/29/2014 00:00

PLAINTIFF'S EXHIBIT

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

+rmc
the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]		Admit/Discharge	10/25/2014
MRN:	[redacted]		Discharge Date:	10/30/2014
Account Number:	[redacted]		Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted]	8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01			

MAR

Medications

Admin Date/Time: 10/28/2014 23:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 23:00

Admin Date/Time: 10/28/2014 20:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 20:00

Admin Date/Time: 10/28/2014 17:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 17:00

Admin Date/Time: 10/28/2014 16:00
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 16:00

Admin Date/Time: 10/28/2014 16:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 16:00

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC003

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the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	**Admit/Discharge**	10/25/2014
MRN:	[redacted]	**Discharge Date:**	10/30/2014
Account Number:	[redacted]	**Admitting:**	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	**Attending:**	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/28/2014 12:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 12:00

Admin Date/Time: 10/28/2014 11:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 11:00

Admin Date/Time: 10/28/2014 08:00
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 08:00

Admin Date/Time: 10/28/2014 08:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 08:00

Admin Date/Time: 10/28/2014 04:45
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/28/2014 05:22**
Admin Details: (Not Done) Not Appropriate at this Time
sodium chloride
Action Details: Perform: Downing RN,Jamie B 10/28/2014 04:45

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/28/2014 04:27
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/28/2014 04:27**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Downing RN,Jamie B 10/28/2014 04:27; VERIFY: Downing RN,Jamie B 10/28/2014 04:27

Admin Date/Time: 10/28/2014 00:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/28/2014 01:04**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Downing RN,Jamie B 10/28/2014 01:04; VERIFY: Downing RN,Jamie B 10/28/2014 01:04

Admin Date/Time: 10/27/2014 23:44
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 23:44**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Downing RN,Jamie B 10/27/2014 23:44; VERIFY: Downing RN,Jamie B 10/27/2014 23:44

Admin Date/Time: 10/27/2014 23:08
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 23:09**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Downing RN,Jamie B 10/27/2014 23:09; VERIFY: Downing RN,Jamie B 10/27/2014 23:09

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Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/27/2014 20:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 21:19**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Downing RN,Jamie B 10/27/2014 21:19; VERIFY: Downing RN,Jamie B 10/27/2014 21:19

Admin Date/Time: 10/27/2014 17:48
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 17:48**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Craft RN,Susan M 10/27/2014 17:48; VERIFY: Craft RN,Susan M 10/27/2014 17:48

Admin Date/Time: 10/27/2014 16:08
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 16:08**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Craft RN,Susan M 10/27/2014 16:08; VERIFY: Craft RN,Susan M 10/27/2014 16:08

Admin Date/Time: 10/27/2014 16:07
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 16:08**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 16:08; VERIFY: Craft RN,Susan M 10/27/2014 16:08

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/27/2014 11:43
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 11:54**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Modified) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 11:43; Modify: Craft RN,Susan M 10/27/2014 11:54; VERIFY: Craft RN,Susan M 10/27/2014 11:54

Admin Date/Time: 10/27/2014 11:40
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 11:43**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Craft RN,Susan M 10/27/2014 11:43; VERIFY: Craft RN,Susan M 10/27/2014 11:43

Admin Date/Time: 10/27/2014 08:08
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 08:09**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Craft RN,Susan M 10/27/2014 08:09; VERIFY: Craft RN,Susan M 10/27/2014 08:09

Admin Date/Time: 10/27/2014 08:08
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 08:09**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 08:09; VERIFY: Craft RN,Susan M 10/27/2014 08:09

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Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/27/2014 06:28
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/27/2014 06:28**
Admin Details: Auth (Verified)
Patient Response to Medication: No Adverse Reaction to Medication, Temperature decreased; PRN Medication Effectiveness: Yes
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 06:28; VERIFY: Reese RN,Angelia E 10/27/2014 06:28

Admin Date/Time: 10/27/2014 04:41
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/27/2014 04:42**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:42; VERIFY: Reese RN,Angelia E 10/27/2014 04:42
Reason for Medication: Reese RN,Angelia E 10/27/2014 04:42
Fever

Admin Date/Time: 10/27/2014 04:35
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: *INT FLUSH 1 mL
Admin Details: **(Auth)** IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:35; VERIFY: Reese RN,Angelia E 10/27/2014 04:35
Early/Late Reason: Reese RN,Angelia E 10/27/2014 04:35
Other :

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/27/2014 04:35
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:36; VERIFY: Reese RN,Angelia E 10/27/2014 04:36
Early/Late Reason: Reese RN,Angelia E 10/27/2014 04:35
Other :

Admin Date/Time: 10/27/2014 04:34
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Reese RN,Angelia E 10/27/2014 04:36; VERIFY: Reese RN,Angelia E 10/27/2014 04:36

Admin Date/Time: 10/26/2014 22:56
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56
Early/Late Reason: Reese RN,Angelia E 10/26/2014 22:56
Other :

Admin Date/Time: 10/26/2014 22:56
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Subclavian
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC009

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 22:55
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56

Admin Date/Time: 10/26/2014 18:18
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 18:18**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 18:18; VERIFY: Gray RN,Taylor C 10/26/2014 18:18
Early/Late Reason: Gray RN,Taylor C 10/26/2014 18:18
Med Not Available

Admin Date/Time: 10/26/2014 18:18
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 18:18**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 18:18; VERIFY: Gray RN,Taylor C 10/26/2014 18:18

Admin Date/Time: 10/26/2014 15:52
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 15:52**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 15:52; VERIFY: Gray RN,Taylor C 10/26/2014 15:52

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 14:33
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 14:33**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 14:33; VERIFY: Gray RN,Taylor C 10/26/2014 14:33

Admin Date/Time: 10/26/2014 14:06
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 14:06**
Admin Details: Auth (Verified)
PRN Medication Effectiveness: Yes; Temperature Rectal: 37.2; Temperature Method: Rectal
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Williams RN,Sarah B 10/26/2014 14:06; VERIFY: Williams RN,Sarah B 10/26/2014 14:06

Admin Date/Time: 10/26/2014 11:28
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 11:28**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 11:28; VERIFY: Gray RN,Taylor C 10/26/2014 11:28
Reason for Medication: Gray RN,Taylor C 10/26/2014 11:28
Fever

Admin Date/Time: 10/26/2014 11:22
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 11:23**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 11:23; VERIFY: Gray RN,Taylor C 10/26/2014 11:23

Request ID: 5707899

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0011

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/26/2014 09:21
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 09:21**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 09:21; VERIFY: Gray RN,Taylor C 10/26/2014 09:21

Admin Date/Time: 10/26/2014 07:17
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 07:17**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 07:17; VERIFY: Gray RN,Taylor C 10/26/2014 07:17

Admin Date/Time: 10/26/2014 05:04
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 05:07**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/26/2014 05:07; VERIFY: Morton RN,Teresa L 10/26/2014 05:07

Admin Date/Time: 10/26/2014 05:04
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 05:07**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 05:05; VERIFY: Morton RN,Teresa L 10/26/2014 05:05

Patient:	[redacted]	**Admit/Discharge**	10/25/2014
MRN:	[redacted]	**Discharge Date:**	10/30/2014
Account Number:	[redacted]	**Admitting:**	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	**Attending:**	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 04:25
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 04:25**
Admin Details: Auth (Verified)
PRN Medication Effectiveness: Yes; Patient Response to Medication: Temperature decreased; Temperature Method: Rectal; Temperature Rectal: 37.5
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 04:25; VERIFY: Morton RN,Teresa L 10/26/2014 04:25

Admin Date/Time: 10/26/2014 02:49
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 02:49**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 1 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 02:49; VERIFY: Morton RN,Teresa L 10/26/2014 02:49
Reason for Medication: Morton RN,Teresa L 10/26/2014 02:49
Fever

Admin Date/Time: 10/26/2014 02:49
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 02:49**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 02:49; VERIFY: Morton RN,Teresa L 10/26/2014 02:49

Admin Date/Time: 10/25/2014 23:31
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/25/2014 23:32; VERIFY: Morton RN,Teresa L 10/25/2014 23:32

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/25/2014 23:31
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/25/2014 23:31; VERIFY: Morton RN,Teresa L 10/25/2014 23:31
Early/Late Reason: Morton RN,Teresa L 10/25/2014 23:31
Patient Not Available/Off Unit

Admin Date/Time: 10/25/2014 23:30
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/25/2014 23:32; VERIFY: Morton RN,Teresa L 10/25/2014 23:32

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/28/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/28/2014 04:27 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/28/14 5:00:00 AM EDT, Stop date 10/28/14 4:27:11 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/28/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 23:44 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/28/14 12:00:00 AM EDT, Stop date 10/27/14 11:44:47 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/28/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/28/2014 01:04 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/28/14 12:00:00 AM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 23:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 11:00:00 PM EDT, Stop date 10/27/14 11:09:03 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

+rmc
the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803)395-2200

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 20:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 21:19 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 8:00:00 PM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 17:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 17:48 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 5:00:00 PM EDT, Stop date 10/27/14 5:48:59 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 16:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 16:08 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 4:00:00 PM EDT, Stop date 10/27/14 4:08:22 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0016

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 16:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 16:08 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 4:00:00 PM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 12:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 11:43 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 12:00:00 PM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 11:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 11:43 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 11:00:00 AM EDT, Stop date 10/27/14 11:43:45 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 08:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 08:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 8:00:00 AM EDT, Stop date 10/27/14 8:09:14 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 08:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 08:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 8:00:00 AM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 06:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:38 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 6:00:00 AM EDT
Order Comment: As needed

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:36 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 5:00:00 AM EDT, Stop date 10/27/14 4:36:09 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 02:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:36 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 2:00:00 AM EDT
Order Comment: As needed

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 12:00:00 AM EDT, Stop date 10/26/14 10:56:39 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 11:00:00 PM EDT, Stop date 10/26/14 10:56:38 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 22:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 10:00:00 PM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 18:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 18:18 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 6:00:00 PM EDT
Order Comment: As needed

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the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803)395-2200

Patient:	[redacted]	**Admit/Discharge**	10/25/2014
MRN:	[redacted]	**Discharge Date:**	10/30/2014
Account Number:	[redacted]	**Admitting:**	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	**Attending:**	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 17:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 18:18 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 5:00:00 PM EDT, Stop date 10/26/14 6:18:44 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/26/2014 15:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 15:52 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 3:00:00 PM EDT, Stop date 10/26/14 3:52:21 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 14:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 14:33 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 2:00:00 PM EDT
Order Comment: As needed

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin Injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 11:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 11:23 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 11:00:00 AM EDT, Stop date 10/26/14 11:23:04 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin Injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 10:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 09:21 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 10:00:00 AM EDT
Order Comment: As needed

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/26/2014 07:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 07:17 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 7:00:00 AM EDT, Stop date 10/26/14 7:17:29 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Patient:	[redacted]	**Admit/Discharge**	10/25/2014
MRN:	[redacted]	**Discharge Date:**	10/30/2014
Account Number:	[redacted]	**Admitting:**	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	**Attending:**	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 06:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 05:07 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 6:00:00 AM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 05:07 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 5:00:00 AM EDT, Stop date 10/26/14 5:07:37 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 02:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 02:49 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 2:00:00 AM EDT
Order Comment: As needed

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/25/14 11:00:00 PM EDT, Stop date 10/25/14 11:32:07 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:24 End-state Reason:
Ordering Physician: Clunis MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:52
Order Details: neonatal sepsis, 425 mg, IV Syringe, q6hr interval, Routine, Start date 10/25/14 11:00:00 PM EDT, 7 day, Physician Stop, Stop date 10/29/14 1:24:00 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/25/14 11:00:00 PM EDT, Stop date 10/25/14 11:32:08 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

Patient:	[redacted]	**Admit/Discharge**	10/25/2014
MRN:	[redacted]	**Discharge Date:**	10/30/2014
Account Number:	[redacted]	**Admitting:**	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	**Attending:**	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:24 End-state Reason:
Ordering Physician: Clunis MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, q8hr Interval, Routine, Start date 10/25/14 11:00:00 PM EDT, 7 day, Physician Stop, Stop date 10/29/14 1:24:00 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/31/2014 00:05 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 60 mg = 0.6 mL, Liquid, Oral, q4hr Interval, PRN Fever, Routine, Start date 10/25/14 10:00:00 PM EDT, Administer for fever GREATER than 101 degF
Order Comment: Target Dose: acetaminophen oral liquid INFANT (0-2 years) 15 mg/kg 10/25/2014 22:00:02

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/25/14 10:00:00 PM EDT
Order Comment: As needed

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:25 End-state Reason:
Ordering Physician: Clunis MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, As Directed, PRN, Other (see comment), Start date 10/25/14 10:00:00 PM EDT
Order Comment: Flush Protocol

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:25 End-state Reason:
Ordering Physician: Clunis MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, q4hr Interval, Start date 10/25/14 10:00:00 PM EDT
Order Comment: As needed

History and Physical Reports

Document Name	History and Physical
Document Status	Auth (Verified)
Performed By	Boltin,Megan Shuler (10/25/2014 22:20)
Signed By	Boltin,Megan Shuler (10/25/2014 22:57)
Authenticated By	Boltin,Megan Shuler (10/25/2014 22:57); Boltin,Megan Shuler (10/25/2014 22:57)

General Admission H&P

Patient: [redacted]
Age: 4 weeks Sex: Male DOB: [redacted]
Associated Diagnoses: **None**
Author: **Boltin, Megan Shuler**

Basic Information
Admit Information: 30 day old AA male infant admitted for neonatal fever .
Source of history: Mother.
Present at bedside: Mother.

Request ID: 5707699 Print Date/Time 06/12/2015 06:36