

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

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SC Court of Appeals

Appeal from Charleston County
Court of Common Pleas

Bentley D. Price, Circuit Court Judge

Appellate Case No. 2020-001643
Circuit Court Case No. 2016-CP-10-05379

The Estate of Delila Parrott,

Respondent

v.

Sandpiper Independent and Assisted Living-Delaware, LLC,

Appellant.

**RECORD ON APPEAL
VOLUME 2**

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1 STATE OF SOUTH CAROLINA) IN THE CIRCUIT COURT
 2 COUNTY OF CHARLESTON) OF COMMON PLEAS
 3) NINTH JUDICIAL CIRCUIT
 4 THE ESTATE OF DELILA) CASE NO.
 PARROTT,) 2016-CP-10-5379
 5)
 6 Plaintiff,) Transcript of Record
 7 vs.) Non-Jury Trial Day 3
)
 8 SANDPIPER INDEPENDENT AND)
 ASSISTED LIVING-DELAWARE,)
 9 LLC,)
)
 10 Defendant.)

11 * * * * *

12
13 B E F O R E:

14 The Honorable Bentley Price

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17 Krista Nicole Carney, Stenographic
 18 Court Reporter, transcribed by a
 19 Stenographic Court Reporter
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2 (The following proceedings were held
3 9/10/2020, Charleston General Session Trial, Judge
4 Price)

5 THE COURT: All right. I hope y'all
6 had a good evening.

7 MR. DAVIS: Yes, sir.

8 THE COURT: So I don't know how
9 extensively we need to get into this. I'm happy to
10 hear from y'all. But I went through all of the
11 phone records, obviously, to try to determine
12 whether, in fact, I could figure it out, I was.
13 But, unfortunately, then I came -- not
14 unfortunately, I went through all that effort y'all
15 gave Amiee the emails. And that resolved my
16 problem.

17 So I got the emails here. The one from
18 Paul says, good morning, you sent me an email
19 requesting that we agree to waive any objection of
20 authenticity. And a need records' custodian in any
21 of the documents exchanged in discovery.

22 I replied, I did not object to your
23 request. However, I think I only referenced
24 medical records. Please allow me to clarify. I
25 agree to waive any objection to the authenticity

1 documents we have exchanged in discovery, no need
2 for record's custodian.

3 I hope this clarifies any potential for
4 any confusion. Please confirm.

5 All right. So, I mean, that boils down
6 to admissibility. So, I mean, y'all made arguments
7 as to whether it's relevant under 403 versus
8 discrimination of value. I'm happy to hear you
9 out. So, I mean, y'all can make arguments to
10 whether it's relevant under 403 versus this
11 probative value. I'm happy to hear you out. I am
12 going to tell you it's not going to be some of the
13 probative information in this case. Any other
14 arguments?

15 MR. REEVES: None from the Plaintiffs.

16 MR. DAVIS: Just the same argument that
17 we raised yesterday, Your Honor, I think it would
18 take a witness with specialized knowledge to really
19 do the analysis of those phone records.

20 I do think, given the fact that I am
21 being denied to cross-examine or talk to a witness
22 about the contents of those records, that you'd be
23 asked to speculate the contents and the
24 definitions. I think it would be highly
25 prejudicial to us to act in that process.

1 THE COURT: Well, for the record, I
2 don't speculate as to what the information is
3 contained. And I was able to decipher the
4 information. I didn't speculate at all, and was
5 able to do it.

6 MR. DAVIS: I take your word. I
7 obviously do.

8 THE COURT: All right. So it's the
9 Plaintiff's case. Call your next witness.

10 MR. REEVES: Your Honor, we have
11 concluded our preservation of evidence. We have an
12 exhibit book. There have been two objections, one
13 of which you just resolved. We will withdrawal any
14 medical bills from that exhibit book, and there may
15 be a couple of more medical records that will go in
16 based off on cross-examination, their experts
17 today. Otherwise, that is what we plan to
18 introduce, less the medical bills, and I think
19 there's actually a page from Ms. Carrington's
20 deposition that stuck in there, Page 941. I'll
21 withdrawal that, because that's probably cumulative
22 and whatever else you call it.

23 THE COURT: All right. So just to
24 be -- make sure we are doing it correctly. You're
25 just going to make the Plaintiff's Exhibit Book

1 just Number 1, and that will be it for the record?

2 MR. REEVES: That's correct; Your
3 Honor.

4 THE COURT: You okay with that?

5 COURT REPORTER: Yes, sir.

6 MR. DAVIS: I agree with everything
7 that he just said. But what I would propose is
8 that on a break that Mr. Reeves and I get together
9 and we'll mark and identify, specifically, what we
10 can send, and go through the record. And get that
11 in an agreement and put it along with her. I just
12 want to look through the actual book.

13 MR. BOSWELL: And, Your Honor, there's
14 a bunch of junk in there. And you probably don't
15 want to go through it. So mainly what we can do is
16 cut out a bunch of stuff that we don't -- that we
17 haven't talked about and we don't think you'll need
18 to look and just make it easier. Can do that
19 during a break.

20 THE COURT: Okay. I looked at most of
21 the stuff already, though.

22 MR. REEVES: I will confer with him.
23 What I don't want to do is if he comes up -- maybe
24 he has an objection he hasn't thought about, or
25 whatever, then I want to have a chance to address

1 that. Otherwise, I think we have an agreement.

2 MR. DAVIS: We do. And I'm not
3 aware -- I think we've argued about everything that
4 we need to argue about. Again, if there's some
5 issue, we'll obviously give you a chance to rule on
6 it.

7 THE COURT: We don't need to put the
8 email in as a Court's exhibit?

9 MR. DAVIS: Actually, yeah. I think we
10 want to put both emails in on that.

11 THE COURT: As a Court's exhibit.
12 Just make that Court's exhibit.

13 COURT REPORTER: Composite?

14 THE COURT: Yes.

15 (Plaintiff's Exhibit 1 was marked
16 Court's Exhibit 1.)

17 MR. REEVES: I'll just confirm we're
18 done. We rest.

19 We'll go ahead and hear your motion for
20 summary motion.

21 MR. DAVIS: Your Honor, Rule 41(d)
22 which I believe governs the Court -- or gives the
23 Court power to dismiss matters where the evidence
24 has failed to recover some matter of law. It's not
25 really an evidentiary evaluation, by my

1 understanding. But, basically, Judge, if the
2 evidence as presented does not support recoveries,
3 as a matter of law, then I'm entitled to have those
4 claims dismissed.

5 For purposes of this motion, Judge, I'm
6 going to zero in on -- there's a pending UTPA,
7 Unfair Trade Practice Claim. I have some grounds
8 on the unlawful death allegations.

9 As to grounds on the failure that we
10 assume the duty is alleged. I have some grounds on
11 the failure that we assume the duty is alleged, and
12 that the punitive damages allegations -- the
13 evidence specifically there has not risen to the
14 proper levels.

15 So I'll take these one at a time, Your
16 Honor. The first one is the UTPA claim. Your
17 Honor, it's well settled law that you cannot bring
18 an Unfair Trade Practice claim in a representative
19 capacity. The case for that purpose is Faircloth
20 v. Jackie Fine Arts. Here the question before the
21 Court is, does a claim under the South Carolina
22 Unfair Trade Practice Act survive the death of an
23 injured party, which is what we have exactly.

24 And the Court said, the same
25 counter-claims, the defendants are guilty of unfair

1 practices and violation of the act.

2 The Statute itself seems to provide the
3 answer to this for liability questions. The
4 Statute provides that any person suffering any
5 action in law, money, et cetera, et cetera, cannot
6 bring this in a representative capacity to recover
7 actual damages. The Court ruled the language of
8 the Statute provides the UTPA action by Plaintiff
9 who actually was the representative capacity.

10 The evidence in this case, obviously,
11 have been brought as a wrongful death and survivor
12 case, which is a classic representative in its
13 capacity, as well as the Statute itself, Your
14 Honor. I have that case here.

15 If for any reason the Court wants to
16 hear me further on why I think the elements fail
17 over this special issue, I'm happy to explain that,
18 as well, Your Honor.

19 THE COURT: Let me hear from the
20 Plaintiffs as to that.

21 MR. REEVES: Judge, he may be correct
22 as to the wrongful death aspect. I do not believe
23 he's correct as to the pain and suffering.

24 And, Your Honor, I'll just respond to
25 that, if he wants to respond to that something

1 else.

2 THE COURT: Well, I mean, these are not
3 economical damages, as to that, which is what your
4 position is; is that correct?

5 MR. DAVIS: That is absolutely correct.
6 This warrants representative capacity both of
7 survival and wrongful death. There's no
8 distinction. That is the type of damages. But it
9 is still brought as a representative capacity.

10 This specific case addresses that very
11 issue. They brought both. And it was tossed.
12 This is a very well settled law, Your Honor.

13 THE COURT: All right. I'll take a
14 look at it.

15 MR. DAVIS: If you don't find that, for
16 some reason, we also don't think there's any
17 evidence from this case that they presented that we
18 did, the Defendants did, that was offensive of the
19 policy, immoral or oppressive. We don't think that
20 they have proven that the public somehow was
21 adversely affected by these actions, Your Honor.

22 And certainly with respect to the
23 troubled provision in the Statute, there's been no
24 evidence that anything that our staff did in this
25 case was intentional of any nature.

1 The best they've done in this case is
2 show that we didn't check somebody off Wednesday
3 and from their prospective they made a negligent
4 decision on Wednesday night to fail to go in.

5 So I don't think the evidence, at least
6 that I've seen, would warrant any punitive award
7 under the UTPA that we knowingly or willingly
8 violated had provisions of the Act. That would be
9 it for the UTPA.

10 THE COURT: Okay.

11 MR. DAVIS: Judge, I'm disappointed on
12 what was mentioned. Burbach vs. Investors
13 Management Corporation. It says, residential
14 leases are things of value, which directly affect
15 the citizens of the state. The fact that our
16 legislator's regulated landlord/tenant relationship
17 enacting South Carolina RLTA, support system
18 conclusion. While landlord/tenant relationships
19 are frequently governed by a contract, landlords
20 have certain statutory duties, as do tenants.
21 These duties protect the public interest that
22 create a framework that governs landlord/tenant
23 relationships, regardless of the private
24 arrangement the parties have made. And that case
25 held that the UTPA was applicable to a

1 landlord/tenant dispute.

2 And, Judge, that doesn't in any way
3 address the fact that this is a residential setting
4 -- representative setting. So it doesn't address
5 that at all. And it's been -- all of the testimony
6 that you've heard in this case is the shield
7 regulations implied in this entity. But that was
8 addressing but I.

9 As to whether or not on the UPTA. This
10 was a heavily regulated industry. So it's
11 completely opposite to the facts in this case.

12 THE COURT: All right. I'll take it
13 into consideration.

14 All right, what's your second?

15 MR. DAVIS: Yes, sir. So the next one
16 goes to the allegations of the wrongful death, Your
17 Honor. And the testimony that you have heard,
18 which I think as a matter of law to reach the
19 burden.

20 So, Your Honor, if you will bear with
21 me for a minute. In any unlawful death case it
22 requires medical expert testimony, to a reasonable
23 degree of medical certainty, that the action --
24 accident has caused the death. That is the black
25 letter law. That's the standard.

1 And, in this case, Your Honor, we don't
2 believe they've met the standard. Just to go
3 through some of the case law on this. The first
4 case that I will cite, Your Honor, is Bowman vs.
5 American AT&T, 410 S.E. 2d 537. Under
6 well-established case law in South Carolina, a
7 medical expert testifying as to causation must
8 testify to that. After taking into consideration
9 on the death, it is his or her professional opinion
10 that the result in question most probably came from
11 the cause alleged.

12 So what you heard a lot of, Judge, was
13 it contributed. There's some respond to language
14 like that or some real possibility. And I'll get
15 into that in a minute. And there's case law that
16 governs you in that context as well. It says,
17 further, when expert testimony is the only evidence
18 that is relied upon to establish proximate cause,
19 the testimony must provide a significant call
20 between the alleged negligence and the Plaintiff's
21 injury, rather than continuous or hypothetical
22 connections. That is the Roper Hospital.

23 The next authority that I would cite
24 for the wrongful death, is when expert opinion is
25 the only evidence a proximate cause relied upon, it

1 must provide a significant causal relation between
2 the alleged negligence and Plaintiff's injuries.
3 That is Ellis vs. Oliver 473 S.E. 2d 793. The
4 testimony regarding showing a call of connection
5 must be the most probable rule. It is not
6 sufficient that the question, possibility or could
7 have or might have, resulted in the injury.

8 The medical expert must go further and
9 testify to take into consideration all the facts,
10 it is his professional opinion that a result of the
11 question most probably caused the alleged death in
12 this case.

13 So, Your Honor, as I listened to the
14 testimony -- and I've heard a lot of testimony over
15 the years -- were these experts struggling to meet
16 that standard. If it was easy, he would have stood
17 up and said, to a reasonable degree of medical
18 certainty, the time on the ground caused the death.
19 Yes, sir. You never heard that testimony. All
20 right.

21 And the reason that you didn't hear
22 that testimony is because they struggled with the
23 time issue. They struggled with the idea that some
24 period of time between zero and 36 hours, which is
25 an acceptable, even under their theory, and 36 to

1 72 hours more probably than not caused her death
2 eight months later. They couldn't say it.

3 And the reason they can't say it, as
4 Dr. Mills admitted on cross-examination to this
5 question, do you intend to offer an opinion in
6 trial in this case, to a reasonable degree of
7 medical certainty, that had Ms. Parrott fell and
8 fractured her hip in multiple places, remained on
9 the floor for 24 to 36 hours and not a longer
10 period of time, that she would not have died nine
11 months later. Answer from Dr. Mills, I can't say
12 that. And would you agree with me that the reason
13 you can't say that is because it is inherently
14 speculative; correct? Answer, yes.

15 So then in the trial of the case, we
16 try to clean that. We had to get around that
17 testimony. So they got him to say, well, it was
18 significant, the longer the time she's on the
19 ground the worse it is.

20 And on cross-examination he was asked,
21 what does significant mean? He said, well, I can't
22 say 25 percent, 50 percent, 75 percent. All I can
23 say is, the longer she's on the ground, the worse
24 it is.

25 And the other thing, too, which caught

1 my attention -- it reminded me of some old law. He
2 never said cause of death. What he said was, it
3 would have shortened her life. Do you remember
4 there were questions about, oh, well, she's got
5 eight years left on her life expectancy. And he
6 said, well, I can't tell you how much longer or
7 shorter she would have lived. Is that four years,
8 is that eight years? I can't say that to any
9 reasonable certainty.

10 What that really was -- and let me
11 address Dr. Bergmann too before I skip to this next
12 part. The question of Dr. Bergmann was, do you
13 intend to provide an opinion at trial that her
14 decline in death would not have occurred, but for
15 some alleged delay in finding her. His answer was,
16 I don't think there's anybody that can say that.
17 And then what he said is, I think it's a real
18 possibility.

19 Now, possibilities are not enough. And
20 on cross-examination he said, well, no, I can't say
21 49 or 51 percent. A, he said its speculative.
22 And, B, he says he can't say that.

23 So, as I'm sitting here listening to
24 that testimony from my view what it actually is to
25 me. And the Court may agree or not, it's loss of

1 chance; right? I can't say it probably caused her
2 death, but she lost the chance to survive a little
3 bit longer. Now, Your Honor, the loss of chance in
4 particular has been soundly rejected in this case,
5 as I'm sure you're aware.

6 And regardless I think it's
7 interesting -- this is the case of Jones v. Owings,
8 Your Honor. And it really sheds some light on the
9 reasoning of why you can't come into Court and say,
10 well, I think it's possible or probable, or I think
11 it shortened her life. Because I can't say how
12 long it shortened her life, but it didn't kill her,
13 but it shortened the amount of years that she was
14 to live.

15 And in rejecting the loss of chance,
16 doctrine, our Supreme Court said lesser standards
17 of proof are understandably attractive in a
18 malpractice case. It goes to physical well being
19 and life itself were the subject of litigation.
20 The strong intuitive sense of humanity tends to
21 emotionally direct us towards a conclusion that an
22 action for wrongful death injured person should be
23 compensated for the loss of any chance of survival,
24 regardless its remoteness. However, we have
25 trepidation that says the rule would be solely

1 more. Even though for a law recovering group not
2 meeting the standard of probability.

3 And, really, I think that's what you
4 heard here. And more importantly, when they
5 couldn't tell you more probably than not that death
6 was caused by some specific period of time on the
7 ground, this cause of action failed as a matter of
8 law, respectfully, Your Honor.

9 THE COURT: All right. Who would like
10 to argue for the Plaintiff?

11 MR. REEVES: Judge, that's a very
12 innovative, well-written argument. It's not
13 relative. Both experts said, the trauma of being
14 on the floor gave her conscious pain and suffering.
15 And it contributed to her death. You were here,
16 just as I was.

17 THE COURT: And you had a third one,
18 Mr. Davis?

19 MR. DAVIS: I do, Your Honor.

20 THE COURT: All right.

21 MR. DAVIS: So, Your Honor, this whole
22 case has been from the beginning of whether or not
23 we have assumed a duty of some nature. Because
24 everybody agrees that there's a lease in place,
25 which set forth a duty between the parties, a

1 contract between the parties.

2 Now, they have tried to assert that we
3 assumed a duty outside the lease under the
4 statement of torts. And the duties, as I see it,
5 is that we agree daily to keep residents safe by
6 checking on their wellbeing. That's the duty.

7 Now, what they're trying to do in this
8 case, Your Honor, is take a system, a check-in
9 system, and call that the breach. But if the
10 breach of how you do the job does not define the
11 system -- in other words, you breach your system,
12 but the duty is if you breach it, what's the duty
13 that you owe me in implementing that system.

14 And that's just the duty here that they
15 say we assume is to keep them safe and check their
16 wellbeing daily. Now, that assumption of duty that
17 they argue to you runs square into the terms of the
18 lease. And I read you the terms of the lease. It
19 basically said, and the witnesses testified about
20 it. It said, all right, we have a contract. You
21 are assuming the risk of your ability and freedom
22 to make decisions as you come into our unit. And
23 with that assumption -- or with that freedom comes
24 the assumption of that risk. So our contract
25 expressly disavows the very duty that they say we

1 assumed.

2 Now, what's interesting to me, Judge,
3 is there is -- and in addition, too, Judge, even if
4 we assume that duty, the way they say, the lease
5 itself says they waive all liability with respect
6 to any breaches of duties or any damages caused by
7 these failures.

8 And I can read you the language, but in
9 context if you assume the risk of freedom, you
10 assume the risk of your actions. And if you're
11 hurt, you waive any liability related to that.

12 And that's really what we have here.
13 So those are contractual rights that we think are
14 blocked by any assumption -- expert contractual
15 assumption of the duty.

16 Because, in essence, Judge, what they
17 want you to do is disregard contractual rights
18 completely, disregard contract law completely. And
19 say, hey, they assumed it, despite the fact in the
20 very lease agreement between us, we say, you are
21 assuming the risk of freedom of making decisions in
22 living.

23 And so for that reason, Your Honor, we
24 think that they have failed to prove that either we
25 assume the duty, or even if we did, that they say

1 liability is blocked, because they waived liability
2 under the terms of the lease.

3 THE COURT: All right. Mr. Reeves.

4 MR. REEVES: I think the testimony
5 yesterday about the lease clearly indicated that
6 the lease was left open to the certain policies and
7 procedures. And, Judge, you heard about this
8 point.

9 But what they're asking you to do today
10 is take the policy they say does not exist. And
11 the Defense to this policy does not exist. But, by
12 the way, if it does exist, it does not create a
13 duty in the case we cited in our pretrial brief.

14 THE COURT: I was just thinking about
15 it. This is kind of odd in the sense that in jury
16 trials, the jury isn't in here to hear any of these
17 arguments. And so whatever I say it doesn't
18 matter, because the jury makes the decision. But
19 what I say now tips the hand as to where we're
20 headed, right, a little bit?

21 MR. REEVES: Yes, sir.

22 MR. DAVIS: Well, when you say it like
23 that.

24 I think these -- in all seriousness,
25 Your Honor, these are legal questions that you have

1 to decide.

2 THE COURT: That's true.

3 MR. DAVIS: They've also, Your Honor,
4 asserted a claim for punitive damages. And I don't
5 -- respectfully, Your Honor, you know punitive
6 damages. This is the highest burden the Plaintiff
7 faces. There is no doubt about it. It's got to be
8 clear and convincing. That's by statute. This is
9 an incredibly high burden. Your Honor, there's
10 been no evidence in this case that Corrine, Beth,
11 or Rebecca, or that the company did anything
12 repeatedly intentionally, recklessly.

13 You know, I get it. If they came in
14 and said, well, Judge, we've proven to you over
15 time they didn't check anybody off. If they would
16 have proven to you that Rebecca said, oh, I don't
17 give a damn, I'm going home.

18 What this case really is in front of
19 you, Your Honor, is potentially about a dispute
20 about Wednesday night, whether we made a reasonable
21 decision there, and then do you believe about Beth
22 Auld seeing her.

23 And for the life of me, I see zero
24 evidence that the people involved with
25 Ms. Parrott's case deserve to be punished by the

1 Court for intentional, reckless, wanton behavior.

2 You heard those folks, we have better
3 things to do. Really what you heard is they made a
4 judgment call, but at the end of the day this still
5 remains a negligence case, respectfully what I
6 believe the evidence to be. And, again, I don't
7 see how this meets the high burden.

8 THE COURT: All right.

9 MR. REEVES: If it please the Court,
10 Your Honor.

11 Two things, I asked Rebecca was it
12 Ms. Parrott's (sic) fault that she didn't go back
13 and get the key? Yes, it was. These folks have
14 adopted that particular position, that is a
15 conscious disregard for Ms. Parrott's rights.

16 They lost the most critical piece of
17 evidence they had that would have helped clear up
18 what happened on Thursday. But we don't have it.

19 And the two people who are responsible
20 for filing those document are the very ones who
21 were on the scene. There is sufficient evidence
22 that if the Court wishes to, clear and convincing,
23 it can award punitive damages.

24 Now, I'm not saying you will. I don't
25 know what you're going to do. I'm not sure you

1 are. But the evidence is here for you to consider
2 that.

3 THE COURT: Anything further?

4 MR. DAVIS: I want to address one
5 thing. The default question, the critical
6 discussion he said, was it her fault. And in
7 answer she said yes. But that was the idea, right,
8 that she changed the locks. And that particular
9 witness didn't know about that evening, the key.
10 So when I corrected that she said, oh gosh, I'm not
11 blaming her, we had the key. So, again, that's the
12 clear and convincing evidence of that.

13 And I do want to talk about this lost
14 document. I'm amazed, frankly, that we are still
15 worrying about this. A document written by Corrine
16 Carrington, right, the day after the event, their
17 star witness, she is the one who said there is a
18 policy. You have to take the good with the bad,
19 don't you, Judge.

20 What she said, under oath, I looked at
21 it, I saw it. Wednesday wasn't checked. Thursday
22 was checked. And you know what, if you're going to
23 argue conspiracy, Judge, we aren't very good at it
24 because we should have fixed Wednesday.

25 But, from my prospective, I don't think

1 that the idea that somehow this missing record
2 creates punitive damages, with context of that
3 document. I feel like I'm doing closing arguments
4 to a jury.

5 THE COURT: That's all right.

6 Well, for your closing arguments, I
7 don't put a whole lot pretexts or exfoliation,
8 if that helps y'all to condense it a little
9 quicker.

10 All right, anything further?

11 MR. DAVIS: Do you have any idea when
12 you'll be able to rule on those? It might help in
13 some way.

14 THE COURT: Now?

15 MR. DAVIS: You had made a mention --

16 THE COURT: You mean as to these?

17 MR. DAVIS: Yeah. As to these legal
18 issues.

19 THE COURT: If that's what you want me
20 to do, and continue with the Defense's case. I
21 don't know if you need to take a call? Do you have
22 your witnesses ready?

23 MR. DAVIS: I would like to hear the
24 ruling, honestly -- I don't mean in any to push
25 you.

1 MR. REEVES: Nothing further from the
2 Plaintiff, Your Honor.

3 MR. DAVIS: Not yet. Still waiting.

4 THE COURT: All right. So as for the
5 Unfair Trade Privacy Act. I do want to read the
6 case law that you have passed up, which is
7 Faircloth versus Jackie Fine Arts before I make a
8 ruling as to that one to determine whether, in
9 fact, if it can be brought as a civil action.

10 And as to the wrongful death, I agree
11 with the Plaintiffs that that cause of action
12 should proceed forward, based on the testimony of
13 both doctors.

14 The assumption of the duty, obviously,
15 that's what the whole case is about. Was there a
16 duty? Was it an understood duty? And was it
17 breached? And I agree with the Defense in that
18 sense, in that this is a negligence case. If
19 there's duty, did they assume the duty, did they
20 breach the duty. And that's what I have to
21 determine.

22 And as to punitive damages, I'm not
23 going to award it at this point in time. I'm just
24 going to allow it to go forward.

25 All right. Are you prepared to call

1 your first witness?

2 MR. DAVIS: We are, Your Honor.

3 THE COURT: Do y'all need a break
4 briefly?

5 MR. REEVES: Your Honor, one thing for
6 the record, we agreed --

7 And, Mr. Davis, correct me if I'm
8 wrong.

9 They have a net worth of information.
10 But if that's something that you need to decide
11 later on, then they will give that information to
12 you.

13 THE COURT: Correct, for the company,
14 for the basis of punitive damage.

15 MR. DAVIS: Correct.

16 THE COURT: I would have to get that in
17 consideration.

18 MR. DAVIS: It's probably a little bit
19 more than that.

20 THE COURT: All right. That's fair
21 enough.

22 Okay. So in that sense, once the case
23 is over, if we are going to go down that road, do
24 you want to bifurcate that portion of it, or no?

25 MR. REEVES: Judge, I'll do whatever

1 you want to do. Whatever is the easiest for the
2 record, and your decision making.

3 THE COURT: All right.

4 MR. RIDDLE: Your Honor, we call Dr.
5 Scott Davidson, our expert witness.

6 THE COURT: Please raise your right
7 hand.

8 Do you swear or affirm the testimony
9 you are about to give will be the truth, the whole
10 truth, and nothing but the truth?

11 THE WITNESS: Yes.

12 DR. SCOTT DAVIDSON,

13 DIRECT EXAMINATION

14 MR. RIDDLE: Your Honor, I'm going to
15 try to use the trial pad. And I might need to pull
16 the podium over here. Is that okay?

17 THE COURT: Whatever you'd like to.

18 BY MR. RIDDLE:

19 Q. Dr. Davidson, good morning.

20 A. Good morning.

21 Q. Can you tell us your full name, please.

22 A. Scott Conrad Davidson.

23 Q. And, Dr. Davidson, where do you live?

24 A. Isle Of Palms, South Carolina.

25 Q. And can you tell the Court about your

1 education, beginning with college.

2 A. I went to -- I graduated from
3 University of Virginia in 1978. I went to medical
4 school at the University of Virginia and graduated
5 in 1994. Then I did my internship and residency at
6 the Medical University of South Carolina, finishing
7 in 1997.

8 MR. BOSWELL: The Plaintiffs are happy
9 to stipulate to his qualifications as an emergency
10 room doctor.

11 THE COURT: All right. Were you going
12 to qualify him as an expert?

13 MR. RIDDLE: Yes, Your Honor. But I
14 would like for him to talk about his work
15 experience, because I think it's relative to our
16 issues in the case.

17 THE COURT: All right. Do you have any
18 objection to him being qualified as an expert?

19 MR. RIDDLE: No, sir.

20 THE COURT: All right. Without
21 objection.

22 MR. RIDDLE: And we're offering him to
23 be qualified in internal medicine and hospital
24 medicine.

25 THE COURT: Okay. Without objection.

1 BY MR. RIDDLE:

2 Q. And so, Doctor, along those lines, can
3 you explain for us what types of practice that
4 you're involved in?

5 A. I work -- well, I'm board certified in
6 internal medicine, and I've worked as a hospitalist
7 since 2006.

8 Q. And you mentioned that you are board
9 certified. Can you explain to the Court what that
10 means?

11 A. There are various organizations that
12 correspond to the type of practice. And I practice
13 concentration in The American Board of Internal
14 Medicine, who is recognized throughout the country.

15 You achieve board certification by
16 taking an examination. And since I became a
17 physician, there's a requirement for
18 recertification ongoing education. And my last
19 certification was internal medicine with a
20 concentration in hospital medicine, which is a new
21 subsection they developed in the past five years or
22 so.

23 MR. RIDDLE: And, Your Honor, I forgot
24 to mention earlier, we'd also like for Dr. Davidson
25 to be qualified as an expert in emergency medicine.

1 I just needed to add that for the record.

2 THE COURT: Without objection?

3 MR. BOSWELL: Yes.

4 THE COURT: All right. He's qualified
5 without objection.

6 BY MR. RIDDLE:

7 Q. Doctor, can you describe the nature of
8 your practice and sort of your experience working
9 in hospitals and your job titles and job duties in
10 those areas?

11 A. Sure. With regard to hospitalized
12 medicine?

13 Q. Yes, sir.

14 A. So in 2006 I joined Roper hospitals.
15 Their Hospice program in 2007 I became a code
16 medical director of it. Through October of last
17 year, I was also chief of medicine for Roper
18 Hospital for about 10 years.

19 Since October of last year, I left
20 Roper Hospital. I worked for a company in
21 Charleston and traveled around the country doing
22 the same thing, primarily, for the past year in
23 Kansas City. I was in New Jersey for about nine
24 days in April, but all doing hospitalist medicine.

25 Q. And, in your practice as a hospitalist,

1 is it common for you to examine patient's lab
2 results and evaluate those lab results and assess
3 the implications of those lab results?

4 A. Yes. In fact, if a patient comes into
5 the emergency department, the emergency department
6 physician feels -- or is of the opinion that the
7 patient needs to be admitted to the hospital for
8 further evaluation of treatment, I've seen the
9 patient. I admit the patient and follow the
10 patient, at least, through my rotation, which is
11 typically seven days.

12 There will be cases where I pick up the
13 patient, that I begin a rotation. The patient is
14 already a patient. My practice is to review
15 everything pertaining to that admission, including
16 the evaluation of the emergency department. So I'm
17 very familiar with the full scope of a
18 hospitalization.

19 Q. And, Doctor, have you reviewed the
20 medical records that we sent you in regard to this
21 case?

22 A. Yes.

23 Q. Did you also review the depositions
24 that we sent to you?

25 A. Yes, I have.

1 Q. Have you reviewed any other documents?

2 A. Just the ones that were provided
3 pertaining to this case. There was the article
4 that I reviewed. That was forwarded to me.

5 Q. And have you developed some opinions
6 about the issues in this case?

7 A. Yes, I have.

8 Q. Can I ask you some questions about
9 those opinions?

10 A. Yes.

11 Q. First of off, Doctor, do you believe
12 that the Roper Hospital records are consistent with
13 Ms. Parrott having been on the ground for 24 hours
14 after the fall?

15 A. For 24 hours, yes.

16 Q. Is it your opinion that Ms. Parrott's
17 time on the ground after the fall did not cause her
18 decline in death?

19 A. Correct. I don't think her time had
20 anything to do with her demise.

21 Q. And in your opinion, Doctor,
22 considering Ms. Parrott's age and medical history,
23 would she likely have had the same outcome, if she
24 was found earlier?

25 A. Yes.

1 Q. And, Doctor, to reiterate, are the
2 objective medical evidence, the objective medical
3 records consistent with Ms. Parrott having been on
4 the ground for 24 hours, after the fall?

5 A. Yes.

6 Q. Are the objective medical records
7 consistent with Ms. Parrott having been on the
8 ground for 72 hours after her fall?

9 A. No.

10 Q. Do you hold these opinions within a
11 reasonable degree of medical certainty?

12 A. I do.

13 Q. And I'll ask you --

14 MR. RIDDLE: A lot of questions here
15 today -- but not too many, Your Honor.

16 BY MR. RIDDLE:

17 Q. Some questions today about your --
18 about these opinions. And can we assume that all
19 of your opinions are stated within a reasonable
20 degree of medical certainty?

21 A. Yes.

22 Q. First, quickly I want you to take a
23 look at some lab results.

24 MR. RIDDLE: I do have some hard
25 copies. This isn't working. In the meantime, I'll

1 use the hard copies.

2 And, Judge, I have to ask my paralegal.
3 She's not here. I'll be right back.

4 THE COURT: Take all the time. No
5 problem.

6 MR. RIDDLE: All right. So I have
7 three copies here.

8 THE COURT: Use the ELMO.

9 BY MR. RIDDLE:

10 Q. All right. Doctor, first there was
11 some discussion yesterday about Ms. Parrott's BUN
12 level and creatinine level and BUN creatine ratio.

13 Can you explain for us, again, briefly
14 what that is referring to?

15 A. Okay. The BUN is the acronym for blood
16 urine nitrogen. It's a medical byproduct that is
17 excreted in the urine. Creatinine is also a
18 metabolic byproduct excreted in the urine.

19 Creatinine is considered sort of a
20 surrogate measure of renal function. It's not
21 perfect. But, in general, lower is better. And
22 higher indicates renal impairment.

23 So, for instance, with untreated
24 end-stage renal disease would have a creatinine of
25 seven, eight. I've seen it as high of 16. In this

1 case it's perfectly normal.

2 Now, when you have a diversion between
3 the BUN and creatinine that is suggestive of
4 dehydration. So you might say that there are many
5 causes of renal failure, untreated hypertension,
6 and various things.

7 But it said, in the case of what we
8 have here, this is suggestive of dehydration
9 without impairment of renal function. Creatinine
10 creatine level is normal.

11 Q. And would you expect to see someone
12 with normal creatinine levels, after having been on
13 the ground for 72 hours?

14 A. No.

15 Q. And would that be because that person
16 would start to exhibit some level of kidney
17 impairment?

18 A. Yes. For two reasons: One, is the
19 severity for dehydration would progress to the
20 point that it would affect the renal function
21 directly. The other thing is we had to -- the CPK
22 would be markedly elevated from someone being down.
23 And that can also affect renal failure.

24 Q. Now, Mrs. Parrott's BUN was elevated in
25 this case; is that correct?

1 A. That's correct.

2 Q. And I think if we look here on this
3 record, we see the BUN here. And this would have
4 been the date of omission, 6/6; is that right?

5 A. That's correct.

6 Q. And so her BUN would have been 40; is
7 that correct?

8 A. Yes.

9 Q. Would a BUN of 40 be something that you
10 would expect to see with someone having been on the
11 ground without food or water for several days?

12 A. I would expect it to be -- for several
13 days, I would expect it to be higher.

14 Q. What's the normal range for BUN?

15 A. Well, it depends on the lab. And if
16 you reference, they put their range is 7 to 22.
17 More or less that's typical of different
18 hospitalists, different chemists.

19 Q. 7 to 22, you said?

20 A. Yes. Specifically, for this lab. But
21 that's the general range.

22 Q. And hers was 40, so it's elevated;
23 right?

24 A. Yes.

25 Q. Isn't that bad, Doctor?

1 A. It's not bad. It indicates that the
2 patient is dehydrated. So when you, in terms of --
3 in certain circumstances in certain laboratories,
4 they're not normal or they catch-drop it, do they
5 indicate that something is horribly wrong or
6 there's an aberration of perturbation. In this
7 case, it's like it's a perturbation for which the
8 patient was appropriately treated with IV fluids.
9 But it's not a harming of renal failure or any
10 untoward consequence.

11 Q. And is it your opinion that your level
12 of elevated BUN would indicate that someone had
13 been dehydrated, as a result of not having access
14 to food or water for 24 hours?

15 A. Exactly.

16 Q. And is it possible that someone could
17 have -- with regard to the creatinine level, is it
18 possible that someone could have a normal
19 creatinine level, after going without food or water
20 for several days?

21 A. No.

22 Q. You mentioned the CPK. Can you explain
23 to the Court what CPK is.

24 A. It's an enzyme that's found in muscle
25 tissue. It used to be used also in the diagnosis .

1 of heart attacks, myocardial function. It's
2 another marker -- another type of enzyme. But
3 that's exclusively to muscle tissue.

4 But the relevance is when muscle tissue
5 is damaged, it could be for a variety of cases. It
6 could be for drugs. In this case, it's that
7 immobility in causing muscle breakdown, and spills
8 into the blood stream. And it can be measured.

9 Its significance is that higher levels
10 can be deleterious to renal function. What goes
11 with the CPK is also called myoglobin. It's what
12 makes red meat red. And that's a toxin to the
13 kidneys.

14 So the significance of an elevated of a
15 CPK is that when it's high, you need to take action
16 to prevent renal damage.

17 Q. All right. Doctor, here on this lab
18 result we see the reference range of 26 --

19 A. 26.

20 Q. To 193; is that right?

21 A. Yes.

22 Q. And does this cardiac markers report
23 indicate that Ms. Parrott's CPK on June 6th was
24 650?

25 A. Right. I think or 656, close enough.

Ty

1 Q. So she did have an elevated CPK?

2 A. She did.

3 Q. And that indicated that there had been
4 some muscle breakdown?

5 A. Yes.

6 Q. What do you believe was the cause of
7 the elevated CPK?

8 A. Being down and immobile.

9 Q. Would a hip fracture contribute to an
10 elevated CPK?

11 A. In and of itself, I think it's
12 possible, and depending on the severity. But
13 probably not in this case.

14 If you had trauma where it was --
15 falling down, probably not. I was thinking more of
16 trauma if you had been hit by a car and you had a
17 hip fracture, and it causes the bone fragments into
18 muscle tissue, something like that. But
19 essentially to your question, no.

20 Q. So laying on the ground, development of
21 skin breakdown --

22 A. Muscle breakdown.

23 Q. Muscle breakdown would contribute to
24 the CPK?

25 A. Yes.

1 Q. Would you expect to see that level of
2 CPK for someone that had been on the ground for 48
3 to 72 hours?

4 A. No.

5 Q. Can you give us a range of what you
6 would expect to see for a CPK in those
7 circumstances?

8 A. Thousands. Thousands. 2-, 3-, 4-,
9 5,000.

10 Q. Are there any other lab results that
11 you would look at to determine the time someone has
12 been on the ground after a fall like this, that
13 would it be helpful for you to determine that?

14 A. Yes. To get back to the previous one,
15 which had the creatinine -- well, for here, this is
16 another one. It says the urine specific gravity
17 which shifted -- five lines down.

18 Q. I'm sorry. I'll ask about that in a
19 minute. Can you tell me the one for creatinine on
20 it?

21 A. Yes. I would expect other differences
22 in the chemistries. Typically, people you can get
23 actually high or low. But much more severe
24 perturbations. Four lines down, the CO2, the
25 bicarb, usually people would become acidotic,

1 meaning that number would be lower.

2 Again, you just find, derangement, much
3 more significant derangements in the blood
4 chemistries, which is what this panel is for people
5 who are down for 48 to 72 hours.

6 Q. So, Doctor, is there any doubt in your
7 mind that Ms. -- based on these lab results, that
8 Ms. Parrott was down for sometime less than
9 72 hours?

10 A. There's no doubt in my mind that it was
11 less than 72 hours.

12 Q. And is it more likely than not that it
13 was close to 24 hours, as far as the time on the
14 ground after the fall --

15 A. Yes.

16 Q. -- based on the lab results?

17 A. Yes.

18 Q. Doctor, there's been some discussion
19 about the EMS reports. And that's the document
20 that I will show you here. This is the first page
21 of that report. And I will show you the section at
22 the bottom, actually.

23 Do you see where the EMS technician
24 determined the length of time Ms. Parrott -- it had
25 been or transpired since Ms. Parrott's fall and hip

1 fracture?

2 A. Yes.

3 Q. And what does this report indicate?

4 A. One day.

5 Q. If we look at the next page of this
6 report, we can see where the EMS technician
7 obtained that information. And starting right
8 here, I'll just ask you to read this sentence.

9 A. Patient states she has been on the
10 floor since Tuesday, but neighbors stated that they
11 saw her walking around yesterday.

12 Q. So did the EMS technician just make up
13 the one day that the technician put in this report?

14 A. I don't know why an EMS technician or a
15 paramedic would fabricate.

16 Q. Does it appear in the report that
17 someone hold the EMS technician --

18 A. That's what it states.

19 Q. That Ms. Parrott had been seen the day
20 before the fall?

21 A. Correct.

22 Q. In your view of that report, is there
23 anywhere it said that the EMS technician told Ms.
24 Parrott, no, no, you have been on the ground since
25 Thursday?

1 A. There's nothing to that effect.

2 Q. Doctor, I just want to ask you a couple
3 of questions about skin breakdown that's been
4 referenced in the Roper Hospital. And there's
5 reference to a blister on Ms. Parrott's right hip
6 an abrasion. Did you see those in the hospital
7 records?

8 A. Yes.

9 Q. Can you tell us what this blister is
10 that's referenced in those hospital records?

11 A. It appears to be a minor skin wound.

12 Q. And what would cause a development of a
13 blister, such as referenced in the hospital
14 records?

15 A. Well, in this circumstance?

16 Q. Yes, sir.

17 A. It could be from being down.

18 Q. And is that a pressure wound on her
19 right hip?

20 A. It's related to that. It's not a
21 decubitus ulcer, per se, but it's a wound, yes.

22 Q. Is it evidence of early skin breakdown?

23 A. Yes.

24 Q. So what is a decubitus ulcer --

25 A. Well, a decubitus ulcer is or pressure

1 ulcer is the consequence of immobility. That if
2 you pinch the skin, you peak the provision from the
3 capillaries. And also just the influx of plasma
4 from the blood that goes through tissue and
5 provides nourishment.

6 When you have that impairment of
7 profusion you start -- you will get devitalized
8 tissue and it will start breaking down and causing
9 an ulcer, where the tissue becomes necrotic
10 starting with the skin and then going to the dermis
11 and then going to the connective tissue, and
12 sometimes to the muscle underneath.

13 Q. And, Doctor, in your experience, as a
14 hospital physician, are there protocols for seniors
15 for hospital staff who prevent -- hospital staff
16 who prevent patients from developing pressure
17 ulcers?

18 A. Yes, absolutely. In the hospital the
19 procedure is to turn patients that are immobile,
20 for whatever reason, they're paralyzed or comatose,
21 is to turn them every two hours, 24 hours a day, to
22 prevent the development of pressure ulcers.

23 Q. So, again, a pressure ulcer begins to
24 develop if someone is immobile for more than two
25 hours?

1 A. Yes.

2 Q. Would you expect to see a blister, such
3 that Ms. Parrott presented to the hospital with for
4 someone who had been on the floor for 24 hours?

5 A. Yes.

6 Q. What would you expect to see, as far as
7 a pressure area or pressure wound, if Ms. Parrott
8 had been on the ground since Tuesday, as the
9 Plaintiff alleges in this case?

10 A. In simple terms, much more severe --
11 well, an actual ulcer with necrotic tissue going
12 down to the deeper levels.

13 Q. And what kind of medical treatment is
14 required for that pressure ulcer?

15 A. It depends. The typical -- at Roper
16 Hospital and the hospitals that I've worked with,
17 the various places, the typical thing -- the
18 typical procedure is that they're photographed
19 immediately upon presentation to the hospital.
20 Most hospitals have a wound care team, who will
21 make an assessment that can it be treated with
22 basic packing and all the different modalities that
23 the wound care nurses have, or they'll make a
24 recommendation that it needs surgical measures
25 where they actually cut out the necrotic tissue,

1 which is at risk for infection and in removing,
2 allowing the fresh tissue. So, again, it's a very
3 aggressive posture for those type of wounds.

4 Q. Did Ms. Parrott require any type of
5 treatment in this case?

6 A. No.

7 Q. Do you recall, from your review of the
8 medical records, what treatment was provided for
9 the blister on her right hip, and the abrasion?

10 A. Sometimes they put a cream on it. I
11 mean, it was open to air. They really didn't do
12 too much other than look at it and occasionally put
13 some cream on it.

14 Q. What does open air mean?

15 A. That means that there's no bandage.

16 Q. They didn't have to put a bandage on
17 it.

18 A. Apparently not.

19 Q. Was it a closed blister?

20 A. Well, I think it was in the course
21 of -- will evolve and they will drain usually,
22 usually you leave that on there, as well. But
23 yeah.

24 Q. And, Doctor, is it your understanding,
25 from the review of the medical records, that Ms.

1 Parrott, after her hip surgery, developed
2 postoperative delirium?

3 A. Yes.

4 Q. And is that something that you've seen
5 before in your practice, working in a hospital?

6 A. Yes. It's not uncommon for someone her
7 age, in that circumstance.

8 Q. What is -- what are the records
9 referring to when it says post-operative
10 complications of acute delirium?

11 A. Some people -- or older people get
12 acutely confused and agitated coming out of general
13 anesthesia. And that appeared to be her
14 circumstance. Not so much to the procedure itself.
15 It's usually the general anesthesia that's involved
16 in the procedure.

17 Q. And is there any significance for you,
18 with regard to that finding of post-operative acute
19 delirium relative to Ms. Parrott's condition after
20 she was discharged from the hospital?

21 A. I mean, it's hard to say. However,
22 looking at the records from her -- from the rehab
23 facility to which she was discharged, she did not
24 appear to be delirious there. So it seemed like it
25 began to improve for a period of time.

1 Q. You mentioned Ms. Parrott having been
2 discharged to the rehab facility. Can you describe
3 for us what type of care and treatment she would be
4 receiving at a skilled rehab facility, after a hip
5 fracture and surgery?

6 A. Well, what's involved in a skilled
7 nursing facility is comprehensive care in the form
8 of medical oversight, physical therapy,
9 occupational therapy, usually conducted twice a
10 day. Depending on the circumstances, speech
11 therapy more apply to stroke patients, which was
12 not her case. But, particularly, the vigorous
13 physical occupational therapy.

14 Q. And at the rehab facility where
15 Ms. Parrott spent 90 days after her surgery, was
16 she receiving constant nursing care and attention?

17 A. That was my impression, yes.

18 Q. And I believe you mentioned that she
19 improved during that 90-day period that she was in
20 skilled rehab?

21 A. Yes.

22 Q. I'm going to show you the final note
23 from Ms. Parrott's physical exam while she was in
24 Sandpiper Rehab after her hip surgery. Can you
25 describe for me what you see in this report?

1 A. She seems to be doing well. So, she's
2 alert, NAD, at the top line of no acute distress.
3 That's the abbreviation. Blind heart exam is
4 unremarkable. Neurologically there are no gross
5 deficits. She seemed grossly intact.

6 MR. BOSWELL: Your Honor, I can't
7 really read that. Can you zoom in a little bit or
8 ask the Doctor what the date is. There's a bar at
9 the top.

10 BY MR. RIDDLE:

11 Q. What's the date on this report, Doctor?

12 A. September 17th, 2016.

13 Q. 2014?

14 A. '14, sorry.

15 Q. Is there any reference here blocked any
16 to any type of neurological deficit?

17 A. No.

18 Q. Is there any reference in the doctor's
19 narrative, subjective notes at the top, to
20 psychological trauma related to the time on the
21 ground after the fall?

22 A. There is no such reference.

23 Q. Doctor, do you recall, based on your
24 review of the medical records, that Ms. Parrott,
25 after she spent 90 days in the skilled nursing

1 facility, was transferred to an assisted living
2 facility, Ashley River Plantation?

3 A. I'm sorry. Could you repeat the
4 question?

5 Q. Do you recall that Ms. Parrott was
6 transferred from the skilled rehab facility to
7 Ashley River Plantation Assisted Living facility?

8 A. Yes, I do.

9 Q. And I'll show you a report. It's got a
10 date at the bottom of September 18, 2014. This
11 appears to be an assessment that was prepared at
12 the time Ms. Parrott was admitted to Ashley River
13 Plantation; is that correct, Doctor?

14 A. That's correct.

15 Q. And can you read the title at the top?

16 A. Clinical science, symptoms of
17 depression in the elderly checklist.

18 Q. Are there any abnormalities noted here
19 with regard to clinical signs and symptom of
20 depression?

21 A. None.

22 Q. So I'll show you one other document
23 here. And this would have been on admission to
24 Ashley River Plantation. And it's a little hard to
25 read. But at the top of this document it says,

1 resident services level of care program. Did I
2 read that correctly?

3 A. Yes.

4 Q. And it says the review date is
5 September 17th, 2014. Did I read that correctly?

6 A. Yes.

7 Q. And there's a couple of items on here.
8 For instance, Number 9 orientation of behavior.
9 This indicates that Ms. Parrott is oriented and
10 alert. Did I read that correctly?

11 A. You did.

12 Q. Is there anything on this report -- and
13 this is Page 1 of 2 -- is there anything on this
14 assessment that indicates that Ms. Parrott was
15 exhibiting psychological trauma at the time she
16 appeared at Ashley River Plantation 90 days or so
17 after her hip fracture?

18 A. There's nothing in here that would
19 indicate that.

20 Q. And this is Page 2 of this report. It
21 has a signature line at the bottom. And, Doctor,
22 it may be difficult to read Joan Acosta on the
23 signature line?

24 A. It appears so, yes.

25 Q. Regardless, that confirms here that the

1 resident or the resident's responsible party signed
2 off on this level of care program or review, as
3 being an accurate assessment of the resident's
4 condition at the time of Ashley River Plantation?

5 A. Yes.

6 Q. So did Ms. Parrott appear to have any
7 problems at the time that she was discharged from
8 Sandpiper Rehab facility and admitted to Ashley
9 River Plantation Assisted Living, other than what
10 you would normally expect for an 80-year-old
11 person?

12 A. She did not appear to have any problems
13 of that sort.

14 Q. Doctor, did your review of the medical
15 records indicate that Ms. Parrott exhibited a
16 precipitous decline very soon after she was
17 admitted to the assisted living facility?

18 A. Yes.

19 Q. What I'm showing you here is a document
20 titled, Physician Visit Summary. And I'll
21 represent to you this is from the Ashley River
22 Plantation Assisted Living record. It says, Delila
23 Parrott is a resident of Ashley River Plantation
24 Assisted Living. Did I read that correctly?

25 A. Yes.

1 Q. And there's a visit summary that
2 indicates that Ms. Parrott was confused and
3 paranoid at that time?

4 A. Yes.

5 Q. And that Ms. Parrott believes the staff
6 is planning to harm her. Did I read that
7 correctly?

8 A. Yes.

9 Q. And down at the bottom from under
10 physician comments, it states hip fracture
11 completely healed, ambulate that as tolerated; is
12 that correct?

13 A. Yes.

14 Q. And under that it says, dementia slash
15 confusion. Informed patient's daughter as soon as
16 possible?

17 A. That's correct.

18 Q. And so, again, the date on this
19 physician visit summary is October 2nd, 2014.

20 And do you recall the admission
21 assessment to Ashley River Plantation, where we
22 just looked at, dated September 18th, I believe?
23 So this would have been somewhere around two weeks
24 after she came to the assisted living facility; is
25 that right?

1 A. Correct.

2 Q. So after she saw the doctor at Ashley
3 River on October the 2nd, I want to show you --
4 well, first of all, Doctor, was there any reference
5 to trauma from time on the ground and then October
6 2nd, 2014?

7 A. No. There was no such reference.

8 Q. So soon after she saw that doctor at
9 Ashley River Plantation, she was admitted to Mount
10 Pleasant Hospital on October 11th, 2014. And this
11 is the admission record from that October 11th
12 admission. Do you see that, Doctor?

13 A. Yes.

14 Q. And, actually, I'm showing the
15 discharge report. And it says that she was
16 admitted on October 11th and discharged on
17 October 15th; is that correct?

18 A. Correct.

19 Q. And it references her primary
20 physician, Dr. Mills. What was the principal
21 discharge diagnosis on that date?

22 A. Delirium and paranoia.

23 Q. And this report references a CT scan.
24 Can you read what this report says about the CT
25 scan?

1 A. Yes. CT of the head without contrast.
2 Contrast refers to an intravenous contrast case.
3 On October 11th, 2014, showed no imminents of acute
4 intracranial abnormality. Diffuse chronic
5 microangiopathic changes.

6 Q. And when it states no evidence of acute
7 intracranial abnormalities, does that mean that she
8 had had a stroke, basically?

9 A. It means that there's no evidence of a
10 mass, a bleed, or an acute stroke.

11 Q. What are diffuse chronic
12 microangiopathic changes?

13 A. They're characteristics on imaging that
14 suggest small vessel disease, that the terminal
15 arteries in the cerebrum that sort of serve -- I
16 don't want to get too complicated here.

17 But, basically, you'll see changes
18 around just below the cortex, which is suggestive
19 of small vessels that become excluded over time and
20 it's correlated with dementia and/or impaired
21 cognitive function.

22 The emporium function, it's sort of an
23 old term. Like a moon, these little spots that
24 correspond to small fargics, also, small vessels a
25 little bit bigger than what's refereed to

1 microangiopathic changes.

2 But little infarctions, which may not
3 be clinically evident, at the time it happened. We
4 have large vessel calculations, the change in
5 subject matter that usually prompt an evaluation at
6 the time, such as you can't speak, or you have
7 weakness, or paralysis. But that, in essence, that
8 she has cerebral matter disease.

9 Q. Is that consistent with, I believe, you
10 said dementia?

11 A. Yes.

12 Q. And decreased cognitive function?

13 A. Correct.

14 Q. And, in this case, do you believe that
15 a CT scan results are consistent with impaired
16 cognitive function for Ms. Parrott?

17 A. Yes.

18 Q. I want to refer you to the hospital
19 course section of this report. I'll just read this
20 and you can tell me if I've read it correct.

21 Doctor, it says, Ms. Parrott is a
22 patient with a known psychiatric history and known
23 conative decline, who presented declined over the
24 procedure of two weeks, with worsening cognitive
25 function. Did I read that correctly?

1 A. Correct.

2 Q. And so would that preceding two weeks
3 be consistent with the time period that she was
4 transferred from the rehab facility to assisted
5 living?

6 A. Yes.

7 Q. Where she was receiving more constant
8 at the rehab facility to a place where she wasn't
9 receiving as much attention at the assisted living
10 facility?

11 A. Yes.

12 Q. All right. So that was October 2014.

13 I'm going to fast forward to
14 December 23, 2014. And this is another physician
15 visit summary at the assisted living facility.

16 Again, that's dated 12/23/14.

17 And, Doctor, can you just take a look
18 at this report and describe what you see here.

19 A. So, apparently, the patient was
20 complaining of RLQ. That's right lower quadrant.
21 They reference the urinalysis of UA, and a culture
22 that was obtained, I think it looks like the 17th,
23 which should have had more blood.

24 And the culture of 40,000 at CFU, you
25 mixed in they had have bacteria likely

1 contamination, in general, most likely -- little
2 commentary that's when you have mixed bacteria
3 usually considering that is a contaminate. And,
4 therefore --

5 Well, anyway it said, will elect to
6 face all symptoms of UTI. So even thought they
7 thought it may be contamination is that still that
8 she had these symptoms and treated and see what
9 happens. Her treatment was Cipro. It's an
10 antibiotic.

11 So then AP, is Assessment Plan, UTI
12 treatment of Cipro hypertension control of mental
13 stable for muscular weakness.

14 Q. Thank you, Doctor. So in this report,
15 the physician who examined Ms. Parrott, I believe
16 she might have a urinary tract infection?

17 A. Yes.

18 Q. And is that a common condition for a
19 patient who had loss of mobility who's
20 80-years-old?

21 A. Yes.

22 Q. Is there any records here to any kind
23 of psychological trauma or anything related to the
24 time on the ground?

25 A. Nothing to that affect.

1 Q. And I believe under -- what's marked as
2 Number 3 on this assessment, on the right of this
3 report, it says dementia is stable?

4 A. Correct.

5 Q. And so she had a diagnosis of dementia;
6 correct?

7 A. Correct.

8 Q. Is there anything in that report that
9 you would expect to see for someone who was
10 80-years-old and suffered a hip fracture?

11 A. There's nothing unusual with that.

12 Q. I'll show you the first page of a
13 report. And, again, we are sort of fast
14 forwarding. We were just on December 23rd. Now,
15 we're going to about 30 days or so to January 20th,
16 2015?

17 A. Uh-huh.

18 Q. Do you see that?

19 A. Yes.

20 Q. And this is a progress note of
21 Dr. Mills; is that right?

22 A. Yes.

23 Q. And it says here, under the symptoms
24 section, that the patient is weak on the left side,
25 somewhat stooped appearing, frail appearing,

1 according to staff she had declined. Will need to
2 check for urinary tract infection. Did I read that
3 correctly?

4 A. Correct.

5 Q. So does this report indicate that she
6 just further declined while she was at the assisted
7 living facility?

8 A. Yes.

9 Q. Is there anything here in Dr. Mill's
10 report that references psychological trauma?

11 A. Nothing.

12 Q. Or any trauma that was associated with
13 having been on the ground after the fall?

14 A. Nothing to that affect.

15 Q. Now, I want to show you this one
16 report. It's going to be difficult to read. It's
17 just for one line here.

18 If you can look like right here,
19 Doctor. Does that appear to say multiple
20 decubitus, currently on Levaquin?

21 A. That's what it appears to say.

22 Q. And would that surprise you for a
23 person like Ms. Parrott who is 80-years-old and had
24 lost mobility because of a hip fracture, begin to
25 develop decubitus ulcers, and as a result of that

1 loss of mobility?

2 A. That's not unusual.

3 Q. And is that just further evidence of
4 her overall decline, as a result of the hip
5 fracture and loss of mobility?

6 A. Correct.

7 Q. Is there anything regarding those
8 decubitus ulcers that she would have developed from
9 loss of mobility that you would associate with the
10 trauma from time on the ground, after her fall?

11 A. Nothing.

12 Q. The next report I'll show you, Doctor,
13 is dated January 27th, 2015; is that correct?

14 A. Correct.

15 Q. So this would have been about seven
16 days after that last assessment we looked at with
17 Dr. Mills?

18 A. Yes.

19 Q. Can you just tell us what you see here
20 in this report?

21 A. Well, do you want me to read it, or
22 give just my overall impression?

23 Q. I would like your overall impression.

24 A. Well, it's an 80-year-old person who
25 has really declined significantly since that she

1 can't even speak to the emergency department
2 physician.

3 Q. Does this report describe a tremendous
4 decline over the last two weeks?

5 A. Yes.

6 Q. Do you see in this report reference to
7 a concern for developing pneumonia?

8 A. Yes.

9 Q. Is that something that you would expect
10 to see for someone who's 80-years-old, lost
11 mobility, as a result of a hip fracture?

12 A. Yes.

13 Q. Is there reference here, Doctor, in
14 this report from Roper Hospital of a trauma-induced
15 decline that's associated with the time on the
16 ground?

17 A. There is no such reference.

18 Q. The next report I'll show you, Doctor,
19 is a consultation at Roper Hospital dated
20 January 28th, 2015. Do you see that?

21 A. Yes.

22 Q. And this appears to be a report of Dr.
23 Livingston; is that right?

24 A. Dr. Livingston is the front physician
25 by Lisa Moore. It's with the Palliative Medicine

1 Service.

2 Q. And the reason I wanted to show you
3 this report is the second paragraph, Doctor. It
4 says, the patient has underlying history of
5 schizophrenia. And there's been some discussion
6 about whether she was ever actually diagnosed with
7 schizophrenia in this case. I don't think it's
8 relevant to the question that I will have for you
9 here.

10 But going on, again, the patient's
11 daughter, Joan, provides all the history. The
12 patient was residing at Sandpiper Independent
13 Living last year and, unfortunately, suffered a
14 fall and fractured her hip. After surgery she went
15 to a skilled nursing facility for 100 days. From
16 there went to Ashley River Plantation for assisted
17 living.

18 Due to her underlying schizophrenia,
19 the patient's daughter stated she had trouble
20 adjusting with an increase in paranoia and
21 ideation. Did I read that correctly?

22 A. You did.

23 Q. And in that section of the report
24 anywhere in this report dated January 28th, 2015,
25 is there any reference to a psychological trauma

1 from the time on the ground after Ms. Parrott's
2 fall?

3 A. There is none.

4 Q. Is there anything in that description
5 of Ms. Parrott's decline that you would not expect
6 to see for an 80-year-old woman who fell and
7 suffered a hip fracture, with a preexisting history
8 of mental health issues?

9 A. This is all fairly typical.

10 Q. And I have one more report for you to
11 look at, Doctor. This is dated January 30th, 2015
12 from Roper Hospital; is that correct?

13 A. Correct.

14 Q. And this is labeled, discharge summary
15 that includes a list of diagnoses on Ms. Parrott's
16 discharge from the hospital on January 30th?

17 A. Yes.

18 Q. All right. And included on this list
19 is debility and failure to thrive. Did I read that
20 correctly?

21 A. Yes.

22 Q. Can you describe for us, Doctor, what
23 that psychosis is referring to?

24 A. Failure to thrive?

25 Q. Yes, sir.

1 A. Failure to thrive is a term to describe
2 a decline in physiological status without one
3 specific predominate diagnosis such as -- you can
4 take a case like a pneumonia, but pneumonia wasn't
5 driving wasn't driving Ms. Parrott's overall
6 decline. That was just really a consequence of the
7 decline.

8 So where a variety of things intervene
9 to cause people to start losing physiological
10 status, they stop eating, they stop moving around.
11 And the consequence of that is death.

12 Q. Do you recall, from your review of the
13 medical records that Ms. Parrott had stopped eating
14 not long before this report?

15 A. Correct.

16 Q. And, in your opinion, is that a common
17 event that's associated with a general failure to
18 thrive?

19 A. Yes.

20 Q. That happens naturally at the end of
21 life?

22 A. Yes.

23 Q. And, again, failure to thrive,
24 debility, the diagnosis that we see on this report,
25 is this the type of decline that you would expect

1 to see for someone Ms. Parrott's age, the history
2 of mental health issues, who suffers a hip
3 fracture, and a loss of mobility?

4 A. Yes.

5 Q. Was this the cause, in your opinion, by
6 Ms. Parrott's time on the ground after the fall?

7 A. It was unrelated.

8 MR. RIDDLE: Doctor, I don't have any
9 other questions for you. Thank you.

10 THE COURT: If you have more than two
11 questions, we're going to take a break.

12 MR. BOSWELL: Your Honor, I was going
13 to ask if we could take a break.

14 THE COURT: Let's do that.

15 You're still under oath. Don't speak
16 with anyone about your testimony.

17 (A brief recess was taken.

18 THE COURT: Are you ready to go?

19 COURT REPORTER: Yes, sir.

20 CROSS-EXAMINATION

21 BY MR. BOSWELL:

22 Q. Dr. Davidson, I'm John Boswell. You
23 gave a deposition in this case. I wasn't there.
24 We didn't meet. I represent, along with Mr.
25 Reeves, who you did meet, the Estate of Ms. Parrott

1 and her family.

2 So I want to ask you a couple of just
3 general questions first, before I get into any
4 specifics about Ms. Parrott.

5 By, in large, if somebody is injured,
6 suffers an injury of trauma, physical trauma, the
7 healthier they are and more fit they are before
8 they go into that situation, more than likely is
9 better the outcome on the other side of it; do you
10 agree with that?

11 A. I agree.

12 Q. So, you know, where you end up, in
13 large measure, kind of depends on where you start,
14 psychically. Do you agree with that?

15 A. I agree with that.

16 Q. I mean, that's pretty clear.

17 And do you know Dr. Mills?

18 A. Yes. I'm acquainted with him.

19 Q. You guys aren't golfing buddies, but
20 you do know of him?

21 A. Yes.

22 Q. Do you know his reputation?

23 A. Yes.

24 Q. Is his reputation as a good doctor?

25 A. Yes.

1 Q. Do you understand that his primary
2 practice is with an older population of patients?

3 A. I didn't know that.

4 Q. Let me say it, he has a very
5 significant part of his practice with older
6 patients. Did you know that?

7 A. I didn't know that as versus the
8 general demographics of Mount Pleasant.

9 Q. Did you know that he is -- he was
10 Ms. Parrott's treating physician for many, many
11 years before her fall and then was the doctor who
12 sort of managed and treated her and saw her after
13 her fall through those last eight months of her
14 life?

15 A. Yes.

16 Q. Were you aware of that?

17 A. Yes.

18 Q. You saw his name kind of all over the
19 medical records?

20 A. Yes.

21 Q. Now, the -- in your direct examination
22 there was bits and pieces of the medical that was
23 pointed out to you, and that you testified about.
24 Do you remember that part?

25 A. Yes.

1 Q. I mean, it certainly there was an
2 effort by pointing to certain things and not
3 addressing other things to sort of reaching a
4 conclusion that Ms. Parrott couldn't have been on
5 the ground as long as we believe she was on the
6 ground; is that fair to say?

7 A. Yes.

8 Q. Now, a minute ago I said a lot of how
9 you end up depends on where you start physically?

10 A. Yes.

11 Q. And, in your opinion, is that before
12 Ms. Parrott was found on the ground, she was a
13 frail lady?

14 A. Yes.

15 Q. That's your opinion?

16 A. Yes.

17 Q. So, let me explore that for just a
18 second.

19 You based that opinion on the fact that
20 she had frequent falls, prior to the fall where we
21 found her on the ground; is that right?

22 A. Yes.

23 Q. What do you consider frequent falls?

24 A. More than the isolated fall or similar
25 in missteps. I don't know if it's -- I can't

1 really come up with an exact threshold.

2 Q. I mean, it could be a fall every month
3 or every couple of months, or certainly at least
4 every year?

5 A. No. I would put it as several months,
6 at least. Put it this way, when people say or
7 reference a loved one as frequent falls, it's an
8 issue, as opposed to the isolated stumble.

9 Q. Sure. Right. And part of this is, you
10 have -- you never laid eyes on Ms. Parrott; is that
11 correct?

12 A. No.

13 Q. Now, you worked at Roper when she went
14 there; right?

15 A. No. I was not involved in her care.

16 Q. Right. So she showed up in the
17 emergency room, somebody took care of her, and then
18 she was turned over to Dr. Mills, but you weren't
19 involved in any part of that?

20 A. Correct.

21 Q. Right. So you got your opinion that
22 she was frail, because of frequent falls, from your
23 review of the medical records?

24 A. Correct.

25 Q. And this is also going to be an obvious

1 question, but have you ever run into medical
2 records that just wasn't accurate?

3 A. It happens.

4 Q. It probably happens a fair amount, too;
5 wouldn't you think?

6 A. Yes.

7 Q. Now, if -- so you -- there's was two
8 things in your deposition you said. But I'm going
9 to ask you specifically. First, you said that you
10 thought Ms. Parrott was frail because she had a
11 frequent falls, and also because she couldn't do
12 her activities of daily living. That's ADL. You
13 see it a lot in ADL, the activities of daily
14 living?

15 A. Yes.

16 Q. And the activities of daily living
17 we're talking about the stuff we all do, you know,
18 get in and out of bed, wash your hair, clean
19 yourself, go to the grocery store, go to eat lunch,
20 all that stuff; right?

21 A. Yes.

22 Q. So, your opinion was Ms. Parrott was
23 frail because she fell a lot and she had trouble
24 with her ADLs.

25 So, let me ask you, if the facts were

1 that she only, prior to her being on the ground,
2 there was only two times that she fell, one was in
3 2007 at Wal-Mart when she slipped on something, and
4 the other was in 2013 at Sandpiper when there was a
5 traffic jam of carts that you put your mail in and
6 stuff and she tripped over one of those carts.

7 Would you consider that frequent falls?

8 A. No, I wouldn't consider that frequent
9 falls. In the record, it indicated that there was
10 a notation that I think it was her daughter put
11 frequent falls, as opposed to two falls separated
12 by it.

13 Q. To be fair, her daughter didn't write
14 anything in the medical records; correct?

15 A. Correct.

16 Q. Somebody interpreted something that
17 might have said and wrote it in the medical
18 records?

19 A. Correct.

20 Q. And you were then reading that?

21 A. Correct.

22 Q. So, I mean, it's kind of like --

23 A. That's a better characterization.

24 Q. Let me ask you a question: This is an
25 80-year-old lady. Did you notice her weight?

1 A. I don't recall her weight.

2 Q. She was right at 149 pounds.

3 A. Correct.

4 Q. That's how much I weigh. And in the
5 time that she fell, do you know what she was doing?
6 She had stepped up on a chair and took a bar and
7 stepped up on a chair and was trying to hang a
8 curtain. And the curtain that she -- you know, she
9 was in a cushion chair.

10 Now, admittedly, that's a stupid thing
11 to do. But does that seem like a frail lady who
12 can do that, less than 150 pounds up with one foot
13 and put her hands over her head to hang a curtain
14 rod?

15 A. That would be unusual for a frail
16 person.

17 Q. Yeah. That doesn't feel like a frail
18 person; does it?

19 A. (Witness moves head up and down.)

20 Q. And if the evidence in this case is
21 that she could do all of her ADLs -- you know, the
22 weekend before she was shopping at the open-air
23 market -- I know that you don't have any of this
24 information, because it's not in the medical
25 record. But were you aware that she could do all

1 her ADLs?

2 A. No.

3 Q. And so when you're looking at these
4 medical records and making an analysis of, well how
5 would she have gone -- you know, how would she have
6 survived or dealt with this long lie, knowing where
7 she started is a factor?

8 I'm not going to say it's the only
9 factor, but it is the only factor. Do you agree
10 with that?

11 A. I agree.

12 Q. So you talked earlier about the BUN.
13 And that is an accumulation of bad stuff in your
14 blood, because your kidneys aren't working right.
15 Or did I get that wrong? I know it's the urine and
16 nitrogen.

17 A. I wouldn't agree with that exactly.

18 Q. And I'm not trying to put words in your
19 mouth. Tell me what -- the accumulation the toxins
20 in the blood that happens over time, it tends to
21 get worse -- as you are getting dehydrated, you get
22 worse over time; is that fair?

23 A. Yeah.

24 Q. And does it tend to get worse and tend
25 to get better at roughly the same rate?

1 A. I'm sorry?

2 Q. So if you're dehydrated and you're on
3 the ground and you're accumulating the toxins in
4 your blood, and then you get bags of fluid and, you
5 know, start urinating and you get whatever you
6 need.

7 So it sort of goes up and then it goes
8 back down once she starts to get treated; right?

9 A. Yes.

10 Q. And another thing that you talk about
11 in your deposition that you didn't talk about here
12 is, it's something called tachycardia. That's
13 really just a fast heart rate?

14 A. Correct.

15 Q. Not related to exercise?

16 A. Correct.

17 Q. If I'm running and my heart is up --

18 A. Hopefully your heart rate is up.

19 Q. Hopefully my heart rate is up.

20 But if there's no reason for my heart
21 rate to be up, that would be considered
22 tachycardia?

23 A. Yeah. I mean -- correct. Yes.

24 Q. Trust me, I'm not trying to act like I
25 know more about this than you do. So, if you don't

1 agree with something I'm saying, please say no, no,
2 that's right, and then explain it to me.

3 A. Okay.

4 Q. I was doing some research and
5 tachycardia is generally considered 100 in an
6 adult?

7 A. You mean as the threshold?

8 Q. Yes.

9 A. Yes.

10 Q. Something like that?

11 A. Yes.

12 Q. Does tachycardia have anything to do
13 with your resting heart rate is?

14 A. Probably.

15 Q. So, if somebody had a resting heart
16 rate of 75, if they got to a 100, would that be
17 tachycardia? Or would they have to go up to like
18 120 or something like that?

19 A. Well, strictly speaking, 100 is
20 tachycardia. Now, as many things that there's --
21 101, 102, 105, is that clinically significant, but
22 depending on the context.

23 Q. Sure. But if somebody is also at like
24 95, they're close tachycardia?

25 How do you say it?

1 A. Tachycardia, yes.

2 Q. Tachycardia?

3 A. Tachycardia. I may be saying it wrong
4 all these years.

5 Q. So at 95 you're close to tachycardia;
6 correct?

7 A. Yes.

8 Q. And so one of the things that you
9 indicated -- you guys didn't talk about it. But
10 one of the things you indicated was an indication
11 that she couldn't have been down on the ground that
12 long and she didn't have tachycardia?

13 A. Well, I'm talking about many different
14 elements. So it's just not one criteria. That was
15 just one of many.

16 Q. Right. So, if I had -- let's say I had
17 a normal BUN rate of 8, and I had a big meal today,
18 and then, how then I didn't eat or drink anything
19 until tomorrow, how high would you expect my BUN
20 rate to have gone?

21 A. So you would -- let me make sure I
22 understand the question.

23 Q. I'm eating lunch today. And I'm eating
24 and drinking, and I'm fully hydrated, fully fed,
25 and I go sit in a chair, and I'm going to read a

1 book for the next 24 hours, and I don't eat or
2 drink anything for the day, where would my BUN rate
3 be tomorrow?

4 A. I would expect it to be double.

5 Q. 16, 18?

6 A. Yeah.

7 Q. Now, in your deposition, you made this
8 point -- and you said it wasn't clear whether she
9 had a decubitus ulcer, because it could have been a
10 scrape on her leg. Do you remember talking about
11 that?

12 A. Yes.

13 Q. Have you changed your opinion about
14 that since then?

15 A. Not really. I think when you look at
16 the record, it's a little bit ambiguous at times to
17 refer to it as an abrasion, which -- I mean,
18 without the benefit to all of us of having a
19 picture of it, an abrasion would -- would I think
20 of an abrasion would not -- in its characteristic.
21 It decubitus or pressure ulcer.

22 But it certainly, for presentation, she
23 could have the beginning of a breakdown from the
24 pressure.

25 Q. Do nurses deal with decubitus ulcers

1 all the time?

2 A. Yes.

3 Q. I mean, that's sort of something that
4 they deal with all the time?

5 A. Yes.

6 Q. So when the nurse who's actually
7 looking at the injury be in the best position to
8 decide whether there's a decubitus ulcer or not?

9 A. Possibly.

10 Q. Okay.

11 A. I mean, the issues then is going to
12 be -- the extremes are going obvious.

13 Now, for things that I familiar in many
14 circumstances where what they see -- they consider
15 minor and therefore their documentation isn't
16 precise, because they figure it's minor, it doesn't
17 matter.

18 Q. But if they took the time to measure
19 something, that is an indication that it was
20 significant to them?

21 A. Possibly.

22 Q. And, again, the problem is that we're
23 sitting here trying to interpret what other people
24 meant when they wrote stuff, et cetera?

25 A. In my experience, they call the wound

1 care team and they document it with photographs.

2 Q. Got it.

3 I meant to ask you this question a
4 second ago: The tachycardia -- if you're giving
5 pain killers, does that tend to also slow your
6 heart rate down?

7 A. Yes.

8 Q. All right. I'm going to zip through a
9 few other things real quick. Dr. Mills testified
10 in this case, and he had the benefit of actually
11 treating Ms. Parrott right after her fall and saw
12 her conditions and all that sort of stuff.

13 And I'm not going to ask you to opine
14 his opinions. We heard that. But you and he
15 agreed on a couple of things. And I want to
16 confirm, that. Ms. Parrott really came through her
17 hip surgery beautifully; didn't she?

18 A. Well, the delirium is an issue. But
19 aside, I guess, beautiful to me would be in someone
20 who did have delirium. By the time she got to the
21 rehab, she was doing as well as expected.

22 Q. Actually, the term you used is she
23 healed wonderfully. Do you agree with that?

24 A. Yes.

25 Q. I mean, honestly we're talking about an

1 80-year-old lady?

2 A. Correct.

3 Q. But she healed wonderfully for somebody
4 who broke her hip?

5 A. Correct.

6 Q. And she had no complications from the
7 surgery?

8 A. Correct.

9 Q. And so -- and you and Dr. Mills both
10 agree about that. And you said that you didn't
11 think the anesthesia that she had would have been
12 any sort of a long-term complication for her
13 either; did you?

14 A. Long term, no.

15 Q. Once she starts to get it out of your
16 system?

17 A. Yes.

18 Q. You do, however, agree that during the
19 period of time, however long it was, that she was
20 on ground, she would have been in tremendous pain?

21 A. From the moment she fell and fractured
22 her hip.

23 Q. Right. So assume for me that she
24 wasn't fragile. You know, that she was strong
25 enough to do something stupid in a chair and that

1 she could do all of her ADLs and stuff like that.
2 It wouldn't be unreasonable to expect that she
3 would have recovered beautifully from the fractured
4 hip and been able to continue -- get back to the
5 independent living and continue her life?

6 If that would had been the outcome,
7 that wouldn't have surprised you; would it?

8 A. No.

9 Q. Now, you are absolutely not giving an
10 opinion in anyway as to the psychological affect of
11 her lying on the ground had on her?

12 A. That's correct.

13 Q. Right. And you made that point a
14 couple of times, and it wasn't asked of you here.
15 So we can say that Dr. Davidson had no opinion
16 about the psychological affect of her being on the
17 ground?

18 A. Correct.

19 Q. And you are firmly of the opinion that
20 the reason that she failed to thrive and the reason
21 that she died prematurely is because she lost the
22 will to live?

23 A. Yeah, I guess it's conceivable that she
24 would have had another recurrence infarction, I
25 don't know.

1 Q. You don't know anything like that.

2 But in your deposition -- and let me
3 make sure -- the thing that really killed her is
4 she lost the will to live?

5 A. Correct.

6 Q. Because there wasn't anything about the
7 hip that would have killed her?

8 A. The hip didn't kill her.

9 Q. Right.

10 A. But when the mortality rate associated
11 with hip fractures, which is not related to a hip
12 fracture with most of those patients anyway.

13 Q. And you're not expressing an opinion
14 whether or not the long lie, it contributed or
15 caused her to lose the will to live? You don't
16 have an opinion about that?

17 A. Correct.

18 Q. I want to cover very quickly a couple
19 of things in the medical records. So on the issue
20 of tachycardia, do you see that when the EMS first
21 hooked her up to the electric monitor, her heart
22 rate was 95?

23 A. Yes.

24 Q. And that's just short of tachycardia?

25 A. Yes.

1 Q. And then she got 100 micrograms of
2 fentanyl?

3 A. I've got the exact amounts.

4 Q. I mean, she was in a lot of pain and
5 they gave her two shots of pain medicine to get her
6 under control?

7 A. Right.

8 Q. That would have had an affect of
9 bringing down her heart rate?

10 A. Yes.

11 Q. Because when she got to the hospital,
12 her heart rate was still at 86?

13 A. Yes.

14 Q. Do you know what her resting heart rate
15 was?

16 A. I do not.

17 Q. Would it surprise you that it was 57?

18 A. When was that?

19 Q. That was when she got to the -- this is
20 when she got admitted. And we'll talk about that
21 in a second.

22 But this is the document when she was
23 admitted into Roper Hospital.

24 MR. RIDDLE: Well, would you mind
25 identifying that document for me, the date of it?

1 MR. BOSWELL: Yeah. I think you
2 actually pulled it up, too.

3 MR. RIDDLE: I don't believe I used it.
4 Well, I used it yesterday with Dr.
5 Mills.

6 MR. REEVES: Further Sandpiper Rehab.

7 MR. BOSWELL: So this is after
8 discharge from the hospital?

9 BY MR. BOSWELL:

10 Q. So this would have been after she was
11 discharged from the hospital and when was admitted
12 to Sandpiper?

13 A. Yes.

14 Q. And you see the pictures there of the
15 human being and the nurses wrote circles. Do you
16 see that?

17 A. Yeah.

18 Q. And you see they drew a picture, and
19 it's Number 4, and it's a 20 centimeter by 20
20 centimeter fluid-filled blister?

21 And that would be consistent with the
22 skin breakdown from pressure on the right hip?

23 A. Yes.

24 Q. Is that what that seems like?

25 There's a nurse's note here I want to

1 show you. And this is on 6/6. You can see here,
2 it's a nurse's note. And down here at the
3 bottom -- earlier Sandpiper's lawyer asked you to
4 read something about -- they said, that there was a
5 neighbor that they said her walking around?

6 A. Yes.

7 Q. And let's be clear. All you know about
8 that is what you read?

9 A. Yes.

10 Q. Do you see here that when the nurses
11 were talking to her after she was -- you know, when
12 they were assessing, she said her, I fell down on
13 Tuesday and have been laying on the floor and just
14 hoping someone would find me. I think I broke my
15 hip. Did you read that?

16 A. Yes.

17 Q. A minute ago we were talking about the
18 BUN level. And here is a date of 10/14. So that's
19 four months, roughly, after her fall. And her BUN
20 level was at eight. These two documents line up to
21 one another. You know, they sort of go like that.
22 So you have to kind of look at two pages.

23 Do you see what I'm talking about
24 there? The date is 10/14 and you go down and you
25 see that on 6/8 she had a BUN -- so a couple days

1 after she had a BUN of 33 and then 6/9 it went down
2 to 22, and many months later it went down at 8.

3 Does that suggest to you that her
4 normal BUN ratio would be about 8; right?

5 A. You mean the ratio, which is the BUN
6 itself?

7 Q. No. I mean the BUN ration itself.

8 A. Could be. It could also. It would
9 also be deformative would be to substantiate that
10 is to what the lab valley that might be in
11 Dr. Mill's records.

12 Q. Yeah. It probably is. But I'm not
13 going to --

14 It's not going to be dramatically
15 different than that; is it?

16 A. I don't know.

17 Q. We do see, however, that if you look at
18 this, she came into the hospital and her BUN level
19 was 40, and the next day it went down 38 and 36.
20 And the next day it went down to 33, and then it
21 went to 22, and then went down to 16.

22 So over five days it went down, you
23 know, like that?

24 A. Yes.

25 MR. BOSWELL: Doctor, thank you very

1 much. Wait a minute.

2 BY MR. BOSWELL:

3 Q. Was there anything in the medical
4 record that you saw that suggested that she had
5 ever had any previous deliriums before her fall?

6 A. No.

7 MR. BOSWELL: Thank you.

8 MR. RIDDLE: I just have one or two,
9 Your Honor, if that's all right.

10 THE COURT: Okay.

11 FURTHER DIRECT-EXAMINATION

12 BY MR. RIDDLE:

13 Q. Doctor, I'm going to show you the
14 nursing report from Roper Hospital that
15 Mr. Boswell just showed you. I believe he directed
16 your attention to this comment from Ms. Parrott, I
17 fell down on Tuesday and I've been laying on the
18 floor. Did I read that correctly?

19 A. Yes.

20 Q. On this same note, there's another
21 comment it says, presenting complaint for patient.
22 Patient was found on the floor by a neighbor who
23 checked on her, unknown how long she was on the
24 floor. Did I read that correctly?

25 A. Correct.

1 Q. So, is it fair to say that the medical
2 records are inconsistent about the time of the
3 fall?

4 A. Correct.

5 Q. And, as far as the narrative medical
6 reports, would you rely on what's in the objective
7 medical records, as in the lab results, more than
8 what's in the narrative reports that are
9 inconsistent, about the time of the fall, when
10 assessing the time of the fall and the length at
11 the time on the ground?

12 A. Well, the laboratory evaluation,
13 barring error is fact. And then narrative, at
14 times, is -- so you put all together what you think
15 is the most logical sequence of events.

16 Q. You mentioned in response to
17 Mr. Boswell's question that Ms. Parrott didn't have
18 any complications from surgery. Would you consider
19 the post-operative delirium a complication from
20 surgery?

21 A. Well, it was a moderate complication.
22 I guess, meaning that it -- that's why I'm saying,
23 it wasn't beautiful, so to speak, which I would
24 characterize as someone who didn't have any
25 delirium and could have some people get discharged

1 within 24 hours of that, or 36 hours.

2 So it was a complication. It wasn't a
3 major complication.

4 Q. And you also testified today that you
5 believe that delirium cleared up when she was
6 admitted to Sandpiper Rehab; is that correct?

7 A. Yes.

8 Q. Would you defer to a cognitive expert
9 or a psychologist with regard to psychological
10 issues or the impact of the delirium on her
11 pre-existing mental condition?

12 A. Sure. Absolutely.

13 Q. Mr. Boswell asked you a question about
14 your own BUN and what you think it would be, if he
15 eat a meal yesterday and didn't eat for 24 hours.
16 Is your assessment different for each patient,
17 about what you'd you expect to see for a BUN?

18 A. Yeah. Everyone is different than --
19 you know, as a rule of thumb, as to opposed to a
20 absolute predictive of measure. Part of it would
21 depend on --

22 Well, for instance, as I recall
23 that Ms. Parrott was taking a diuretic as part of
24 her pre-admission medications. And that will make
25 you urinate more frequently and it could draw to

1 dehydration faster -- or elevated BUN factor than
2 someone who's not taking a diuretic.

3 Q. Sure. So, Ms. Parrott was an
4 80-year-old woman -- and this is in response to Mr.
5 Boswells' questions about your assessment about
6 that Ms. Parrott was frail.

7 And I understand that your comments in
8 that regard in your deposition were based on some
9 of the references in the medical records of
10 frequent falls; right?

11 A. Right. There's also an office visit to
12 Dr. Mills, I think maybe a year before, where she
13 came in requesting a handicapped parking sticker,
14 because of impaired gait. And so, I mean, that
15 factored into my overall impression of someone that
16 had some impairment and mobility and was frail.

17 And, again, the handicapped parking
18 sticker.

19 Q. Right. And do you agree that
20 Ms. Parrott was an 80-year-old woman.

21 MR. BOSWELL: Your Honor, we'll
22 stipulate to the fact that she --

23 BY MR. RIDDLE:

24 Q. Do you agree that she had macular
25 degeneration?

1 A. Well, that's what the records say too,
2 yes.

3 Q. And she had a history of delusions,
4 depression, and anxiety?

5 MR. BOSWELL: Your Honor, I didn't
6 cover any of this stuff in my cross.

7 MR. RIDDLE: I would say that this goes
8 to Dr. Davidson's assessment of her condition
9 before the accident, how that factored into his
10 opinion with regard to how she recovered from her
11 hip fracture. And that was addressed on cross, I
12 think.

13 THE COURT: He's testified as to that.

14 MR. RIDDLE: Well, in that case --

15 THE COURT: I mean, I think he said he
16 had nothing to do with it, and that her will to
17 live was probably the cause. Correct?

18 THE WITNESS: Correct.

19 BY MR. RIDDLE:

20 Q. And with regard to the frequency of
21 falls, is there anything about the frequency of
22 falls, before this accident, impact your opinion
23 about her recovery from the hip fracture and the
24 impact on her decline of that?

25 A. I'm sorry, could you restate that one

1 more time, so I understand the question?

2 Q. Is this idea of the frequency of her
3 fall an important aspect of your opinion with
4 regard to how she recovered from the hip fracture
5 and its impact of her decline and death?

6 A. It's sort of complicated in the sense
7 that she seemed to do fairly well in the rehab with
8 the exception that she seemed to prefer using the
9 wheelchair at rehab at time of discharge, even
10 though that the physical therapist documented that
11 she could be one assist, and could use the walker.
12 But she preferred to use the wheelchair to
13 ambulate.

14 And I thought that is somewhat ominous.
15 Because you had the physical capability of walking
16 without the wheelchair or ambulating without the
17 wheelchair. That your preferences. And that, to
18 me, that's an ominous sign.

19 MR. RIDDLE: Your Honor, I would like
20 to address the will to live comments that he made.

21 THE COURT: Yes.

22 BY MR. RIDDLE:

23 Q. So we talked about how Ms. Parrott's
24 fractured hip, and loss of mobility. You just
25 described that she was primarily using a

1 wheelchair. And we talked about how she developed
2 decubitus ulcers and frequent urinary tract
3 infections. All those things stem from the hip
4 fracture and her loss of mobility; is that correct?

5 A. Correct.

6 Q. And is it common for you to see older
7 patients, in those conditions, experience what you
8 describe as a loss of a will to live and that's
9 what contribute to the decline in death?

10 A. Right. Depending on what kind of
11 study. Because every population is a little bit
12 different. But there's a substantial one-year
13 mortality from the hip fracture related to just
14 functional decline and will to live, so to speak,
15 that people don't ambulate as much as they could.
16 And then they stop eating.

17 Q. So in this case, with regard to
18 Ms. Parrott, what you describe as a loss of will of
19 will live, do you believe that that's related to
20 any type of trauma from being on the ground after
21 the fall?

22 MR. BOSWELL: Your Honor, I think this
23 was covered ad nauseam. And I didn't cross him
24 about that.

25 THE COURT: All right.

1 MR. RIDDLE: And I just want to clarify
2 with regard to th loss of will to live, Your Honor,
3 but I'll sit down.

4 THE COURT: I've got my head wrapped
5 around it.

6 MR. RIDDLE: Thank you, Your Honor.

7 THE COURT: You may be excused. Thank
8 your so very much. I hope you have a wonderful
9 day.

10 All right. Ladies and gentlemen, I
11 have hearings over lunch. So we have got to go and
12 break down. It's 12:07. Try to be back here at
13 1:30. There may be somebody in your seat. You can
14 leave your stuff there. So it there are, just
15 don't come in.

16 MR. DAVIS: We're defiantly going to
17 finish. I'm waiting with you. We have two more to
18 go.

19 MR. REEVES: We're going to be really
20 brief. We'll be ready to go.

21 THE COURT: See you at 1:30.

22 (A lunch recess was had.)

23 (Court resumed at 1:45 p.m.)

24 THE COURT: All right. You ready to
25 go?

1 MR. DAVIS: We are.

2 THE COURT: Do you swear of affirm that
3 the testimony you are about to give will be the
4 truth, the whole truth, and nothing but the truth.

5 DIRECT EXAMINATION

6 DR. MARK WAGNER,

7 BY MR. RIDDLE:

8 Q. Dr. Wagner?

9 A. Yes.

10 Q. Can you tell me your full name,
11 Dr. Wager?

12 A. My name is Dr. Wagner.

13 Q. Where do you live, Dr. Wager?

14 A. I live here in Charleston.

15 Q. Can you quickly give us a rundown of
16 your education, starting with college.

17 A. Sure. I went to college in Denver. I
18 got a Master's Degree in California, my Ph.D is in
19 clinical neuropsychology from the University of
20 Memphis.

21 I first joined the faculty at the
22 University of Rochester Medical Center in physical
23 medicine rehabilitation where I practiced for the
24 past 10 years. And the last 25 to 30 years I've
25 been here at Medical University of South Carolina

1 in the Department of Psychiatry, and then
2 neurology.

3 MR. DAVIS: I'll stipulate that he's a
4 qualified expert.

5 THE COURT: All right. You'll be an
6 expert without objection.

7 MR. RIDDLE: And we would like to
8 identify him as expert in neuropsychology.

9 MR. DAVIS: No objection.

10 THE COURT: Without objection.

11 BY MR. RIDDLE:

12 Q. Can you explain to the Court what
13 neuropsychology is.

14 A. Neuropsychology is -- perhaps the best
15 way to understand it is the psychologic
16 manifestations of neurologic disease. So, when I
17 say psychologic manifestations, I mean cognition,
18 memory, language, perceptual function,
19 psychologic functioning.

20 Q. Doctor, have you, in your capacity as a
21 neuropsychologic, reviewed the medical records that
22 we sent you in this case?

23 A. Yes, I have.

24 Q. Have you reviewed the depositions --
25 some if the depositions taken in this case?

1 A. Yes, I have.

2 Q. And have you developed opinions about
3 the circumstances of this case regarding
4 Ms. Parrott's fall at Sandpiper Village and her hip
5 fracture, and her subsequent time on the ground
6 after the fall?

7 A. Yes, I have.

8 Q. Dr. Wagner, in your opinion, did
9 Ms. Parrott sustain a trauma-induced cognitive
10 decline, as a result of any time at any time on the
11 ground?

12 A. Yes.

13 Q. And there's been some discussion of her
14 loss to will to live. Doctor, did she have a loss
15 of will to live that was directly caused by a
16 psychological decline that could be associated with
17 the time on the ground after the fall?

18 A. No. I believe her loss of will to live
19 occurred very late in the course of October, before
20 her untimely end.

21 Q. And, Doctor, do you hold these opinions
22 within a reasonable degree of medical certainty?

23 A. Yes, I do.

24 Q. I'm going to have some more detail
25 questions for your today. Can we assume that all

1 of your opinions stated here today are stated
2 within a reasonable degree of medical certainty?

3 A. Yes.

4 Q. What is the basis for your opinion that
5 she didn't have a psychological trauma, resulting
6 from the time on the ground after the fall?

7 A. She was evaluated by a psychiatrist a
8 couple weeks after that event. And there was no
9 diagnosis of a PTSD-related trauma.

10 Q. What would you have expected to see in
11 the medical records if Ms. Parrott did have a
12 psychological trauma related to the time on the
13 time ground?

14 A. Most likely psychologic trauma that she
15 would have had relating to laying on the ground
16 would have been posttraumatic stress disorder. I
17 use the term PTSD to refer to that.

18 Q. And what would we see in the medical
19 records, if Ms. Parrott had PTSD?

20 A. Individuals who have had PTSD have
21 terrible recurring nightmares, daymares,
22 flashbacks. There's a tremendous amount of
23 avoidance of any discussion related to traumatic
24 events. Those types of things that are
25 characteristic of PTSD.

1 These problems are so severe that
2 they're just symptoms, but they're symptoms that
3 result in interference with daily life. So in
4 order to reach the level of psychiatric diagnosis,
5 those symptoms have to interfere significantly with
6 daily life.

7 Q. Now, Ms. Parrott had talked to social
8 services workers presents at Sandpiper about how
9 bad the experience was when she was on the ground
10 after her fall. And have you reviewed those
11 records?

12 A. I have.

13 Q. How many references in those social
14 services records were there to this time on the
15 ground after the fall?

16 A. I think there was one, possibly two,
17 references.

18 Q. All right. Was there anything
19 reflected in the psychiatrist's notes about trauma
20 related to the time on the ground?

21 A. The psychiatrist that came in - I
22 actually know her, and value her opinion. She's a
23 geriatric psychiatrist. Those records did not
24 reflect in the PTSD related to time on the ground.

25 Q. And, again, Doctor, explain to us what

1 you would expect to see, for instance, in these
2 Sandpiper Rehab Records, for someone who had PTSD.
3 What would you expect to see in the medical record?
4 How would that look?

5 A. I used to work on a rehabilitation
6 floor in New York at the University of Rochester
7 Medical Center. Many of our patients that had
8 falls where they had a hip fracture or a stroke,
9 would struggle with phycologic issues.

10 Often times manifestation of serious
11 phycologic problems related to an accident, such as
12 a fall or a stroke result in not participating in
13 rehabilitation.

14 Patients often give up on. They refuse
15 to attend their therapies. When they attend their
16 therapies, they don't participate. The gains from
17 rehabilitation are really minimal. That would be
18 the kind of thing that I would expect to see, if
19 there was a psychiatric trauma.

20 Q. What about -- would there be repeated
21 references to the traumatic events within the
22 medical records?

23 A. Yes, of course. So this is something
24 that the nurses may witness. People waking up in
25 the middle of the night, screaming about, you know,

1 recurring dream of laying on the ground, comments
2 may appear throughout the daytime of the traumatic
3 event.

4 There may be avoidance. These would
5 all be symptoms that would be on the surface
6 observable to any and all that are that are
7 involved in someone's care.

8 Q. And is that what you have seen here,
9 Doctor?

10 A. That's my experience.

11 Q. Is that what you have seen in this
12 case?

13 A. No, I didn't see any reference to any
14 of that.

15 Q. Other than what we just talked about
16 with regard to the social services records?

17 A. That's correct. She seemed to be in
18 isolation.

19 Q. Did Ms. Parrott have any diagnosis -- I
20 believe you already said this she was not diagnosed
21 with PTSD; correct?

22 A. That is correct.

23 Q. Did she have any other diagnosis that
24 could be associated with the trauma from time of
25 her fall.

1 A. There was none.

2 Q. If she did have trauma from the time on
3 the ground after the fall, is there any way that
4 she wouldn't be -- wouldn't have been diagnosed
5 with?

6 A. I believe that if she had that, it
7 would have been found -- there are the people that
8 evaluated were experts in their field.

9 Q. Including the psychiatrist who saw her?

10 A. Yes.

11 Q. Doctor, was it your impression, from
12 reviewing the Sandpiper records -- and I'm talking
13 about the Sandpiper Rehab records during the
14 90 days after she was discharged from the
15 hospital -- was it your impression that Ms. Parrott
16 steadily improved during that time she was in
17 rehab?

18 A. Yes. I was impressed by the progress
19 that she had made when she entered the
20 rehabilitation program. She was wheelchair
21 dependent. She was described as moderate assist,
22 meaning moderate to help her stand to get around,
23 to take care of her basic ADLs.

24 She consistently progressed to the
25 point where she was independent ambulated where she

1 left the Sandpiper Rehab Facility.

2 Q. But Ms. Parrott was not able to return
3 to her previous level of function; right?

4 A. She made tremendous gains, but not back
5 to her normal baseline. The implication of that
6 was pretty significant. So, she was unable to
7 return to her previous level of care, which was her
8 target, her personal target.

9 Q. Do you believe that that loss of
10 immobility impacted her Mr. Parrott's psychological
11 condition?

12 A. Yes.

13 Q. In your experience, will a hip fracture
14 and resulting loss of mobility significantly impact
15 a patient's psychological condition?

16 A. Oh, absolutely. So in the elderly, hip
17 fracture and resulting changes are life breaking
18 events.

19 Q. Can you describe what you mean by that,
20 Doctor?

21 A. A life breaking event is a hip
22 fracture, where an individual is forever changed.
23 A life breaking event following a hip fracture
24 would result in individuals not being able to
25 return to their previous level of independent

1 living where they could have good quality of life.

2 Often times following a hip fracture
3 there's improvement. But in the elderly often not
4 back to normal baseline, such that they need
5 additional assistance in daily living in the form
6 of some sort of institutional care.

7 Q. And how does that impact a person
8 psychologically?

9 A. Terribly. So, it's a drastic change in
10 quality of life. So much so that hip fractures in
11 the elderly are a very feared event.

12 Q. Now, do you understand that Ms. Parrott
13 had a preexisting mental health and psychological
14 issues?

15 A. Yes.

16 Q. She had a history of psychosis and
17 delusional care psychosis?

18 A. Delusional disorder, yes.

19 Q. She also was depressed and had anxiety;
20 is that correct?

21 A. Yes. She had been treated for
22 depression for many years. Her symptoms I think
23 dated back to her '40s.

24 Q. Now, there's been evidence that she had
25 an intense period of this delusional disorder in

1 2009. And she received some medication and
2 treatment and that stabilized her. Are you
3 familiar with those records?

4 A. Yes. Those are the Baptist Psychiatric
5 records.

6 Q. And based on your review in the medical
7 records, does she continue to stay on medications
8 to address her mental health issues and
9 psychological issues from that time until the time
10 her of fall?

11 A. Yes. Those were chronic medicines that
12 she had been on for years.

13 Q. An she wasn't on this Seroquel, I think
14 is what was prescribed in 2009, if I'm not
15 mistaken; is that right?

16 A. That's correct.

17 Q. But she was on some other medications
18 that seemed to maintain her condition, at least to
19 where she wasn't having these intense delusions; is
20 that correct?

21 A. That's correct.

22 Q. A person in that condition, Doctor,
23 would a hip fracture and loss of mobility, having
24 greater psychological impact on this person for
25 someone who's in good health, who has a baseline of

1 normal mental?

2 However, you would phrase it, where she
3 wasn't suffering from depression and anxiety?

4 A. Yes, that's possible.

5 Q. It's possible that she would be
6 particularly vulnerable to the affects of the hip
7 fracture and loss of mobility?

8 A. Yes.

9 Q. And it's for all of the reasons that
10 you described with regard to the impact of loss of
11 mobility on an older person and how that impacts
12 them psychology?

13 A. Yes, it is.

14 Q. Now, there's been evidence that the hip
15 fracture itself, Doctor, was not the direct cause
16 of death for Ms. Parrott. Is that your
17 understanding, based on your review of the medical
18 records?

19 A. It was not the direct cause. But hip
20 fractures are known to increase the risk of
21 mortality and morbidity.

22 Q. Why is that?

23 A. Mostly it relates to mobility. So
24 individuals that have had hip fractures often spend
25 less time walking around. Walking is an important

1 component of blood circulation. And then there's
2 the issue of deconditioning.

3 So if you -- this happens to astronauts
4 demand on their physical system they become
5 deconditioned. These are both major problems in
6 the elderly that probably risk their increase of
7 death, or stroke, or things like that.

8 Q. And, of course, you've already talked
9 about the psychological impact of those conditions;
10 correct?

11 A. Yes.

12 Q. Particularly, for a person like
13 Ms. Parrott who already had fragile mental health?

14 A. Yes.

15 Q. Does pain medication impact someone's
16 psychological condition?

17 A. A little bit.

18 Q. Doctor, did Ms. Parrott have post-op
19 delirium after her surgery for the hip fracture?

20 A. Yes, she did.

21 Q. Can you describe what post-operative
22 delirium is.

23 A. Post-operative delirium is a form of
24 brain damage. It's a transient brain damage. It's
25 a waxing and waning in mental status. It's

1 something that sometimes treatable. It's a very
2 negative prognostic indicator for outcome.
3 Delirium is the leading cause of death in medical
4 hospitals.

5 Q. Did Ms. Parrott's delirium appear to
6 clear, after she was transferred to Sandpiper
7 Rehab?

8 A. Her delirium cleared, but she suffered
9 from damage to her brain that did not.

10 Q. I'm going to show you a medical record
11 here from Mount Pleasant Hospital, dated October
12 11th, 2014. And there's reference to a CT scan
13 here of Ms. Parrott's head that showed diffuse
14 chronic micrognathic changes, including several
15 previous lactentium infarction. Can you explain
16 what that is?

17 A. That's physical evidence of brain
18 damage. These are -- for lack of a better term are
19 ministrokes that have occurred. It's a lack of
20 blood supply to the tissue and it results in the
21 tissue death or permanent brain change.

22 Q. And is that associated with dementia
23 and loss of cognitive function?

24 A. Yes.

25 Q. And is that something that progresses

1 over time in a chronic fashion?

2 A. Yes.

3 Q. Have you reviewed the CT scan before in
4 this case?

5 A. I've not seen the actual images, but
6 I've read the reports. I've seen the actual
7 reports.

8 Q. And were you able to compare that to
9 prior studies that were done on Ms. Parrott?

10 A. Yes.

11 Q. Was there any difference between this
12 CT scan and the ones that were done earlier?

13 A. Yes. There were two scans. I believe
14 one was in 2009 the other one is this 2014 scan.
15 It looks to me, from the two reports, that there's
16 been a progression of the surgical vascular disease
17 or ministrokes that have occurred in the brain.

18 Q. When you say a progression --

19 A. Meaning there's more of it.

20 Q. And is the progression of the cerebral
21 vascular disease consistent with decreasing
22 cognitive function?

23 A. Yes. So damage to the brain results in
24 decreases cognitive function, probably losing ties
25 with reality.

1 Q. Does that have anything to do with
2 trauma, from lying on the ground after the fall?

3 A. No.

4 Q. Doctor, to the extent -- and I don't
5 think you would disagree, Doctor, that it was, to
6 say the least, unpleasant for -- it was unpleasant
7 for someone to be on the ground for a long period
8 of time after the fall?

9 A. Of course. It was a verbal experience.

10 Q. And to the extent that it was
11 unpleasant for Ms. Parrott, do you see that it
12 somehow was the cause of her psychological decline?

13 A. No.

14 Q. And we talked about the hip fracture
15 and the loss of mobility that impacted the
16 postoperative delirium and just the general
17 progression of her cerebral vascular disease;
18 right?

19 A. Right.

20 Q. Are those all things that are
21 contributing to her decline?

22 A. Yes. The time on the ground was a bad
23 event. But the hip fracture was many times worse.

24 So the hip fracture resulted -- like I
25 said before, the hip fracture is a life-breaking

1 event in the elderly. It forever changes the
2 nature of life. For many individuals there's a
3 high risk of mortalities.

4 For many people, a hip fracture results
5 in death. For this that survive, it's the rare
6 individual that gets back to their normal baseline.
7 And instead the individuals, especially the elderly
8 have long chronic problems in taking care of --
9 just the basic things, such as getting around,
10 walking, talking, caring for themselves. They're
11 in need of assistance.

12 And it often results in a high level of
13 dependent on others, sometimes to the extent to
14 having to live in an extended care facility.

15 Q. So you said, Doctor, that Ms. Parrot
16 did not have PTSD; is that right?

17 A. That's correct.

18 Q. And I'll represent to you that the
19 Plaintiff's expert has testified to the same thing,
20 she did not have diagnosable PTSD.

21 A. And I would add that Dr. Craig didn't
22 diagnosis PTSD either.

23 Q. And that was the physiatrist at
24 Sandpiper Rehab during the 90 days after she was
25 discharged from the hospital?

1 A. Yes. Yes.

2 Q. Is there any other condition -- I may
3 have asked this before, Doctor. But is there
4 anything else, short of PTSD, that she's been
5 diagnosed with that could be associated with this
6 time on the ground after the fall?

7 A. No.

8 Q. So in light of all the things that
9 we've just talked about, without question,
10 according to all of the medical evidence and all
11 the experts who testified in this case, contribute
12 to Ms. Parrott's decline and ultimate death, is it
13 possible for anyone to say that this period of time
14 on the ground after the fall was the direct cause
15 of her death?

16 A. Absolutely not. It was a bad
17 experience. But, like I said before, the hip
18 fracture is the straw that broke the back.

19 Q. Is that your opinion, within a
20 reasonable degree of medical certainty?

21 A. Yes, it is.

22 Q. Is there any doubt in your mind about
23 that?

24 A. No doubt whatsoever.

25 MR. RIDDLE: I don't have any other

1 questions. Answer any questions that the
2 Plaintiff's attorney might have for you.

3 CROSS-EXAMINATION

4 BY MR. REEVES:

5 Q. The last question that you were asked
6 is, can anybody have an opinion that these things
7 she went through contributed to her death or cause
8 or aggravate her death? And you said no one can
9 know that; is that correct?

10 A. Yes.

11 Q. Well, then how can the reverse be true?
12 How do you know what somebody else can't know?

13 A. I'm not sure I understand your
14 question.

15 Q. I'm not sure I understand your answer.
16 How can you say that nobody can know
17 and have an opinion that they can't know when you
18 say somebody can know?

19 A. Nobody can know?

20 Q. Yes.

21 A. What?

22 Q. That this long lie -- this traumatic
23 experience she had could not have contributed,
24 aggravated, or caused her death?

25 A. I don't think the long lie contributed

1 to her problems. It was a bad experience. The hip
2 fracture was much, much worse. That was a
3 life-breaking event.

4 She went through a period of recovery.
5 She had some expected frustrations with her
6 rehabilitation program. But she rallied to the
7 challenge. She got progressively better.

8 Her course over the period of time from
9 when she had the hip fracture until she was
10 discharged to the Ashley River Plantation was one
11 of dramatic improvement.

12 When she was admitted to the Ashley
13 River Plantation, the admission note referenced
14 that her self esteem was fine. She was doing okay
15 with concentration. She was not talking about
16 death. Hopelessness was not a problem. She didn't
17 express feelings that she wanted to die. There was
18 no particular somatic problems.

19 So by the time that she had gotten to
20 the Ashley River Plantation, she was doing well,
21 but not back to her baseline.

22 Q. First of all, I appreciate you going
23 through that very comprehensive list of your facts.

24 Do you have an answer to my question?

25 My question is this: Simple question,

1 yes or no, how can you say what somebody else can't
2 know? How can you have an opinion about somebody
3 else not having an opinion, about this issue? I
4 just don't understand that.

5 A. I don't know that that's a yes or no
6 question.

7 Q. Well, can you try to answer it yes or
8 no?

9 A. Can you rephrase it?

10 Q. Can you have an opinion about what you
11 claim someone else can't know?

12 A. Yes.

13 Q. All right. Very good. Doctor, you
14 just mentioned that the psychiatrist that you had
15 significant respect for had seen Ms. Parrott and
16 did not diagnose her with PTSD; is that correct?

17 A. That's correct.

18 Q. But you told me in your deposition that
19 one didn't need a diagnosis, one didn't need a
20 diagnosis of PTSD to suffer trauma; isn't that
21 true?

22 A. That's correct.

23 Q. And you didn't tell the Court when you
24 were giving your opinion just a moment ago. But it
25 doesn't matter if you've a diagnosis.

1 If the trauma occurs, then it can be
2 traumatic; correct?

3 A. Yes, that's correct. Trauma is a bad
4 memory. But in order for this to be significant
5 and rise to the level of psychiatric problems that
6 would have functional implications, that would
7 result in a psychiatric diagnosis.

8 There's no question that the event was
9 traumatic for Ms. Parrott.

10 Q. Well, you know, you told us the
11 psychiatrist that you have significance for her.
12 Her notes says that she has received Valium. I'm
13 assuming Valium is to calm anxiety?

14 A. Yes.

15 Q. This is in July, about a month after
16 she was removed from the hospital, where she was
17 taken after the long lie. It says that chart
18 reviews shows patient confused, stated people
19 coming from the woods and leaving things in my
20 room. She had received Valium. She seemed tearful
21 and expressed wishes that she would be better off
22 dead.

23 And a moment ago -- well, first of all,
24 is that the same record that you reviewed before
25 your testimony today?

1 A. I've looked at that records.

2 Q. And this is the record of the
3 psychiatrist with whom you have great respect for;
4 is that correct?

5 A. Yes.

6 Q. Then she says this, Ms. Parrott recalls
7 the fall, her fear and banging on the floor at the
8 wall for two days.

9 Now, you said a moment ago she didn't
10 have flashbacks. What is that?

11 A. That's a desperation trying to alert
12 others to her situation. She wanted to be saved.
13 She wanted to live. She was banging on the floor
14 in hopes that somebody would discover her.

15 Q. In that effort of situation she's
16 recalling that particular circumstance on July 7th,
17 a month later.

18 Would you classify or would you agree
19 with me that that's a flashback?

20 A. No. I would disagree in the sense that
21 you're using that in the psychiatric sense. I
22 think you're using that in -- that's a bad memory.

23 So flashback, bad memory -- of course,
24 she remembered the event. And it was a bad memory.

25 Q. And the bad memory would come up again;

1 wouldn't it?

2 A. I'm sorry?

3 Q. The bad memory would come up again and
4 again; wouldn't it?

5 A. If she had PTSD, yes, that would be a
6 recurring problem.

7 Q. Are you telling me that because she
8 didn't have PTSD she would not recall banging on
9 the floor and waiting for someone to come save her?

10 A. No. I'm sure she would remember that
11 for the rest of her life.

12 Q. And you described in your deposition
13 that scenario -- I think you used the very phrase
14 of intrusive memory; is that right?

15 A. That's how it's phrased in the DSM
16 psychiatric manual, yes.

17 Q. Well, I wouldn't know all that, but you
18 would I'm sure.

19 Well, let me ask you this: Intrusive
20 means that it kind of comes and goes without
21 warning; doesn't it?

22 A. Yes.

23 Q. So you would agree with me that from
24 the time that she was rescued on the floor until
25 the time that she passed away, she had intrusive

1 memories of this horrific event in June of 2014;
2 correct?

3 A. I don't know the frequency of which she
4 experienced those intrusive memories.

5 Q. Can we agree that she did?

6 A. No. The intrusive memories were very
7 infrequent. She did remember the event, but it was
8 not haunting her in the sense of constantly
9 recurring.

10 Q. If she told her daughter that, I just
11 don't want to live anymore, would you relate that
12 juw5 to the hip or the long lie?

13 A. I would relate that to the hip.

14 Q. And, in fact, the long lie issue, in
15 your opinion, cleared up as soon as EMS picked her
16 up and took her to the hospital? That was the end
17 of impact or effect of the long lie; is that
18 correct?

19 A. No. It was a memory that persisted,
20 because of that memory that she had.

21 Q. We did agree, in your deposition, that
22 the long lie, however long it was caused Ms.
23 Parrott hopelessness?

24 A. Yes.

25 Q. Caused her helplessness?

1 A. Yes.

2 Q. She thought about that?

3 A. Yes.

4 Q. She thought about maybe nobody is
5 coming to get her?

6 A. Yes.

7 Q. You also told me that she thought
8 someone should have to get her at a certain time,
9 that the failure of that occurrence would have
10 aggravated or increased her frustration about being
11 helpless and hopeless; correct?

12 A. I would agree.

13 Q. And that while you didn't agree that
14 she had been on the floor for 72 hours, you do
15 agree that she was on the floor for some period of
16 time; is that correct?

17 A. Yes.

18 Q. And, in fact, your whole deposition was
19 premised on your belief that she had fallen on
20 June 7th; isn't that correct?

21 A. There was a confusing history of how
22 long she was on the ground. Some people had said
23 24 hours, others had said 72, but...

24 Q. Well, you have the wrong history,
25 though, based on your deposition testimony because

1 you told me you fell on July 2nd. That not
2 correct; is it?

3 A. She fell on July 6th -- or June 6th,
4 excuse me.

5 Q. And at the time you had not reviewed
6 the depositions where there had been testimony
7 about when she had fallen and how she was found; is
8 that correct?

9 A. No.

10 Q. You mentioned a moment ago that this
11 event of her lying in her waste, and no food and
12 water, the physical pain, the emotional pain, had
13 no impact upon her death about eight months later?

14 A. Had no impact on her what?

15 Q. On her death? It did not cause her
16 death?

17 A. No, it did not.

18 Q. I asked you about The New England
19 Medical Journal arguments that have been
20 circulating here. Mr. Mills talked about it. I
21 think Dr. Bergmann talked.

22 And I think I asked you about it. You
23 said before your deposition when you rendered all
24 you opinions, that you had not reviewed any
25 articles about long lie; is that correct?

1. A. That's correct, right.

2 Q. The New England Journal article does
3 say that people on the floor for 70 hours have a 67
4 percent mortality; is that correct?

5 A. That's correct. For that sample that
6 they studied.

7 Q. Right.

8 A. That sample consisted of people that
9 had fallen, that had strokes, that had tried to
10 commit suicide, and had alcohol-related problems.

11 Q. Right. But the longer the lie, the
12 less likely you are to survive it or at least
13 survive it without traumatic results?

14 A. And the lie time, in that particular
15 article, was estimated by the EMS staff.

16 Q. I understand that. I'm just simply
17 asking you the longer you're on the floor, the
18 worst your results are; isn't that correct?

19 A. That's correct.

20 Q. Now, when I asked you about her
21 recovery, you indicated that she had a very good
22 recovery. And then I asked you about whether that
23 recovery would have impacted about the long lie.
24 And your response was, what doesn't kill you makes
25 you stronger; is that right?

1 A. That was tongue to cheek, yes.

2 Q. Tongue and cheek?

3 A. It's not a medical diagnosis that I was
4 giving. We were talking about hypothetical
5 situations there.

6 Q. We were talking about an 80-year-old
7 woman who was left on the floor from Tuesday night
8 to Friday night without one single person cared
9 her, and you the audacity to tell me that that's
10 tongue and cheek, sir? Isn't that true?

11 A. We were debating about hypotheticals
12 that --

13 Q. That's what you said?

14 A. Yes.

15 MR. DAVIS: Judge, it's argumentative.
16 He's been interrupting. And he needs to give the
17 witness an opportunity to answer the questions.

18 THE COURT: On cross-examination,
19 Doctor. He'll ask you a question. And you have to
20 say yes no and, fully explain. Okay.

21 THE WITNESS: Okay.

22 BY MR. DAVIS:

23 Q. Were you being tongue and cheek in your
24 deposition, when I asked you the question as to
25 whether or not it caused Ms. Parrott to feel bad

1 when she peed on herself? And you said, no, it,
2 probably made her feel better. Was that tongue and
3 cheek?

4 A. No, it was not.

5 MR. REEVES: I no further questions.

6 RE-DIRECT EXAMINATION

7 BY MR. RIDDLE:

8 Q. Doctor, you weren't talking about
9 Ms. Parrott in response to Mr. Reeves'
10 hypotheticals about when you said what doesn't kill
11 you makes you stronger; did you?

12 A. We were not.

13 Q. And in this case Ms. Parrott did
14 demonstrate a good recovery at Sandpiper Rehab
15 after she was discharged from the hospital and she
16 plateaued and then declined; is that correct?

17 MR. REEVES: Object. That's improper
18 recross.

19 THE COURT: Stick to it, please.

20 BY MR. RIDDLE:

21 Q. Now, Ms. Reeves -- well, he didn't show
22 it to you, but he asked you about what he referred
23 to as the psychiatrist notes.

24 And I believe, if I'm not mistaken,
25 that he was actually referring to comments from the

1 social service assistant from Sandpiper Rehab?

2 A. We didn't look at the actual record.

3 MR. REEVES: I have the -- that's the
4 incorrect record. It's the one that he relied on
5 on direct.

6 BY MR. RIDDLE:

7 Q. So these comments were to the social
8 services person at Sandpiper Rehab?

9 A. Yes.

10 Q. And I'll show you the -- and the social
11 services system is not a person who is a qualified
12 diagnosis psychological condition; is that right?

13 A. That's correct.

14 Q. And there are two references here on --
15 on these social services records on 6/2014?

16 MR. REEVES: Objection, improper
17 recross.

18 THE COURT: What are you getting at?

19 MR. RIDDLE: I'm getting at the fact
20 that asked Dr. Wagner about the times that she had
21 recurring memories on the time on the ground.

22 BY MR. RIDDLE:

23 Q. And my question for Dr. Wager is, that
24 there are two references here. Are there any other
25 references in the entire medical record, besides

1 those two and what is repeated here in the
2 psychiatrist report that was taken from the
3 comments of the social services?

4 THE COURT: You can answer the
5 question.

6 THE WITNESS: Those are the only
7 references.

8 BY MR. REEVES:

9 Q. And if there are any others, would you
10 like to see them, Doctor?

11 A. Yes.

12 Q. And would you render opinions on them,
13 if there are other references to recurring dreams
14 and thoughts, at the time of the fall?

15 A. Yes.

16 Q. And I believe you testified on direct
17 that if someone had PTSD there would recurring
18 thoughts, and dreams, and nightmares, and daymares
19 about this incident, over the course of time
20 repeatedly again and again for months; correct?

21 A. Absolutely.

22 Q. Is that what we see here, Doctor?

23 A. It is not.

24 Q. Is that why you think she did not have
25 a trauma-induced cognitive decline from the time on

1 the ground?

2 A. That's correct.

3 Q. And, in fact, when Ms. Parrott
4 described these things to the psychiatrist, as Paul
5 mentioned, the psychiatrist did not diagnosis her
6 with PTSD?

7 A. She did not.

8 Q. What were the diagnosis from the
9 psychiatrist?

10 A. Preexisting delusional disorder,
11 delirium resulting.

12 Q. Did the psychiatrist identify signs and
13 symptoms that were consistent with dementia?

14 A. There was a test that was administered.
15 It's called the Blessed Test. And the findings
16 from that test were consistent with mild dementia.

17 Q. And is that consistent with what we
18 were just looking with regard to the CT scan to the
19 head that showed that vascular changes?

20 A. That would be entirely consistent with
21 that.

22 Q. And it that related at all to the time
23 of the ground to the fall?

24 A. Absolutely no relationship.

25 Q. Mr. Reeves asked you about the New

1 England Journal Medicine article. Was that article
2 about --

3 Well, first of all, did that article
4 change your opinion at all with regard to this
5 case?

6 A. It does not. I don't think it really
7 relates to this case.

8 Q. Why doesn't it relate to this case?

9 A. That was a random sample of individuals
10 that had fallen on the floor. The cause of the
11 fall was -- there were multiple kinds of cases.
12 There were a handful of cases that were hip
13 fractures, like the one that they we're talking
14 about here.

15 But there were other cases that were
16 aid's related falls. There were of alcohol-related
17 falls. There were cases of just frail elderly
18 falling without any kind of fracture, not being
19 able to get up. In fact I think, that was a good
20 percentage of the cases.

21 So the findings on that particular
22 study are not specifically relevant for this
23 particular case.

24 Q. Mr. Reeves also ask you some questions
25 about the period of time on the ground. And he

1 referenced your comment about June 7th being the
2 date of the fall.

3 Doctor, in your opinion, is there any
4 difference between the psychological -- actually,
5 let me rephrase my question.

6 Does it impact your opinion at all
7 whether or not Ms. Parrott was on the ground
8 24 hours versus 48 hours or more?

9 A. From a psychologic prospective, no.

10 Q. Is your opinion based on the diagnoses
11 and description of Ms. Parrott's symptoms that are
12 contained in the medical records?

13 A. Yes.

14 Q. Is there anything else that is
15 motivating anything your opinion, with regard to
16 the fact that Ms. Parrott's -- that psychological
17 trauma did not impact her decline and death?

18 A. No. I'm basing my opinion on all of
19 the medical record facts that I had before me.

20 MR. RIDDLE: Thank you, Doctor.

21 MR. REEVES: No, sir. Thank you very
22 much. You may be excused. I hope you have a
23 wonderful day. And thank you for being here.

24 MR. COURT: All right. Call your next
25 witness.

1 MR. DAVIS: The defense would call
2 Dr. Brian Lancense.

3 THE COURT: Put your hand of the bible.
4 Do you swear or affirm that testimony
5 you are about to give will be the truth, the whole
6 truth, and nothing but the truth?

7 THE WITNESS: Yes, sir.

8 DR. BRIAN LANCENSE,
9 DIRECT EXAMINATION

10 BY MR. DAVIS:

11 Q. May I call you Brian?

12 A. Yes.

13 Q. Brian, congratulations, you're the last
14 witness. If I'm not quick I have a big feeling I
15 may be in trouble with the judge.

16 So, do me a favor, tell the Judge a
17 little bit about your education and background, and
18 kind of what you do.

19 A. Graduated premed, went on to get two
20 MBAA; one in health administration, one in national
21 business. So I worked in pharmaceutical industry
22 as a research biologist and also as a research
23 chemist.

24 What got into long-term care through
25 hospitals, I worked with a company where the

1 hospitals asked us to manage their centers. Been
2 in the industry for a long time. I've left several
3 times. I have left to start an impairment
4 administrative program for Northwestern. And then
5 left, again, to work in a hospital setting. I
6 managed ambulances, helicopters, health flight,
7 that type of stuff social work discharge.

8 THE COURT: All right.

9 BY MR. DAVIS:

10 Q. Do you hold any license or skills?

11 A. I do I have a license as a skilled
12 nursing administrator in Virginia.

13 MR. DAVIS: All right. Your Honor, at
14 this time, we would offer him an expert in the
15 expert senior living, and skilled as it applies to
16 nursing administrator.

17 MR. REEVES: No objection, Your Honor.

18 THE COURT: Without objection.

19 BY MR. DAVIS:

20 Q. Now, Brian, you have reviewed a lot of
21 things in this case; correct?

22 A. Yes, sir.

23 Q. You read all the depositions, to your
24 knowledge, and after you the documents. And after
25 reviewed all that, have you reached an opinion to a

1 reasonable degree of certainty within your of
2 field, as to whether or not Sandpiper's employees
3 in the case met the proper standard -- industry
4 standards and how they responded to the facts of
5 this case?

6 A. Yes. It does it seem -- from reading
7 all that information that within each circumstance
8 they responded reasonably.

9 Q. Can you hold that opinion to a
10 reasonable degree of certainty?

11 A. Yes, sir.

12 Q. Now, the Judge has heard a lot about
13 independent living. Would you give me him a
14 thirty-second explanation of why independent living
15 is different from the heavily regulated areas of
16 skilled assisted and those kinds of things?

17 A. Sure. The major difference between
18 independent living, assisted live, and skilled
19 nursing, which would typically be CCRC campus is
20 independent living is going by landlord/tenant law.

21 It has no care component. Assisted
22 living has a care component also that is regulated
23 by the State. Skilled nursing has a much larger
24 care component regulated by state and federal.

25 From what I was understand, I was not

1 able to find any documentation that Sandpiper
2 Center, the Independent Living was part of a CCRC
3 in the State of South Carolina.

4 Q. Meaning it doesn't have regulations?

5 A. No.

6 Q. All right. So you had an
7 opportunity -- I'm not going to pull the lease out,
8 but you've had the opportunity to review the lease;
9 is that correct?

10 A. Yes.

11 Q. And from an industry's perspective, an
12 independent living -- independent senior facility,
13 is that generally the source, duties, and
14 responsibilities between the parties?

15 A. Yes.

16 Q. And do you recall seeing in this
17 section seeing in this section, a specific
18 section -- and I'm going to try to pull it up here
19 momentarily -- that deals with -- I think it's
20 called assumption --

21 A. Assumption of risk.

22 MR. REEVES: Judge, I'm going to object
23 to him making comments on the wall. That's your
24 job.

25 MR. DAVIS: Judge, he's an expert in

1 the area and he can explain why that might appear
2 from a contract from an industry prospective.

3 THE COURT: What's the last thing you
4 said?

5 MR. DAVIS: He's going to explain to
6 you why it appears a contract in an industry
7 prospective and to why that term of provision is in
8 there. Not legally, but why they have it in the
9 industry.

10 BY MR. DAVIS:

11 Q. So do you recall in that particular
12 paragraph -- and this is on Sandpiper 5, Page 5.
13 So I really just want to direct your attention to
14 the -- read the first sentence to the Judge for us,
15 please.

16 A. Both Sandpiper and --

17 COURT REPORTER: I'm sorry can you
18 speak up and speak a little slower when you are
19 reading.

20 THE WITNESS: Both Sandpiper and you
21 agree that your freedom to make personal health and
22 non-health-related decisions, the freedom to
23 travel, to come and go as you please, the decisions
24 that affect and control your day-to-day activities
25 should all remain within your sole decision, so

1 long as as it does not adversely affect other
2 occupants.

3 Q. And read the second sentence, please.

4 A. As such, both Sandpiper and you
5 understand and realize that such decision-making
6 ability carries an inherent possibility of
7 adversity that may directly or indirectly affect
8 you as an occupant.

9 Q. And the last sentence.

10 A. Therefore, you and your representative,
11 if appropriate, agree to assume such risk and
12 related consequences, and as it relates to
13 Sandpiper and its agents --

14 Q. Okay. That's fine.

15 Why would there be in a lease -- why
16 would there be a discussion about freedom and if
17 there's a risk that come associated with -- in
18 senior with that freedom that you have, and if
19 something happens you're responsible? Why is that
20 in there?

21 A. In independent living, you're bound by
22 the landlord/tenant laws. And so the person living
23 in that apartment or complex has the ability to
24 make their own decisions that is typically involved
25 in this, unless it's delineated in the lease.

1 Q. Now, you mentioned the standard of
2 care. Is there any medical standard of care in
3 this context of independent living?

4 A. Not independent living.

5 Q. Is there any regulatory standard of
6 care in this context?

7 A. Not in independent living.

8 MR. DAVIS: Can you pull up Sandpiper
9 123.

10 BY MR. DAVIS:

11 Q. So the Judge has seen this. This is
12 the daily check sheet, receptionist's duties and
13 procedures, referencing the daily check sheet. You
14 saw this?

15 A. Yes, sir.

16 Q. Now, with respect to this document --
17 and in particular what it says there, would that
18 constitute -- again, from an industry prospective a
19 fall policy?

20 A. No, it wouldn't necessarily be a
21 policy. It may be a procedure that they adopted.

22 Q. And if it's a procedure that they
23 adopted, would you expect them to perform it
24 reasonably?

25 A. Yes, sir.

1 Q. Now, I'm going to ask you some specific
2 questions about this. Do you see anything in here
3 about the family being required to be called if
4 they can't get in?

5 A. No, sir.

6 Q. Do you see anything in here about call
7 911 if you can't get in?

8 A. No, sir.

9 Q. Does it say anything about what
10 happened if the master key doesn't work, if the
11 locks have been changed?

12 A. No, sir.

13 Q. So, what if anything, does that leave
14 to the staff in terms of decision making and
15 discretion and things like that?

16 A. It allows them the ability to have some
17 discretion in decision making when it comes to
18 implementing this procedure.

19 Q. And you understand, I guess, that this
20 was created by a receptionist to help folks do
21 their job; right?

22 A. Yes, I do.

23 Q. And with respect to a practice, is
24 there anything unusual about the way this is
25 written? Would you expect anything more or less?

1 A. No, not really. I think this is pretty
2 standard again independent living, that they do
3 daily check sheets.

4 Q. Now, from your prospective, one of the
5 arguments in this case is that this created a duty
6 to check daily the wellbeing and ultimate safety of
7 every resident every day.

8 From your prospective, as an expert in
9 the industry, is that what the daily check system
10 was ever designed for?

11 A. So in each community it may be a little
12 bit different. But in general an independent
13 living daily check sheets are in place for the
14 staff to -- a lot of times monitor activities.
15 It's not typically set in place as a safety
16 mechanism.

17 Q. And from your experience, working in
18 the industry, what is the -- really the safety
19 system that facilities rely on to respond to
20 residents who may have issues?

21 A. Most have something very similar to
22 what Sandpiper had, which was a safety pendent or
23 some sort of a call bracelet that if somebody needs
24 immediate interaction or immediate assistance they
25 can push that pendent.

1 Q. And why from -- as an expert in the
2 industry, why is that a system for responding to
3 emergencies or residents who have fallen and hit
4 themselves?

5 A. The daily check sheet would be very
6 inadequate as a safety measure.

7 Q. Why is that?

8 A. It would be an extended period of time
9 before somebody would be checked. Again, the
10 safety monitor or the pennant, a lot of times are
11 monitored by security professional.

12 In this case, it was monitored by the
13 staff. And they had pretty specific things that
14 they needed to do once that was alerted.

15 Q. Assuming that there was some obligation
16 to be daily safety, would a combination of those
17 things be a reasonable thing to put in place?

18 A. Oh, definitely.

19 Q. All right. Now, I'm going to skip and
20 move ahead. I'm going to just right to Wednesday.
21 The Judge is very familiar to what transpired on
22 Wednesday. So I'm going to ask you focus really
23 one thing.

24 We know -- at least so far that Rebecca
25 Munoz goes to the door, she tries the key, and

1 can't get in. And she phones her mother, right,
2 and talks to her. Is not told that there's a
3 spare --

4 MR. REEVES: Judge, he's leading this
5 witness. And I would just ask him to stop, please.

6 THE COURT: Just ask him what he knows.

7 MR. DAVIS: I'm laying a foundation.

8 THE COURT: I understand.

9 BY MR. DAVIS:

10 Q. So with respect to what she knew at the
11 time, would one reasonable option in this case,
12 with your opinion as an expert, be to go check the
13 box for the extra key?

14 A. Yes, it would. So she -- it would be a
15 reasonable expectation to do that.

16 Q. And based on your understanding of the
17 facts, would she have been able to do that if she
18 had that key?

19 MR. REEVES: Objection, Your Honor.
20 How is he supposed to know that?

21 MR. DAVIS: Because he's an expert and
22 he's reviewed all the depositions.

23 MR. REEVES: That is an improper
24 opinion --

25 MR. DAVIS: And also --

1 THE COURT: Hold on. Hold on. Ask the
2 question again.

3 BY MR. DAVIS: Based on his review of
4 the evidence and testimony in this case, I'm asking
5 him --

6 THE COURT: You asked him whether
7 her -- I think you said her actions. And then you
8 something like whether it was appropriate. And he
9 objected, saying she wouldn't what her actions
10 were.

11 MR. DAVIS: So in response to the
12 objection as an expert he's read all the testimony
13 and considered that in rendering his opinion.

14 MR. REEVES: Judge, to save some time,
15 he can answer.

16 THE COURT: Just give me your opinion
17 on. If you feel as though this course of action
18 that she took, based on the information that she
19 had, that she didn't realize that the locks had
20 been changed, do you think it was appropriate that
21 she went, tried, she thought she had the master
22 key, she didn't. She didn't try again. She called
23 her mom and left.

24 THE WITNESS: I think that when she
25 went to open that door, she fully expected to able

1 to get in, using a master key.

2 When that key she not available, she
3 went back and she called her mother, who happened
4 to be a long-time employee, who knew the situation,
5 and did this training for the receptionist.

6 When she was told that there was no
7 master key, I think that -- well, in my opinion,
8 she felt like she had passed it off to the right
9 person, who was going to check the next day. And
10 she made a very reasonable assumption to that.

11 BY MR. DAVIS:

12 Q. And do you hold that opinion to a
13 reasonable degree of certainty in your field of
14 expertise?

15 A. Yes.

16 Q. Now, let's talk a little bit about
17 Thursday. Now, do you have an opinion to
18 reasonable degree of medical certainty within your
19 field of expertise as to whether or not the staff
20 that the response on Thursday was appropriate,
21 given your understanding of the facts in this case,
22 as from your review of the depositions?

23 A. Absolutely. The information that had
24 been shared the night before, the next day when her
25 mother came in to do her duties, she saw Ms.

1 Parrott. She marked the sheet that she had been
2 seen, and everybody went about their business.

3 Q. And from your review of the records,
4 how do you know that, in fact, Ms. Auld, checked
5 the sheet? Do you recall?

6 A. Actually, I think it was pretty
7 apparent from the investigation that was done
8 during -- it was all done in the same day. When
9 Ms. Corrine came in, she checked the sheet.

10 It's pretty apparent that she looked at
11 the sheet. She noticed that Wednesday was not
12 checked. She noticed Thursday was checked. She
13 then verified with Ms. Auld that she had actually
14 seen Ms. Parrott.

15 She verified that verbally with her.
16 So I feel certain it had been done correctly.

17 Q. And based on your review of the
18 evidence, have you reached an opinion to a
19 reasonable degree of certainty, in your field of
20 expertise, as to whether or not if, in fact, she
21 saw Ms. Parrott, as you believe that was in
22 compliance with the check system as it's been
23 articulated here?

24 A. Yes. Yes, sir.

25 Q. I'm going to ask you the same question

1 to Friday. From your review of the evidence and
2 testimony in this case, did you reach an opinion to
3 a reasonable degree of certainty, in your field of
4 expertise, as to whether or not the staff compiled
5 with their duties on Friday?

6 A. Yes. When she went to open the door --
7 at some point she had been informed about the
8 separate key to open the door for Ms. Parrott.

9 Q. And there's been some testimony from
10 Lila Watters that there was no response on Thursday
11 and Friday. Have you seen that testimony, in your
12 review of materials?

13 A. Yes. In my review she seemed like she
14 was --

15 MR. REEVES: Objection, Your Honor. He
16 can talk about what she said.

17 THE COURT: All right. Do you want to
18 rephrase the question?

19 THE DAVIS: Yes, sir.

20 BY MR. DAVIS:

21 Q. From what you reviewed in the
22 deposition testimony, what was your impression of
23 the testimony that you reviewed?

24 A. She appeared to be a poor historian.

25 Q. And with respect to your opinions in

1 this case, do you believe that the staff applied on
2 Friday, why do you think --

3 Or have you reached an opinion as to
4 whether or not the staff failed to respond to
5 Ms. Watters' reply to Ms. Parrott no being at Bingo
6 that evening?

7 A. Reading through everything, it didn't
8 appear that Ms. Watters had spoken to the staff
9 about that.

10 Q. Do you recall whether Corrine
11 Carrington said she spoke to Ms. Watters or she
12 came up to her?

13 A. I didn't see that.

14 Q. And with respect to Ms. Rebecca Munoz,
15 did you see any evidence that she said, yes,
16 Ms. Watters came up to me and I didn't respond?

17 MR. REEVES: Objection, Your Honor.

18 THE COURT: On what basis?

19 MR. REEVES: He's using this witness to
20 testify about other witnesses, what they did or did
21 not do. He's bolters witnesses. And that
22 improper.

23 MR. DAVIS: He's been classified as an
24 expert.

25 THE COURT: All right. I'll allow it.

1 BY MR. DAVIS:

2 Q. Now, I want to -- we covered all
3 three days quickly. Now, I want to ask you a
4 question in terms of --

5 You know what, I actually think I do.
6 I appreciate your time. I'm going to get you out
7 of here.

8 Have all of the opinions you've
9 rendered today within a reasonable degree of
10 certainty?

11 A. Yes.

12 MR. REEVES: The Plaintiff has no
13 questions of these witness.

14 THE COURT: What's your full name.

15 THE WITNESS: Brian Joseph Lancenese,
16 L-A-C-E-N-E-S-E.

17 THE COURT: I've asked this question of
18 several witnesses. I would be interested to get
19 your take on it. This facility had a policy in
20 which they call it a practice that they implemented
21 whereby, obviously, there are certain steps that
22 are taken to ensure that each resident is seen each
23 day. I agree that there is a difference of opinion
24 as to why that was done. Some people indicate to
25 keep up with their -- what they do, their routines.

1 How many people are going to be at bingo.

2 But the fact remains is that there are
3 steps that are taken. All right. Why or what is
4 the policy or what is the practice if, in fact,
5 someone has not checked off during the day?
6 Because the point is to check off 50 off in a day.
7 If you don't check off one in a day and you come
8 back into work the next day, what is the practice
9 to what ensure that what happened to that person,
10 why was it not checked off. Do you have any
11 opinion as to that?

12 THE WITNESS: I do, actually. In my
13 experience, in independent living, because of the
14 independence and the ability to do what they want
15 to do and go where they want to go, there are often
16 times when somebody was not necessarily seen that
17 day, but the staff should pass that information
18 along, to the next group coming on saying, hey, I
19 didn't see -- in this case -- Ms. Parrott today,
20 you want to make sure to look for her tomorrow.

21 THE COURT: Okay. That's the common
22 practice?

23 THE WITNESS: Yes.

24 THE COURT: Anything as to that?

25 MR. DAVIS: No, sir.

1 THE COURT: You are free to go. Thank
2 you so very much for being here.

3 All right. Real briefly, how long do
4 you think you need for closing, Mr. Reeves.

5 MR. REEVES: 12 to 15 minutes.

6 MR. DAVIS: 15 minutes on this side.

7 THE COURT: Let's take five minutes to
8 get composed and we'll come back.

9 MR. REEVES: I will withdrawal the
10 medical bills in the exhibit book --

11 MR. DAVIS: I just want to make sure --

12 MR. REEVES: -- and the records that we
13 talked about today should go in the notebook.

14 THE COURT: We just need to go through
15 the formal process.

16 COURT REPORTER: I marked them already.

17 THE COURT: You get two bites at the
18 apple. You want both bites?

19 MR. REEVES: Yes, sir.

20 (A brief recess was taken.)

21 CLOSING ARGUMENT

22 MR. REEVES: Your Honor, if it please
23 the Court.

24 THE COURT: Yes, sir.

25 MR. REEVES: Ms. Parrott was promised

1 that she would be checked on everyday. She was
2 not. As a result of that, she laid on the floor,
3 with a broken -- fractured hip, in conditions that
4 we can talked about all day long.

5 It's hard for me to understand how
6 horrific it must have been in the condition that
7 she was in. On top of which she was in consistent
8 and constant pain from the fracture.

9 And going through this left her marked,
10 undermine, and it took her life years earlier than
11 her expectancy was to be.

12 Your Honor, my opposing counsel are
13 good lawyers, but the defense in this case is that
14 they had no duty to come to her aid. And we've
15 spent three days talking about something -- in
16 fact, the last witness here is called a procedure.
17 I don't know what the difference is.

18 I do know this, there were definitive
19 steps. There was a goal. And I never heard the
20 word privacy exception until opposing counsel
21 brought that up.

22 Your Honor, we have spent years
23 litigating this issue. And on Friday they came up
24 with this thing, which says check-off policy. And
25 I heard what you said about records, but I find it

1 coincidentally. That every record that could hurt
2 Ms. Parrott was readily available. And the only
3 record that could have hurt them is not.

4 It seems to be the point has gotten
5 away from the Defense, because they now say, that
6 well, if we don't have a policy and the staff comes
7 in and testifies that they did. Well, plan B is,
8 well, you know we saw her on Thursday so it doesn't
9 matter anyway.

10 And I want to ask the Court to consider
11 the evidence, that a vibrant and self-sufficient
12 woman, very smart, very reasonable, described by
13 everyone, was perfectly capable of remembering of
14 what day she fell.

15 The only people that were, quote, in
16 controversy about the day of the fall, was medical
17 staff. And, quite frankly, I'm surprised that they
18 don't have any number of days on there.

19 If you're going to find for the
20 Defendants then you are going to have to accept the
21 following coincidences. First of all, that
22 Ms. Parrott didn't know when she fell. And,
23 coincidentally, it just so happens that the exact day
24 she fell, she magically stopped answering her
25 phone. And if you look back over those records

1 before, Your Honor, there's not a single 24-hour
2 period in those previous two months where she
3 didn't use a cell phone or a landline.

4 Coincidentally, at that same time, her
5 best friend is looking for her, because she hadn't
6 seen her on Thursday. And she can't find her. And
7 it's not noteworthy, Your Honor, there's not a
8 single bit of testimony from anybody in this trial
9 that Ms. Watters was known to make up stories and
10 cry wolf and fabricate. The best they could do is
11 say, she was confused.

12 Coincidentally, when Ms. Parrott alleged
13 that she was on the floor, everyone agrees that she
14 was missing on Wednesday. Coincidentally, on
15 Thursday Beth Auld says, if I marked her down, she
16 was there. I saw her. But, coincidentally, it can't
17 just happen. Coincidentally, Lila Watters called for
18 her on Thursday afternoon. No answer.

19 Coincidentally, the Defendant's next
20 position is that it's Ms. Parrott's fault. To have
21 said that with a straight face is bothersome. To
22 even say it period is bothersome.

23 Because all Ms. Parrott did was rely on
24 what she believed to be the policy. That was
25 straightforward. Everybody in this room knew it.

1 Everybody in this room admitted that it was there.

2 And Ms. Parrott expected somebody to
3 find her. And that time came and went.

4 Your Honor, Dr. Mills did as good a job
5 as any physician in explaining what to some degree
6 is common sense. But, more importantly, what is
7 extremely well-founded, using labs. And in a twist
8 of irony that can only come about in a trail,
9 Dr. Davidson said today when asked about how your
10 BUN goes up and down. He said they generally go up
11 and down in the same manner.

12 And this is critical, Your Honor. He
13 said in response to John's question about, well, if
14 I eat today and I don't eat tomorrow and my BUN
15 is 8 today and I've done the normal eating and
16 drinking. And I go then for 24 or the next day, is
17 what he said, what would you expect my BUN to be,
18 he said about 16.

19 Your Honor, if you look at all of the
20 numbers on the labs that all of us have introduced
21 and talked about, on June 6th, when she's admitted
22 to the hospital is void. Her normal is about 8 to
23 10.

24 And, Judge, if you could just use some
25 simple math, to get to 40 it took about three days.

1 And if you look at those labs, she came
2 back to normal in about three days. And as
3 Dr. Davidson said, the labs don't lie.

4 Your Honor, the Defendants spent a lot
5 of time about asking our experts about percentages
6 of and this and 24 hours, and 12 hours, and
7 46 hours. And every conceivable manner in which
8 they could bring these numbers up.

9 But, again, everybody agrees, including
10 Dr. Wagner. It was traumatic for her, while she
11 was on the floor. And I wish I better words to say
12 that, because trauma seems a little bit
13 insufficient on what she went through.

14 She went from being a reasonably
15 healthy 80-year-old woman, who did a lot of things,
16 to declining. And it is the Defendant's position
17 today and throughout this trial, has not even
18 entered the hemisphere of responsibility.

19 It is, we didn't have a policy. It is,
20 quote, if we had one, it really wasn't a policy.
21 And if we had one, it had a privacy exception.

22 And if all that fails, then she didn't
23 fall on Tuesday. And if all else fails, it was a,
24 quote, bad dream.

25 Judge, Dr. Mills who knew Ms. Parrott,

1 known her for years, was as well prepared to answer
2 the questions for this Court. And while the
3 Defendants dispute this issue about causation, both
4 he and Dr. Bergmann said more likely than not that
5 this long lie, that this being in the condition
6 that she was in, caused her conscious pain and
7 suffering. It caused her to be vulnerable. It
8 caused her to think about dying alone. It caused
9 her make decisions during those three days that no
10 human being should have to make.

11 And, judge, if it is true, what the
12 Defendant's expert say, that somehow when she got
13 off the floor and it all became a memory, we
14 wouldn't have war veterans with problems. Once the
15 thing is done, you should be better.

16 And, Judge, you do have to rely on the
17 medical and professional experts in those opinions,
18 but it doesn't also just make common sense, to lie
19 there like she did, it impacted her.

20 And, Judge, before I came, I looked at
21 the charge, had this been a jury trial, on what
22 juries can consider as far as damages when
23 someone's been injured. And, Judge, I think
24 there's about 21 different things, including pain
25 and suffering, anxiety, fear, frustration, loss of

1 quality of life, loss of enjoyment of life, loss of
2 fellowship. The list just goes on.

3 And, Judge, I don't know of any of
4 those that have been excluded these that dispar
5 against the other. And both sides have taken
6 medical records out of a record that is extremely
7 wrong. And we both tried to put forth our best
8 position about the fact that she suffered after it.

9 But you know who knows best about
10 Ms. Parrott is her daughter. And I don't think
11 anybody can claim that Joan Acosta got up here and
12 exaggerated.

13 It is also noteworthy what Ms. Watters
14 said that after she saw Ms. Parrott, she just gave
15 up. And those people know her. Dr. Mills said, I
16 saw her decline. I would offer that the decline
17 that led up to her death eight months later was
18 caused -- aggravated or contributed to the long
19 lie. And I point out that there's sufficient
20 evidence more likely than not that is a given.

21 Judge, when she was finally rescued, I
22 wish it were true that she could have forgotten.
23 That it was just something that happened. But she
24 had an anticipation and expectation that Sandpiper
25 will be a place where she could grow older. She

1 could remain relevant and safe.

2 Your Honor, I want to address one thing
3 about the issue with the panic button. I believe
4 the issue of comparative negligence comes off the
5 table, that Ms. Parrott's claim of damages starts
6 at the moment that Rebecca Munoz inserted the key.

7 Because, at that point, Your Honor, it
8 didn't matter what the panic button did or did not
9 do. Because if you follow the logic of the
10 Defense, had Rebecca Munoz or anybody else had
11 gotten the panic alert, the response would have
12 been she changed her locks, don't worry about it.

13 It's also important to note not
14 everybody there wore those, nobody everybody pushed
15 them.

16 However, again, Your Honor, if we grant
17 to Sandpiper, which I don't know that we should, it
18 seems to me the facts support -- if Rebecca Munoz
19 wasn't going to check on her until Wednesday
20 afternoon, let that start with where the damages
21 are. And, at that point, Your Honor, there's no
22 excuse for not going in.

23 You've heard enough -- there's dead
24 fish all over this courtroom regarding how many
25 times we've talked about keys and policy.

1 In fact, the last witness whose name I
2 cannot pronounce, Brian said that it was reasonable
3 for Ms. Munoz to do what she did with the key.
4 Apparently, somebody told her the key was there.
5 That's just simply not true. She said or agreed in
6 her deposition testimony is correct, I just
7 happened to go look for the key again.

8 Your Honor, I think the evidence
9 supports the fact that this Defendant has
10 vigorously contested every evidence in this case.
11 And I don't know that you would call what we did or
12 we didn't do during this litigation is trying to
13 teach somebody a lesson. But I can tell you this,
14 here we are this far down the road and they're
15 still denying the policy that's obvious.

16 And there's splitting hairs ten ways to
17 Sunday about what that means. And they're coming
18 up with exceptions that don't exist. And I want
19 you to know, Judge, that unless you take a stand
20 for community where we all live and work, that I
21 don't believe this Defendant is ever going to get.

22 Because after three days of trial, they
23 still don't get it. And you have the opportunity
24 to stand up and say, you know what, if you don't
25 want to take responsibility for this case, I

1 understand that. If you don't want to admit that
2 you did something wrong, I understand that. If you
3 are going to hide behind something that's obvious,
4 I understand that.

5 But there is a day of reckoning. And
6 it needs to be today. Your Honor, the damages in
7 this case are extensive and beyond anything that I
8 have ever had any experience about.

9 And, Judge, I know that it's very
10 difficult to put numbers on anything like this. In
11 fact, some people would say, you couldn't pay me
12 enough to do this. But this Court only has one
13 remedy and that is to award damages. And I'm going
14 to humbly ask you that based on the facts of this
15 case, a motion that you award to Ms. Parrott's
16 Estate of \$500,000. And I'm going to respectfully
17 humbly ask you to award for her wrongful death
18 \$500,000. And I'm going to ask you to place
19 punitive damages on this case, as you see fit.

20 Because somebody needs to send a
21 message, that you can't ask lie to somebody. You
22 can say to Ms Parrott, here's what you have to go
23 through; you're going to fall and you're doing
24 something really stupid and we're not really care
25 about it, and we are going to leave you for there

1 days, and you're going to have to get in touch with
2 your mortality, you're going to have to get in
3 touch with your vulnerability, and you're going to
4 have lose all bodily function and control. And
5 you're going then have to be sick, in your mind,
6 for the rest of your born days. And you're going
7 to lose about eight years off your life. And, by
8 the way, Ms. Parrott, how much would that be worth
9 to you? I think she would tell us what she said, I
10 think I just want to die.

11 We have met the burden. Any smaller
12 verdict will send the wrong message. I ask this
13 Court to find for the Plaintiff. And, Your Honor,
14 I also at this time withdraw the Plaintiff's cause
15 of action in the Unlawful Fair Practice.

16 I'm going to leave it in your capable
17 hands for the wrong death. I'm going to ask you to
18 find for the Plaintiff and award the damages.

19 THE COURT: All right.

20 CLOSING ARGUMENT

21 MR. DAVIS: May it please the Court.

22 THE COURT: Yes, sir.

23 MR. DAVIS: I want to express my
24 appreciation to both the Court, court
25 administration, Aimee. I just appreciate the

1 opportunity to be in here again. It's been a long
2 time. I also want to compliment opposing counsel.
3 I think they've done an admirable job trying the
4 case. I think they've been professional and
5 respectful. And it's just been a pleasure working
6 with everyone over the week, Your Honor.

7 You know, Judge, it's interesting when
8 I started this case I told you I thought they had
9 the burden to prove to you some things. The burden
10 of proof is a funny thing. This is an important
11 case. There's no doubt it's an important case to
12 Ms. Acosta. I know that. And I know how hard this
13 is for her. And I don't enjoy being here, being in
14 front of her, and talking about wrongful death, and
15 things like that.

16 But, you know, Your Honor it's equally
17 important to Beth Auld and Eric Hadley who have
18 been accused of wrongful death. Okay. And so this
19 is a big issue for both sides, who have spent a lot
20 of time and energy in their positions.

21 And, you know, Counsel said that we
22 were hiding. We're not hiding from anywhere.
23 We're here to answer for the charges, which have
24 been rendered against us, Your Honor. And whether
25 or not -- you know, it's interesting, there's been

1 a giant disconnect between both sides in this case
2 about whether this damn thing was a policy or a
3 practice. That's an industry term.

4 Lawyers can screw stuff up. And we
5 screwed that up. Because you heard from Mr. Hadley
6 that policy to them is a whole other thing. The
7 question is, was the practice going, which it was.
8 We didn't hide from that. We didn't say it wasn't.
9 That's exactly what we said. We do dispute about
10 what that practice was designed for.

11 The practice was part of a bigger
12 system. And, no, we don't think that we had an
13 obligation to keep people safe, daily under all
14 circumstances. But we do agree that we took steps
15 to ensure, the best that we could, that residents
16 were seen. And that if there was an emergency, we
17 had a system in place to respond.

18 And here's something to me really
19 interesting about the panic button. At the end of
20 the day, Your Honor, you heard one witness tell you
21 what the industry standards are. You have no other
22 evidence to consider. But you have one expert who
23 told you that the exact system that we have is the
24 proper system. He also told you the check system
25 is not designed for the safety goals, the wellbeing

1 goals that you have. That's what the industry
2 standard is.

3 So when you start thinking about it,
4 you say, okay, what evidence that I'm going to
5 point to? It isn't that. You don't have one set
6 of expert testimony. Respectfully, we believe that
7 should control, at least, what that was in place
8 for, and how it's supposed to work.

9 Now, I did tell you, Your Honor -- I
10 hope I've got it right -- I felt for them to come
11 into here and get an award to you, the first thing
12 they're going to have to prove to you is that
13 Ms. Parrott fell on Tuesday. And they have to
14 prove that to you.

15 And really the only evidence that they
16 have -- and really they're stuck with Tuesday is
17 because that's the statement Ms. Parrott made.

18 And it was interesting. I just heard
19 Mr. Reeves just say, well, there's been no
20 inconsistency about her own testimony about what
21 she said and what she believed.

22 I think want to draw the Court's
23 attention to really some key elements. So the
24 patient states that she's been on the floor since
25 Tuesday, but neighbors said they saw her walking

1 about yesterday.

2 Now, Judge, from the very first moment
3 that the EMS people arrived, there's inconsistency
4 right there. And not only that, they go and ask
5 the neighbors, and the neighbors stated that they
6 saw her the next day. I'm not picking on
7 Ms. Parrott.

8 But what I am saying is you have --
9 according to the Plaintiffs, you have an elderly
10 lady who's been through a traumatic experience that
11 so bad that it's caused her to have undiagnosed
12 PTSD. And the inconsistencies starts here. And it
13 actually continues.

14 Matt, will you pull up the 66 nurse's
15 note for me, please.

16 So within hours of this happening --
17 and let's assume that she's now recovered some from
18 her EMS, when she has her faculties back.

19 When you look at the nurse's notes in
20 the emergency room, the first entry from a nurse,
21 who has zero interest in this dispute, presenting
22 complaint per patient. Per patient, is what she
23 told me. Patient was found on the floor by a
24 neighbor who checked, unknown how long she was on
25 the floor.

1 Go down to the next this document.

2 The very same day I fell on Tuesday.

3 Inconsistencies right out of the box. EMS saying
4 she was seen. That is -- to say that she knew
5 exactly when she fell in the face of inconsistencies
6 and records taken right in those days, I think
7 that's a huge hurdle on the Tuesday question.

8 Now, Your Honor, you've seen in the
9 medical records two days repeated, sometimes three
10 times, but mostly you see fell two days ago. Well,
11 Your Honor, does two days mean I'm on the ground
12 all day Thursday, I'm on the ground all day Friday.
13 Is that two days? From my perspective, it could
14 be.

15 Is it Wednesday, Thursday, Friday?
16 That ain't two days. So if you assume, all right,
17 Thursday is a separate, Wednesday is a separate
18 day. Guess what, the farthest you get back in
19 these medical records is Wednesday. You never get
20 to Tuesday. And the reason you don't get to
21 Tuesday, Your Honor, is because we don't believe
22 the evidence has shown that she fell Tuesday.

23 Certainly -- I mean, they bare the
24 burden of proving that to you, that it was Tuesday.
25 Because if it ain't Tuesday, and they can't prove

1 it to you, you find that it's equal, you can't find
2 against us.

3 Now, Your Honor, this is June 12th,
4 five days, she comes back to us, and she tells
5 Corrine Carrington she tells me she was on the
6 Wednesday. That's within five days.

7 So now, within five days, you've heard
8 Tuesday, you've heard Wednesday, you've heard, I
9 don't know how long. And I am no way being
10 critical of Mrs. Parrott. But what I am being
11 critical of is the credibility of this evidence.

12 And for you to render a verdict for a
13 million dollars, which he's just asked for, in the
14 face of this evidence, that's a huge hurtle,
15 respectfully, to me, Your Honor.

16 Now, I want to touch a little bit on
17 Wednesday. Because really, Your Honor, the whole
18 point of this, the whole point of the expert, the
19 whole point of our defense is that we had an
20 employee who was faced with two options -- what we
21 believe to be reasonable options.

22 But one of them is theirs. One of them
23 is theirs, go look for the key. I get it. But one
24 of them is also ours, which is in this
25 circumstance, on these facts -- and Beth Auld, in

1 particular, having been the single -- you heard
2 her. Goodness gracious, not a nicer, more honest
3 person in the world on the stand. She has been for
4 25 years taking care of these folks. And she says,
5 I think it's reasonable, let's just check on her in
6 the morning.

7 We believe, Your Honor, that this
8 option is reasonable. I'm not saying their option
9 isn't reasonable. But what I am saying is
10 negligence is picking an option that nobody would
11 pick.

12 Now, in this case, Your Honor, we
13 believe you could pick either option and meet the
14 standard. There's also something that I think
15 permeates this case. It permeates the passion of
16 the case. It permeates everything that they have
17 put together for you. And it's hindsight.

18 And if I take the fact away from you
19 that she might be injured on the ground, with a
20 broken hip, in an awful condition, and you were to
21 think to yourself, okay, knock, knock, knock. I
22 want to go in. She's not there. Hey, we can't get
23 in, let's just check her in the morning.

24 There's no evidence of an emergency.
25 There's no evidence that the panic alarm went off.

1 She's not hollering. She's not screaming. And if
2 you take that back off the table and somebody says,
3 you know what, let's check on her in the morning.
4 I've been here 25 years. Everybody says, let's do
5 that.

6 In this case, it would have worked
7 fine. But if you think about that choice, is it
8 really right to say, that's a choice that nobody
9 would make. And that's what they're arguing to
10 you.

11 You may remember that I asked a
12 question of Ms. Acosta on the stand about -- this
13 is directly related to Wednesday. Well, do you
14 remember your mother telling me about the
15 housekeeper, who checked on her Friday.
16 Ms. Watters, who we know looked on her. And she
17 said, I heard her and it was awful.

18 You know what struck me about that, is
19 that if she could hear both of those people on
20 Friday, why couldn't she hear on Wednesday? We
21 heard this idea that she was hard of hearing. But
22 if she could hear that on Friday, why can't she
23 hear it on Wednesday, if she's in that condition.
24 It doesn't make any sense.

25 We also heard that she had a shoe and

1 she was able to bang. So she could hear two people
2 knock. And she is not able to hear Rebecca when
3 she goes there. I think, Your Honor, that's a very
4 difficult hurdle evidentiary-wise to get over.

5 Now, I'm going to give you a hindsight
6 fact, is that Thursday she's checked off and seen.
7 So if you consider that to be a fact in the case
8 because it's on a document. And because Beth Auld
9 believes it to be the case, isn't it more likely
10 that was either asleep.

11 We believe, collectively, the evidence
12 is much more supportive than that, in that context,
13 Your Honor.

14 Now will you put up Sandpiper 36,
15 please.

16 This to me, Your Honor -- I heard
17 counsel stand up and say that every record that
18 favors them is available, and everything that hurts
19 them isn't available.

20 You know what, Your Honor, respectfully
21 this piece of evidence is the evidence they cannot
22 get around. And for two reasons -- for three
23 reasons, it's incredibly reliable. One, the date.
24 Two, Ms. Carrington, who has zero reason to make
25 anything up. And, three, it has both good

1 information and bad information.

2 Wednesday, no check. Thursday, she's
3 checked off. And that's not all it tells you.
4 And, Judge, this is before any lawsuit. This is
5 before the emotion of this case has comes to life.
6 This is done with nobody looking at you saying,
7 you're in trouble. This is actually the person
8 who's supposed to be looking in her mind to see if
9 there's anybody that should be in trouble.

10 So she's collecting the information.
11 What does this show you? She was checked off.
12 That was not enough for Corrine Carrington. What
13 she did is she called Beth and said that she was
14 adamant that she would not sign off anyone unless
15 she had seen them.

16 You combine that with the lady who you
17 heard here, and you determine that that can't
18 possibility be true and you ignore all of that,
19 that is the Court's prerogative.

20 Respectfully, I believe that evidence,
21 they can't get around. They've tried desperately
22 to get around it. Do you remember the grey-hair
23 questions. There's a lot of people with grey hair,
24 you must have confused people. Well, Beth Auld
25 worked there for 25 years. Corrine Carrington told

1 you -- again she was their star witness. She's the
2 one that establishes the policy. Corrine
3 Carrington say, I wanted to double check.

4 I went to her, I looked at her, and she
5 saw me right in the eye. I saw her. I saw her at
6 lunch. And she said, good morning, Beth.

7 And, you know, the funny is if that
8 statement had come out of Beth Auld's mouth --
9 maybe if there would have been some reason for her
10 to make it up, because she might in trouble in this
11 case.

12 But Corrine Carrington, no motivation
13 than the truth. She's the one that said it. She's
14 the one who backed up Beth. Beth, to her credit,
15 said, we've talked about it so much, I don't
16 remember whether I saw her or whether it's this
17 case.

18 But that series of events, Judge, to me
19 on Thursday stops the case. Because all the
20 questions, all the questions of Tuesday and
21 Wednesday, did she hear her, did she not, they end
22 right there. Because she is seen. And nobody
23 contends that if she was seen Thursday we did
24 anything wrong, under the check-in system.

25 You know, it's interesting -- you know

1 my position on the phone records, so I'm not going
2 to address it. Because I heard counsel say that
3 she never went any period of time within 24 hours
4 without making a call. So I have tried to make my
5 way through those records. And I've identified
6 three different time periods, one 57 hours, where
7 she went without making or answering a call one,
8 another one she went 49 hours without making or
9 answering a call. And I agree that information is
10 probative, assuming we know what it means. And
11 respectfully I don't believe we have enough
12 information.

13 I'm challenged. I'm going to give you
14 an example of where it happened, where she went 59
15 hours without picking up the phone. So you might
16 say to yourself, what's the response to that
17 objection. I actually think that's very
18 speculative.

19 You heard Dr. Davidson today tell you
20 that in his opinion there's no way that she was
21 in that condition for 72 hours. You know what's
22 consistent with that? Thursday's check-off sheet
23 with Beth Auld. He said, yeah, it's obvious that's
24 been in there 24 hours. You know that's consistent
25 with she fell Thursday night and Ms. Watters

1 ultimately went and found her with Rebecca on
2 Friday.

3 I mean, to me, Your Honor, this case
4 fails at Thursday. I have to disregard a mountain
5 of evidence on that.

6 Now, I want to talk a little bit about
7 Ms. Watters and her testimony.

8 Do we have the ability to play some of
9 her tape?

10 MR. RIDDLE: I can try.

11 MR. DAVIS: So here's what I understand
12 they're trying to do with Ms. Watters. And maybe
13 I'm wrong. I think it's two things. I think one
14 is Ms. Watters, well, was asking for help on
15 Thursday, asking for help on Friday. And then
16 Beth, and this crowd, they just ignored her.
17 That's one thing. But that is evidence that nobody
18 saw her Thursday and Friday.

19 Now, Your Honor, I hope that this case,
20 and a million dollar request for damages, doesn't
21 turn on the testimony of Ms. Watters, who is age 82
22 and obviously very confused.

23 Can you play some of her testimony.

24 (Partial playback of Ms. Watters
25 deposition testimony was played.)

1 MR. DAVIS: Think about that, Your
2 Honor. She lives one minute away. They called her
3 every single day. And what she remembers is
4 Rebecca said, I don't have her name and number.

5 She has -- to rely on this testimony on
6 this case from Thursday and Friday ignoring us, I
7 just don't think it's reasonable. But looking at
8 this, that is testimony that is not reliable, from
9 my prospective.

10 (Partial playback of Ms. Watters
11 deposition testimony was played back.)

12 MR. DAVIS: On Thursday she asked the
13 manager and she asked Rebecca to go. Thursday is
14 all about Beth Aud. You heard Corrine -- I asked
15 her, did y'all go. No, she never came to me.

16 She's completely confused. It's not
17 reliable testimony, Your Honor. And just even
18 assuming it was true, wouldn't it be easier for her
19 to just go down and walk one minute and check.
20 Wouldn't Rebecca have done that? Let's assume that
21 she has Beth confused. Beth can walk one minute
22 check on her. This testimony is not, respectfully
23 is not reliable. And it's a huge part of their
24 case.

25 (Partial playback of Ms. Watters'

1 deposition testimony was played.)

2 MR. DAVIS: We did the same routine
3 Friday, Rebecca and I. Rebecca didn't work
4 Thursday. Bless her heart, she's confused, Your
5 Honor.

6 Next one.

7 (Partial playback of Ms. Watters'
8 deposition testimony was played back.)

9 MR. DAVIS: Probably she would have.
10 You know, the point of that testimony, Your Honor,
11 is she said Corrine didn't go on Friday. I asked
12 Corrine to go and she said, it's okay, she's with
13 her family, don't worry about it. That didn't
14 happen. Corrine said it didn't happen.

15 She's obviously confused and the fact
16 that this case is built on her testimony to me,
17 Your Honor, is a very, very weak link, and,
18 respectfully, don't believe that her testimony
19 about the events of Thursday or Friday should be
20 considered in the context of your final decision,
21 Your Honor.

22 Your Honor, so counsel wanted to
23 mention comparative narratives. Your Honor, I want
24 to be clear about one thing, is that Mrs. Parrott
25 was free to live and as she wanted to live. She

1 was free to live independently. She was free to
2 make the decisions that she wanted to make.

3 You know what, she made a series of
4 decisions in this case which, in hindsight were
5 mistakes. And they're not mistakes that have
6 anything do with us. Because she lived
7 independently. She was free to do. But it
8 directly impacted her being on the ground for as
9 long as it was.

10 The first one is quite obvious, is the
11 panic button. And I didn't understand a word
12 what -- at least the argument -- I just didn't
13 understand the argument that somewhat the panic
14 button wouldn't matter from the moment that they
15 put the key in." It the exact opposite of that. If
16 you put a key in and she hears somebody trying to
17 get a key in, trying to jiggle the door, knocking
18 on the door, you hit the button.

19 And that's what the industry expert
20 told you. That's what Mr. Hadley told you. And,
21 Your Honor, isn't it common sense to sit here in
22 this courtroom and tell you that the panic button
23 is irrelevant, respectfully, I don't believe that's
24 a reasonable position to take.

25 Had she had worn the button that day --

1 if she didn't get on the chair -- I saw Ms. Acosta
2 getting up -- I got nervous nerves when I saw her
3 getting on this chair.

4 But the panic button or even call us.
5 You know, one of the things that I want to point
6 out to you is the lease -- I don't care what the
7 lease says, if an 80-year-old lady had called Beth
8 Auld and said I need some help with my curtains,
9 they would have helped her.

10 So if this Court is inclined to award a
11 million dollars, a million dollars, based on
12 Ms. Watter's testimony and ignoring the testimony,
13 that Beth Auld saw her, and ignoring all of this,
14 and you come to that conclusion, then you're
15 absolutely right.

16 But if you come to that conclusion, is
17 it not also fair to really ask the question of how
18 much did those decisions really directly cause the
19 time period on the ground. Is it 50 percent,
20 51 percent. I don't know.

21 But I know this, there were important
22 decisions and they directly contributed to how much
23 time it took to locate her. And I can't -- I'm
24 trying to remember a case where I have to bring
25 this up in the context of a liability, but there's

1 no choice. There's just no choice.

2 So, Your Honor -- I can't help myself.
3 I'm going to too dang long. But when you get to
4 the question about wrongful death, I respectfully
5 am going to ask you to look at the testimony from
6 these experts. Because it does not meet the
7 standard.

8 The law is very clear. You must
9 testify that it most probably caused the death in
10 this case. And the reason every one of those
11 witnesses struggled is because nobody can say the
12 difference between 24 hours, 36 hours, or 72 hours
13 caused this death eight months ago, eight months
14 later. It just can't.

15 So that's why you heard the convoluted
16 questions and answers. And I heard counsel argue
17 that he didn't really understand why were asking
18 percentage questions. I'll answer that directly.
19 Because the law requires me to ask it. And had
20 they said the answer, more probably than not, I
21 wouldn't even be talking about it. But they did
22 not.

23 We could spend hours listening to
24 testimony. So I have a whole bunch of arguments on
25 that. I am not going to ask the Court to consider

1 something that was testified to by Mr. Wagner.
2 This was life-threatening event, and it was related
3 to the hip.

4 And you heard two doctors tell you
5 there's a one-year mortality related who had fallen
6 and broke their hips. It's like 70 percent. But
7 it's real. And Your Honor knows that. When
8 elderly fall and break their hip it is a very
9 natural chain of events. One-year mortality. She
10 passed away eight months later. It's consistent
11 with what makes the most sense. But what it is not
12 consistent with, respectfully, Your Honor, is this
13 argument about how many hours she was on the
14 ground. It's okay to be on the ground for 24 to
15 36, but if you're on the ground 36 to 72, it must
16 have killed to you. And, respectfully, that's just
17 not a medical reason position to take. And that's
18 why the doctors struggled with it so hard. And why
19 our expert had no trouble saying no, to a
20 reasonable degree of medical certainty, it does
21 not.

22 And we gave you an explanation. It was
23 a life-breaking event. That's related to the hip,
24 Your Honor.

25 So Mr. Reeves is an excellent lawyer.

1 But make no mistake, he's asked you to punish
2 Sandpiper, which is a facility of people and
3 employees who take care of elderly people in this
4 community.

5 And you met Beth Auld, one of the
6 people who's dedicated 25 years to taking care of
7 elderly people. If you come to the conclusion that
8 she made a mistake, I understand it. I get it,
9 Your Honor.

10 But for Mr. Reeves and Mr. Boswell to
11 come in here and tell you that you should punish
12 these people for intentional reckless disregard,
13 respectfully, Your Honor, that is not Beth Auld and
14 it ain't Eric Hadley.

15 I don't think by any stretch of the
16 imagination what the law required and what the law
17 demands for punitive damages was met in this case.

18 I told you 20 minutes and it's probably
19 too dang long. And I appreciate the opportunity to
20 be in front of you. It's my first time. It was a
21 pleasure. And I appreciate everybody's work. And
22 I just thank you for your time.

23 THE COURT: All right. Thank you so
24 very much.

25 MR. DAVIS: I would ask that you bring

1 a verdict back to us.

2 THE COURT: Understood.

3 All right, Mr. Reeves.

4 FURTHER CLOSING ARGUMENT

5 MR. REEVES: I'd like to address the
6 argument that only the Defendant has provided
7 testimony about the industry standard. The case
8 law in this State regarding the applicability of
9 policies and procedures, as it relates to
10 establishing a duty, does not require an industry
11 standard. It says that a company can develop a
12 policy or procedure. And if does so, that it must
13 carry out that policy and procedure in a reasonable
14 manner. Industry standard is irrelevant.

15 Number two, I find it helpful that
16 opposing counsel brought up the decision by
17 Ms. Parrott, and because of that decision she ended
18 up in bad shape.

19 There was some other decisions made,
20 too, Your Honor. Rebecca Munoz said I made a
21 decision to not go in. I made the decision to not
22 get the key that was there. A lot of lawyers made
23 a decision to ask about Ms. Parrott (sic). And
24 those little things they played certainly show an
25 older woman who three years later is doing the best

1 that she can, to consider the facts.

2 But there's two things that she never
3 wavered on. I didn't see her Wednesday, Thursday,
4 or Friday. The other thing that she didn't waver
5 on, Your Honor, is they gave me the key to go find
6 her. And if we are to put as much credibility on
7 Ms. Carrington's report then we should, as
8 Mr. Davis we should, and that report says that
9 Ms. Watters was given a key and she found
10 Ms. Parrott.

11 Opposing counsel made a comment about
12 the neighbors saying that she had been seen. Well,
13 apparently the Defendants have forgotten the
14 testimony from Ms. Munoz, who said the only two
15 people in the room were Ms. Watters, myself, and
16 Ms. Parrott.

17 I know where the information came from
18 that she was seen on Thursday. That's Rebecca
19 Munoz.

20 And, Your Honor, I would also remind
21 this Court that we are basing factual scenarios in
22 this case on Ms. Watters, just like we are
23 Dr. Bergmann, just like we are Joan Acosta, the
24 Defendant's experts. Because there is one thing in
25 this case, and that is she suffered.

1 And, Your Honor, I would close by
2 saying that I don't know what Ms. Watters has to
3 gain about making this stuff up. I don't know what
4 Dr. Mills has to gain about testifying they way he
5 did. I don't know what Dr. Bergmann has to gain
6 about testifying the way he did. Well, Joan Acosta
7 does have something gain.

8 But every witness who provided an
9 opinion said that to a reasonable degree of
10 professional certainty, these are my opinions. I
11 just wish at some point the Defendants would have
12 said, we really did have a policy.

13 Thank you, Your Honor.

14 THE COURT: All right. Thank y'all so
15 very much. Just for the record, I don't know if
16 you caught it earlier, but Mr. Davis said at the
17 appropriate time, I want to renew my motions. I
18 thought he did. But just for the record, make sure
19 we get that done.

20 MR. DAVIS: I appreciate that. I don't
21 think I did. I made myself a note. I want to, at
22 this time, renew the motions that I made that I
23 believe these claims failed to meet the law under
24 the UTA. I renew all of the motions and grounds of
25 motions that I made prior with regard to wrongful

1 death and punitive damages.

2 THE COURT: And my previous ruling
3 stands. However, I did take the Unfair Trade
4 Practices under advisement. So, for the record,
5 that has been withdrawn and therefore it's moot.

6 From the Plaintiff, anything further.

7 MR. REEVES: No, sir.

8 THE COURT: All right. So, I know this
9 has been a long time coming for everybody. And,
10 obviously, I want to have a little bit of time to
11 deliberate. And I know that everybody wants to
12 have some type of verdict today.

13 But I'm going to give it -- give me
14 some time. I want to read some stuff. If I feel
15 like it's going on, I may come back and ask you
16 what your opinion, obviously, is about hanging in
17 here a little bit longer. If not, then I'll come
18 back and give you my ruling. We'll be in recess.

19 (Court was in recess at 3:58 p.m.,
20 resuming at 4:50 p.m.)

21 THE COURT: Thank you very much.
22 Please be seated. All right.

23 So, first off, it was a unique
24 experience for me to enjoy the lawyers. That's, by
25 the way, not a common thing. So I really

1 appreciate y'all working together. I can't tell
2 y'all how often it is that I have to make a
3 decision on everything.

4 And, you know, for y'all have to agreed
5 on most everything 99 percent of the time -- I was
6 just telling Aimee, you're going to see a lot of
7 bad lawyers and you'll see a lot of bad trials and
8 you're going to see a lot of good ones.

9 Unfortunately, your first one was a
10 good one. Because sometimes in a bad cases you
11 know they don't agree on anything. And they object
12 to everything.

13 And I just want to thank y'all so for
14 very much for doing because it made my life so much
15 more enjoyable, and Aimee got to see good lawyers
16 really do a good job, which obviously makes this so
17 difficult.

18 Ms. Acosta, I would be remiss if I
19 didn't say I know this still weighs heavy on you,
20 so I'm sorry for that. I know it's tough on you.
21 I've watched you throughout the trial. And I know
22 that this had made you very upset. So I commend
23 you for hanging in here. I do this everyday. We
24 see this stuff everyday. So I commend you for
25 staying in here and participating as well as you

1 did.

2 As most of you know, this is a bench
3 trial. And so things are different. My role in a
4 non-jury trial is different in the sense that I get
5 to determine the credibility of the witnesses. I
6 get to take direct evidence and give it the weight
7 that I want give.

8 I believed some of the witnesses in
9 this cases. Sometimes I don't believe any of this
10 testimony in this case. And that's my right to do
11 that. I've given certain weight to certain amounts
12 of evidence in this case. And I have given very
13 little weight to certain amounts of evidence in
14 this case. And I have given very little weight to
15 some people's credibility. So that's the other
16 thing that I get to take into consideration is with
17 witness' credibility and the way that they present
18 themselves on the stand or on the videos.

19 So I want to start by certain findings
20 of fact. Number one, I found for the Plaintiff.
21 So the concern or the finding of facts as to policy
22 and procedure, I don't care what they call it. If
23 Sandpiper wants to call it a policy, they can call
24 it a policy. If they want it a procedure, it's a
25 procedure.

1 But two things happened. So, it was
2 relied upon by Ms. Acosta. I assume -- Ms. Parrott
3 she was very intelligent. She was also a nurse.
4 But she also understood that she wanted some
5 substance of independence, which everyone has
6 discussed. But I think she also wanted some sense
7 of solace for her daughter, to say I'll be okay. I
8 can live independently. They have these policies
9 set. They have these procedures set. And so I
10 think she did that for her daughters as well. And
11 I think it was the right thing to do. And I would
12 want the same.

13 The fact that -- because of that
14 policy, I asked over and over and over -- and I
15 asked it as quickly on maybe the second witness.
16 What's the point of having a policy if you're not
17 going to follow it. Why is every single resident
18 not checked off everyday. That's the point. What
19 if somebody had fallen the night day and you didn't
20 find them that day. And then the next day you go
21 back.

22 The whole point of the policy is that
23 if you're going to have it, you better follow it.
24 And I find that Sandpiper didn't do that.

25 Unfortunately, I don't blame the fact

1 that there was a separate key and that she went
2 back -- and did not go back that night. Obviously,
3 if she had done that we wouldn't be here. But she
4 didn't. And I find that to be negligent.

5 And in doing so, you have to determine
6 whether there was a duty owed to Ms. Parrott, based
7 on that policy that they had. And I find that
8 there was. I find that they had a policy, that was
9 a written policy. It was a known policy. It was
10 part of their selling to the residents, a selling
11 point, I guess, to the residents. And they should
12 adhere to the policy. And they didn't. And they
13 had a duty to Ms. Parrott and they breached it.
14 And, unfortunately, Ms. Parrott suffered very
15 greatly.

16 As to the second issue that seems to be
17 a contested issue, is how long do we think that Ms.
18 Parrott sat there. I believe, based upon the
19 testimony -- I and don't give a whole lot of
20 credence to Ms. Watters, other than I agree with
21 Ms. Reeves. She always had a routine with
22 Ms. Parrott. And for those three days, she never
23 her. I don't think that can be disputed. I agree
24 that the Defense that Ms. Watters she may have a
25 slippery memory on certain things, but I don't

1 think she does on that. And here's why, the phone
2 records back that up. All right. I agree that if
3 you want to talk about 54 hours prior to it not
4 getting a call. But I think Ms. Parrott was a very
5 active person and she stayed on her phone. She
6 called people. I think that was a big issue, the
7 fact that there was no phone calls made or
8 anything.

9 And had it been 24 hours, I would have
10 felt differently. 48 hours, maybe not. But for
11 all those days she didn't make one single call. I
12 find that evidence that she had already been
13 injured.

14 Also, the medical testimony was very
15 convincing. The BUN numbers, the fact that it went
16 from -- it basically went down in half. So the
17 fact that a normal is 8, and we started at 40, and
18 we didn't down almost half every single time, if
19 you do the math, that's 4 days. That's how long
20 she sat there.

21 The fact that Ms. Parrott gave
22 conflicting accounts, I don't find a whole lot of
23 weight in that at all, based on the fact she has
24 had some psychological issues and she just laid,
25 unfortunately, on the floor in the dark for 5 days

1 not knowing whether she would be rescued. And,
2 unfortunately, had some issues, meaning she
3 defecated herself. And that's awful.

4 And, also, I find the medical testimony
5 to very convincing as to the blisters and the sores
6 on the her side, and the level of dehydration also
7 to be very convincing, as to the doctors and so
8 forth.

9 So I find that she was there from
10 Tuesday until Friday when they found her that
11 night.

12 One of the most concerning things that
13 I -- that get me is, I can't image the kind of pain
14 that this lady sat in. I find that she sat there
15 for 5 days. I can't remember -- I mean, every
16 doctor has said not only is it the one painful
17 things in the world, it kills people. And she sat
18 there and survived it for 5 days.

19 MR. BOSWELL: It was 3 days.

20 THE COURT: With no food, no water, and
21 again, you know, being concerned about whether or
22 not anybody was going to come and get her.

23 So I find that her damages are pain and
24 suffering, certainly extensive mental suffering.
25 And then as to the loss and enjoyment of life, I

1 was really taken aback by the fact that I told you
2 that I took the book home and reviewed it pretty
3 much every night.

4 And I looked at her credit card
5 receipts. Nobody really talked about those. But I
6 did hear it in opening. I went back and took a
7 look. She spent money everyday. She went to
8 thrift stores. And for some reason she liked
9 McDonald's. And so she would go there a lot.

10 And then after the injury, nothing.
11 She never spent another dime. She never got the
12 chance to go do any of those things, without
13 someone either taking her, participating with her,
14 or something along those lines.

15 A lot of this, I couldn't agree more
16 with the Defense's position, that this is extremely
17 difficult in the sense that this is all happened.
18 I mean, the fact that we know all this stuff is in
19 hindsight, because we now know, in my opinion, that
20 she was down for 3 days.

21 And so as to that, the other things
22 that pursued the Court was what I discussed earlier
23 today. I had the opportunity to take into account
24 the credibility of witnesses. And I can give what
25 weight what I want to their testimony. And I can

1 accept some in part. I can disregard some in part.
2 I can take it all or taken known of it. And that's
3 what I've done.

4 I find Ms. Acosta to be extremely
5 credible. I find that the evidence that
6 Ms. Carrington told her that there's a 24
7 visualization of every resident, and that there was
8 a policy in place. As I explained earlier, there's
9 no exception to that policy. Ms. Acosta testified
10 to that. She testified that that's why she was
11 allowing her mom to live there.

12 I think Ms. Carrington was very
13 credible and reliable. She admitted that there was
14 a policy for each resident on a daily basis. She
15 went through the checklist of everything that they
16 were to do. And, obviously, we have seen that
17 exhaustively for the past three days.

18 She also testified that the staff had
19 been informed about of key change. And that she
20 was very comfortable and that they informed and
21 knew about the change, and that was in the lockbox.
22 Now, whether that trickled down to all staff
23 members, we just don't know, but that's what she
24 testified to.

25 Ms. Auld, the Defense even -- was very

1 gracious and understanding that she testified that
2 it had been so long that maybe she had a mental
3 illness. But she told Ms. Carrington that she may
4 have seen here.

5 And I understand the Plaintiff's
6 position that there's a lot of grey hairs and we
7 don't know who seen who, what, when and how. But
8 the answer is, we don't know. I indicated earlier
9 I was not going to put that much emphasis on the
10 which exfoliation of all that evidence.

11 But something that was extremely,
12 extremely concerning to the Court, and it kind of
13 took be aback when it was first said, was that
14 policy was just found on Friday. We've litigated
15 this thing for four years. The fact that that just
16 popped up is extremely, extremely -- probably one
17 of the most telling parts of my decision. I think
18 they hid the decision. Now, I can't say that. I
19 can't prove that. But the fact that that was just
20 produced after however many thousands of documents,
21 depositions were taken, emails were sent, and the
22 Friday before trial they find it.

23 I agree with Mr. Davis in the sense
24 that Ms. Watters does seem confused. And
25 Mr. Reeves does point out something very telling,

1 and I believe it, and give some weight to
2 Ms. Watters, not all, to her testimony. She did
3 seem confused. And certainly my decision is not
4 based off of Ms. Watters at all -- her testimony.

5 But she had really one thing. That's
6 her routine and Ms. Parrott. She's not going to
7 forget that. And there's no real dispute and she
8 goes and addresses her concerns with that front
9 desk that she hadn't seen her. So I believe her to
10 that extent.

11 I found Mr. Hadley to be extremely
12 intelligent, extremely knowledgeable for someone in
13 his field, certainly very credibility. The only
14 issue, of course, is that Mr. Hadley's position was
15 that -- or his testimony was basically to infer and
16 insinuate that it was not a policy. And he
17 couldn't get away from the fact that it was a
18 practice. So I believe that. I think he knew it
19 was there.

20 Again, I spoke earlier about Dr. Mills
21 and his findings. I found him to be extremely
22 credible. He's got no motive whatsoever to lie or
23 misrepresent information. And the fact that he
24 testified about her mental capacity and the things
25 that he see, basically all his experience in

1 elderly patients in their 80s and 90s. I found him
2 to be extremely convincing and found him to be very
3 credibility, and also with Dr. Bergmann.

4 Those are my findings. As y'all are
5 fully aware, there has to be a submitted order.
6 I'm going to ask that counsel for the Plaintiff,
7 that you prepare the order. However, be prepared
8 that it's probably going to get chopped up pretty
9 good, because this is my order. You are going to
10 do the front legwork. I'll do all the back
11 legwork.

12 I find that there is no evidence
13 whatsoever to award any punitive damages in this
14 case. However, as a survival action, I'm awarding
15 \$500,000 and wrongful death \$500,000. That's my
16 finding.

17 Anything further from the Plaintiff?

18 MR. REEVES: Nothing at this time.

19 THE COURT: Anything from the Defense?

20 MR. DAVIS: Posttrial review just
21 10 days.

22 THE COURT: 100 percent absolutely.

23 (The court proceedings concluded at
24 5:03 p.m.)

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State of South Carolina)
)
County of Charleston)

I, Krista Nicole Carney, Official Court
Reporter for the Ninth Judicial Circuit of the
State of South Carolina do hereby certify that the
foregoing is a true, accurate and complete
Transcript of Record in the Court of General
Sessions for Charleston County, South Carolina, on
the 10th of August, 2020.

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

March 4, 2021

Krista nicole carney

Krista Nicole Carney,
Official Stenographic Court Reporter

STATE OF SOUTH CAROLINA	)	THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	DOCKET NO. 2016-CP-10-5379
	)	
	)	
ESTATE OF DELILA PARROTT	)	
	)	
Plaintiff	)	
	)	
vs.	)	
	)	
PREMIER SENIOR LIVING, LLC,	)	
et al	)	
	)	
Defendants	)	
	)	
	)	
	)	
	)	
	)	TRANSCRIPT OF RECORD

November 4, 2020
Charleston, South Carolina

B E F O R E:

THE HONORABLE BENTLEY PRICE, JUDGE

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[Certified Transcript Provided for: Stephen L. Brown, Esq.]

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No exhibits were introduced

PROCEEDINGS

THE COURT: All right. We are here today on the defendant's post-trial motion for relief under Rule 52 and 59. All right. I'll be happy to hear from you.

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

THE COURT: Yes, sir?

MR. DAVIS: Again, Jay Davis on behalf of the defendants. Your Honor, I appreciate the opportunity to be before you today; the opportunity to be heard on it. I'm not going to go through every argument and every authority recited in the briefs; of course I'm happy to answer any specific questions you have as to the issues we raised in our motions.

I really just for purposes of argument today I want to focus in on two primary arguments and areas; again unless the Court wants further clarification on any specific point.

THE COURT: All right.

MR. DAVIS: So the first one, Your Honor, is we think that the Court's finding of a legal duty in this case to conduct a wellness check is incorrect under the law respectfully.

We believe that the evidence in the case is that this was a pure landlord tenant relationship as we've talked about. That relationship is controlled legally by

1 a lease and the Residential Landlord Tenant Act. And in
2 this case there is no allegation that any of those
3 standards were violated. And we know this was a -- it's
4 undisputed that this was independent living and Ms.
5 Parrott lived independently by choice and right. And
6 that she executed a lease, and that lease Your Honor
7 defined the legal relationship between the parties.

8 And Ms. Parrott, it's undisputed, signed the lease
9 and agreed to the terms in the lease. Specifically we
10 know based on the lease itself and the evidence in this
11 case this was not assisted living. The only services
12 that were to be provided were contained in the lease.

13 We know the wellness checks as alleged by the
14 plaintiffs and as found by the Court were not contained
15 within the lease. There was no consideration of that
16 service. And we know specifically from the lease itself,
17 Your Honor that Ms. Parrott assumed the risk of living
18 independently and she waived all liability for a decision
19 she made with respect to her day-to-day activities.

20 Now, Your Honor, to me and this has been an issue
21 from the beginning of this case between the two sides we
22 think the Court has decided that this internal policy
23 that we had created a legal duty. And we think, Your
24 Honor, what has happened is there is a conflation of the
25 policy itself verses the duty itself. So a violation of

1 a policy the Court is absolutely correct can be evidence
2 of negligence. But the policy itself, the violation of a
3 policy, doesn't create a legal duty. It can only be used
4 as evidence to show a breach of a legal duty.

5 We think in this case that the Court has found that
6 the policy created the duty and we don't think that's
7 appropriate under the law. The threshold question of is
8 there a duty has to be answered in the negative
9 respectfully Your Honor in this case because under the
10 Carson case, 486 S.E.2d 3 cited in I think the order and
11 even in our filings.

12 The question for the Court is is there some basis
13 for the duty itself. And under that case there needs to
14 be a statutory basis for the duty, contractual basis for
15 the duty, some special relationship, some special
16 property interest, some special circumstance.

17 And in this case, Your Honor, respectfully there is
18 no evidence to support the finding of a duty. And that
19 duty is different than the policy that the Court found
20 was violated. And for purposes of this case there
21 really is no credible evidence to support it.

22 Not in the lease there were no statutes presented to
23 the Court that were violated. There was no expert
24 testimony presented to the Court saying we violated a
25 legal duty. And as the Court is well aware the common

1 law imposes no duty to act. And what has happened in
2 this case, and the plaintiffs have done a very good job
3 of conflating an internal policy with a legal duty. And
4 so it's like we have skipped to whether or not there was
5 a breach of a particular duty based on the policy itself
6 without actually finding a proper legal duty.

7 I do think, Your Honor, also important to this
8 analysis is the fact that there was really only one
9 expert who testified in this case to the Court talking
10 about what the proper standards are for responding to the
11 preventing harms like occurred in this case, which is a
12 fallen resident.

13 And the evidence in this case was clearly the only
14 evidence the Court heard was that the panic button system
15 itself; that's how you complied and dealt with any duty
16 to respond to the call, and the wellness check according
17 to the industry and the experts is not designed for that.

18 And that evidence, I mean that opinion makes sense
19 because under the theory of this case and what has been
20 found is it would be okay for Ms. Parrott to lay on the
21 ground for 36 hours.

22 And that's why the expert told you or told the Court
23 and argued to the Court and I've argued to the Court is
24 that's why it can't be a duty; it's an internal policy
25 that may be relevant on the breach of a duty assuming the

1 duty exists. And really, Your Honor, there is no
2 evidence that the Court heard from anybody with any real
3 experience or really any experience in the industry to
4 say that duty is tied, the duty of a wellness check is
5 somehow tied to this residency.

6 So, the other area that I want to touch on, Your
7 Honor is the Court's finding with respect to wrongful
8 death. Respectfully, Your Honor, we believe that the
9 evidence in this case failed to meet the stringent
10 requirements of the law on proving wrongful death.

11 And not only the legal, I guess the legal bases Your
12 Honor, but if you look at it and you could kind of
13 aggregate everything together what we have is a
14 speculative determination that a fall which occurred,
15 which we're not responsible for; we didn't cause eight
16 months prior to Ms. Parrott's death was most probably the
17 cause of her death.

18 But even more importantly Your Honor to tie that
19 death to this case the Court has to distinguish in the
20 number of hours that she was on the ground causing the
21 death.

22 So respectfully there really is no, we know from the
23 plaintiff's case that a long time as they describe it is
24 anything beyond an hour. We know that she was on the
25 ground for -- let me back up. So anything longer than

1 one hour is a long time. We know, and the plaintiff's
2 don't challenge that for the first 24 hours that's okay.
3 And so what the Court has been asked to do and has found
4 is that without really adequate scientific or medical
5 evidence to assess the distinction between being on the
6 ground more than ten hours eight months prior to her
7 death being on the ground 12 to 15 hours, 15 to 24, 25 to
8 36 which one of those most probably caused the death.

9 And respectfully that analysis is not supported by
10 the expert testimony. In fact, the expert testimony that
11 the Court heard was very, very clear. And I want to
12 point out to just two quotes from the case that we heard
13 both in deposition testimony and from the stand that I
14 think, Your Honor, really confirm which, if you step back
15 and look at it make a lot of sense is that this is
16 speculation because it is hard to say medically well, you
17 know she would have been fine if she was on the ground 24
18 hours but the moment she hit 25 hours she is going to die
19 eight months later.

20 That to me is pure speculation and it wasn't just
21 me, Your Honor, I'll read you the testimony from cross-
22 examination with Doctor Mills, and this was elicited by
23 my co-counsel:

24 Question: Do you intend to offer an opinion at the
25 trial of this case to a reasonable degree of medical

1 certainty that had Ms. Parrott fallen and fractured her
2 hip in multiple places and remained on the floor for 24
3 to 36 hours or a longer period of time that she would not
4 have died nine months later.

5 And Doctor Mills, who is the sole basis and sole
6 medical opinion that the Court has based its decision on
7 wrongful death Your Honor said: I cannot say that.

8 Next question: And would you agree with me that the
9 reason you can't say that is because it is inherently
10 speculative. And the answer was: Correct.

11 Doctor Lawrence Bergman the other plaintiff's
12 expert, medical expert, he cannot quantify. He said,
13 look I think the fall contributed. I think the mini
14 strokes contributed. I think the trauma from some period
15 of time on the ground contributed.

16 But he could not testify to any degree of reasonable
17 certainty or amount how much any of those three impacted
18 the outcome in this case. I'll give you another quote
19 from again, elicited from the stand:

20 Do you intend to provide an opinion at trial that
21 her decline in death would not have occurred but for some
22 alleged delay in finding her? He said: I don't think
23 there is anybody that could say that.

24 So respectfully, Your Honor, the wrongful death case
25 is really founded on speculative testimony. It does not

1 meet the standard of care, the standard required in this
2 state.

3 And as we know from Long v American Telegraph --
4 AT&T the medical expert testifying to causation must
5 testify that after taking into consideration all the data
6 it is his or her professional opinion that the result in
7 question most probably came from the cause alleged.

8 And you will remember they really struggled with
9 that question. The experts couldn't say it, incredibly
10 they couldn't say it, because if you really drill down on
11 it Judge, how in the world can you reach out eight months
12 and say you know what she had a terrible time in the
13 first 24 hours but it was much worse later or different
14 amounts. It was testimony that if it was beyond eight
15 hours that could be enough.

16 So the Court has been asked and found respectfully
17 to have based the wrongful death decision on what is
18 clearly speculative opinions by the experts. I want to
19 touch on a couple of other admissions that I think go to
20 this question of speculation, Your Honor.

21 First Doctor Richard Mills he never referred the
22 plaintiff for a psychological evaluation during the eight
23 months after her fall. He never diagnosed her with
24 trauma induced, psychological decline. He's not a
25 psychiatrist. He's not a psychologist. He deferred to

1 those expertises and in particular deferred to a
2 neurocognitive expert to diagnose trauma induced
3 cognitive decline.

4 I'm not going to touch on the defense experts and
5 the sufficiency of that testimony, Your Honor. But I do
6 want to just point out to the Court the one thing that
7 all the medical experts agreed on is that trying to tie
8 this death eight months later to some particular time
9 period on the floor, which was traumatic for Ms. Parrott,
10 is just speculative. And that is what all of them said.
11 When pressed they couldn't testify to a reasonable degree
12 of medical certainty that in fact that caused her death.

13 So for that reason, Your Honor, respectfully we
14 believe the wrongful death cannot stand under the
15 stringent standards of the law. We believe the duty
16 analysis is flawed because it doesn't arise to the
17 standard required to create the duty. And because the
18 violation of policy can only be used to evaluate whether
19 there was a breach of a specific duty and does not create
20 the duty itself.

21 So those are the two areas Your Honor I really
22 wanted to focus in on. I am happy to address anything
23 specific that we've raised in our pleadings or the Court
24 has any concerns about.

25 THE COURT: All right. For the record I have read

1 your submittals for today's hearing. So I'm apprised of
2 everything you've argued along with those two issues as
3 well. All right. I'll give you an opportunity to
4 respond.

5 MR. REEVES: May it please the Court, Your Honor?

6 THE COURT: Yes, sir.

7 MR. REEVES: Thank you for your patience with you
8 today.

9 THE COURT: Not a problem.

10 MR. REEVES: Your Honor, I will address as best I
11 can what Mr. Davis has brought to your attention. But I
12 would ask the Court to consider this. A lower Court is
13 not required to set up findings on all the myriad facts
14 and circumstances that arise in trial in a particular
15 case.

16 The findings must be sufficient to allow an
17 appellate court in its capacity as reviewer to ensure the
18 law is faithfully executed below. Your Honor, without
19 waiving any objections to any issues that were not raised
20 at the DV or not raised before this trial, I'm going to
21 address the defendant's position.

22 I could not tell from my notes whether all these
23 issues were raised at the appropriate time or they were
24 simultaneous and appropriate objections but I will
25 address them without waiving that objection. Your Honor,

1 as to the lease verses the policy the Court's order more
2 than sufficiently addresses that issue. What I am
3 surprised at is the attempt to divert the Court's
4 attention at trial and here today to the lease without
5 regard to the policy. The lease has nothing to do with
6 what Sandpiper decided to do about helping out people who
7 were going to rent from them and go and live in this
8 community.

9 They had no problem taking their money. They had no
10 problem making promises up front that we're going to
11 check on you once a day. And Your Honor if this was such
12 a straight-forward event why did we not receive the
13 policy until the Friday before trial? I still am
14 somewhat confused about that.

15 But in any event the law is clear. Once you
16 undertake a duty, and they did, all their staff testified
17 they did, you have to exercise that duty in a reasonable
18 manner. And the fact that an expert testified that in
19 his opinion the industry standard regarding reliance on a
20 panic button was the appropriate way to check for
21 wellness does not negate nor extend in any manner to the
22 company if it chooses to do its own policy.

23 And that's what Sandpiper did and your order found
24 appropriately that that's what happened and therefore
25 that issue was appropriately decided by this Court with

1 appropriate supporting evidence from the testimony of the
2 staff. And I would also point out that the policy in
3 writing was exactly what we said it was for the four
4 years and including at trial.

5 Your Honor, the defendants raised the issue that the
6 plaintiff provided insufficient evidence to support the
7 contention that Ms. Parrott suffered on the ground and
8 ultimately that suffering and that long line of traumatic
9 experience and exposure to that caused her death.

10 They had raised issues about 24 verses 27 verses 48
11 verses 32 verses whatever you want to choose. But here's
12 what they need to realize and here's what's in the
13 evidence is both experts, and I believe even their
14 expert, testified the longer you're on the floor the
15 worse off you are. Nobody denied that.

16 Whatever complaints the defendant has about Doctor
17 Mills' testimony because he did say, Your Honor, clearly
18 do you have an opinion to a reasonable medical certainty
19 that the long line caused, aggravated or contributed to
20 her death. Yes. What is that opinion? That it did.
21 That's all he's got to say.

22 The Court has the ability to determine the
23 sufficiency of that evidence based on testimony given.
24 Your Honor, Doctor Bergman's testimony that has presented
25 here today is completely taken out of context because

1 they have to admit that he did say in the deposition not
2 only did that particular traumatic experience lead to her
3 pain and suffering but also to her death his testimony
4 was 49, 51 I don't know but I do know this, it had a
5 significant impact and he testified that more likely than
6 not that impact caused harm to her while she was living
7 and contributed to her death.

8 Your Honor, the defendants have raised but not
9 brought to your attention today the issue that this Court
10 did not make a finding on comparative negligence. I
11 don't pretend to know if you should or not. But I would
12 address that issue and I would address the issue by
13 respectfully requesting the Court simply make a finding
14 that Ms. Parrott was not comparatively negligent.

15 Let me suggest why the evidence supports that
16 without contravention ---

17 THE COURT: --- well, let me stop you there just
18 for one second and I don't mean to interrupt. It's funny
19 you brought that up because when I read his memorandum
20 how does he know if I did it or not in my deliberation?
21 Or how does anybody know whether I determined it because
22 maybe I did. Maybe I was going to give her two million
23 and found it to be civil comparative. Who knows? Nobody
24 knows what I considered and what I didn't in my
25 deliberation, correct?

1 MR. REEVES: That is correct, Your Honor. And it
2 was a challenge to bring this up because you did not
3 provide that information in the request for the order. I
4 only bring it up here in the event that it needs to be
5 addressed.

6 And based on what you -- I didn't mean that the
7 Court didn't address it. I just simply want to point out
8 this fact. In order for someone to be comparatively
9 negligent there has to be some duty that they violated.

10 Now Your Honor you've heard today and you heard it
11 at trial all we got here is a landlord and tenant act --
12 a tenant agreement. What we also don't have is there is
13 no evidence to support the fact that Sandpiper had a
14 mandatory rule that Ms. Parrott use the emergency button.
15 In fact the testimony was we give them out. Some use
16 them, some don't. A lot of them don't even wear them and
17 you're not required to.

18 So the question I would just point out to the Court
19 assuming it's relevant is this; how could she be
20 comparatively negligent when she had no duty to do
21 anything? And Your Honor respectfully please don't take
22 offense. I just brought that up because you did not ask
23 for that in your order.

24 Your Honor, the order is sufficient on all fours.
25 The order sufficiently covers the fact that a policy can

1 set the duty of a corporation. And it doesn't matter if
2 it's for courtesy or for pay the case law is clear
3 gratuitously or otherwise. If you take, undertake to act
4 and you don't do that action reasonably then you are
5 liable for any damages that flow from that and the
6 plaintiff proved those damages at trial. Thank you, Your
7 Honor.

8 THE COURT: All right. Yes, sir?

9 MR. DAVIS: Your Honor, I don't have anything
10 unless you just want me to address any particular points.

11 THE COURT: No. Give me one second.

12 [Whereupon, the Court reviews documents]

13 MR. DAVIS: Let me check...

14 THE COURT: Sure.

15 [Whereupon, Mr. Davis reviews documents]

16 MR. DAVIS: I think I said this Your Honor but just
17 we rely on our original filings if you would be good
18 enough to read and consider we would appreciate that.
19 Thank you, Your Honor.

20 THE COURT: All right.

21 [Whereupon, the Court reviews documents]

22 THE COURT: I was just going back through because
23 you had specifically enumerated certain issues that you
24 had and I was just making sure whether I had any
25 questions concerning them. I had written some questions

1 out to the margin but I believe y'all have answered them
2 all. So if there is nothing further as usual you will
3 have my answer by the end of the day.

4 MR. DAVIS: Thank you, Your Honor.

5 MR. REEVES: Thank you, Your Honor.

6 MR. LYLE: Thank you, Your Honor.

7 MR. RIDDLE: Thank you, Your Honor.

8 *****END OF TRANSCRIPT OF RECORD*****
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C E R T I F I C A T E

I, the undersigned, Joyce C. Rueger, Official
Circuit Court Reporter for the Ninth 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 proceedings had and evidence introduced in
the trial of the captioned case, relative to appeal, in
the Court of Common Pleas for Charleston County, South
Carolina on the 4th day of November, 2020.

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

January 4, 2021

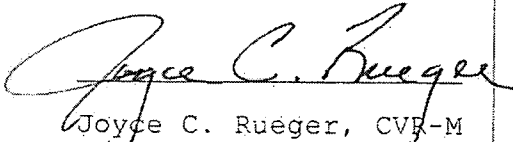
Joyce C. Rueger, CVR-M
Court Reporter

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January 4, 2021


Joyce C. Rueger, CVR-M
Court Reporter

1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
2 COUNTY OF CHARLESTON) NINTH JUDICIAL CIRCUIT
3) C.A. NO.: 2016-CP-10-5379
4
5
6 THE ESTATE OF DELILA PARROTT,)
7 PLAINTIFF,) VIDEOTAPED DEPOSITION OF
8 VS.) LILA WATTERS
9 SANDPIPER INDEPENDENT &) FEBRUARY 2, 2017
10 ASSISTED LIVING-DELAWARE, LLC,)
11 DEFENDANT.)
12 _____
13
14
15 Videotaped Deposition on oral examination of Lila
16 Watters, reported by Laura S. DeCillis, Certified Court
17 Reporter and Notary Public in and for the State of South
18 Carolina; said deposition taken at Sandpiper Village, 1224
19 Village Creek Lane, Mount Pleasant, South Carolina, on
20 Thursday, the 2nd day of February 2017, scheduled for
21 10:00 a.m. and commencing at the hour of 10:02 a.m.
22
23
24
25

APPEARANCES

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Mount Pleasant, South Carolina 29464

Also present:

Kevin O'Quinn, Videographer
Kristina Strickler

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EXHIBITS

(None were proffered)

1 This deposition is taken in accordance with the
2 South Carolina Rules of Civil Procedure.

3 It is agreed and stipulated by the deponent and
4 respective counsel that the reading and signing of the
5 deposition by the deponent is expressly waived.

6 VIDEOGRAPHER: We are now on the record at
7 10:02 a.m. on February 2nd, 2017. This is the video
8 deposition of Lila Watters, taken by the plaintiff in
9 the matter of the Estate of Delila Parrot versus
10 Sandpiper Independent and Assisted Living Delaware,
11 LLC, in the Court of Common Pleas, case number
12 2016-CP-10-5 -- or, excuse me, 10-5379.

13 This video deposition is being held at 1224
14 Village Creek Lane in Mount Pleasant. Today the court
15 reporter is Laura DeCillis representing Garber Court
16 Reporting, office located in Columbia, South Carolina.
17 And currently speaking, my name is Kevin O'Quinn. I'm
18 the legal videographer representing Legal Media of
19 Charleston with an office located in North Charleston,
20 South Carolina.

21 Counsel, please state your appearances for the
22 record.

23 MR. REEVES: My name is Paul Reeves and I
24 represent the Estate of Delila Parrott.

25 MR. BUCKNER: My name is Perry Buckner and I

1 represent Sandpiper.

2 MR. REEVES: Ms. Watters, he's going to swear
3 you in.

4 Whereupon:

5 Lila Watters, having been duly sworn
6 and cautioned to speak the truth, the whole truth and
7 nothing but the truth, testified as follows:

8 EXAMINATION BY MR. REEVES:

9 Q. Well, Ms. Watters, I'm sorry I called you by the
10 wrong last name. Would you state your full name for the
11 record, please.

12 A. Lila Watters.

13 Q. Ms. Watters, would it be okay if I called you
14 Ms. Lila for this deposition?

15 A. That's fine.

16 Q. Okay. What is your address where you live
17 today?

18 A. REDACTED --

19 Q. Okay.

20 A. REDACTED .

21 MR. BUCKNER: Paul, I don't want to interrupt,
22 and I know I should have done this before and I apologize,
23 but I just want to make sure that we've got on the record
24 your and my discussion about the arbitration agreement.

25 MR. REEVES: Sure.

1 MR. BUCKNER: And, obviously, my concern was
2 that if you are going to argue a waiver of our arbitration
3 rights by conducting this deposition today and I was going
4 to move for a protective order and to quash the deposition,
5 you indicated you would not do that and you were kind enough
6 to consent to that. I've sent you a letter and you may have
7 already sent it back, but I just wanted to put that on the
8 record before we get going. And I'm sorry to wait until 15
9 seconds in. Was that agreeable to you?

10 MR. REEVES: That's agreeable.

11 MR. BUCKNER: Thank you.

12 MR. REEVES: We're not creating or extinguishing
13 any rights by this deposition.

14 BY MR. REEVES:

15 Q. Ms. Watters, how long have you lived here?

16 A. July will be five years.

17 Q. Okay. And do you live alone?

18 A. Yes.

19 Q. And did you grow up in Charleston?

20 A. Yes.

21 Q. All right. And before you retired what did you
22 do for a living, if you did work?

23 A. A housewife mostly.

24 Q. Mostly?

25 A. A receptionist.

1 Q. And do you have any family living in Charleston
2 County?

3 A. I have a brother.

4 Q. All right. And when did you first meet
5 Ms. Parrott?

6 A. I thought it was when she came in, but then I
7 found out she'd been here like a couple of months before me
8 but I had not seen her. So a couple of months after she
9 moved in.

10 Q. All right. And do you recall about when that
11 was, Ms. Watters?

12 A. No.

13 Q. Okay. How did you meet her, or how did you come
14 to know her?

15 A. Well, we ate together and we just liked each
16 other and we were together Saturdays and Sundays. We'd play
17 Bingo together, we did everything together.

18 Q. Is it correct then that before you moved here
19 and before she moved here, you did not know Ms. Parrott?

20 A. No.

21 Q. Okay. Ms. Lila, did Ms. Delila have a car here,
22 to your knowledge?

23 A. She did, but she sold it.

24 Q. Okay. Did she drive much, if you know?

25 A. We both drove weekends.

1 Q. All right. You said you all became friends.
2 Where would you all -- how would you all normally meet up?
3 Did you have dinners together --

4 A. In the activity room.

5 Q. Okay. All right. Did you all have a routine
6 with each other?

7 A. Did we what?

8 Q. Did you have a routine with each other? Did you
9 all do things on a normal routine every day?

10 A. Not every day. But mostly weekends we went
11 places together.

12 Q. Okay. Did you normally eat together?

13 A. Yes.

14 Q. Okay.

15 A. For one meal.

16 Q. Which meal was that usually?

17 A. A lot of times she didn't come for dinner.

18 Q. Right. Okay. What meal would you all usually
19 eat together?

20 A. Lunch.

21 Q. Okay. And so you would see her at other times
22 during activities in the community room?

23 A. Oh, yes.

24 Q. Okay. Did Ms. Delila keep a normal schedule as
25 to when she would do certain things, activities or eat or

1 **anything like that?**

2 A. More or less. Sometimes she would not play
3 Bingo with me because she told me she couldn't see too well.

4 **Q. Okay.**

5 A. But she -- she played every time she could on
6 Tuesday and Friday night and also other days.

7 **Q. Ms. Lila, at some point there was a circumstance**
8 **where she did not show up for dinner for a couple of days.**

9 MR. BUCKNER: Object to the form of the
10 question.

11 BY MR. REEVES:

12 A. I mean, maybe just one day she'd take dinner
13 home with her.

14 **Q. Okay.**

15 A. Or she fixed a sandwich at home.

16 **Q. Okay.**

17 A. But she would -- I would know when she wasn't
18 coming. She usually told me.

19 **Q. She did?**

20 A. Yes.

21 **Q. All right. How close was her residence to your**
22 **residence?**

23 A. A half a block.

24 **Q. Okay. Do you recall there being a time when you**
25 **inquired of folks here at the premises as to the well-being**

1 of Ms. Parrott?

2 MR. BUCKNER: Object to the form.

3 BY MR. REEVES:

4 A. What, now?

5 Q. Did there come a time when you became worried
6 about Ms. Delila because she had not -- you had not seen
7 her --

8 A. Well, yes.

9 Q. -- currently?

10 A. Yes.

11 Q. Can you tell me what happened. Can you tell me
12 how that came about, please?

13 A. Well, it was on a Tuesday and she didn't want to
14 play Bingo. And when I got home from Bingo, she had left me
15 a birthday message. Because Wednesday was my birthday and I
16 was going to my brother's so she wouldn't see me probably,
17 especially if she didn't come for dinner. And I asked them
18 if they had seen her Tuesday and they said, yes, but not
19 that night. And -- no, not -- they saw her that night. I
20 don't know about the lunch.

21 Q. Okay.

22 A. I don't remember if she was there or not.

23 Q. And your birthday was on Wednesday?

24 A. Yes.

25 Q. Is that REDACT?

1 A. Yes.

2 Q. All right. Did you see Ms. Delila on REDACTED?

3 A. No.

4 Q. Okay. And she left you the birthday wish
5 message on Tuesday evening?

6 A. Yes.

7 Q. All right. Did you know you were not going to
8 see her on REDACTED?

9 A. I didn't -- if she didn't come to dinner I would
10 not see her.

11 Q. Okay. Did you see her on June 5th?

12 A. On Tuesday?

13 Q. No. That would be Thursday.

14 A. On Thursday? No.

15 Q. Okay. What, if any, concerns did you have about
16 not seeing her on Thursday? Did you expect to see her?

17 A. Yes.

18 Q. All right. And what did you do, if anything,
19 once you did not see her?

20 A. I called her, went down and knocked on the door.
21 And the lady at the desk called her several times and went
22 down and knocked on the door.

23 Q. Do you know the name of the lady at the desk?

24 A. Rebecca.

25 Q. And did you ask Rebecca to call and check on

1 **Ms. Delila?**

2 A. Yes.

3 **Q. All right. Did she receive an answer to your**
4 **knowledge?**

5 A. She said she didn't have her name and telephone
6 number -- her address and telephone number.

7 **Q. Repeat that, Ms. Lila? I'm sorry.**

8 A. She did not have her address and telephone
9 number.

10 **Q. What did Rebecca do to try to -- she just tried**
11 **to call her from what you observed?**

12 MR. BUCKNER: Object to the form.

13 BY MR. REEVES:

14 A. What did she do? Well, she -- she went down
15 there and knocked on the door and rang the phone.

16 **Q. Okay. All right. And did she get any response**
17 **to your knowledge?**

18 A. No.

19 **Q. Did you do anything else on Thursday to**
20 **determine -- let me rephrase that.**

21 **What, if anything, did you do on Thursday to try**
22 **to check on Ms. Delila other than talk to Rebecca?**

23 A. I went down there and went on the front porch
24 and moved a rocking chair over and made a little bit of
25 noise, and nothing.

1 Q. Okay. Did you try to call her telephone number?

2 A. Oh, yeah. Several times.

3 Q. Did you ever receive an answer?

4 A. No.

5 Q. On Friday morning, this would be June 6th, did
6 you see Ms. Delila that morning?

7 A. No.

8 Q. Did you do anything as a result of not seeing
9 her?

10 A. We did the same routine, Rebecca and I.

11 Q. Okay. And did she call again?

12 A. Oh, yeah.

13 Q. Do you know if she received an answer?

14 A. No. Nobody -- we didn't.

15 Q. Okay. Did you go to Ms. Delila's room or her
16 apartment?

17 A. Oh, yes.

18 Q. And you did not receive any notice or any --

19 A. I knocked on both doors, nothing.

20 Q. Did you speak with Rebecca again that day about
21 trying to get into Ms. Delila's apartment?

22 MR. BUCKNER: Object to the form.

23 BY MR. REEVES:

24 A. No.

25 Q. Okay. What happened next on Friday then?

1 A. On Friday, I -- I went -- I called her again.
2 And Rebecca kept saying she was probably with one of her
3 daughters. And I said, I don't think so. She would let me
4 know, I think. So I asked for -- I went down to play Bingo
5 Friday night and she wasn't there. So I went and asked
6 Rebecca, I said, I want every master key you have, I've got
7 to get in there. She said, we don't have it because she
8 changed the locks on the door.

9 So I started to leave after Bingo and I said,
10 no, I'm not going. I've got to get in there. So I just
11 plopped my stuff down and went back and Rebecca had the key,
12 and that's all I know. I opened the door and I went in and
13 I found her.

14 Q. You found Ms. --

15 A. And we called an ambulance and that was it.

16 Q. Okay. I know this story is difficult for you
17 and I don't mean to -- but I have to ask you a few detailed
18 questions, okay? If you'll bear with me just a minute,
19 okay?

20 Initially, Rebecca told you she did not have a
21 key --

22 MR. BUCKNER: Object to the form.

23 BY MR. REEVES:

24 Q. -- is that correct?

25 A. Yes.

1 Q. All right. What, if anything, did you tell her
2 when she said, I don't have a key? What was your response
3 to that?

4 A. I couldn't fight City Hall. I mean, I -- I
5 can't argue with staff.

6 Q. Okay.

7 A. Well, the manager came out Friday afternoon when
8 I was there and she said that she was probably with her
9 daughter and she probably didn't turn a key in. And I --
10 and I said to her, well, you had all that information on me
11 when I moved in, but no address or telephone number. And I
12 just -- because she had -- the manager had left when I went
13 back to Rebecca and Rebecca had found the key. And I said,
14 where was the key? And she said it was in a lock box in the
15 manager's office. I mean, she just opened the drawer and
16 there it was.

17 I don't know if she was going down if I hadn't
18 stayed and asked for the key or not. Probably she would
19 have, because I think she had just found the key.

20 Q. Did you ask for a key on Thursday?

21 A. No. That was Friday that I asked for all the
22 master keys they had.

23 Q. Okay. What, if any, requests, Ms. Lila, did you
24 make of the manager or Rebecca on Thursday for them to go
25 and check on Ms. Delila?

1 MR. BUCKNER: Object to the form.

2 BY MR. REEVES:

3 A. I'm not really hearing all -- did I do what?

4 Q. Okay. I'm sorry. I'll speak a little bit
5 closer. Did you ask the manager or Rebecca to go check on
6 Ms. Delila on Thursday?

7 MR. BUCKNER: Object to the form.

8 BY MR. REEVES:

9 A. We both did, yes.

10 Q. And on Friday you said you spoke with the
11 manager. Who was the manager that you spoke with?

12 A. Corrine. And I don't know her last name.

13 Q. Okay.

14 A. She told me that Rebecca's mother had seen
15 Delila and she didn't know whether it was lunch or dinner.
16 And I said, well, I didn't see her.

17 Q. May I ask you, what day was Ms. Corrine
18 referring to when she said Rebecca's mother saw her at lunch
19 or dinner?

20 A. She said she saw her on Thursday but she didn't
21 know whether it was lunch or dinner.

22 Q. Did you, on Thursday, Ms. Lila, attend lunch and
23 dinner?

24 A. Yes.

25 Q. Did you see --

1 A. No.

2 Q. -- Ms. Delila at lunch or dinner? Was it your
3 routine, if she was going to eat, that you and her would eat
4 together?

5 A. Was it our routine? We ate at the same table.

6 Q. Okay. All right. Did you see Ms. Delila at any
7 time on Friday before you went to her room?

8 A. No. When I was talking with Rebecca, she said
9 that, my mother would not say she saw her if she didn't see
10 her, calm down. That's what she said to me.

11 Q. Okay. Does Rebecca still work here?

12 A. No.

13 Q. Does Corrine still work here?

14 A. No.

15 Q. Did Rebecca offer you any explanation, if
16 anything, about the key and why she was not able to produce
17 that earlier?

18 A. She said she found it in a lock box in Corrine's
19 office, is what she said.

20 Q. Did anyone go with you to Ms. Delila's room when
21 you took the key to open the door?

22 A. (Shakes head).

23 Q. No?

24 A. No.

25 Q. Did you ask anyone to go with you?

1 A. No.

2 Q. Where did you find Ms. Delila when you came into
3 the room?

4 A. She was on the floor.

5 Q. Can you describe where in the apartment she was
6 on the floor?

7 A. Well, yes. Like if this is the wall, there's a
8 window here and the chair was there. There was a big chest
9 of drawers here, one of those great big ones. The
10 four-poster bed was here and she was between the bed and
11 chester drawers.

12 Q. Okay. What did you notice about her appearance?
13 Did she appear to be injured?

14 MR. BUCKNER: Object to the form.

15 BY MR. REEVES:

16 A. She was lucid. She was fine.

17 Q. Okay.

18 A. I mean, she just said, oh, I'm so glad to see
19 you, don't leave me, don't leave me. I said, I've got to
20 call an ambulance.

21 Q. Did you call the ambulance, Ms. Lila?

22 A. No. She said, my phone's over there. But I
23 didn't. I went back and asked Rebecca to call the
24 ambulance. And then she did and then Becca came and the
25 ambulance people came.

1 Q. All right. Do you know where Ms. Lila was --
2 excuse me, Ms. Delila was taken by ambulance? Do you know
3 where she went?

4 A. (Shakes head). No.

5 Q. Did you visit her after she was taken by EMS
6 away from the premises?

7 A. Not to the hospital. But she was sent to rehab
8 at Sandpiper and I went over there a lot.

9 Q. All right. So you saw her there?

10 A. Yes.

11 Q. What did you observe about her going through
12 rehab? Did that appear to help her?

13 A. I just argued with her, telling her to shape up.

14 Q. And did she?

15 A. No. She said, that did something to my mind.
16 So a couple of times when I went over, I said, just stop it,
17 you're hallucinating. And it didn't stop.

18 Q. When she said that did something to her mind,
19 what was she speaking of, the incident?

20 A. Well, people were after her or wanted to kill
21 her and stuff like that.

22 Q. All right.

23 A. She said she looked out the window and there was
24 a lady down on the ground being killed and she was afraid
25 she was going to be next. And I said, oh, stop it, you're

1 hallucinating. See? I can look over it like that, trying
2 to bring her around. I just told her all kind of fool
3 things, we need you -- I need you at Bingo and we miss you
4 and all that stuff. And she's -- and then she got to
5 where -- I went over one day and she was not there. And I
6 said to this janitor -- he said, she got to where she
7 couldn't even stand up. And he said, okay. And she went to
8 17 North, or St. Francis, 17 North.

9 In the meantime, I had gone downtown to a
10 nursing home and -- no, I'm sorry. That wasn't from rehab.
11 That was from the nursing home downtown.

12 Q. Yes, ma'am.

13 A. And I went down there and they told me where she
14 was. So then I came and went to 17 North. She went, how
15 did you find me? I said, I told you I'd follow you
16 everywhere you go. And she said, well, I don't want anybody
17 to know I was here, not even my daughters. And I said,
18 well, I'm here. And, I said, you've got to go back to where
19 you were. You can't sit here in this corner like this
20 and -- you didn't ask me this, but she was kind of in a
21 lounge chair all covered up and I sat on the foot of the
22 lounge chair and it kept going down and I went on the floor
23 and she giggled a little bit. Well, the nurse heard her. I
24 think it was the next day or the next day they sent her
25 right back where she came from.

1 Q. Okay.

2 A. She thought that was so funny when my butt hit
3 the floor.

4 Q. All right.

5 A. So she just thought she was going to be next,
6 so -- that she would be killed next. She had to get away
7 from that nursing home where she was.

8 Q. Ms. Lila, did the Ms. Delila that you knew
9 before the incident where she fell in her room where you
10 found her and the Ms. Delila you knew afterwards, was there
11 any changes? Was she the same? Did she change?

12 MR. BUCKNER: Object to the form.

13 BY MR. REEVES:

14 A. I would say yes.

15 Q. How so?

16 A. She just didn't care, didn't make sense anymore.

17 Q. Did Ms. Delila tell you or say anything to you
18 about how long she had been on the floor before you found
19 her?

20 A. She told the ambulance people. She said, I've
21 been here since Tuesday night. And this was Friday night.
22 And the ambulance guy said, you mean Thursday. And she
23 says, no, I don't.

24 Q. Okay. Ms. Lila, after this event happened, did
25 anyone from Sandpiper speak with you about what had happened

1 or how it had happened or provide to you any information
2 about the events?

3 MR. BUCKNER: Object to the form.

4 BY MR. REEVES:

5 A. Not that I recall.

6 Q. Okay. Did you have, after this -- after you
7 found Ms. Delila, did you have any more conversations with
8 Rebecca about what had happened?

9 A. No. Not that I recall.

10 Q. Okay. What, if any, effect did the
11 circumstances of Ms. Delila being in her room have on you
12 and Rebecca? Did that cause any problems with your
13 relationship with her?

14 A. Well, I didn't -- yes and no. I mean, we were
15 okay after that.

16 Q. Okay.

17 A. It just took me a while, you know, for -- to get
18 over her telling me in the tone that she told me about, if
19 my mother didn't see her, she wouldn't say she had seen her
20 if she hadn't seen her. Yeah, we were okay after that.

21 Q. Okay.

22 A. And we didn't talk about anything.

23 Q. Okay. After this event, Ms. Lila, did you speak
24 with Ms. Corrine any more about --

25 A. No.

1 Q. -- what had happened? All right. Ms. Lila,
2 does anyone at this premises have a key for your apartment?

3 A. The staff -- the office does. They have a
4 master key for everybody.

5 Q. Right. Do you know, when you found Ms. Delila,
6 whether she was wearing an emergency button?

7 A. She was not.

8 Q. All right. Do the patrons or residents of this
9 premises wear emergency buttons?

10 MR. BUCKNER: Object to the form.

11 BY MR. REEVES:

12 A. We all do as far as I know.

13 Q. Okay.

14 A. I did. I don't wear it but I have it.

15 Q. I understand. I understand. Why do you not
16 wear it all the time?

17 A. I hadn't really felt like I needed it until the
18 last six months or so.

19 Q. Okay.

20 A. And I tell myself I'm going to start using it
21 every day and I forget.

22 Q. Okay. All right. Is that true for other
23 residents?

24 A. What?

25 Q. Is that true for other residents, too?

1 A. I -- I don't know.

2 Q. Okay. Ms. Lila, you said earlier you met with
3 Joan Acosta and a gentleman named Leon Parrott a couple of
4 months ago; is that correct?

5 A. (Nods head).

6 Q. And did you tell them this story?

7 A. Yes.

8 Q. Okay. All right.

9 A. But Delila had told her daughter everything, you
10 know, when -- because she remembered everything at first.

11 Q. Right.

12 A. And she told her -- had already told her
13 everything.

14 Q. Did Ms. Acosta make any statements to you about
15 whether she believed her mother and what her mother told her
16 about how she came to be on the floor and how long she was
17 there?

18 MR. BUCKNER: Object to the form.

19 BY MR. REEVES:

20 A. She just said that she had hurt her leg and she
21 was down for like three months. And she hurt it -- and she
22 was on the floor and it was at night and on the steps and
23 she said she just -- all she could do was think about her
24 mother lying there in the dark all that time. And, of
25 course, she said, I was only there like about three hours

1 and it was scary, she said, though.

2 Q. Okay. Do you recall having a conversation with
3 Ms. Acosta, Joan Acosta, at Ms. Delila's funeral about what
4 had happened?

5 A. I did not go to the funeral.

6 Q. Okay.

7 A. I saw her the night before she passed.

8 Q. I see. I see.

9 A. And she was at -- somewhere in Mount Pleasant.

10 Q. Okay.

11 A. A friend took me over and I saw her.

12 Q. Okay. Did you talk with Ms. Acosta about what
13 had happened with Ms. Delila when you found her?

14 A. Yes.

15 Q. Okay.

16 A. But Delila had already told her everything --

17 Q. Okay.

18 A. -- that I could tell her.

19 Q. After you had found her and the EMS was called,
20 did she ever come and live back in that apartment again?

21 A. No.

22 Q. Okay. Do you know how long after this event
23 that Ms. Delila passed away?

24 A. Maybe a year and-a-half.

25 Q. Okay.

1 A. Maybe. I'm not sure.

2 Q. Okay. Did Ms. Delila tell you how she had come
3 to be on the floor when you found her?

4 MR. BUCKNER: Object to the form.

5 BY MR. REEVES:

6 A. She was hanging a curtain and she fell off the
7 chair.

8 Q. Okay. Ms. Lila, I want to make sure I've got
9 some dates right and if you don't know the answer just tell
10 me. But if your birthday was on REDACTED then the message
11 you received from Ms. Delila telling you happy birthday was
12 on June 3rd; is that correct?

13 MR. BUCKNER: Object to the form.

14 BY MR. REEVES:

15 A. Right.

16 Q. Okay. All right. And when you first observed
17 her as you've testified, or when you did not see her on
18 Thursday, that's when you started making phone calls and
19 going to her apartment?

20 MR. BUCKNER: Object to the form.

21 BY MR. REEVES:

22 A. Uh-huh.

23 Q. All right. You need to say yes or no.

24 A. Yes.

25 Q. All right. On Thursday could you get anybody

1 from the premises to go into the room to check on
2 Ms. Delila?

3 MR. BUCKNER: Object to the form.

4 BY MR. REEVES:

5 A. No. They just -- she just said that she must be
6 with her daughter.

7 Q. Okay.

8 A. And I said, have you heard from her? And they
9 said, no, and -- she said she must be with one of her
10 daughters.

11 Q. Okay. Ms. Lila, did anyone ask you for your
12 information about what you knew about this circumstance
13 after it happened? Did anybody ask you what had happened?

14 MR. BUCKNER: Object to the form.

15 BY MR. REEVES:

16 A. Yeah. I have to sort of take that back because
17 it was Elenore.

18 Q. And who is Elenore, please?

19 A. Elenore Kissell.

20 Q. Is she a resident or does she work --

21 A. Yes.

22 Q. -- here?

23 A. She's a resident.

24 Q. Okay. Ms. Lila, do you know if anyone else
25 besides yourself visited Ms. Delila's room on Thursday or

1 **Friday before you found her?**

2 A. No. I don't know.

3 Q. Okay. Did she live alone?

4 A. Yes.

5 Q. Ms. Lila, was it Ms. Delila's habit to tell you
6 **what her schedule was going to be for any day or week?**

7 MR. BUCKNER: Object to the form.

8 BY MR. REEVES:

9 A. No. But she would tell me, my daughter's coming
10 tomorrow for a couple of hours, or something like that.

11 Q. Okay. Ms. Lila, did you report to Joan Acosta
12 **that you had tried to recreate what Ms. Delila went through**
13 **in your own room?**

14 MR. BUCKNER: Object to the form.

15 BY MR. REEVES:

16 A. I did.

17 Q. Tell me about that. What did you do?

18 A. Well, she was telling me about when she was
19 lying on the floor after she hurt her leg. And so one night
20 I got down on the floor just to see what it was like and it
21 was really black dark and I said, I can see it would be
22 scary.

23 Q. Were you close to Ms. Delila?

24 A. I thought so.

25 Q. Okay. How did you feel when she passed away?

1 A. Really bad. I knew I was going to miss her, but
2 these things happen.

3 Q. Ms. Lila, has anything changed here about the
4 way this premises checks on people or checks on people's
5 well-being based on what you've observed?

6 MR. BUCKNER: Object to the form.

7 BY MR. REEVES:

8 Q. You can answer.

9 A. I see a lock box at the desk now that I hadn't
10 seen before.

11 THE WITNESS: Is that new, that box -- that box
12 there with all those keys in it?

13 BY MR. REEVES:

14 Q. I don't know.

15 A. I've noticed that several times. There's a box
16 there, a lock box that has all the keys in it.

17 Q. Okay. Ms. Lila, has anyone at the premises
18 promised to check on you every so often? Is that a rule
19 here? Does anybody do that here?

20 MR. BUCKNER: Object to the form.

21 BY MR. REEVES:

22 A. They can't promise to do that, no.

23 Q. Okay.

24 A. It's independent living.

25 Q. Okay.

1 A. But they do.

2 Q. How do they do that?

3 A. By telephone.

4 Q. Okay. And under what circumstances would they
5 check on you by telephone?

6 A. If they don't see you that day they call you
7 that night.

8 Q. Were they doing that when Ms. Delila fell in her
9 apartment?

10 MR. BUCKNER: Object to the form.

11 BY MR. REEVES:

12 A. Yes.

13 Q. They were? Who would usually do the calling, if
14 you know?

15 A. Who what?

16 Q. Who would do the calling if you know?

17 A. The person that was on duty that day.

18 Q. At the time this happened, Ms. Lila, who else
19 worked at the front desk other than Rebecca, if you know?

20 A. Rebecca and her mother, Beth, and -- gee, I
21 forgot.

22 Q. That's okay.

23 A. I don't know -- I don't remember who else, but
24 there was somebody.

25 Q. Was Ms. Beth the woman who supposedly saw

1 **Ms. Delila on Thursday?**

2 A. Yes.

3 **Q. Does she still work here?**

4 A. No.

5 **Q. Okay.**

6 A. At least she told the manager that she saw her.
7 She said, I saw her but I don't know if it was lunch or
8 dinner. And that's when I said, well, I didn't.

9 **Q. Okay. Ms. Lila, I'm going to let you answer any**
10 **questions that Mr. Buckner may have for you. I appreciate**
11 **your time.**

12 MR. BUCKNER: Thank you.

13 EXAMINATION

14 BY MR. BUCKNER:

15 **Q. Ms. Watters, my name is Perry Buckner and I**
16 **represent Sandpiper in this case who's been sued by**
17 **Ms. Parrott's family, so I represent the defendant in this**
18 **case; do you understand that?**

19 A. (Nods head).

20 **Q. And it's my understanding, and you can tell me**
21 **if I'm wrong, that you were contacted by Ms. Parrott's**
22 **family to talk about this incident with Delila, correct?**

23 A. Yes.

24 **Q. And they asked you to appear for a deposition**
25 **here today; is that correct?**

1 A. Yes.

2 Q. Do you want to be here today, Ms. Watters?

3 A. Not necessarily.

4 Q. All right.

5 A. But I think she would do it for me. And then
6 her daughter. I like both of her daughters very much and --

7 Q. All right. And --

8 A. It was like that.

9 Q. -- you understand that when we try this case, if
10 we do try it, whether it goes to court or arbitration,
11 you'll be a witness at the trial or arbitration?

12 A. That means I'm going to be involved in what?
13 Because I would like this to end it right now.

14 Q. Well, unfortunately, I can't promise you that.
15 You've been identified by the plaintiff and you will be a
16 witness for the remainder of the case, regardless --

17 A. Well, I'm not going -- I'm not going to leave
18 Sandpiper.

19 Q. Right.

20 A. Right now I have some problems of my own.

21 Q. Right. But you were asked to be here today by
22 Ms. Delila's family, correct?

23 A. Mr. Parrott.

24 Q. All right. And who else?

25 A. And Jane, her daughter.

1 Q. All right. And how much of what you recall
2 about this incident with Delila is of your own independent
3 recollection as opposed to what somebody else might have
4 told you since it happened?

5 A. Nobody's told me anything.

6 Q. All right. Have you met with Mr. Parrott or
7 Ms. Acosta about this incident?

8 A. They came to my apartment, yes.

9 Q. All right. And they videotaped you when they
10 came?

11 A. No.

12 Q. Did they ever videotape you --

13 A. No.

14 Q. -- to talk about this incident?

15 A. No. They took a tape, though.

16 Q. Oh. When you say a tape, do you mean like a
17 tape recorder --

18 A. Yes.

19 Q. -- an audio recording? All right. And when did
20 that audio recording take place? Do you remember --

21 A. The end of December.

22 Q. Of this year?

23 A. Yes.

24 Q. Was Mr. Reeves there?

25 A. Last year in December.

1 Q. All right. December of 2016?

2 A. Yes.

3 Q. Was Mr. Paul Reeves there that day?

4 A. No.

5 Q. All right. Had you met with Mr. Reeves --

6 A. No.

7 Q. -- before today?

8 A. No.

9 Q. Have you spoken to him on the phone?

10 A. No.

11 Q. All right. Do you keep a daily journal in your
12 apartment or a diary or anything like that?

13 A. No.

14 Q. You had referenced earlier that there were
15 several attempts, both by staff and yourself, to call
16 Ms. Delila; is that correct?

17 A. Oh, yes.

18 Q. Do you recall her phone number?

19 A. Lord, no.

20 Q. All right. Would it have been a phone number
21 that was regarding a phone in her apartment, though?

22 A. I think it was her cell phone.

23 Q. All right. And were you calling her from your
24 cell phone?

25 A. I don't have a cell phone. But, yes, from my

1 apartment.

2 Q. All right. And what is the number for your
3 apartment phone?

4 A. 6703. 843-6703.

5 THE WITNESS: Do we have an 884?

6 BY MR. BUCKNER:

7 Q. You said the number was 843 --

8 A. Yeah.

9 Q. And then what --

10 A. I think 884-6703 is my phone number.

11 Q. All right. Would that have been your phone
12 number at the same time --

13 A. Yes.

14 Q. -- when this incident occurred? It would have
15 been the same number as when this incident occurred?

16 A. Yeah.

17 Q. All right. And you have lived here at Sandpiper
18 for a little over five years; is that --

19 A. No. It will be five in December, I think.

20 Q. All right. And the folks like Ms. Strickler and
21 other people that work here, they've always been nice to
22 you?

23 A. Absolutely.

24 Q. And they've always done anything you've ever
25 asked of them?

1 A. Yes.

2 Q. All right. And you enjoy living here, that's
3 fair to say?

4 A. Yes.

5 Q. Otherwise, you wouldn't live here, would you?

6 A. No.

7 Q. All right.

8 A. I'm happy here.

9 Q. And was Ms. Parrott always happy here when she
10 was here?

11 A. As far as I know.

12 Q. Your understanding of Ms. Parrott's fall was
13 that she was hanging curtains on a rocking chair; is that
14 right?

15 A. I don't think it was a rocking chair. I think
16 it was a stuffed chair. And I don't know if it was a
17 recliner or not but it was a stuffed chair.

18 Q. All right. And, obviously -- and you can tell
19 me if I'm wrong -- but, obviously, that initial fall in no
20 way, shape or form could be attributed to the acts of
21 somebody working for Sandpiper, right? They didn't cause
22 that fall, did they?

23 A. No.

24 Q. All right. And you didn't see that fall and you
25 don't know when that fall occurred, do you?

1 A. No.

2 Q. All right. And if I have documents in my
3 possession, and when I say -- I'm not talking about things
4 that necessarily might be here. But if the folks at
5 Sandpiper took statements and reports about their
6 conversations with you after this incident occurred, would
7 that be something that would jog your memory about maybe
8 talking with them about this?

9 MR. REEVES: Object to the form.

10 BY MR. BUCKNER:

11 A. Yeah.

12 Q. All right. Do you recall those conversations?

13 A. Yes.

14 Q. With Ms. Carrington?

15 A. Yes.

16 Q. And they occurred after this incident, correct?

17 A. Yes.

18 Q. All right. So when you testified earlier in
19 response to Mr. Reeves' question that you hadn't spoken with
20 anybody at Sandpiper about this incident, were you mistaken?

21 A. No.

22 Q. All right.

23 A. I didn't speak to anybody at Sandpiper.

24 Q. All right.

25 A. Just Elenore one -- because she's the one that

1 took me to see her the night before she passed away.

2 Q. All right. If Ms. Corrine Carrington documented
3 that she spoke with you after Ms. Parrott was found in her
4 apartment, do you have any reason to dispute that?

5 A. She did not talk to me.

6 Q. All right. How about Ms. Beth Auld?

7 A. No.

8 Q. All right.

9 A. Nobody talked to me after.

10 Q. Even Rebecca?

11 A. Nobody.

12 Q. All right. And if those folks documented a
13 conversation they had with you after this incident, is there
14 any way that that could have taken place on Thursday before
15 Ms. Parrott was discovered?

16 A. I don't know that anything was documented. We
17 just didn't talk about it after that.

18 Q. All right. Was Ms. Carrington, insofar as you
19 know, an honest person?

20 MR. REEVES: Object to the form.

21 BY MR. BUCKNER:

22 A. As far as I know.

23 Q. And she took her job very seriously as far as
24 you know?

25 MR. REEVES: Object to the form.

1 BY MR. BUCKNER:

2 A. She did.

3 Q. All right. And do you believe that she would
4 fraudulently document something in a report that didn't
5 occur?

6 MR. REEVES: Objection.

7 BY MR. BUCKNER:

8 A. I don't know that she documented anything and I
9 I don't know that she would do it if it didn't occur. I
10 mean, I know she did it properly.

11 Q. All right. What is your relationship, if any,
12 with Ms. Beth Auld?

13 A. Fine.

14 Q. And is Ms. Auld an honest person?

15 MR. REEVES: Object to the form.

16 BY MR. BUCKNER:

17 A. As far as I know.

18 Q. And Ms. Auld has no reason to lie or mislead
19 anyone about what might have happened to Ms. Delila, right?

20 A. None, that I know of.

21 Q. And you're aware, per your conversation with her
22 daughter Rebecca, that Ms. Auld claims that she saw
23 Ms. Delila on Thursday before the Friday that she was
24 discovered, correct?

25 A. That's what she told the manager, Corrine.

1 Q. All right. And can you think of any reason
2 sitting here today that will Ms. Auld would tell
3 Ms. Carrington something that wasn't true?

4 MR. REEVES: Objection.

5 BY MR. BUCKNER:

6 A. No.

7 MR. BUCKNER: Could we go off for a second?

8 VIDEOGRAPHER: Off the record at 10:43.

9 (Momentarily off the record)

10 VIDEOGRAPHER: Back on the record at 10:44.

11 BY MR. BUCKNER:

12 Q. Ms. Watters, I don't have too much for you so
13 I'm going to try to be quick so we can get this done. I
14 promise, I'm not going to keep asking you too many
15 questions, and I appreciate your patience.

16 What, if anything do you know about
17 Ms. Parrott's paranoia before this incident?

18 A. I didn't see it at all.

19 Q. All right. And are you aware that she asked the
20 staff at Sandpiper to change the locks on her door because
21 she was paranoid?

22 A. Yes.

23 Q. All right.

24 A. She didn't tell me until after the fact.

25 Q. But you don't dispute that she did that because

1 of paranoia?

2 MR. REEVES: Object to the form.

3 BY MR. BUCKNER:

4 A. I don't know why she did it. I thought it was
5 kind of dumb, but she did it.

6 Q. All right. And are you aware of any
7 conversations that she had with Ms. Carrington or any other
8 security staff about accessing keys to her apartment?

9 A. What Delila told me was when they -- she had her
10 locks changed she gave the key to Rusty, our maintenance
11 man, and he took it to Corrine.

12 Q. All right. Do you know whether Ms. Delila asked
13 Corrine to have any sort of a special arrangement for her
14 key? In other words, to restrict access to it?

15 A. She just sent -- she sent a new key back and the
16 old ones, the old key and the brand new key. And she said
17 she sent the brand new key by Rusty.

18 Q. And she didn't ask the folks at Sandpiper,
19 obviously, before she changed her locks, right?

20 A. I don't know.

21 Q. All right. You discussed earlier with
22 Mr. Reeves a -- I think you called it an emergency button --

23 A. Yes.

24 Q. -- that some residents wear?

25 A. Yes.

1 Q. But, obviously, this is an independent living
2 village, correct?

3 A. Yes.

4 Q. And residents like yourself independently choose
5 whether to wear that button or not, correct?

6 A. I'm sorry. Do that one more time?

7 Q. Yes, ma'am. Residents like yourself, you choose
8 for yourself whether to wear that emergency button or not --

9 A. Yes.

10 Q. -- correct?

11 A. Yeah.

12 Q. And the folks at Sandpiper can't force you to
13 wear that against your will, can they?

14 A. No.

15 Q. And they wouldn't have done that with
16 Ms. Delila, would they?

17 A. No.

18 Q. Insofar as you know, no?

19 A. Yeah.

20 Q. And do you have any knowledge sitting here today
21 whether Ms. Delila was in fact wearing her emergency button?

22 A. She was not.

23 Q. All right.

24 MR. BUCKNER: Could we go off for just one
25 minute?

1 VIDEOGRAPHER: Off the record at 10:47.

2 (Recess from 10:47 a.m. to 10:53 a.m.)

3 VIDEOGRAPHER: On the record at 10:53.

4 BY MR. BUCKNER:

5 Q. Ms. Watters, I promised you I didn't have much
6 longer and I don't have much longer so I'm trying to get
7 through it, so please be patient. I appreciate all of your
8 help so far.

9 You had testified earlier that you and staff
10 from Sandpiper went to Ms. Parrott's apartment on Thursday,
11 the day before she was found; is that --

12 A. We didn't go together but we both went.

13 Q. All right. And it was Rebecca, Beth Auld's
14 daughter, that went?

15 A. Yes.

16 Q. All right. And she knocked on the door?

17 A. She said she did.

18 Q. All right. And when did you first find out that
19 she had tried to visit Ms. Parrott on that Thursday?

20 A. She told me she was checking every day. And
21 that's when she said she might be with one of her daughters.
22 And I said, I don't think so, she would let me know.

23 Q. And at that time had Rebecca spoken with her
24 mother about seeing her that day, that Thursday?

25 A. I was not involved in that. Rebecca and Beth

1 and Corrine. Corrine's the one that told me that Beth said
2 she saw her, but she couldn't remember if it was lunch or
3 dinner.

4 Q. All right. And I want you to -- I know you
5 don't know anything about that and I'm not asking you to
6 because we can't know something about something we have no
7 clue about. But I want you to assume for a second that
8 Ms. Auld had seen Ms. Parrott on that Thursday, okay? Will
9 you do that for me for purposes of this question?

10 A. Well, nobody at the dinner table had seen her.

11 Q. I know. I'm asking if you will assume that
12 Ms. Auld did in fact see her.

13 MR. REEVES: Objection.

14 BY MR. BUCKNER:

15 A. I think she made a mistake.

16 Q. All right. And had Ms. Auld seen her on that
17 Thursday?

18 A. No. She made a mistake.

19 Q. All right. And why is it that you believe she
20 made a mistake?

21 A. Because she wasn't there for any meal and she
22 didn't contact me, so --

23 Q. All right. And who was at lunch that Thursday,
24 if you ate lunch that Thursday?

25 A. I don't know. We keep changing people at our

1 table. People leave all the time.

2 Q. Do you recall anybody who was there?

3 A. Ellen Haimen and Beulah were two of the oldest
4 ones since I've been there.

5 Q. All right. And --

6 A. And Matilda.

7 Q. All right. How about at dinner? Do you recall
8 who was there on Thursday at dinner?

9 A. Nobody had seen her.

10 Q. But I'm asking you what other residents were at
11 dinner.

12 A. I don't remember who came to dinner and who
13 didn't come to dinner. I mean, they might just come in and
14 you see them and they just take their dinner home and eat
15 it.

16 Q. Is it your understanding that Ms. Beth Auld no
17 longer works here?

18 A. She does.

19 Q. She does work here?

20 A. Yes.

21 Q. Okay. And I don't want to pry, but because
22 you've been identified as a witness and you're giving a
23 deposition today, I have to ask you a couple of questions
24 that I wouldn't otherwise do.

25 Are you on any sort of medication today that

1 would affect your ability to testify in any way?

2 A. I'm on medication but nothing that affects me.

3 Q. All right. What medications are you on?

4 A. I'm -- blood pressure medication.

5 Q. And that's it?

6 A. (Nods head). Well, she put me on an
7 antidepressant when a medication they gave me is not
8 working.

9 Q. All right.

10 A. But it doesn't have anything to do with my
11 ability to remember what happened.

12 Q. Have you spoken -- besides the Parrott family
13 including Ms. Parrott's daughter, have you spoken with
14 anybody else about this case?

15 A. Only Elenore Kissell.

16 Q. And that would be it?

17 A. Yes.

18 Q. All right.

19 A. No. I did tell Barbara Hardy. I remember now.

20 Q. All right. Who is Barbara Hardy?

21 A. She's another resident.

22 Q. All right. Does she still live here?

23 A. It is not mentioned -- it's not been mentioned
24 since I told her about Delila, because she and I became good
25 friends, too.

1 Q. All right. Does Barbara still live here?

2 A. Yes.

3 Q. What apartment does she live in?

4 A. C-1, I think. Right across the street from me.

5 Q. All right. And what apartment was Ms. Parrott
6 in at the time of this incident where she fell?

7 A. She was in S-something. It was only about a
8 half a block from me. I could walk down there.

9 Q. All right. Do you recall who her next door
10 neighbors were on each side --

11 A. No.

12 Q. -- of her?

13 A. No.

14 Q. All right. Did she have folks living in those
15 apartments on each side of her?

16 A. As far as I know, yeah. She told me she took a
17 shoe and banged on the chester drawers but nobody heard her.
18 But she heard me when I was on the porch. She said, well,
19 why didn't you come to the window? I said, I can't answer
20 that, why I didn't. It was only like three feet away. I
21 thought if she couldn't hear me from the door, she couldn't
22 hear me from the window. I didn't -- I didn't go to the
23 window but she wanted to know why I didn't go to the window.

24 Q. I don't think I have any other questions. Thank
25 you for your time.

REEXAMINATION

BY MR. REEVES:

Q. Ms. Watters, do you like living here?

A. What?

Q. You like living here a lot?

A. Yes.

Q. And it's been an enjoyable experience for you?

A. Is this an experience for me?

Q. It's been an enjoyable experience for you?

A. Yes. Yes.

Q. You don't want to hurt anybody at this residence?

A. No.

Q. You just -- have you told the truth today, though?

A. Yes.

Q. Does it bother you to have to tell this story even though you like living here?

A. Well, yes. I just don't want Sandpiper to get mad with me --

Q. Okay.

A. -- for doing it.

Q. But you've told the truth today?

A. Yes.

Q. Thank you, ma'am.

1 A. I just think she would have done it for me and
2 then I did like her daughters. I said I'd do it, so I'm
3 doing it.

4 **Q. And you've told the truth?**

5 A. Yes.

6 **Q. Okay. Thank you, ma'am.**

7 MR. REEVES: That's all I have.

8 MR. BUCKNER: Nothing else.

9 VIDEGRAPHER: This will conclude the video
10 deposition of Ms. Lila Watters. We're off the record
11 at 11:01 a.m. on February 2nd, 2017.

12 (The taking of the deposition concluded at
13 11:01 a.m.)

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CERTIFICATE OF REPORTER

I, Laura S. DeCillis, Certified Court Reporter and Notary Public in and for the State of South Carolina at Large, do hereby certify:

That the foregoing deposition was taken before me on the date and at the time and location stated on Page 1 of this transcript; that the deponent was duly sworn to testify to the truth, the whole truth and nothing but the truth; that the testimony of the deponent and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed; that the foregoing deposition as typed is a true, accurate and complete record of the testimony of the deponent and of all objections made at the time of the examination to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

I further certify that the original of said transcript shall be hereafter sealed and delivered to PAUL L. REEVES, ESQUIRE, Reeves and Lyle, 1527 Blanding Street, Columbia, South Carolina, 29201, and that this original transcript shall be retained by the above party, who shall be responsible for filing same with the court prior to trial or any hearing which might result in a final order on any issue.

Witness my hand, I have hereunto affixed my official seal this 15th day of February 2017, at Columbia, Richland County, South Carolina.

Laura S. DeCillis,
Certified Court Reporter
State of South Carolina at Large
My Commission expires
August 4, 2026

1 IN THE COURT OF COMMON PLEAS
2 FOR THE STATE OF SOUTH CAROLINA
3 CHARLESTON COUNTY

4 DEPOSITION OF LAWRENCE BERGMANN, Ph.D.

5 THE ESTATE OF DELILA PARROTT,
6

7 Plaintiff,

Case No. 2016-CP-10-5379

8 vs.

9 SANDPIPER INDEPENDENT AND ASSISTED
LIVING-DELAWARE, LLC,

10 Defendant.
11

12 DEPONENT: LAWRENCE BERGMANN, Ph.D.

13 DATE: June 25, 2020

14 TIME: 10:21 AM

15 LOCATION: REMOTE VIDEO CONFERENCE
16

17
18 REPORTED BY: TERI L. KENNELLY, RPR, CRR
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A P P E A R A N C E S

ON BEHALF OF THE ESTATE OF DELILA PARROTT:

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1527 Blanding Street
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ON BEHALF OF DEFENDANT:

YOUNG CLEMENT RIVERS
BY: MATTHEW O. RIDDLE
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Charleston, SC 29402

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2 identification.)

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4 identification.)

5 (Exhibit No. 3 marked for
6 identification.)

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8 identification.)

9 (Exhibit No. 5 marked for
10 identification.)

11 (Exhibit No. 6 marked for
12 identification.)

13 (Exhibit No. 7 marked for
14 identification.)

15 (Exhibit No. 8 marked for
16 identification.)

17 (Exhibit No. 9 marked for
18 identification.)

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20 identification.)

21 (Exhibit No. 11 marked for
22 identification.)

23 (Exhibit No. 12 marked for
24 identification.)

25 (Exhibit No. 13 marked for

1 identification.)
2 (Exhibit No. 14 marked for
3 identification.)
4 (Exhibit No. 15 marked for
5 identification.)
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7 identification.)
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10 (Exhibit No. 18 marked for
11 identification.)
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13 identification.)
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15 identification.)
16 (Exhibit No. 21 marked for
17 identification.)
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19 identification.)
20 (Exhibit No. 23 marked for
21 identification.)
22 (Exhibit No. 24 marked for
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25 identification.)

1 (Exhibit No. 26 marked for
2 identification.)

3 (Exhibit No. 27 marked for
4 identification.)

5 (Exhibit No. 28 marked for
6 identification.)

7 (Exhibit No. 29 marked for
8 identification.)

9 LAWRENCE BERGMANN, Ph.D.,
10 having been first duly sworn, was examined and
11 testified as follows:

12 EXAMINATION

13 BY MR. RIDDLE:

14 Q. All right. Dr. Bergmann?

15 A. Yes.

16 Q. Hey, my name is Matt Riddle. We sort of
17 just spoke for a little bit before we went on the
18 record here. I represent Sandpiper, the
19 defendant in this case we're here to talk about
20 today. And I understand that you have been
21 retained by the plaintiff in this case to provide
22 opinions as an expert in the field of psychology;
23 is that correct?

24 A. Yes.

25 Q. Okay. So the purpose of the deposition

1 today is just for me to ask you some questions
2 about your opinions and find out what your
3 opinions will be or what your opinions are and
4 what your testimony will be at the trial in this
5 case. Okay?

6 A. Yes.

7 Q. Is that your understanding of the
8 purpose of the deposition today?

9 A. Yes, it is.

10 Q. All right. And would you agree that if
11 after today your opinions change in any way or
12 that you have any new or different opinion after
13 today, that the defendants would be entitled to
14 know about that before any trial in this case?

15 A. Yes.

16 Q. Okay. And that we would have an
17 opportunity to ask you about any new or different
18 opinions after today before a trial in this case?

19 A. Yes. That's fine.

20 Q. Okay. And I believe I have taken your
21 deposition before in a Workers' Comp case a few
22 years ago.

23 A. I think so. That's primarily what I was
24 doing up until I retired.

25 Q. So I know you've had your deposition

1 taken before; is that correct?

2 A. I have.

3 Q. All right. I'll just remind you of a
4 couple of, I guess, ground rules for depositions.
5 If you don't understand any of my questions, just
6 ask me to repeat myself or rephrase, and I'll be
7 happy to do that. Okay?

8 A. Yes.

9 Q. Try to remember to use verbal responses.
10 So, for instance, yes or no instead of just
11 nodding your head or saying huh-uh or uh-huh.
12 And if you need to take a break at any time, just
13 let me know, and we can stop any time you want.
14 Okay?

15 A. That's fine, thank you.

16 Q. Let's see. I guess first if you can
17 just kind of give me a quick rundown of your
18 background. We do have your CV, but just for our
19 purposes today, can you let us know what your
20 educational and work history is?

21 A. Sure. I completed my undergraduate
22 degree from Emory University in sociology. I
23 completed a master's degree in clinical
24 psychology from Eastern Illinois University. I
25 completed a Ph.D. in counseling from University

1 of South Carolina.

2 I'm licensed as a professional counselor
3 in South Carolina. My work history is pretty
4 simple. In the -- in about 1982 I founded Post
5 Trauma Resources, a specialized practice related
6 to trauma, and was the owner until about maybe
7 six or seven years ago when I sold the practice
8 to the staff.

9 I continued to do clinical work
10 until about a year ago when I retired from all
11 patient care. Right now, I'm doing some
12 consulting work and disaster response. I do some
13 consulting in Workers' Compensation cases as well
14 still.

15 **Q. What percentage of your consulting work**
16 **would you say is in Workers' Compensation?**

17 A. It would probably be more than half.
18 I'm not doing a whole lot of consultation. I
19 work with The Directions Group. You probably
20 know Steve Yuhas, and he consults me on
21 psychological injury cases.

22 (Off-the-record discussion.)

23 **Q. Okay. And, Doctor, can you hear me**
24 **okay?**

25 A. Yeah. You're fine. I'm fine.

1 Q. All right. I can hear you.

2 And I guess I need to say this for
3 the record. Our court reporter is not there with
4 you today, is she?

5 A. No.

6 MR. RIDDLE: We're doing this
7 deposition by remote video. Are there any
8 objections to the format of this deposition,
9 Paul?

10 MR. REEVES: Yes.

11 MR. RIDDLE: There aren't any
12 objections? I'm sorry.

13 MR. REEVES: No objections.

14 Q. Okay. And I'll just assume that you can
15 hear me, okay, Dr. Bergmann. If at any time you
16 can't, just let me know and we'll try to fix it.
17 Okay?

18 A. I sure will. Thank you.

19 Q. So, yeah. I'll say that -- tell Steve I
20 said hello. I see him a lot with the South
21 Carolina Workers' Comp Educational Association.

22 A. Right.

23 Q. Done some work with them and Kids'
24 Chance. It's a Workers' Comp charity I'm
25 involved with, so --

1 Let's see. So you mentioned that
2 you're licensed as a --

3 A. A professional counselor.

4 **Q. Professional counselor, okay. Is there**
5 **any board certification involved with that**
6 **license?**

7 A. No. At one time, I was certified as a
8 trauma response specialist, but as I moved toward
9 retirement, I discontinued that.

10 **Q. When did you discontinue that?**

11 A. I'd say it could have been as long as
12 seven or eight years ago.

13 (Off-the-record discussion.)

14 **Q. And when you were certified as a trauma**
15 **response specialist, did that require board**
16 **certification?**

17 A. It's not a board certification in the
18 sense of a physician. It's an application and a
19 submission of experience in subject matter
20 expertise.

21 **Q. Have you ever had any other licenses or**
22 **certifications besides what you just told me**
23 **about?**

24 A. Yes. Up until last year I was also
25 licensed as a professional counselor supervisor.

1 **Q. What is the difference between that**
2 **license and the --**

3 A. In order to -- in order to be licensed
4 in South Carolina, you -- there's a certain
5 amount of supervision that's required. And so
6 the State in their wisdom decided to set up two
7 licensure tracks, and so some professionals are
8 licensed as supervisors to provide that
9 supervision to people entering the profession.

10 **Q. And did you decide to discontinue that**
11 **license because you were retiring from clinical**
12 **practice?**

13 A. I decided to not renew it because I
14 wasn't planning on supervising any clinicians.

15 **Q. Do you see any patients at all now?**

16 A. Nope.

17 **Q. And tell me more about the -- you said**
18 **disaster response work, I believe.**

19 A. That's correct.

20 **Q. Can you describe that in a little more**
21 **detail for me.**

22 A. So when I worked with Post Trauma
23 Resources, we traveled extensively to provide
24 emergency trauma response as well as to help
25 companies plan for violence and for disaster.

1 And there's a company out in Denver
2 called Blue Moon Consulting that uses me for my
3 psychological expertise in disaster. They're
4 primarily crisis communications and logistics and
5 security, and at times they need someone who has
6 an expertise in the mental health field and
7 disaster, and so occasionally I still work for
8 them.

9 **Q. What does that entail exactly when**
10 **you're called on by them?**

11 A. It could be telephonic consultation. It
12 could be trauma response. For example, several
13 years ago there was an apartment complex fire in
14 the Dallas area, and I traveled to Dallas to work
15 with the staff and the residents in the housing
16 complex. And sometimes I've done some proposal
17 writing for them as well.

18 **Q. Other than the consulting work that you**
19 **described and providing expert opinions such as**
20 **in this case and the disaster response work you**
21 **just described, do you have any other current**
22 **source of income?**

23 A. No.

24 **Q. So what percentage of the current work**
25 **that you're doing would you say is in**

1 counseling -- I'm sorry, in expert opinion type
2 work?

3 A. I'd say about a third, but honestly,
4 this is the only expert witness I'm doing right
5 now. I'm retired, and occasionally some people
6 remember me, ask me to do something. I'm not
7 actively seeking clients. I have -- just like
8 you go to meetings, I went to meetings and met
9 people. And occasionally, they seek me out, but
10 very occasionally.

11 Q. Sure. Okay. So are you currently
12 involved in any Workers' Comp cases at the
13 moment?

14 A. No.

15 Q. And this is the only --

16 A. That's not true. That's not true.
17 Steve has asked me about a case that he said I
18 may be evaluating later in the month, but I don't
19 have any firm plans to do that yet.

20 Q. All right. And this is the only court
21 case that you're --

22 A. Yes.

23 Q. -- you've been retained as an expert in?

24 A. Yes.

25 Q. One thing I forgot to mention earlier --

1 and this is probably even more important since
2 we're doing this remotely. Sometimes I ask
3 disjointed questions or kind of trail off and
4 then continue with a question, and that's my
5 fault. But try to wait until I've finished my
6 complete question before you respond so we're not
7 talking at the same time, and that makes it
8 easier for our court reporter, and it'll make the
9 record clearer as well.

10 A. Thank you, I can do that.

11 Q. And I'll try to wait until you finish
12 your answer before I move on to the next question
13 also.

14 Have you ever been sued for any
15 reason related to your counseling or psychology
16 practice?

17 A. No.

18 Q. Have you ever had any limitations on
19 your counseling license or any of the licenses
20 that you've held?

21 A. Yes.

22 Q. And what were those limitations?

23 A. I mentioned to you that there's -- there
24 are two licenses in South Carolina. I was
25 practicing before there was any licensure, and in

1 2004, I learned that my supervision license
2 wasn't applicable to my clinical work. When I
3 learned that, I turned myself in to the licensing
4 board, and we agreed on a remedy so that I could
5 continue work. And they required that I take the
6 clinical test, which I did. I passed. They
7 didn't require any supervision or anything else.
8 So we came to an agreement that I would take the
9 test, and I did.

10 **Q. So the supervision license that you held**
11 **at that time you said did not apply to clinical**
12 **work?**

13 A. My contention was that during the
14 licensing -- when licensing was established, I
15 had called them, and I said, Do I need two
16 licenses? And they said, No. As long as you're
17 licensed as a supervisor, you're fine.

18 When I went to some -- to a class with a
19 friend, who was also on the board, and I
20 mentioned what was happening, he said, I think
21 that's a problem.

22 So when I learned there might be a
23 problem, I immediately called the board to, I
24 guess, in quotes, turn myself in to try to
25 rectify the situation. And because -- they were

1 fine, and they came up with a solution, and I
2 agreed to the solution, even though I felt like
3 there was some disagreement about what the board
4 had said. You know, you can't really fight LLR.
5 And so I took the test. I had been in practice
6 for over 20 years. The test was not an issue,
7 and I went back to work.

8 Q. So -- and I hate to keep prying about
9 this, but I just --

10 A. Sure.

11 Q. -- want to make sure that we're clear on
12 all of it. So did you have -- you had just the
13 supervisor license up until that date?

14 A. Correct. That's right.

15 Q. And how many years were you practicing
16 as a clinical -- or counselor with that type of
17 license?

18 A. You know, I'm not really sure because I
19 don't know when licensure started. Could have
20 been as long as 20 years. That was what was so
21 ridiculous about it. It wasn't like it just
22 happened.

23 And I'm fairly well known in the
24 professional community, so it wasn't like I was
25 hiding. It was -- it was a misunderstanding, and

1 both of us thought we were right. And you really
2 can't fight city hall, and I didn't try to. I
3 came -- came to terms with them so I could work.

4 **Q. So you took the class and became**
5 **licensed as a result of that discovery?**

6 A. No, I didn't take a class. There's a --
7 there's an exam that all licensees take, and I
8 studied for the exam, and I passed the exam, and
9 that was the end of it.

10 **Q. Okay. There was no fine or penalty**
11 **other than that.**

12 A. I agreed to pay \$500 in fines. And by
13 the way, that's public information. If you go to
14 the LLR website, all the disciplinary actions are
15 there, and you're free to read the -- there's a
16 name for what they do -- the order, I guess.
17 That's really what happened. And I agreed to
18 comply with their request so I could go to work.

19 **Q. Sure. And since 2004, has there been**
20 **any other issue or problem with your license?**

21 A. No, sir.

22 **Q. Thank you. Let's see. Do you have**
23 **hospital privileges?**

24 A. No. Mental health counselors don't have
25 hospital privileges.

1 **Q. Okay. I wasn't sure how that worked**
2 so -- have you ever had any complaints filed
3 against you by any disgruntled patients, that
4 sort of thing?

5 A. Yes.

6 **Q. Do you remember any specific instances**
7 **of that --**

8 A. I do.

9 **Q. -- that you can think of?**

10 A. The complaint was that I had encouraged
11 a domestic violence victim to leave her husband.
12 The husband complained that I was unethical. The
13 board denied that. It didn't go anywhere, but he
14 did file a complaint against me.

15 **Q. Any other complaints filed?**

16 A. No.

17 **Q. Have you ever testified in a trial**
18 **setting in South Carolina?**

19 A. I have.

20 **Q. When was that?**

21 A. All through my career. I've testified
22 in military courts, both in the Marines and in
23 the Army. I've testified in civil cases on the
24 federal level and the state level and in criminal
25 cases. And I've also testified in an Equal

1 Employment Opportunity case somewhere along the
2 line as well as Workers' Compensation.

3 I've never actually been to a hearing,
4 but I've been deposed hundreds of times in
5 Workers' Compensations -- Workers' Compensation
6 cases.

7 **Q. Right. Have you ever had your**
8 **qualifications as an expert witness limited in**
9 **any way?**

10 A. No.

11 **Q. And again, we established this earlier,**
12 **but you've been retained by the plaintiff in this**
13 **case to offer your opinions?**

14 A. Yes.

15 **Q. What is your fee for that type of work?**

16 A. My fee is \$200 an hour for the work that
17 I do in preparation and in research, and \$300 an
18 hour for depositions.

19 **Q. Have you submitted any invoices for your**
20 **work so far in this case?**

21 A. Yes, I have.

22 **Q. Do you know what the amount of that bill**
23 **was?**

24 A. Just give me one second, and I can tell
25 you. \$2,200.

1 Q. Just a couple more questions about your
2 work background. Before you retired when you
3 were seeing patients in, I guess, a clinical
4 setting, do you know how many patients you would
5 see per week?

6 A. Toward the end of my career, I was
7 working two days a week every other week, and I
8 would see about ten people a day.

9 When I was working full-time, I would
10 see about ten people a day, five days a week, so
11 I stayed busy. But as my -- as I could and my
12 career slowed down, I cut back on my schedule. I
13 also moved out of town, and so we were traveling
14 to Columbia.

15 Q. So you've been primarily living in
16 Edisto for a while now, I guess?

17 A. For almost five years.

18 Q. Okay. And then when you were working
19 two days a week, you would travel up to Columbia
20 for a couple days and then back to Edisto?

21 A. Exactly. My wife likes to flip houses
22 so she always had a project in Columbia, and we
23 would go up, and she would work, and I would
24 work. And when we owned the practice, Susan was
25 the director of the practice.

1 Q. That's your wife?

2 A. Yes, Susan Bergmann. Yeah. She ran the
3 practice, and I ran my own practice, basically.

4 Q. When you were seeing -- when you were
5 working full-time five days a week, can you
6 estimate what percentage of your work at that
7 time, if any, was related to this type of work,
8 expert opinions, and providing opinions in
9 Workers' Comp cases?

10 A. Well, in terms of expert opinions, not
11 very much. You're always asked to provide your
12 opinion in Workers' Comp cases, because both
13 attorneys are requesting your opinion and, of
14 course, case managers are. That's sort of part
15 of being in a Workers' Compensation setting. So
16 I would say 100 percent of my cases ended up with
17 some sort of legal involvement. In a funny sort
18 of way, that's what keeps people from being
19 interested in Workers' Comp, but for me that is
20 what kept it interesting. I got to learn a lot
21 about the law and Workers' Comp and the medical
22 field, and it fascinated me. And I never
23 considered that to be a hassle or problem.

24 So that was a big percentage of what I
25 do, and of course, nurses show up. I mean, you

1 know the whole drill, so it's very much involved
2 in the legal system.

3 Q. So was that -- you said almost 100
4 percent of your patients were referred through
5 the Workers' Comp system?

6 A. I'm going to say about 80 percent by the
7 time I started to slow my practice.

8 Q. And as far as nonclinical work, that's
9 purely you're asked to provide an opinion -- and
10 let's limit it to trial, court cases, nonWorkers'
11 Comp cases. Do you know what percentage of cases
12 you've been asked to provide opinions for the
13 plaintiff versus defendant?

14 A. I've only done it several times, so let
15 me think about that for just a second.

16 Q. Sure.

17 A. If I had to make a guess, I would -- I
18 think it would be about 75 percent for the
19 plaintiff and 25 percent for the defense.

20 Q. How many times do you think you've been
21 asked to provide trial testimony like you've been
22 asked to do in this case?

23 A. Four or five times.

24 Q. When was the last time that you were an
25 expert in a state court case or federal court

1 **case?**

2 A. About a year ago, working with Steve
3 Yuhas, he had a client that was involved in a
4 motor vehicle crash in Georgia, and I worked for
5 the defense. It never actually ended up going to
6 trial, but I had been retained, and I was working
7 with the defense to help them understand the
8 psychological consequences of this crash. It was
9 a paramedic or EMS worker who had been injured.

10 **Q. And that one had a Workers' Comp**
11 **component to it?**

12 A. You know, I want to say no for some
13 reason. It seemed like it was a civil case by
14 the time it came to me. I just don't recall.

15 **Q. You were not a treating doctor in that**
16 **case?**

17 A. No.

18 **Q. Or treating counselor, I guess.**

19 A. No.

20 **Q. All right. So you've been asked to**
21 **provide your expert opinion in this case. Did**
22 **you ever meet Delila Parrott?**

23 A. No.

24 **Q. And her daughter, Joan Acosta, I believe**
25 **is the PR for the estate, unless I'm mistaken.**

1 MR. RIDDLE: Paul?

2 Q. Have you met Ms. Joan Acosta?

3 A. Yes, I have.

4 Q. Did you meet her in person?

5 A. We would work together occasionally when
6 I was in clinical practice.

7 Q. Have you met with her about this case?

8 A. I spoke to her when she expressed
9 interest in my being part of the case, but I have
10 not met with her.

11 Q. When did you speak with Ms. Acosta?

12 A. I think it was more than a year ago.

13 Q. At that time, had you spoken with
14 Mr. Reeves yet about the case?

15 A. No. Ms. Acosta called me first.

16 Q. And what was the nature of that
17 conversation with Ms. Acosta?

18 A. She described to me what happened, her
19 perception of what had happened, and asked me if
20 I would be able to be part of the case. And I
21 told her that I would need to see materials and
22 understand more before I could offer any opinion.

23 Q. Was that phone call from Ms. Acosta the
24 first information that you had received about
25 this case?

1 A. Yes.

2 Q. Do you remember specifically what she
3 told you about her perception of what happened?

4 A. No. And I think that's probably now
5 just complicated by having read her deposition
6 and all the other materials. I don't think I
7 remember much about the phone call other than she
8 had asked me to be involved.

9 Q. Had you had any communication with
10 Ms. Acosta outside of the professional setting
11 before this case?

12 A. Just at Workers' Compensation meetings,
13 social, hello, kind of things, but we weren't
14 friends or -- we were colleagues, and we would be
15 socially friendly.

16 Q. In preparing for this deposition today
17 and in the notice for this deposition, we sent a
18 list of documents that we had requested from you
19 along with a subpoena and the deposition notice.
20 Did you receive that list?

21 A. I did.

22 Q. And you've produced a number of
23 documents, some of which got supplemented to us
24 yesterday. And one of those was a file that was
25 labeled Parrott_Acosta notes, and we've marked

1 that as Exhibit Number 20 for the deposition
2 today. Do you have that there available to you?

3 A. I think so. If you just give me a
4 second.

5 Q. Sure.

6 A. I'm sorry, I know I have it. It's just
7 going to -- it's in a long list of things.

8 Q. If it helps, the stuff that we sent this
9 morning has all these files in numerical order.

10 A. Okay. As the number of the --

11 Q. Exhibit.

12 A. Okay, that would be helpful. There it
13 is. I see it. That was very helpful. Number
14 20, I see it.

15 Q. And I apologize that we had to send so
16 many documents at once. When we're doing these
17 depositions remotely, we're not sure which
18 exhibits we're going to use and which we might
19 not use so we have to send everything.

20 A. That's fine. It was fine.

21 Q. So Number 20 is -- there's what appears
22 to be a cover page, and it's a blue page that's
23 marked Defendant's Exhibit 20. Are you looking
24 at that?

25 A. It's headed General Questions.

1 Q. And is this cover page and the documents
2 attached -- was this packet something that was
3 sent to you in the course of this litigation?

4 A. Yes.

5 Q. And do you remember when you received
6 this packet?

7 A. Not exactly. I assume that I received
8 them all simultaneously when I started to look at
9 the materials, but I've looked at them so much,
10 my computer doesn't tell me when that is. I
11 imagine it was last fall sometime.

12 Q. Do you know if you had spoken with
13 Mr. Reeves by the time you received this packet?

14 A. Yes.

15 Q. So -- and I'll just try to establish a
16 timeline. Ms. Acosta called you at some point
17 over a year ago probably and talked to you a
18 little bit about the case; is that right?

19 A. That's correct, yes.

20 Q. Okay. And then at some point after
21 that, Mr. Reeves got in touch with you?

22 A. Yes.

23 Q. Is that correct? Okay. And did you and
24 Mr. Reeves talk on the phone or meet in person?

25 A. We spoke on the phone.

1 Q. And what was the substance of that first
2 conversation with Mr. Reeves?

3 A. Well, Mr. Reeves and I have known each
4 other for a period of time, so we discussed what
5 he might be interested in, and I described the
6 process that I use to look at cases. And he said
7 he would send me materials to look at.

8 Q. Did -- did you recommend Mr. Reeves to
9 Ms. Acosta?

10 A. No. It's just a small world.

11 Q. Sure. Did you talk about the specific
12 allegations in this case in that first
13 conversation with Mr. Reeves?

14 A. I don't have any independent recall of
15 that, but I'm sure we did. I'm quite positive.

16 Q. And I guess you don't remember if there
17 was any specific information given to you at the
18 time about the facts and circumstances of this
19 case?

20 A. As I've said, everything has been
21 polluted now by the amount of time that I've
22 spent looking at the materials. And I just
23 couldn't honestly tell you what I learned during
24 those initial conversations.

25 Q. All right. So this first page that we

1 were looking at earlier in Exhibit 2 -- I'm
2 sorry, Exhibit 20 is labeled General Questions,
3 and then there's -- the second page, it says,
4 Part one, overall health. Do you see that?

5 A. I do.

6 Q. And then attached with that are a number
7 of medical records.

8 A. Was that a question?

9 Q. Are there a number of medical records
10 attached with that?

11 A. Yes, there are.

12 Q. Okay. And then on what's been marked as
13 page 8 of this document package, there's a
14 heading that says Psych Admit, 2009.

15 A. That's correct.

16 Q. And then there's a list of questions
17 below that; is that correct?

18 A. Yes.

19 Q. And so that kind of is the pattern of
20 this packet, right? I mean, basically there's a
21 -- there's a cover page to a certain number of
22 medical records with a series of questions about
23 the content of those records. Is that accurate?

24 A. Yes. That -- I'm sorry. Yes, and those
25 then were duplicated by the other records that

1 were sent to me.

2 Q. Did you receive this packet before --
3 you -- well, let me rephrase that, I'm sorry.

4 Was this the first series of
5 documents that you received in this case, this
6 Exhibit Number 20?

7 A. I believe they came en masse
8 electronically to me on a CD.

9 Q. So it was this packet along with all of
10 the other medical records, complete medical
11 records?

12 A. Well, I don't know about all because I
13 don't know if I have everything, but the ones
14 that I reviewed. I don't think I received
15 anything additional. I don't recall if I did.

16 Q. And just to be -- just to make sure
17 we're clear, I'll refer to another exhibit. This
18 is what we've marked as Defense Exhibit 3, and
19 it's titled Materials Received and Reviewed,
20 Delila Parrott. Do you see what I'm looking at?

21 A. Yeah. Those numbers are very helpful.
22 Thank you so much.

23 (Off-the-record discussion.)

24 Q. So, Doctor, getting back to that list,
25 is this a complete list of all of the documents

1 and records that the plaintiff provided you to
2 review in this case?

3 A. Yes, and there were -- there were a
4 couple articles that were not medical records.
5 There was an article on what's called Long Lie
6 that Mr. Reeves sent me. And I didn't include
7 that on this list.

8 Q. You did send us some articles in
9 response to our subpoena associated with this
10 deposition today, and I'll have a couple
11 questions about those later. But as far as what
12 was provided to you initially on that disc -- and
13 I'll just state for the record that you held up a
14 disc and showed it to me. Was that a disc that
15 Mr. Reeves sent to you?

16 A. Yes, it was.

17 Q. And on that disc, was there this packet
18 that we've marked as Exhibit Number 20?

19 A. Yes. I can't be absolutely sure if I --
20 if I received records after that or not. I don't
21 think so, and if I did, there weren't very many.
22 I just don't recall at this point.

23 Q. Okay.

24 A. This is a list of everything I
25 eventually reviewed.

1 Q. All right. As best as you can recall,
2 did you receive that packet of records with the
3 notes on the blue cover pages that we've marked
4 as Exhibit 20 along with a number of other
5 records, all of or most of which are included on
6 this list that you've sent us that we marked as
7 Exhibit Number 3?

8 A. Yes.

9 Q. Do you recall if you reviewed the packet
10 with the blue cover pages before you reviewed any
11 other records in this case?

12 A. No. I don't -- I don't think I reviewed
13 it first.

14 Q. Do the notes and questions on these blue
15 cover pages on Exhibit Number 20 appear to be
16 giving you basically a roadmap for what the
17 plaintiff is seeking as far as your opinion in
18 this case?

19 A. I think it's pretty clear what they're
20 seeking, but that's not really the way I work. I
21 looked at all this information to -- and the
22 research to prepare my opinion, not the blue
23 sheets or any conversation I had.

24 Q. Sure. And just to answer the question
25 specifically, though, I mean, would you

1 characterize these blue sheets as -- and the
2 questions on these blue cover sheets as kind of
3 providing a roadmap for what the plaintiff would
4 like your testimony to be in this case?

5 A. I don't think so.

6 Q. How would you characterize it?

7 A. I guess that would be a no. I'm sorry.
8 I would characterize it as -- if these are from
9 Ms. Acosta, I would characterize those as her
10 concerns and questions, most of which don't
11 really have anything to do with my area of
12 expertise. Most of them are medical records.

13 Q. And your area of expertise again would
14 be in the field of psychology and mental health?

15 A. That's correct.

16 Q. Do you intend to offer any opinions in
17 this case outside of that area of expertise?

18 A. No.

19 Q. Since that first conversation with
20 Mr. Reeves on the phone that you told me about
21 and the time he sent you these records, have you
22 had occasion to meet Mr. Reeves again about this
23 case?

24 A. We've never met about this case.

25 Q. Have you had occasion to speak with him

1 on the phone again about this case since he
2 provided the medical records to you?

3 A. Yes.

4 Q. And what was the nature of -- well,
5 first, how many times do you think you've spoken
6 to him on the phone since you got the medical
7 records from him?

8 A. Maybe about three times.

9 Q. And what was the substance of those
10 conversations?

11 A. Offering -- offering my take on the
12 materials that I had reviewed. And I think at
13 some point we talked about the deposition. I
14 think at one point it was scheduled for last
15 fall, possibly, so we talked about that.

16 Q. And what did Mr. Reeves tell you about
17 the deposition?

18 A. Just that at one point I think it was
19 scheduled, and then it was unscheduled. It
20 didn't happen.

21 Q. When was the last time you spoke with
22 Mr. Reeves before the deposition today?

23 A. Yesterday.

24 Q. What was the substance of that
25 conversation?

1 A. He asked me some questions about what my
2 opinions would be, and I answered those questions
3 for him.

4 Q. Did you refer to any specific documents
5 during that conversation?

6 A. I think I referred to some of the
7 research articles that I had reviewed and some of
8 the depositions as well.

9 Q. Did you refer to any of the medical
10 records in your discussion with Mr. Reeves
11 yesterday specifically?

12 A. Yes.

13 Q. Do you remember which records you talked
14 about?

15 A. Dr. Davidson's deposition, Dr. Mills'
16 deposition. Let's see. Oh, Dr. Hart-Craig's
17 report. I think that's it.

18 Q. So was Dr. Hart-Craig's report the only
19 specific narrative medical report that you and
20 Mr. Reeves talked about yesterday?

21 A. I think so, yes.

22 Q. And the other documents that you talked
23 about, I believe you said were all depositions
24 that have been given in the course of this -- the
25 discovery in this case?

1 A. Yes.

2 Q. All right. So I guess can you just give
3 me a general overview about what your opinions
4 are in this case? We talked a lot about the
5 information that was given to you from the
6 plaintiff, and I guess just kind of give me a
7 rundown of all of your opinions or the opinions
8 that you intend to give at trial in this case.

9 A. Sure. So Ms. Parrott had a pre-existing
10 psychological condition that was fairly serious.
11 She had a delusional disorder that continued up
12 until the time of her death.

13 And those mental health issues
14 would tend to make her more vulnerable to any
15 other stresses and potentially traumatic events
16 that she might experience in her life. The fall
17 that Ms. Parrott took certainly was traumatic,
18 would be traumatic for anyone, and it hastened
19 Ms. Parrott's worsening condition and -- and
20 played a part in her demise.

21 Q. And I'll just try to run through what I
22 believe you just told me, and you can tell me if
23 I've mischaracterized or not, okay?

24 A. Yes.

25 Q. You mentioned that Ms. Parrott had a

1 pre-existing psychological condition; is that
2 right?

3 A. That's correct.

4 Q. Okay. And I believe you said it was
5 fairly serious?

6 A. Yes. It required hospitalization in I
7 think 2009 at the Baptist Medical Center.

8 Q. And did you say that it was -- that that
9 pre-existing condition made her more vulnerable
10 to any other stresses or traumatic events that
11 she might experience in her life?

12 A. Yes.

13 Q. And did you say that the fall that
14 Ms. Parrott took was traumatic and that it
15 hastened or worsened her condition?

16 A. I think the fall and the lack of
17 response to her after she fell. I probably
18 should have been more precise there.

19 Q. And then, finally, I think you said that
20 those circumstances -- and I guess -- would you
21 clarify it to say that the fall and any alleged
22 lack of response after the fall, I believe you
23 said, played a part in her demise?

24 A. Yes.

25 Q. Do you intend to offer any other

1 opinions or -- in this case?

2 A. I think that's a summary of my opinion.

3 Q. So I think I'll try to drill down on a
4 couple of those things. And if that prompts you
5 to think of any other opinions that may be more
6 covered by this overview, then, you know, just
7 let me know.

8 A. I will.

9 Q. All right. So are the opinions -- are
10 your opinions in this case based on your review
11 of the medical records and deposition testimony
12 notes that we have reviewed?

13 A. And also the scholarly and other
14 articles that I used for research.

15 Q. All right. I'd like to refer you to
16 what we marked as Exhibit Number 2, which is a
17 document that is labeled Compilation of Notes.

18 A. Yes, sir.

19 Q. Do you have that?

20 A. I do.

21 Q. Did you prepare this document?

22 A. Yes.

23 Q. And this appears to be sort of an
24 outline of the -- of some of the records and
25 deposition testimony in this case with reference

1 to page numbers?

2 A. Yes.

3 Q. Would you say that's an accurate
4 description of this document?

5 A. Yes. And just to clarify that a little
6 bit more, since I didn't meet Ms. Parrott, the
7 only information that I could use to offer an
8 opinion would come from medical records and the
9 information collected in depositions.

10 Q. We've been going for about an hour now.
11 Do you want to take a break or are you okay?

12 A. Were you asking me?

13 Q. Yes.

14 A. Oh, I'm fine. Let's keep going. I'll
15 let you know when I need to take a break. Thank
16 you.

17 Q. Okay. All right. I guess what I'd like
18 to do now is go through some of the medical
19 records specifically and sort of establish the
20 timeline of Ms. Parrott's condition and just --
21 and in the course of doing that, ask you
22 questions about your opinions in this case.

23 A. Okay.

24 Q. And I'll continue to refer to the
25 exhibits the way we have them labeled, and these

1 won't be in numerical order by the chronology.
2 They're sort of all over the place. I apologize
3 for that.

4 A. That's okay. I think as long as I have
5 the number, I can find it, and I appreciate that.

6 Q. Okay. So the first one I wanted to pull
7 up was what we marked as Exhibit 26. And that's
8 a report, I believe, of Dr. -- well, this is --
9 it's labeled Mills, but the doctor who prepared
10 this report, according to the signature on the
11 report, is Dr. Thomas Feely. Did I read that
12 correctly?

13 A. Yes.

14 Q. And this report is dated April 13th,
15 2009. And this appears to describe Ms. Parrott's
16 complaints of insect bites that she perceived.
17 Is that accurate?

18 A. Yes, it is.

19 Q. And looking down at the section that's
20 been labeled Physical Exam, after the doctor
21 provides the vital signs there, it says, Elderly
22 female, agitated and tearful over the bugs that
23 the rest of us cannot see. Did I read that
24 correctly?

25 A. Yes.

1 Q. And then under the Assessment and Plan
2 section, there's a note that says, Psychosis,
3 patient refuses to go back home where her house
4 is infected. She is tearful, agitated, and
5 anxious. Did I read that correctly?

6 A. Yes, you did.

7 Q. Okay. So is this the -- is this one
8 aspect of the pre-existing psychological
9 condition that you mentioned earlier?

10 A. Yes, it is.

11 Q. And I believe to my knowledge this is
12 the first reference in the medical records, first
13 in terms of chronologically, that we see a
14 reference to this -- what I'll refer to as
15 delusion. I don't know if that's the correct
16 terminology. Are you aware of any prior
17 reference to it in the medical records?

18 A. No, but I don't know that this is the
19 first. I just know this exists. I'll take your
20 word for that it is the first. It seems like it
21 would be early anyway.

22 Q. Are you familiar with this particular
23 record?

24 A. I've seen this, yes.

25 Q. So that would bring us to Exhibit 25,

1 which is Palmetto Baptist.

2 A. Okay.

3 Q. Do you have that document?

4 A. Yes, sir, I do.

5 Q. And the first page of the -- of what
6 we've marked as the exhibits is Bates stamped at
7 the bottom PHB 0053. Do you see that?

8 A. Yes, sir.

9 Q. And is the date on this record April
10 14th, 2009?

11 A. Yes.

12 Q. Give me just one second. I'm going to
13 pull up -- all right. So the report we just
14 looked at from Dr. Feely was dated April 13th,
15 and then it appears I guess the next day is when
16 she appeared to Palmetto Baptist, on April 14th;
17 is that right?

18 A. Yes.

19 Q. All right. And I'll read a portion of
20 this first page, and you can tell me if I've read
21 it correctly. And this is on page -- again,
22 what's been marked as PHB 0053, and it says,
23 Patient presents with complaint of being a host
24 for biting gnats since 2/09. These have gotten
25 worse with time. She states that they, quote,

1 "plant larva on me," comma, "and I feel it when
2 it hatches," period, end quote.

3 She states that the bugs get into
4 all her orifices and are even capable of pushing
5 the ear plugs out of her ears. She wears these
6 to prevent the gnats from going in her ears. She
7 stopped taking Xanax for about one week because
8 she wanted to stay awake 36 hours so she could
9 kill all the bugs. She stopped her CPAP machine
10 in early February since she thought the bugs got
11 inside of it.

12 She won't visit family or anyone
13 because she feels she is a host for these
14 critters and is contagious.

15 She has had her house fumigated
16 four times. She does three to four loads of
17 laundry and vacuums daily to deal with them. She
18 has been throwing away many of her things
19 including cherished items so that the fumigation
20 can get to all surfaces to kill the bugs.

21 She reports having suicidal
22 ideation for two to three weeks with plan to
23 overdose because she is so overwhelmed by the
24 bugs. Did I read that correctly?

25 A. Yes.

1 Q. So is that the pre-existing serious
2 psychological condition that you were referring
3 to a moment ago?

4 A. Yes. I think there were other symptoms
5 that are in the record about her being depressed
6 and having generalized anxiety, but certainly the
7 delusions are a very serious mental health
8 disorder.

9 Q. Is it your understanding from reviewing
10 these records, generally, that Ms. Parrott's
11 husband had died not long before this hospital
12 appearance?

13 A. Yes.

14 Q. In some patients, can an event like the
15 death of a spouse prompt this type of
16 psychological reaction?

17 A. I'm not an expert in delusional
18 disorders, but I would think that would be
19 doubtful. This is such a serious condition that
20 there's probably a biochemical component to this.

21 And while stress would certainly
22 play a part, this -- this is a very serious
23 condition, and I just -- I can't imagine that the
24 loss of a husband would be the primary trigger
25 for this.

1 I read at least one article in
2 preparation that this kind of delusional disorder
3 might be the result of too much serotonin, which
4 is one of the important neurotransmitters in our
5 brain.

6 Q. What could have accounted for
7 Ms. Parrott having too much serotonin, if that
8 indeed was a factor in her having these
9 delusions?

10 A. Biology or the use of medications that
11 increase serotonin. And there are many
12 medications that do that. My guess is it's just
13 a biological consequence of her genetics and
14 life. That's sort of like asking why do people
15 get cancer.

16 Q. And I'll just point you to a couple of
17 the other descriptors that the examining doctors
18 used in these records. This is on the page
19 that's been marked PHB 0250. This appears to be
20 notes of Dr. James Bouknight.

21 A. Bouknight.

22 Q. Bouknight.

23 A. Bouknight, but yeah.

24 Q. Okay. Thank you. And this just gives
25 us a little more detail in that it describes

1 Ms. Parrott saying that she believed the bugs
2 were crawling all over her skin, into her ears,
3 into her vagina, and into the rectal area to the
4 point that she no longer wants to live. She
5 wants to kill herself. Her plan would be to
6 overdose with a handful of pain medicine. Do you
7 see where I'm reading there?

8 A. I do.

9 Q. And did I read that correctly, Doctor?

10 A. Yes, you did.

11 Q. And this -- let's see. Would that
12 description be consistent with what you would
13 describe as auditory and visual hallucinations?

14 A. No.

15 Q. Why not?

16 A. Because these symptoms are consistent
17 with delusions. Auditory hallucinations are
18 hearing things. And typically hallucinations --
19 I'm trying to decide how to best distinguish
20 them. Experiencing somebody talking about you or
21 seeing something, and delusions are more ideas
22 and feelings.

23 So this would -- and there is an
24 overlap, of course, but these would typically be
25 referred to as delusions. And a special kind of

1 delusion. Parasitosis is the term used to
2 describe this syndrome.

3 Q. We had talked about Ms. Parrott's
4 husband having passed away not long before this.
5 And I'll just refer you to the page that's marked
6 393 of this same Exhibit Number 25.

7 A. The PHB 393? Is that what you're
8 referring to?

9 Q. Yes, sir.

10 A. Okay.

11 Q. And it says, The patient is a
12 74-year-old who has actually -- and this is under
13 the History of Present Illness section. The
14 patient is a 74-year-old who has actually worked
15 as a CRNA for many years. She has had
16 progressively more problems since her second
17 husband died approximately two years ago. It
18 goes on to say that she's been taking Xanax for
19 sleep since her husband died. Did I read that
20 correctly?

21 A. Yes, you did.

22 Q. Okay. So I think before you said you
23 would not agree -- and correct me if I'm wrong --
24 would not agree that Ms. Parrott's husband dying
25 would trigger these type of delusions with the

1 parasitosis. Would you agree that, at least
2 according to this note, that her husband dying
3 had an impact on her mental health to some
4 extent?

5 A. I didn't say it didn't have an impact on
6 her. And even Dr. Bouknight said progressively
7 more problems. And I think Dr. Bouknight and I
8 would both agree that she very likely had
9 problems, maybe this problem or other problems,
10 even before her second husband died. I don't
11 think what he's saying isn't consistent at all
12 with what I'm saying.

13 Q. Okay. I just wanted to be clear about
14 what your opinions are. I'm not challenging you
15 on that or anything. Just want to make sure that
16 I understand what you plan to testify to in this
17 case.

18 So along those lines, would you
19 agree that Ms. Parrott's husband dying and the
20 grief associated with that and -- according to
21 this note, she has some sleeplessness and had
22 been taking Xanax. Would those circumstances
23 have contributed to her developing this
24 parasitosis?

25 A. I think contributing is a fair word, so

1 I'll agree with that, yes, sir.

2 Q. Just as a layperson, I could see if
3 you're not sleeping for days on end, that would
4 have an adverse impact on you psychologically.

5 Is that a fair assessment?

6 A. Very fair. And it sounds like from the
7 prior note, she wasn't taking the medicine
8 because she -- she felt like that the delusions
9 would get worse if she slept. So, yeah, all
10 that -- it's a pretty serious mental illness.

11 Q. There's a consultation on the page
12 that's been marked PHB 0395. It looks like it
13 starts sort of at the bottom of that page.

14 A. Yes, sir.

15 Q. Elizabeth Patrick, MD. Do you know her?

16 A. No, I don't.

17 Q. Does this appear to be some type of
18 mental health assessment or --

19 A. Actually, my -- I'm sorry.

20 Q. Go ahead.

21 A. Actually, my guess is that she was
22 working on the unit and maybe Dr. Bouknight was
23 gone or -- I mean they're both MDs. I doubt that
24 Dr. Bouknight would call in somebody for another
25 opinion. He was quite well respected and well

1 known and had a lot of experience, even by then.
2 I'm not sure if it would have been a weekend deal
3 or what, to be honest.

4 Q. This note references in the History of
5 Present Illness section that Ms. Parrott did,
6 quote, Seemed to have increased blues due to her
7 macular degeneration, which has kept her from
8 doing many of the hobbies she has had for many
9 years, end quote. Did I read that correctly?

10 A. Yes.

11 Q. Would you agree with Dr. Patrick's
12 assessment here that macular degeneration can be
13 another factor that might contribute to increased
14 mental health problems for Ms. Parrott?

15 A. Absolutely. And I can see a
16 relationship between not being able to see and
17 feeling as if something is on you. She -- most
18 of us could at least test reality by saying, oh,
19 there's really nothing there or there is
20 something there. Ms. Parrott may not have had
21 the ability to do that.

22 Q. Did you get any sense in your review of
23 the records of the progression of her macular
24 degeneration and exactly how bad of a problem
25 that was for her?

1 A. No. And I'm not a medical expert, so it
2 probably wouldn't mean that much to me. I just
3 know that limited vision can impact people
4 emotionally as well as physically.

5 Q. Do you believe that her limited vision
6 impacted her emotionally, Ms. Parrott, in this
7 case?

8 A. I think it's likely it did, yes.

9 Q. And just for our purposes here,
10 generally speaking, macular degeneration is an
11 eye condition that impacts your vision, correct?

12 A. That's correct.

13 Q. And I know you're not offering testimony
14 as a medical doctor, but just so someone reading
15 this would know what we're referring to.

16 A. Yes, sir.

17 Q. We've included some discharge
18 information in these records that begin on the
19 page that's marked 0399, I believe.

20 A. I see that.

21 Q. Based on your -- and without reading
22 everything here, based on your review of these
23 records, what was her condition on discharge from
24 the hospital?

25 A. It sounds like she was improved. The

1 notes say her symptoms improved fairly
2 dramatically.

3 Q. What was the -- what interventions did
4 the hospital physicians implement that they
5 believed addressed her condition at that time?

6 A. Well, of course the medical doctors were
7 prescribing medicines and making medication
8 changes, but there were also psychological
9 interventions going on at the same time, and
10 those are reflected I think in other notes. And
11 then I saw that Dr. Taylor had done some testing.

12 Q. Who is Dr. Taylor?

13 A. He's a psychologist.

14 Q. What were the other interventions
15 besides medication that you --

16 A. Just knowing the program, they put them
17 in group counseling, and they make them come eat
18 together and socialize and get out of their room,
19 and they talk with nurses. So it's not -- it's
20 not just a medical program. It's supposed to be
21 a continuum of care. It's a psychiatric
22 hospital, a modern one, where people are supposed
23 to be doing things and working on things to
24 improve them.

25 Q. Specifically, what were the medications

1 that Ms. Parrott received to address her
2 psychological condition?

3 A. The notes say that they added Lexapro,
4 and they also added Seroquel.

5 Q. And she had already been prescribed
6 Xanax at that time?

7 A. That's correct. And it looked like they
8 increased the dose of the Xanax. Oh, excuse me,
9 that's PRN. They gave her the opportunity to
10 take more, but apparently she didn't need it.

11 Q. And that PRN is as needed, correct?

12 A. Yes.

13 Q. So what type of medication is Seroquel?

14 A. It's an antipsychotic that is also used
15 for people that are very, very nervous and
16 anxious. People who have stress disorders
17 occasionally use Seroquel.

18 Q. And you don't prescribe medication in
19 your practice; is that correct, Doctor?

20 A. No, sir. That's -- a physician
21 prescribes medication, but we had a psychiatrist
22 in our office for over 20 years, and I learned
23 quite a bit about medicine. So you just asked me
24 what it was, and I wasn't commenting on whether
25 it was appropriate or not. That's what Seroquel

1 is.

2 Q. And I wasn't asking you to comment about
3 that. I just wanted to make sure that -- I don't
4 think I had mentioned that in the record before,
5 so I wanted to make sure that we had documented
6 that.

7 A. Sure.

8 Q. But you did work I guess closely with
9 the psychiatrist in your office during the time
10 you were treating patients in a clinical setting?

11 A. Yes, I did.

12 Q. So you would at least be able to answer
13 my questions today about what these medications
14 are and what they were intended to do?

15 A. Sure. And if I can't, I'll let you know
16 that too.

17 Q. Okay. Thank you. So what about
18 Lexapro? Is that just a general antidepressant?

19 A. Uh-huh. It increases serotonin. The
20 current models for depression are that a lack of
21 serotonin may be responsible for at least some
22 components of depression, so that increases
23 serotonin, which seems a little funny given that
24 one model for parasitosis is too much serotonin.

25 Q. Are there any other -- I guess you --

1 I'm not sure if this is the right term -- but
2 psychotropic medications listed among these
3 discharge medications?

4 A. Nope. Those are -- of the ones I
5 recognize, those are the only psychotropics. I
6 don't know what Cardizem is, so I can't comment
7 on that.

8 Q. So -- and the reason I wanted to look at
9 these records in more detail was really just to
10 make sure that we establish and we know what her
11 condition was at that time, at least back in
12 2009.

13 A. And I think I was pretty clear that she
14 had a significant mental health issue. The nice
15 thing was, apparently through this treatment,
16 there was -- there was some improvement so that's
17 -- that's nice. That's a good course of
18 treatment for her, I guess.

19 Q. There was one other thing I wanted to
20 ask you about here. Give me just a minute to
21 review.

22 MR. REEVES: Matthew, would you
23 mind if we took a restroom break briefly?

24 MR. RIDDLE: Sure.

25 MR. REEVES: If you want to finish

1 this question, that's fine. I just -- whatever
2 is convenient.

3 MR. RIDDLE: Yeah, as soon as I --
4 let me get this question, and then we can take a
5 quick break.

6 MR. REEVES: Okay. Sounds good.

7 Q. I'm sorry, Doctor. I appreciate your
8 patience. I'm just having a hard time finding
9 this one comment I wanted to ask you about.

10 A. That's fine.

11 Q. Okay. This was on page 395, which is --
12 on this PDF it's on page 8 out of the 14 pages of
13 this exhibit. It's been marked 0395.

14 A. Okay. I'm there.

15 Q. And I think -- I guess this is the
16 consultation I was asking you about before with
17 Dr. Elizabeth Patrick, and it -- in the History
18 of Present Illness, it says that she was admitted
19 for psychotic depression. Would you agree that
20 that is an accurate assessment of Ms. Parrott's
21 condition at the time, psychotic depression?

22 A. I don't think I can answer that
23 question. It seems a little bit unlikely, but I
24 really have no way of knowing. I can't really
25 question her at this point.

1 **Q. Just as to the specific terminology of**
2 **that diagnosis?**

3 A. Yeah. I mean -- well, you know about
4 the DSM and all the different rules and issues
5 with making a diagnosis. And clearly she was
6 depressed. Whether she was psychotic or
7 delusional, that sounds like a good argument over
8 coffee with Dr. Patrick.

9 **Q. Okay. So that's kind of a matter of**
10 **degree when you're labeling something as either**
11 **psychotic or delusional?**

12 A. That's why people that do this enjoy it
13 because they can fight with each other about a
14 word. But clearly the point is she was very
15 sick, and she went into this treatment for about
16 three weeks and came out somewhat better.

17 **Q. And there's other comments in these**
18 **records from Palmetto Health Baptist that she had**
19 **threatened suicide; is that correct?**

20 A. That's correct.

21 MR. RIDDLE: All right. Paul, we
22 can take a quick break now.

23 (A recess was taken.)

24 **Q. All right. Dr. Bergmann, where we left**
25 off before we took a little break, we were

1 talking about the Palmetto Health Baptist
2 records. And again, I was just trying to kind of
3 go through and establish exactly what
4 Ms. Parrott's condition was before the incident
5 that's the subject of this case. Okay?

6 And a couple more records I wanted
7 to look at along those lines. In Exhibit Number
8 29, these are records from Dr. Mills, or this is
9 a report or reports from Dr. Mills who I believe
10 was Ms. Parrott's primary care physician. Is
11 that your understanding?

12 A. Yes, it is.

13 Q. And he practiced at East Cooper Internal
14 Medicine; is that right?

15 A. I think so, yes.

16 Q. So these -- this Exhibit Number 29 has
17 been Bates labeled ECIM at the bottom, page
18 numbered. So the page number I wanted to look at
19 was 67.

20 A. Okay.

21 Q. If I can find it. It's towards the end
22 of this packet that we marked as the exhibit.
23 Have you found that?

24 A. Yes, I have.

25 Q. And this is a report dated June 12th,

1 2013; is that correct?

2 A. Yes.

3 Q. And does this report indicate that
4 Ms. Parrott had moved to Sandpiper at this time?

5 A. Yes.

6 Q. And, in fact, it says that she was
7 stable and doing well, and she had enjoyed being
8 at Sandpiper?

9 A. Yes.

10 Q. What -- in this -- do you see this list
11 of current medications that's here on the left
12 panel of this particular report?

13 A. I do.

14 Q. What psychotropic medications was
15 Ms. Parrott taking at that time or was she
16 prescribed at least at that time?

17 A. It looks like she was still taking an
18 antianxiety agent and an antidepressant.

19 Q. What was the antianxiety agent?

20 A. Alprazolam -- Xanax.

21 Q. Is that the generic name for Xanax?

22 A. Yes. I butchered it, but yes.

23 Q. Alprazolam?

24 A. Yes. See, that's very good.

25 Q. Well, I don't know if that's how you say

1 it either but --

2 A. Sounds pretty good.

3 Q. And then the other one, you said --

4 A. I think that's Celexa. I'd have to look
5 it up, but I think that's Celexa.

6 Q. Which one is that in this list?

7 A. The one C-I-T-A-L-O- --

8 Q. Citalopram?

9 A. Yeah, citalopram. I believe that's --
10 I'm pretty sure it's an antidepressant.

11 Q. So at this time, it looks like she
12 had -- she was prescribed Xanax PRN, and Celexa,
13 one tablet once a day?

14 A. Uh-huh.

15 Q. Is that a yes?

16 A. I'm sorry. Yes, that's correct.

17 Q. All right. And the next documents I
18 wanted to have you take a look at are marked as
19 Exhibit Number 21. And this is a -- these have
20 been labeled Sandpiper_Parrott. Do you see these
21 records?

22 A. I do.

23 Q. All right. And what I want to refer you
24 to first is on page 67, what's been marked as
25 Sandpiper Parrott 067. It's the next-to-last

1 page of this little packet that's been marked as
2 the Exhibit Number 21.

3 A. Okay. I see it.

4 Q. All right. And that's -- the date is
5 June 6th, 2013, on this note here?

6 A. That's correct.

7 Q. And it appears to document that
8 Ms. Parrott reported that she had some coins
9 missing from her apartment?

10 A. That's correct.

11 Q. And then the person who signed this, it
12 appears later -- this is -- I'll tell you is
13 Corrine Carrington. That's the signature here.
14 First of all, have you seen these particular
15 documents before?

16 A. Yes, but when they're handwritten, it's
17 hard to decipher them. I'm aware that they were
18 here, and I'm aware that she was continuing to be
19 delusional at Sandpiper.

20 Q. Okay. And, yeah, that's the gist of my
21 question. This was June 6th, 2013.

22 A. Right.

23 Q. It's around the same time as that report
24 we just looked at from Dr. Mills. His report
25 didn't specifically reference it, right, any kind

1 of ongoing delusions, correct? His report didn't
2 mention it?

3 A. No, but that's probably not something
4 that she would volunteer to him anyway, and I
5 think -- it just -- it just seems likely that
6 even though she'd improved after a hospital stay
7 that these symptoms were long-lasting. It's not
8 like most people improve from these symptoms.
9 They improve, but they don't go away.

10 Q. They don't go away completely?

11 A. No, sir.

12 Q. And it looks like Ms. Acosta -- or I
13 presume that this is Ms. Acosta. She's referred
14 to as the daughter in these notes. If you'll
15 look on what's been marked as 068, there's some
16 reference to that -- she added that the mother
17 has a lot of paranoia and has had some
18 anxiety/paranoia for years. Did I read that
19 correctly?

20 A. Yes.

21 Q. And would you say that these comments
22 and some other comments here, that she's fearful
23 of people coming in without her knowledge, is
24 this further indication of her ongoing paranoid
25 delusions?

1 A. I'd rather we just say delusions.

2 Q. Okay. As opposed to characterizing them
3 as paranoid?

4 A. Yes.

5 Q. Can you say why you don't like that
6 word, paranoid delusions?

7 A. Well, I think to me paranoid is a
8 specific diagnosis. In thinking that somebody is
9 coming in may or may not be paranoid, it may be
10 more of a symptom of delusion, a high level of
11 anxiety. We're having another one of these
12 philosophical conversations. I don't think it's
13 probably worth discussing, honestly.

14 Q. Okay. I guess the reason I used the
15 word paranoid because this note reflects that her
16 daughter had said that. But from a clinical
17 diagnosis standpoint, you're saying that it might
18 not quite fit the -- what you would say would be
19 the definition of clinical paranoia?

20 A. That's all I'm saying.

21 Q. Is that correct?

22 A. Exactly.

23 Q. The other notes that I wanted you to
24 take a look at here -- let's see. I want to make
25 sure I'm going in chronological order. The next

1 one is the first page of this packet. It's
2 marked page 063, and the date is 9/25/13. Do you
3 see where I am?

4 A. I see it.

5 Q. Here she saw a van outside her
6 apartment -- and you can tell me if you think I'm
7 characterizing this incorrectly, but it looks
8 like she was concerned that someone in the van
9 was stalking her. Is that accurate?

10 A. I don't see the word "stalking." Is
11 there a word that describes other than the van
12 sitting outside that I missed?

13 Q. If you -- so at the end of the first
14 note at the top that's labeled the Record of
15 Concern, the last line says, She stated that --
16 and then it says, parentheses, over. So if you
17 go to the next page, it looks like the notes
18 continue there. And it says, stated that her
19 daughter that lives on James Island was being
20 stalked and she thinks they, parentheses, or he
21 is now stalking her.

22 A. Okay.

23 Q. Did I read that correctly?

24 A. You did. Like I said, I -- when you're
25 going through hundreds of pages of documents, it

1 gets really frustrating to read these almost
2 illegible notes, so that's exactly what it says.

3 Q. Oh, I know. I know that feeling well.

4 So -- and this goes on to say that
5 she had followed up -- Ms. Carrington, who signed
6 this note, reports that she had followed up and
7 that Ms. Parrott said that her daughters, quote,
8 don't understand. Do you see where I'm reading
9 that there?

10 A. No, I don't.

11 Q. On that page 63.

12 A. The first area or the second?

13 Q. The second area says that she had
14 offered to call the police or any of her
15 daughters. She declined. States they don't
16 understand.

17 A. I do see that.

18 Q. Would you say that this incident or
19 comments from Ms. Parrott is another indication
20 of her ongoing delusions?

21 A. Yes.

22 Q. And this was September 25th, 2013,
23 again?

24 A. Yes.

25 Q. And then the last one I wanted to look

1 at is on -- has been marked page 065. And these
2 notes are from February 28th, 2014, and
3 March 4th, 2014. You see those dates there?

4 A. I do.

5 Q. Okay. And so the events that we're --
6 that are the subject of this --

7 MR. REEVES: Excuse me, Matthew,
8 I'm sorry. What page are you on again? I'm
9 sorry.

10 MR. RIDDLE: It's 065.

11 MR. REEVES: Thank you.

12 Q. And so this -- the events of this case
13 are June 2014. Is that your understanding,
14 Dr. Bergmann?

15 A. Yes, that's correct.

16 Q. Or the subject of the allegations in
17 this case occurred in June 2014.

18 A. Yes.

19 Q. So this would have been maybe a little
20 over three months before the events in this case;
21 is that correct?

22 A. Yes.

23 Q. All right. And at that time, this is --
24 these notes reflect that Ms. Parrott had changed
25 her locks at that time?

1 A. Yes.

2 Q. Is that accurate?

3 A. Yes.

4 Q. Okay. And that these were -- there was

5 a discussion between Ms. Carrington and Mr. --

6 I'm sorry, Ms. Parrott about access to the unit

7 and having a key that would be able to access

8 Ms. Parrott's unit; is that correct?

9 A. It is.

10 Q. And looking on the follow-up page that I

11 guess was the back of this report page -- it's on

12 page 66 -- it says that -- it says that

13 Ms. Parrott had told Ms. Carrington that no one

14 is to go into her apartment ever.

15 Do you see where I'm reading there?

16 A. Yes.

17 Q. Is this type of behavior -- would you

18 say it's kind of a further indication that her

19 delusions were continuing at that time?

20 A. Yes.

21 Q. Was that a yes, I'm sorry?

22 A. Yes.

23 Q. All right. And that -- I believe those

24 were all the records I wanted to sort of run

25 through from prior to the incident. Let me pull

1 up your notes here. And your notes that we've
2 marked as Defendant's Exhibit 2 reflect that you
3 reviewed the Palmetto Baptist records, some
4 records from Sandpiper, and deposition testimony
5 of Ms. Acosta, Dr. Davidson, and Dr. Mills; is
6 that correct?

7 A. Yes. And I reviewed others, but the
8 purpose of this was just to indicate, yes,
9 Ms. Parrott had this serious pre -- pre-existing
10 condition. It's not everything.

11 Q. Okay. And then getting to the incident
12 itself -- and I'll just sort of follow through
13 your document that's labeled Compilation of Notes
14 here. The next section of this sort of outline
15 is labeled Incident Factors.

16 A. That's correct.

17 Q. And number 1 in this list is Sandpiper
18 2014, and it references Carole Harvey. Who is
19 Carole Harvey and what -- do you know what
20 specific page in the document production this
21 note refers to?

22 A. I can probably find it. I think she was
23 one of the social workers at Sandpiper.

24 Q. Okay.

25 A. I have it, actually. I'm not sure how

1 I'm going to help you -- oh, it says Sandpiper
2 Rehab 0594. Is that enough for you to find it?

3 Q. I think so. Let me see. Sorry.

4 A. That's all right. And it would be the
5 6/20/2014 note, and she's described as a social
6 service assistant, which does not mean a social
7 worker, I don't think.

8 Q. Give me just one second to try to find
9 that. I do want to make sure I don't have any
10 questions.

11 A. I'm glad you're having to look instead
12 of me.

13 Q. What was the Bates number again?

14 A. 0594.

15 Q. I think we do have this in our exhibits.
16 Maybe not.

17 A. I can send it to you if you'd like.

18 Q. No, I've got it. I just want to --

19 A. Okay.

20 Q. All right. So for the record, what
21 you're referring to in your notes that we've
22 marked as Exhibit Number 2 is the document that's
23 been Bates labeled Sandpiper Rehab 0594?

24 A. That's correct.

25 Q. And at the bottom of that page, there is

1 a note from the social services assistant, Carole
2 Harvey --

3 A. Yes.

4 Q. -- dated June 20th, 2014.

5 A. Yes.

6 Q. Is that the note that you're referring
7 to in your notes?

8 A. Yes.

9 Q. All right. And what is the -- what's
10 the purpose of your reference or the significance
11 of your reference to this note in your outline
12 that you've provided us?

13 A. It's one person's opinion concerning the
14 potential traumatic nature of the event.

15 Q. All right. So are you relying on the --
16 on Ms. Harvey's characterization of the
17 circumstances of Ms. Parrott's fall and -- and
18 the period of time that she was -- or she alleges
19 that she was on the floor to inform your
20 assessment of the significance of the trauma that
21 Ms. Parrott experienced as a result of this
22 incident?

23 MR. REEVES: I object to the form
24 of the question.

25 A. No.

1 Q. Okay. You can still answer, Doctor.

2 A. No.

3 Q. You're not relying on her
4 characterization of the events to assess the
5 level of trauma that Ms. Parrott experienced?

6 A. No. I can say more about that, but you
7 asked me a yes-or-no question.

8 Q. Are you relying on it at least in part
9 to inform your opinion?

10 A. A small part.

11 Q. Okay. Can you explain that some more?

12 A. Sure. I don't rely on any one piece of
13 information to try to create conclusions. What I
14 try to do is to understand how the totality of
15 opinions is reflecting what that experience might
16 be and how that fits what I know about a
17 traumatic event, potential traumatic event, and
18 how I understand that to be consistent with
19 what's going on in the scholarly area.

20 I also know that there are some --
21 that there's a question about whether Ms. Parrott
22 was on the ground for two days or two hours. And
23 so while I think the length of time that she was
24 on the floor is significant, in my opinion,
25 whether it was two days or less than two days,

1 the event could still be very significant and
2 potentially traumatic for the person who
3 experienced that.

4 So I'm well aware that there's
5 disagreement over the length of time. I can't
6 see that anybody has ever agreed on how long it
7 was. So it would be a little silly of me to take
8 Ms. Harvey's report, which obviously comes from
9 Ms. Parrott's report which is being questioned.
10 So I understand that I don't know how long she
11 was there, but I also know an awful lot about
12 trauma, and I know that -- that although the
13 length of time is a factor, it's not necessarily
14 the only factor.

15 So I tried to take into
16 consideration that number, that two-day number,
17 may not be accurate. It's mentioned over and
18 over again, and it almost has a life of its own,
19 and I don't know where that life comes from. But
20 I certainly --

21 **Q. And --**

22 A. I certainly know that I don't know how
23 long she was there, but I do know she was there
24 for a period of time. And given what I know
25 about people who fall and about anxiety and about

1 the helplessness that she likely experienced, I
2 don't think I really need to know the exact
3 number of hours that she was on the ground.

4 Q. And would you say that's particularly
5 the case with a patient like Ms. Parrott who has
6 a history of paranoia -- and I'm sorry, I know
7 you didn't want to use that term, but a history
8 of delusions and anxiety?

9 A. I think it's well known that people that
10 have pre-existing conditions are more susceptible
11 to the consequences or to the development of
12 consequences after a traumatic event. So that's
13 why there's really no argument. We went through
14 all that pre-existing stuff. To me that just
15 makes the case.

16 And the case is, here is an exquisitely
17 fragile woman from a mental health point of view
18 and from a disability point of view and likely
19 from a medical point of view. And so whether
20 it's two days or one day or 18 hours, you -- you
21 know, you sort of have to take the victim the way
22 they are, and this is a person who didn't really
23 need to be in this situation.

24 Q. Well, since we've kind of hit on this,
25 I'll ask you. Just putting aside any alleged

1 delay in finding her, just the -- just
2 considering a fall from a height, which -- and I
3 don't believe we talked about it specifically
4 yet, but Ms. Parrott -- is it your understanding
5 that she had climbed up on a chair and was
6 hanging curtains?

7 A. Yes.

8 Q. When she fell to the ground -- and I
9 believe all the -- you know, there is a dispute
10 about how long she was there before she was
11 found, but I believe all of the records, and
12 correct me if I'm wrong, indicate that she was
13 not wearing her emergency call button; is that
14 correct?

15 A. That's my understanding.

16 Q. Okay.

17 A. Or -- I don't know that. I know she
18 didn't use it.

19 Q. Sure. And she fractured her hip as a
20 result of the fall?

21 A. Correct.

22 Q. Is that correct?

23 A. Yes.

24 Q. And then -- and that left her with less
25 functional capacity than she had before the fall.

1 **Is that fair to say?**

2 A. I'm assuming. I'm not a medical doctor,
3 but I can't imagine somebody with a hip fracture
4 getting up and walking away.

5 Q. Okay. And we've already established
6 that Ms. Parrott had a history of delusions,
7 correct?

8 A. Correct.

9 Q. And anxiety, right?

10 A. Yes.

11 Q. She had expressed, at least back in
12 2009, suicidal ideations; is that accurate?

13 A. Well, that's true, but that's quite a
14 long time ago. I'm not sure if she was
15 experiencing that at the moment that she fell.
16 There's no evidence to that.

17 Q. And she had -- and we didn't touch on
18 this specifically, but the -- some of the
19 diagnostic imaging while she had been in the
20 hospital, she had some CT scans of her head. You
21 remember seeing those?

22 A. Yeah. I remember that there was some
23 neuropsych testing that said she had a mild
24 cognitive impairment.

25 Q. And the diagnostic imaging indicated

1 that she had lacunar infarcts or chronic
2 microvascular ischemic disease. Do you remember
3 seeing those terms?

4 A. I do. That's beyond the scope of my
5 expertise though. I looked at the testing. I
6 know that functionally she had some cognitive --
7 some mild cognitive issues.

8 Q. Would you agree that those kind of
9 things -- basically what I think can be referred
10 to as ministrokes -- would you agree that that
11 would have some impact on her cognition and her
12 mental health?

13 A. Yes. And again, making the point that
14 I'm making, I think, bolstering my opinion that
15 this was a woman who was exquisitely vulnerable
16 because of her -- I guess I should have mentioned
17 that I created a list -- because of her physical
18 issues, her pre-existing condition, and her what
19 were termed mild cognitive issues. This is
20 probably not the lady that you wanted to fall
21 down and lie there for some period of time.

22 We've already talked about the impact of
23 visual impairment, but if you add mild cognitive
24 impairment, this was a -- sort of perfect storm.
25 And then on top of that, adding this period of

1 time, which she may or may not have been able to
2 perceive correctly. It may be less, but she
3 might have felt like it was two days. We don't
4 know that.

5 And who knows what it feels like
6 when you can't see, you're not thinking the way
7 you used to, you're in pain, and then nobody
8 comes to get you.

9 Now, it seems obvious to me that
10 you can't discount any of those things as
11 contributory. And that's why I offered the
12 opinion that I did. It seems common sense to me.

13 **Q. So along those same lines and keeping**
14 **all that in mind, putting aside any delay in**
15 **finding her, just a fall and a hip fracture and**
16 **the associated disability after an event like**
17 **that, that would be enough on its own to**
18 **aggravate and accelerate all these pre-existing**
19 **issues, wouldn't it?**

20 A. It's possible. And I was really curious
21 about that. I have to say I'm not an expert in
22 falls. But there's actually quite a bit of
23 literature in the course of improvement for
24 people that have -- that take falls and break
25 their hip. And it turns out that most people do

1 fairly well. About 80 percent recover and
2 recover well.

3 So granted, Ms. Parrott had these other
4 challenges, but I don't think you can discount
5 the lack of attention and however long she was on
6 the floor.

7 I'm not -- I'm a scientist. I'm
8 sort of reasonable. You know, to say it's all
9 this or all that, that's not -- that's not the
10 way human nature is, and that's not the way
11 biology is. What I'm saying is that these
12 factors together were the thing that caused
13 Ms. Parrott to eventually pass away. That seems
14 like common sense to me.

15 **Q. But there's no way, Doctor, for you to**
16 **parse out exactly to what extent any alleged**
17 **delay in finding her contributed to her decline**
18 **and ultimately her death?**

19 A. I don't think there's any way -- I know
20 you would like me to give you a percentage.
21 That's impossible. But I do know that people who
22 are traumatized have been known to have shorter
23 lifespans. There's literature to that, and I
24 think I included a review article, a meta
25 analysis where multiple studies have shown that

1 exposure to trauma impacts lifespan. So I
2 factored that in too.

3 The hip injury, which most people
4 recover from, and the trauma, regardless of the
5 exact length, speeded this woman's death, I
6 believe.

7 Q. Do you intend to provide the opinion at
8 trial that her decline in death would not have
9 occurred but for some alleged delay in finding
10 her?

11 A. I don't think there's anybody that can
12 say that. I believe that played -- that that
13 played a role. Now, how significant, I can't
14 give you a percentage, but for the reasons I
15 mentioned, that it was traumatic, it caused her
16 increased psychological symptoms after, and it is
17 known that people who are traumatized can
18 experience shortened lifespans, I think it played
19 a role. I don't think it's possible to say the
20 exact percentage of what that role would be. But
21 I think that's in a sense what I am saying.

22 Q. And I asked this in a slightly different
23 way just now, but --

24 A. Okay.

25 Q. -- just to make sure that I'm clear

1 about what your opinion will be. Putting aside
2 any alleged length of time in finding her, a
3 fall, a hip fracture, hip open reduction internal
4 fixation surgery that she's had, that alone for a
5 patient like Ms. Parrott, that would likely cause
6 her to have a decline similar to what she's had,
7 right?

8 A. I don't think we can say likely. I
9 think what makes this likely is the long fall.
10 Given that most people do recover from hip
11 fractures -- I know it had to hurt like hell.
12 I'm sure of that. And it was scary. But the
13 real -- the real trauma here is the helplessness,
14 the hopelessness, not knowing if someone is going
15 to rescue you. I don't think that you can
16 diminish the significance of that regardless of
17 how long it was.

18 Q. So if it had been one hour, you think it
19 would have been the same impact as 12 hours?

20 A. No. I don't believe that. But whether
21 it's one day or two days or 12 hours or one day,
22 I mean -- I don't really know what the various
23 arguments are about how long she was there. I
24 just know that the magic two-day statement that
25 seems to be a recurrent thread is not really the

1 issue here.

2 The issue is that she felt so hopeless
3 -- apparently she peed on herself and defecated
4 and possibly might have tried to hurt herself
5 shows the desperation, that regardless of the
6 length of time -- although I do think it is
7 likely a significant cause to her -- it was a
8 horrible thing that happened to her.

9 And, yes, the fall was bad, but it's the
10 additional experience that goes along with the
11 fall that really makes this thing more difficult.
12 And that's really my opinion.

13 **Q. Okay. And so -- and I'm trying not to**
14 **hammer this too much, but I do want to make sure**
15 **that I'm clear on it. You said 12 hours or 24**
16 **hours. So you think if she had been there for 12**
17 **hours, you can't say what difference it might**
18 **have been between 12 hours and 24 hours, as far**
19 **as the impact and her -- on her decline and**
20 **death?**

21 **A. I think 12 hours is a long time to feel**
22 **like you're not going to be rescued and nobody is**
23 **going to come and get you. That's a long time.**
24 **Two days, that's an incredible amount of time. I**
25 **imagine if I was in that situation for four hours**

1 and I couldn't see, I couldn't get up, whatever,
2 that seems like a long time.

3 So I don't even know what times we're
4 talking about. Two days would be horrendous. 12
5 hours would be horrible. I don't know. I just
6 don't know. And I'm not going to be able to
7 parse it any more than that.

8 You know, the thing is you have to
9 have -- you have to in a sense put yourself in
10 this lady's situation and use common sense,
11 again, to imagine what the fall, the pain, and on
12 top of that not being able to get help must have
13 meant to her. And that's all I've done.

14 And the only reason that I outlined
15 things in that way -- in this way is to show that
16 there's -- there's some agreement, even in
17 Dr. Davidson's deposition that what happened
18 could significantly impact her emotionally. And
19 Dr. Mills thought it did and, of course,
20 Ms. Acosta did and even Carole Harvey did, you
21 know, the Sandpiper employee. So I don't think
22 I'm making any great leap here.

23 It just seems obvious that if you fall,
24 you want to be rescued pretty damn quickly
25 because you're in pain and you can't see and you

1 can't get up and that's a really bad thing.

2 Q. Okay. You said a lot there, and there
3 were a couple things I did want to try to follow
4 back on, if I can remember. So I think one of
5 the first things you said was -- and this may
6 have been a couple questions back -- was that,
7 you know, you're not a medical doctor, right? So
8 will you provide any testimony about the extent
9 to which she recovered from the hip fracture and
10 the impact of any alleged delay in finding her on
11 her recovery from the hip fracture?

12 A. No.

13 Q. You mentioned that she -- there was some
14 indication -- and I think you used the word
15 "possibly" -- that she had tried to harm herself.

16 A. Yes.

17 Q. What is the basis for your conclusion in
18 that regard?

19 A. I knew you were going to ask me that.
20 There was a note somewhere -- and I don't know if
21 it came from Ms. Acosta's deposition or somewhere
22 else -- that she had tried to rip a vein in her
23 arm and -- yeah, on page 164, line 4, of
24 Ms. Acosta's deposition, Ms. Acosta stated that
25 she -- that Ms. Parrott tried to open up an

1 artery. And I think in the medical records there
2 was some indication that she did have some kind
3 of an injury to her wrist.

4 So that's not open and closed, but it's
5 an indication of possibility that she might have
6 tried to harm herself during this period of time.

7 **Q. All right. Along those lines, we can**
8 **take a look at a couple records, and I'll have**
9 **some questions about it.**

10 In Exhibit 22, the Sandpiper Rehab
11 records -- and you had mentioned this report
12 earlier from Dr. Hart-Craig.

13 A. Uh-huh.

14 **Q. And this is -- the PDF file is 64 pages,**
15 **and this starts on the 53rd page of that PDF.**

16 The Bates stamp number is 0315.

17 A. Okay. Hold on. I'm a little lost now.

18 **Q. Okay.**

19 MR. REEVES: Could you repeat the
20 references again, please. Thanks.

21 MR. RIDDLE: Exhibit 22, and this
22 is what was previously marked Sandpiper Rehab
23 0315.

24 A. 0315?

25 **Q. Yeah. And this comes on the 53rd page**

1 of this PDF file that we sent. It's a 64-page
2 document that's been marked as Exhibit 22.

3 A. Okay. So I go 312, and then I don't see
4 a 313 or a 314. I just see 327. So can you tell
5 me what's on the top so I can look at it.

6 Q. It says MUSC Health, and there's a
7 barcode, and it says Physician Consultation
8 Report.

9 A. Okay. I see that.

10 Q. And the reason I wanted to look at this
11 particular report, we were talking about any
12 indication in the medical records that
13 Ms. Parrott had attempted suicide during the time
14 she was on the floor after her fall. Right?

15 A. Are you asking me if that's in the
16 record?

17 Q. Well, my initial question was, you know,
18 what was the basis of your conclusion that she
19 had possibly attempted suicide while she was on
20 the floor. And so I think you first referenced
21 Ms. Acosta's deposition testimony, right?

22 A. That's correct.

23 Q. And so I'm trying to see -- I just want
24 to bring your attention to a few sections of the
25 medical records to see if that would impact your

1 opinion as to any potential suicide.

2 A. Okay, sure. Yes.

3 Q. So, for instance -- so this report of
4 Dr. Craig, yeah, it starts on 0315, and then I'm
5 looking on the second page of her report. And
6 this is another one of those handwritten reports
7 that you enjoy reading.

8 A. And I was using a typed copy that
9 Mr. Reeves provided to me.

10 Q. Okay.

11 A. I'm assuming it's accurate, but honestly
12 I can't read a good bit of that.

13 Q. All right. So there is this section
14 that's assessment/plan, and I would say it's one,
15 two, three, four, five, six -- it's about six
16 lines up.

17 A. Okay.

18 Q. And at the end of this line, it says, No
19 formal suicide attempts. Did I read that
20 correctly?

21 A. Yep. I didn't take that as being
22 referring to the incident itself. Is that what
23 you think that she's referring to?

24 Q. Well, my question would be, you know,
25 what is your impression of what that comment

1 **means in her report?**

2 A. Well, that's her assessment at that
3 moment in time. You know, the other thing about
4 that report is -- isn't that -- yeah, here we are
5 back to the two-day thing. So if there was no --
6 if there was no suicide attempt and we're taking
7 that as true, does that mean she did lay there
8 for two days?

9 See, I think this is all -- these are
10 all reports, so I don't think this says that she
11 didn't try to kill herself during the event. I
12 think what it says is at the time of the
13 assessment, she was not actively suicidal. That
14 was my view of it.

15 **Q. All right. So you think that Dr. Craig**
16 **would write no formal suicide attempts to**
17 **indicate that at that current time that**
18 **Ms. Parrott was not suicidal?**

19 A. The recent past. The only thing -- the
20 only sentence in here that refers to the incident
21 is the last sentence, which says, She recalls the
22 fall, her fear, and laying on the floor/wall for
23 two days. Everything else does not refer to the
24 incident. That's why I interpret it that way.

25 **Q. Are you aware of any evidence other than**

1 **Ms. Acosta's own testimony to indicate that there**
2 **was a suicide attempt?**

3 A. You know, I wrote it down in my notes,
4 but I didn't write the citation. So I'm going to
5 say that there probably is one, but I would have
6 to look it up. I don't think I would have -- I
7 don't think I would have remembered that if I --
8 if that hadn't been somewhere in the record, so
9 I'm going to say I don't know, but I think so.

10 Q. And I know -- we -- we're likely to have
11 a trial in this case within the next month or so,
12 Doctor. And if there's a report in here
13 somewhere that says that this woman tried to
14 commit suicide, you know, and that's what you're
15 basing your opinion on, then I think I need to
16 know about it now.

17 A. I'm being honest with you. I'm telling
18 you what I remember. There's 4,000 pages of
19 documents here. I'm not relying on that. I use
20 that as an additional factor. It's not a
21 linchpin of what I'm saying.

22 I think we talked about in the beginning
23 that you -- that if I had any other information,
24 I could provide that to you, and I'll be glad to
25 try to do that if you'd like.

1 Q. Okay. But as we sit here right now,
2 you're not aware of a report that says that
3 Ms. Parrott attempted suicide while she was on
4 the floor after her fall?

5 A. I don't think anybody ever said that. I
6 think what the medical record said, from my
7 memory, was that she had a wound in a place that
8 was consistent with Ms. Acosta's report, that she
9 had tried to take her life.

10 Q. So getting back to your testimony just
11 now about the trauma and this causing a decline
12 in -- or contributing to a decline in
13 Ms. Parrott's condition, what is the basis of
14 your opinion that she had a decline? And
15 describe the nature of that decline.

16 A. The deposition of Dr. Mills where he
17 describes the decline, the deposition of
18 Dr. Davidson where he said it's possible that
19 that would cause a decline in her situation,
20 something like that. And Ms. Acosta says that
21 psychologically her mother never came back.

22 So, remember, I didn't speak to
23 her, so all I have are the people that either
24 knew her or treated her. And there's -- it seems
25 to be pretty consistent. Nobody is saying that

1 she was unimpacted.

2 Q. And what was the nature of the impact --
3 well, actually, first of all, let me back up.

4 You mentioned the deposition testimony
5 of Dr. Mills, Ms. Acosta, and Dr. Davidson in
6 support of your conclusions that there had been a
7 decline. What specifically in the medical
8 records that have been produced in this case are
9 you relying on to support your opinion that there
10 was a decline after the fall?

11 A. Well, the -- number one, the depositions
12 are reflective of the medical records, and
13 they're much easier to understand, but -- let's
14 see.

15 On ECIM0025, I think that's where
16 Dr. Mills says that Ms. Parrott wasn't the same.
17 It's a little -- it's a little hard to tell
18 because of the way these medical professionals
19 write, and they leave dangling sentences.

20 But he writes, She is not the same
21 since the fracture. She is often agitated and
22 irritable. She does not have any focal weakness
23 since the fall. And then in the deposition he
24 says the same thing.

25 Now, he may be referring to what

1 Ms. Acosta said, but it doesn't necessarily seem
2 like it. And regardless, in the deposition, he
3 does say that.

4 Q. And the record you were referring to
5 just now, is that the October 9th, 2014, report
6 from Dr. Mills?

7 A. Yes. Last three lines of the history of
8 present illness.

9 And I also think -- well, that's on
10 the depositions.

11 Q. All right. Does that record from
12 Dr. Mills reflect that Ms. Parrott's daughter was
13 with her that day?

14 A. Yes.

15 Q. But you said it's not clear from that
16 record whether the information that Dr. Mills is
17 reporting is based on what Ms. Parrott's told her
18 or what Ms. Parrott herself was reporting?

19 A. Well, I think it's sort of irrelevant,
20 because in the deposition, Dr. Mills offers the
21 same conclusion. So my sense is it's not what
22 Ms. Acosta said.

23 But I know what Dr. Mills said, and
24 he said that she was not the same after the
25 incident. Her mental condition suffered. The

1 event was traumatic, triggering, worsening of her
2 condition, and impacted her emotional state.

3 So, you know, the problem with
4 medical records is, if you know how people write
5 them -- and I've written them for 40 years --
6 sometimes a deposition is actually more
7 reflective of an opinion, but I think that
8 clearly -- pretty clearly that note is -- well,
9 it is consistent with what he said, and so I
10 think that he was right in his opinion.

11 Q. Okay. And again, this is October 9th,
12 2014. It also says that Ms. Parrott had not been
13 there since January; is that right?

14 A. Hold on. That's correct, yes.

15 Q. And he references her fall in June?

16 A. Yeah. He says three days so I don't
17 know.

18 Q. And so this is about four months after
19 that fall at Sandpiper?

20 A. Yes.

21 Q. And you reviewed the Sandpiper Rehab
22 records. I believe she was at Sandpiper Rehab
23 immediately after the fall up through about
24 September; is that correct?

25 A. Yes.

1 **Q. Is there anything in those records that**
2 **reflects a real serious decline?**

3 A. It says on page 55, slowed response.
4 Page 106, required reassurance that she was not
5 alone. On page 110, she feels like she will not
6 be a happy person again.

7 **Q. And these are comments that are referred**
8 **to in your outline that you provided us in**
9 **advance of the deposition today, right?**

10 A. Yeah. Remember, I haven't seen her, so
11 the only data that I have are the data that are
12 in the records, the data that are in the
13 statements made in the depositions, and the
14 science that is either consistent or inconsistent
15 with what's being reported. I haven't made
16 anything up. I haven't created anything. I've
17 just collected. And the collection of all these
18 opinions together are consistent.

19 You know, the thing you haven't
20 mentioned is the idea of secondary gain and
21 Ms. Acosta's statements possibly not being true
22 because she is the daughter. You know, that's a
23 possibility, but her -- her report seems so
24 consistent with what everybody else has said, I
25 didn't really think that secondary gain was a big

1 issue for her or in the deposition.

2 So I didn't rule it out, that she was
3 exaggerating or not telling the truth, but I
4 don't have any evidence to suggest that she was.
5 And because of the consistency in her reports and
6 Dr. Mills and even Sandpiper, I think her -- it's
7 likely that her reports are more accurate than
8 not.

9 **Q. Okay. And my question about the**
10 **Sandpiper Rehab records that you referenced**
11 here -- and this -- I think you kind of listed
12 what's on your notes here, you know, that she had
13 a slow response and abnormal affect, poorly
14 controlled pain, required reassurance that she
15 was not alone, moderate depression, wouldn't
16 those --

17 A. Excuse me, but I didn't read all those.
18 I just read the ones that I thought were related.

19 **Q. Right.**

20 A. So poorly controlled pain, I mean, she
21 had an injury, so that's clearly not the result
22 of the lie. And slowed response might be, but
23 not necessarily. I didn't read that. But
24 required reassurance that she was not alone,
25 well, if you've not been helped, it seems that

1 being anxious about being alone would be
2 reasonable.

3 And if she says she will not be a
4 happy person again, that seems like an indication
5 that she's really struggling.

6 Q. But these are all assessments that you
7 would expect to see for an 80-year-old woman who
8 had had a hip fracture and was unable to walk any
9 longer, correct?

10 A. Not necessarily. That she does not want
11 to be alone? And remember, this is only --
12 you're sort of cherry picking here now. That's
13 just one record, and then you have other records
14 and statements by the people that know her best,
15 her attending physician and her daughter. And
16 even your expert seems to, when he's willing to
17 give an opinion, seems to note that there's a
18 possibility this could impact her. So I don't
19 think you can cherry pick one record because I
20 haven't relied on one record.

21 Q. Well, my point was -- and I'm
22 referencing your notes on this outline here. And
23 just to be clear, this is the Exhibit Number 2
24 that's -- and this is -- we're looking at page
25 11, Parrott Bergmann subpoena response 0011.

1 And the point of my questions is
2 that -- that the notes at Sandpiper Rehab -- and
3 tell me if you agree -- that they don't reflect
4 the significant cognitive issues that appear
5 later in the records, into October, that
6 Dr. Mills was referencing in his October report
7 that we just looked at and that are referenced, I
8 believe, in the Ashley River Plantation notes
9 that are also -- that you also comment on here in
10 your outline.

11 Would you agree that it appears to be
12 around October is when she kind of demonstrated a
13 more serious decline in her condition?

14 A. I think -- I think what I can agree to
15 is that the notes from Sandpiper aren't exactly
16 the same as what Dr. Mills said or what's in the
17 Roper St. Francis notes later on. I wouldn't
18 expect them to be exactly the same because the
19 time frame is different.

20 **Q. All right. So, again, the date of that**
21 **Dr. Mills report we were just looking at is**
22 **October 9th, 2014, correct?**

23 A. Yes.

24 **Q. All right. I'm going to ask you to now**
25 **look at what we've marked as Exhibit 28.**

1 A. Okay.

2 Q. Which this is labeled Five Star. And
3 I'll just explain that these are the records that
4 we I believe received from the plaintiff in
5 document production that are the Ashley River
6 Plantation records, and it's also, I guess, known
7 as Five Star Assisted -- Five Star Senior Living,
8 so that's the way they've been labeled here.

9 A. Correct.

10 Q. Do you see that exhibit?

11 A. I do.

12 Q. The first couple pages of this exhibit
13 are records that we have -- or that were included
14 with those Ashley River Plantation records, and
15 these are from Mount Pleasant Hospital. Do you
16 see what I'm looking at?

17 A. Yes, sir, uh-huh.

18 Q. And it says the date of admission was
19 October 11th, 2014.

20 A. Yes, sir.

21 Q. And would that have been a couple days
22 after she saw Dr. Mills?

23 A. Yes.

24 Q. Now, this says -- at the beginning of
25 the section that's titled Hospital Course, and it

1 says that she, quote, Presented after a
2 precipitous decline over the preceding two weeks
3 with worsening cognitive function, end quote.

4 Did I read that correctly?

5 A. Yes.

6 Q. And the reason I'm referencing this
7 report here is just to ask you, you know, is that
8 more indication that there had been a -- kind of
9 a steep dropoff with -- around this period of
10 time in her function --

11 A. That's what --

12 Q. -- in October 2014?

13 A. I'm sorry. That's what the note says,
14 yes.

15 Q. And do you have any reason to dispute
16 the accuracy of this particular report?

17 A. There's no way I can.

18 Q. And looking back at your notes that
19 you've provided us, you've listed Sandpiper 2014,
20 Ashley River Plantation, and Roper St. Francis
21 under this heading, Post Incident Factors?

22 A. Yes.

23 Q. And so is it correct for me to assume
24 that these are the medical records that you are
25 primarily relying on in support of your opinion

1 with regard to her decline after this incident?

2 A. They're one component.

3 Q. Are there other medical records that
4 you're relying on besides what are listed here in
5 this outline?

6 A. Not that I recall.

7 Q. Are there specific portions of the
8 Ashley River Plantation record that you're
9 relying on? Because you haven't included page
10 numbers for that one.

11 A. Yeah. I can't say. Apparently not.
12 I'm not sure why I didn't put page numbers there.

13 Q. Would you agree that the Sandpiper
14 records from June until September 2014 don't
15 contain any reference to delusions?

16 A. I can't really recall if they do or not.
17 And even if they don't, I'm fairly certain she
18 had them. She had them for years and years. I
19 don't think they just went away. We've talked
20 about the -- usually they're pretty chronic.
21 They might have got tired of writing about them,
22 and she might have got tired of reporting.

23 Q. Are they documented in the Ashley River
24 Plantation notes?

25 A. I don't know.

1 Q. Your outline here lists some terms,
2 confused, anxious, paranoid, anxiety, quote, evil
3 spirits; is that right?

4 A. Yes.

5 Q. And are those terms that you pulled from
6 the notes in the Ashley River Plantation records?

7 A. Yes.

8 Q. And you don't know sitting here right
9 now if those same comments were in the Sandpiper
10 Rehab records from the previous months?

11 A. No, I don't.

12 Q. And the reason I'm harping on this,
13 Doctor, is just to try to see if you agree that
14 there appears to have been some, you know,
15 distinct period at the end of September or the
16 beginning of October where Ms. Parrott really had
17 a precipitous dropoff.

18 A. Well, it seems clear that she did, but I
19 don't think that really changes my opinion. She
20 -- she could be impacted and get worse and
21 struggle and then for one reason or another have
22 a precipitous decline or somebody noticed a
23 precipitous decline. So I think that's pretty
24 consistent with what I've been saying. Sort of
25 like at some point, somebody noticed.

1 Q. Is it just as likely that she had some
2 impact from these ministrokes that are documented
3 in the diagnostic imaging that suddenly caused
4 her to have a significant decline or demonstrate
5 a significant decline?

6 MR. REEVES: Let me object to the
7 question.

8 A. I'm not a doctor, so I can't answer that
9 question.

10 Q. Would you defer to the testimony of a
11 medical doctor about the impact of any of the
12 what I'll refer to as ministrokes?

13 A. I think that would depend on the
14 psychiatric experience of the physician and
15 whether they factored in these other things that
16 we've been talking about. I don't think just a
17 picture of somebody's head is really an accurate
18 way of determining function. We know that you
19 can't look at a CT scan and know how a person is
20 functioning. That's why we have
21 neuropsychologists and others doing this testing.
22 But I think it would be helpful to have another
23 opinion.

24 Q. Before I forget to ask this, Doctor,
25 have the opinions that you've provided so far

1 today been stated to a reasonable degree of
2 medical certainty?

3 A. Not medical certainty, but professional
4 certainty.

5 Q. And to the extent that you rely on any
6 testimony of Ms. Acosta -- and this may seem
7 obvious -- but I want to ask you just to make
8 sure we get it on the record -- are you assuming
9 that her -- the truthfulness of her testimony?

10 A. No. I just explained that I have to
11 factor in the potential for secondary gain.
12 That's the importance -- that's why it's so
13 important to have as many sources of information
14 as possible. So you have the medical records,
15 you have the science. Yeah, you have the family.
16 Of course, they have biases. We all do. Doesn't
17 mean it's not useful. It just means that you
18 have to understand the role that that kind of
19 relationship can play in the provision of
20 information.

21 Q. But to some extent, you did -- you are
22 relying on aspects of her testimony to inform you
23 as to things that might not appear in the medical
24 records specifically? Is that fair to say?

25 A. Well, I actually used the word

1 "possibly," to acknowledge that I wasn't 100
2 percent sure about the suicide attempt. I think
3 that's how this conversation started. So I try
4 to be sort of careful in -- in using words.

5 And, you know, I have no way of
6 knowing if that really happened. But I also
7 haven't seen anything yet that shows me that this
8 Ms. Acosta is exaggerating or lying. Doesn't
9 mean she isn't, and I'm very well aware that
10 people that do what I do are no better than
11 others at understanding who's telling the truth
12 and who's not.

13 So the only way to guard against
14 that is to use multiple sources of information,
15 be very careful about how you draw conclusions.
16 There have been many studies that show that
17 mental health people are horrible lie detectors
18 but so are attorneys. Even lie detectors don't
19 do such a good job.

20 MR. REEVES: Gentlemen, the page
21 number of the medical record that references a
22 wrist injury, for all concerned, is Roper
23 6/6/2014-107.

24 THE WITNESS: Can you say that
25 again so I might try to find it?

1 MR. REEVES: It's Roper -- well,
2 the Bates number is Roper 6/6/2014-107.

3 THE WITNESS: I have like five
4 different files of Roper. Can you help me at
5 all? I have Roper downtown, Roper St. Francis,
6 Roper 6/6, Roper 7/15, Roper 10/11, and Roper GI.

7 MR. RIDDLE: It would be in the
8 Roper 6/6.

9 THE WITNESS: Okay. 1 of 487
10 pages?

11 MR. RIDDLE: Yeah. It's on 107.

12 Q. I don't believe that I have included
13 this in the exhibits that we sent in advance of
14 this deposition, but it's been in -- it's been
15 produced in discovery. We've identified it by
16 the page number.

17 And, Doctor, do you see where we're
18 looking now?

19 A. I'm getting there. Give me one more
20 second, please.

21 Q. Okay.

22 A. I see 107.

23 Q. At the top, it says legend charting.

24 A. Yes, sir, I do see that. Left wrist.

25 Q. Laceration, left wrist?

1 A. Yes.

2 Q. So it looks like this is a -- possibly a
3 list of skin abnormalities that Ms. Parrott had.
4 Do you agree with that characterization?

5 A. You know, I can't really say. I don't
6 know what that term "open to air" means, if that
7 means there's an open cut there or not. So I
8 don't think I can comment on that.

9 Q. But a laceration means a cut, right?

10 A. Yeah. What does open to air mean?

11 Q. Yeah, I don't know so -- but it -- I
12 guess is there any indication here what the cause
13 of this wound was?

14 A. No. Absolutely not.

15 Q. So that could have just been a scrape
16 that she had on her arm from the fall, right?

17 A. It's possible, yes.

18 Q. And if anyone does find a reference in
19 the medical records to Ms. Parrott telling a
20 physician or a physician concluding that they
21 thought that she had tried to commit suicide
22 while she was lying on the floor, we can
23 reconvene to talk about it, correct?

24 A. Of course.

25 Q. I appreciate your patience, Doctor. I'm

1 just looking at my notes right now to see what
2 else I want to ask you about. I know there's got
3 to be something else I wanted to follow up on.

4 Yeah. The discovery responses that
5 we've gotten from the plaintiff in this case
6 included their expert witness disclosures that
7 indicated that you would provide an opinion about
8 PTSD. Are you assigning a clinical diagnosis of
9 PTSD in this case?

10 A. No.

11 Q. Do you intend to offer an opinion at
12 trial that Ms. Parrott exhibited PTSD after this
13 fall?

14 A. I think I'm prepared to say that she had
15 some symptoms that are often components of PTSD
16 but not that she has a diagnosis of PTSD.

17 Q. Did you see any indications in the
18 medical records that any of her treating
19 physicians had diagnosed her with PTSD?

20 A. I said I didn't either, but anxiety.
21 PTSD is an anxiety disorder, being concerned
22 about being alone, being scared. You know, those
23 are all symptoms that accompany a traumatic
24 event, but I'm not going to diagnose her with
25 PTSD.

1 Q. So some of the symptoms that are
2 described in the medical records are components
3 of PTSD, but you didn't see all of the elements
4 of that particular diagnosis reflected in the
5 records?

6 A. Well, I think it would be pretty hard to
7 make a diagnosis around a person you haven't met.
8 A diagnosis comes from the combination of
9 history, data, interview, testing, you know.
10 Clearly I can't do that.

11 Q. And that kind of leads me into my next
12 questions. Towards the end of Ms. Parrott's
13 life, their creeps into the medical records a
14 reference to schizophrenia. Did you see that any
15 mental health professional had diagnosed
16 Ms. Parrott as a schizophrenic at any point in
17 her life?

18 A. Absolutely not. That's a throwaway term
19 for crazy these days. You know, not too many
20 people go around saying, This patient has
21 parasitosis, so they end up being schizophrenic.
22 No, there's no really evidence of that that I can
23 see.

24 Q. So to the extent that the death
25 certificate indicates that the cause of death was

1 schizophrenia, would you, as a mental health
2 professional, disagree with that assessment?

3 A. Yes, because don't you have to die of
4 something physical? Doesn't your heart have to
5 stop or something has to happen to you, and --

6 Q. I'm not a doctor, but, yeah, I would
7 think so.

8 A. But I think even -- didn't Dr. Mills
9 even mention that in his deposition, that he
10 never did, and that he couldn't quite understand
11 why they would do that? I don't know.

12 So I guess the answer to the
13 question is that's -- I've never seen that, and I
14 can't imagine that somebody dies from
15 schizophrenia directly. Now, they may die from
16 running in front of a car and they might be
17 schizophrenic, but not from schizophrenia itself.

18 Q. What opinions do you intend to offer in
19 this case, if any, about Ms. Parrott's death and
20 how her mental health condition contributed to
21 her death?

22 A. Just that I think it did contribute to
23 her death. That's really as far as I can go.
24 Because in the end, there were medical issues
25 that killed her. And, of course, we all know

1 that medical issues are affected by -- are
2 affected by psychological issues. But that
3 connection is hard to discern.

4 So these are my opinions. I think it's
5 more likely than not that the length of time she
6 was on the ground and the helplessness and all
7 things we discussed today impacted her and
8 contributed to her death. And that's -- that's
9 my opinion.

10 **Q. In what way did her mental health**
11 **condition contribute to her death specifically?**

12 A. Well, in one way, I think I've -- I read
13 this possibly, at least in one case -- maybe
14 Dr. Davidson mentioned too -- the loss of will.
15 Dr. Mills mentioned it that if you're very
16 depressed and very hopeless and very anxious,
17 sometimes you just give up.

18 And we all know and can think of
19 examples where people who give up or in so much
20 pain die very quickly. I guess the classic
21 example of that is the wife who loses her husband
22 and two weeks later, the wife is dead too.

23 Now, how can you explain that? You
24 can't really do that on a cellular level, but we
25 all know that sometimes people decide that they

1 really don't want to live anymore, and the body
2 takes over.

3 Q. So is it your opinion in this particular
4 case that -- with a reasonable degree of
5 certainty that more likely than not that
6 Ms. Parrott's death was caused by her loss of
7 will?

8 A. I didn't say that. That was what the
9 expert said, what the provider said, and I was
10 just saying that that can play a factor. You
11 were asking me what the connection was.

12 Listen, I don't think in the end
13 anybody knows 100 percent for sure. It just
14 seems that all the data and all the scholarly
15 information points to a commonsense conclusion.
16 And that is that this -- the way this fall
17 occurred and the length of time, whatever it was,
18 where Ms. Parrott was not rescued, took an awful
19 toll on her and eventually contributed to her
20 death.

21 (Off-the-record discussion.)

22 Q. So, Doctor, we had a little bit of a
23 break there. And I just want to make sure that I
24 understood your last answer to my question. You
25 had mentioned loss of will as kind of a term that

1 one of the doctors had used or had appeared
2 somewhere in the medical records to indicate
3 something that might account for at least
4 partially Ms. Parrott's decline. And I had asked
5 you if it was -- if you intend to give the
6 opinion that more likely than not she had a loss
7 of will that caused her death.

8 A. No, I'm not.

9 Q. Okay. And this is a little off topic
10 from what we were on, but I just had a note here
11 to follow up on something you said earlier about
12 most people recovering from hip injuries. Is
13 that comment that most senior citizens recover
14 from hip injuries?

15 A. That was in some of the articles I sent.
16 I was curious about that myself. I think the
17 recovery rate is close to 80 percent.

18 Q. Okay.

19 A. Now, that's -- that's not a determining
20 factor in my opinion, but I think it just shows
21 that a hip injury in and of itself isn't an
22 automatic death sentence.

23 Q. And we can talk more about any of the
24 conclusions in those articles and how they might
25 apply to the specific circumstances of this case

1 as we go through those in just a minute, which
2 I'll try to quickly hit on those once we're
3 finished here.

4 All right. I think we can go ahead
5 and look at some of these articles that you
6 provided. So in response to our subpoena, you
7 sent, first, a list that's titled Reviewed
8 Article List, and we've labeled that Defendant's
9 Exhibit 4.

10 A. Yes.

11 Q. Did you pull these articles specifically
12 in preparation for the deposition today, or --

13 A. No.

14 Q. -- over the course of your review of the
15 records and developing your opinions, you just
16 sort of would pull these periodically?

17 A. Correct. I was trying to educate myself
18 on something I don't know that much about, which
19 is hip fracture at old age.

20 Q. So -- and again, you would agree that
21 it's outside the scope of your expertise to
22 provide any opinion about -- specifically about
23 her hip fracture and the recovery from the hip
24 fracture; is that correct?

25 A. Yes, yes.

1 Q. Before we get into those articles, I
2 just saw a note here that I wanted to ask you
3 about, delirium. There's a reference to delirium
4 in the hospital records immediately after the
5 incident in this case. Does that sound familiar?

6 A. I think I recall that.

7 Q. I mean, would Ms. Parrott's delirium as
8 reflected in those medical records have impacted
9 her ability to recall events accurately around
10 the time of the fall?

11 A. It's possible, yes.

12 Q. Is it likely that her delirium would
13 impact her ability to recall events with any
14 accuracy?

15 A. I don't -- I don't really have any way
16 of knowing that. I think that's why I've sort
17 of, in a joking way, referred to the two days
18 because that's what she said, but I never really
19 attributed two days to being 48 hours on the
20 ground, as I've mentioned. I just -- I don't
21 know what that number is.

22 Q. And do you intend to provide any opinion
23 about how long you think she was on the ground in
24 this case?

25 A. No. I was hoping you would do that.

1 Q. I've got my opinion. I think Paul has
2 his opinion. I guess that's something for --
3 that will be decided by somebody other than us.

4 A. Exactly.

5 Q. Doctor, you mentioned these articles
6 that you listed. You said, I think, that you had
7 reviewed these to educate yourself about hip
8 fracture and the effects of hip fracture on
9 elderly people; is that correct?

10 A. Yes, it is.

11 Q. All right. Are there any other opinions
12 for which you're relying on any of these specific
13 articles that we haven't already discussed?

14 A. I don't think so. Just to remind you,
15 it's not that these articles -- that I rely on
16 these articles. They're another bit of
17 information to make a good judgment. So an
18 article, the records, the depositions, all those
19 together I used to form my opinion.

20 Q. And what role does a study, research
21 study, such as some of these that you've provided
22 us, what role does that play in your assessment
23 or in your development of an opinion in this
24 case?

25 A. Well, for example, I didn't know if 90

1 percent of people who have hip fractures die
2 within six months. I didn't know that. When I
3 know that 20 percent do, that's -- that's an
4 interesting fact to have.

5 I knew from my clinical experience and
6 my career that people that have PTSD die sooner,
7 but I couldn't really cite any article or the
8 studies, so it was helpful to have my perception
9 reinforced by the article that -- by the review
10 article that I posted there.

11 **Q. Which one of these articles talks about**
12 **death rates within six months?**

13 A. None of them do. I was just using that
14 as an example of what I was learning. I think
15 these articles -- and I can't say I've read every
16 single word of them but -- just that -- for
17 example, the Mundi, et al., article says the
18 overall mortality rate is 21 percent.

19 **Q. Which one is that? What's the title of**
20 **that study?**

21 A. It's Mundi, et al., M-U-N-D-I.

22 And then the article under that
23 says the mortality rate is 17 percent. So that's
24 why I mentioned before I learned that a hip
25 fracture is not necessarily a death sentence.

1 Q. I'm sorry. I don't have these labeled
2 by the title -- by the author of the study.

3 A. I thought -- it says Reviewed Article
4 List. Isn't that the one we're looking at here,
5 Number 4?

6 Q. Yeah, I'm trying to find the actual
7 article.

8 A. Oh, the actual article, I can't help you
9 there. I provided those, but they aren't
10 organized. This is just a list of the articles
11 with conclusions. So the Mundi article is Number
12 17.

13 Q. All right. And so specifically with
14 regard to this article, you simply read it to
15 have a better understanding about typical
16 mortality rates after a hip fracture?

17 A. Exactly. Clinicians are trained as
18 scientists and so we tend to like to read
19 articles and learn things, and that's what I was
20 doing.

21 Q. Is there any indication in this report
22 that the study was limited to elderly patients?

23 A. Can't recall.

24 Q. There may be --

25 A. Have to look at the methodology.

1 Q. And I don't want to --

2 A. If you look on -- if you look on page
3 56 -- so in this particular article, this is a
4 meta review of I don't know how many articles
5 that pulled data together. And on 56, if you
6 look over on the right-hand column, it shows the
7 average ages to be in 70s of the sample size, 77,
8 79, 81. So these are all people older than 75 in
9 this particular study.

10 Q. Okay. Thank you. I guess the way I can
11 ask this or to try to address some -- all these
12 articles without getting too much into the
13 weeds -- and I'll try to do this, but I don't
14 know how successful I'll be. We'll see. Do you
15 intend to rely on any of these articles to
16 support the conclusion that Ms. Parrott's mental
17 health condition after the fall --

18 A. Only in -- go ahead.

19 Q. Yeah. Are you relying on these articles
20 to support the conclusion that Ms. Parrott's
21 mental health condition after the fall was a
22 greater than 50 percent factor in her decline and
23 ultimate death?

24 A. No.

25 Q. Getting away from the articles a little

1 bit -- and I'm sorry to jump around so much. I'm
2 just trying to make sure I cover everything here
3 at the end.

4 Do you agree that the medical
5 records do not reflect after the fall that
6 Ms. Parrott had or demonstrated the level of
7 parasitosis that she did back in 2009?

8 A. They may not reflect it, but that
9 doesn't alter my opinion that it wasn't present.
10 And there are all sorts of reasons that things
11 don't make it into medical records.

12 For example, if you're in the
13 hospital, it may not come up. It might have been
14 such a chronic condition that people don't write
15 it down. So, you know, you have to understand
16 the context of medical records. These are people
17 working, and having written medical records for
18 40 years, sometimes you don't want to write
19 everything down every time you see a person.

20 So medical records are a reflection
21 of treatment, but they're not a total indication
22 of treatment.

23 Q. So -- and we talked at length about this
24 already, but back in 2009, you know, she thought
25 she had the bugs crawling in all of her orifices.

1 I don't think we actually read it from the
2 records before, but she was using duct tape.
3 There's reference in some of the other reports --
4 and you're nodding your head. I think you recall
5 references to duct tape --

6 A. I do.

7 Q. -- over her orifices to keep the bugs
8 from crawling in. And she specifically said that
9 she was going to -- she was planning to take a
10 bunch of pills and try to kill herself. Do you
11 remember those references?

12 A. I recall that.

13 Q. Is there anything like that reflected in
14 the medical records after the fall?

15 A. No, but I think what's sort of
16 interesting that's reflected in the record is
17 that after her hospital stay at Baptist, she
18 seemed to do a little bit better, and it might be
19 because they had changed her medicines.
20 Remember, they -- she never took the Seroquel,
21 which is totally understandable. It's a horrible
22 medicine with lot of side effects.

23 But it's very possible that the
24 combination of the Xanax and the antidepressant
25 plus whatever else was going on in her life

1 reduced the symptoms -- not eliminated them, but
2 reduced them, and so that's why they're not
3 reflected in the medical records in the same way.

4 Q. Okay. And my point in asking that,
5 Doctor, is that, you know, I mean, it seems to me
6 that she just didn't appear to be as bad off
7 toward the end of her life as she was back in
8 2009 in those records. Would you agree with that
9 assessment?

10 A. I would agree that she was in crisis in
11 2009, and I would also agree that after the fall
12 and the period of time she laid down that she --
13 her condition deteriorated.

14 Q. But she --

15 A. You can't really -- it's not rational to
16 say -- not that you're not rational. It's not
17 reasonable to say that in 2009 when she was in
18 crisis she was at this point, and then later, she
19 wasn't. Well, of course she wasn't. She was in
20 a crisis. She was hospitalized. She was
21 treated. And apparently at Sandpiper she was
22 happy, even though she continued to be
23 delusional. I don't know how happy you can be
24 when you're delusional, but she functioned and
25 did and saw people, so clearly she was able to

1 function in a diminished capacity after her
2 crisis. And that diminished even more after the
3 consequences of her fall.

4 MR. RIDDLE: All right. Doctor,
5 I'm just going to look over my notes a little
6 more here. I think I'm about done, but just give
7 me a few minutes to take a look at a couple of
8 things. I might have some more questions.
9 Thanks for your patience.

10 THE WITNESS: Sure.

11 (A recess was taken.)

12 MR. RIDDLE: All right. Doctor, I
13 think those are all the questions I have for you
14 right now. You can answer any that Paul might
15 have for you. I might have a couple follow-up.

16 THE WITNESS: Thanks very much.

17 MR. REEVES: I don't have any
18 questions.

19 (The deposition was concluded at
20 1:58 P.M.)
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25

1 CERTIFICATE OF REPORTER
2 STATE OF SOUTH CAROLINA
3 COUNTY OF CHARLESTON

4 I, Teri L. Kennelly, Registered
5 Professional Reporter and Notary Public for the
6 State of South Carolina at Large, do hereby
7 certify that the witness in the foregoing
8 deposition was by me duly sworn to testify to the
9 truth, the whole truth and nothing but the truth
10 in the within-entitled cause; that said
11 deposition was taken at the time and location
12 therein stated; that the testimony of the witness
and all objections made at the time of the
examination were recorded stenographically by me
and were thereafter transcribed by computer-aided
transcription; that the foregoing is a full,
complete and true record of the testimony of the
witness and of all objections made at the time of
the examination; and that the witness was given
an opportunity to read and correct said
deposition and to subscribe the same.

13 Should the signature of the witness
14 not be affixed to the deposition, the witness
15 shall not have availed himself/herself of the
16 opportunity to sign or the signature has been
waived.

17 I further certify that I am neither
18 related to nor counsel for any party to the cause
19 pending or interested in the events thereof.

20 Witness my hand, I have hereunto
21 affixed my official seal on July 10th, 2020, at
22 Charleston, Charleston County, South Carolina.
23
24
25

Teri L. Kennelly, RPR, CRR
NCRA REGISTERED PROFESSIONAL REPORTER

My Commission expires
January 8, 2029

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Education

University of South Carolina
Columbia, South Carolina

Ph.D., Counseling, emphasis in psychology
and psychotherapy. "Vietnam Veterans and Their
Partners: A First Look," dissertation of the year. May,
1982

Eastern Illinois University
Charleston, Illinois

M.A. in Clinical Psychology.
August, 1977

Emory University
Atlanta, Georgia

Social Psychology fellowship. Awarded by
Department of Sociology, 1975-1976

Emory University
Atlanta, Georgia

B.A. with Honors in Sociology.
June, 1975

Experience

Consultant/Expert Witness
Edisto Island, South Carolina

Consultant/Expert Witness

Real time trauma response, violence prevention
coordination/training. Traumatic stress expert
witness. Workers' compensation evaluation and
review of treatment. Patient treatment at Post
Trauma Resources until 2019.
2012 to present

Post Trauma Resources
Columbia, South Carolina

Founder/President

Traumatic stress response and treatment firm serving
business/industry, public sector, individuals,
families and organizations exposed to traumatic
events. Real time trauma response to business,
cities, law enforcement, fire service. Clinical
treatment. Provide violence prevention training/
consultation. Supervision of fourteen clinical and
support staff. Coordinate day to day operations,
planning, marketing and community outreach.
1982 to 2012

Blue Moon Consulting
Denver, Colorado

Senior Consultant

Real time response to industrial accidents and

	place violence. Develop and implement crisis management and violence prevention programs. 2015 to present
Marsh Reputational and Management Practice New York, New York	Senior Consultant Coordinate human impact/disaster services corporate and community clients. Design and implement humanitarian assistance and family liaison programs. Real-time consultation. 1985 to 2015
Fire Department (City) Columbia, SC	Behavior Health Coordinator Coordinate prevention and intervention for 400 person fire department including screening, peer support, training, crisis intervention and trauma response. 1995 to 2017
Lexington/Richland Alcohol and Drug Abuse Council Columbia, South Carolina	Staff Psychologist In-house consultant for treatment services in local substance abuse agency. Clinical supervisor, staff training, outreach. EAP referrals. April, 1982 to August, 1984
Family Service Center Columbia, South Carolina	Mental Health Educator Plan, publicize and present programs in mental health prevention and family life. Coordinate development of an employee assistance program. February, 1981 to April, 1982.
Disabled American Veterans, Vietnam Veteran Outreach Columbia, South Carolina	Psychological Consultant Individual, marriage and group therapy for combat veterans experiencing posttraumatic stress disorder Consultation with community agencies. Train mental health professionals. January, 1979 to June, 1982
Santee-Wateree Mental Health Center Bishopville, South Carolina	Psychologist Mental health services to rural county, outreach. Consultation/training for schools and agencies. August, 1977 to August, 1978

MAJOR PRESENTATIONS

Response to Community Disaster	Sponsored by the University of South Carolina, S.C. Department of Health and Environmental Control, regional sites.
Violence in the Workplace	National Safety Council, Sonoco Products, Palmetto

	Safety Council, SCANA, Duke Power, NC Human Resource Management Association, Council on Education Management, SC HR Management Association, SC, Occupational Safety Conference, International Association of Hospital Security, Mid-Michigan Hospital System, Lexington Medical Center, San Diego, CA, Charlotte, NC, Greensboro, NC, Charleston, SC, Columbia, SC, Myrtle Beach, SC, Lansing, MI
Developing Humanitarian Assistance	Marsh, Corporate Response Group, Kroll, Amoco Corporation, Lucent Technologies, Club Car, Colonial Pipeline, AgFirst, BASF, others. Chicago, IL, London, GB, Kuantan, Malaysia, Houston, TX, Atlanta, GA, Augusta, GA, Columbia SC
Trauma Response in Corrections Corrections	National Institute of Corrections (15 states), Office for Victims of Crime, S.C. Department of Corrections, Virginia Department of Corrections, Florida Department of Correction Columbia, SC, Tampa, FL, Richmond VA, and others
Traumatic Stress and Health Care Personnel	Midlands AHEC, Low Country AHEC, Richland Memorial, Baptist Medical Center Center, Baptist Medical Center Charleston, Columbia, Greenwood, SC
Management of Death Row Staff	National Academy of Corrections Longmont, CO
Psychosocial Response to Pandemic	Sponsored by SC Department of Health and Environmental Control, regional sites.
Managing Psychological Injuries	S.C. Municipal Association, S.C. Workers' Compensation Educational Association, S.C. Occupational Health Nurses Association. Columbia, SC Charleston, SC Greenville, SC
Post Trauma Response for Schools	Richland County School District 1, Richland County School District 2, Lexington School District 5, RESA VI (4), Greenwood School District V, Midlands Technical College, S.C. School Psychologists Association (2), School District of Edgefield, SC. Columbia, SC, Wheeling, WV, Greenwood, SC
Traumatic Stress and the Fire Service	Missouri Fire School, International Society of Fire Service Instructors, New England Fire Chiefs Assoc., S.C. Fire Chiefs' Association, S.C. Fire Academy, Southeastern Fire School, National Fire Protection Association

	Jefferson City, MO, Cincinnati, OH, Hyannis, MA, Columbia, Myrtle Beach, SC, Atlanta, GA
Managing Trauma at Work	Workers Compensation Educational Association, S.C. Occupational Health Nurses, others Columbia, SC, Charleston, SC
Death Notification	S.C. Highway Patrol, S.C. Department of Public Safety Columbia, SC
Trauma Response for EAP's	Employee Assistance Professionals Association, St. Louis Employee Assistance Association New Orleans, LA, St. Louis, MO
Developing Post-Trauma Programs in Corrections	National Institute of Corrections Boulder, CO
Workplace Trauma	International Society for Traumatic Stress Studies New Orleans, LA
Responding to Work-Related Trauma	Family Service America Milwaukee, WI
Immediate Responses to Aircraft Disasters	Southeast Mental Health Center Memphis, TN
Responding to Victims of Crime	S.C. Criminal Justice Academy Ten Programs for Law Enforcement
PTSD Among Emergency Workers	Society for Traumatic Stress Studies Denver, CO
Critical Incident Stress and Fire Service	Trenton Fire Department Trenton, NJ
The Rape Response Syndrome	Waccamaw Center for Mental Health, Department of Social Work, Conway, SC, Parris Island, SC Conway, SC
A Generic Counseling Model for PTSD	Society for Traumatic Stress Studies Atlanta, GA
Marketing Post-Trauma Services	Society for Traumatic Stress Studies Atlanta, GA, Denver, CO
Traumatic Stress and EMS	Southeastern Symposium, Midlands EMT Training Consortium, Lexington EMS, Richland County EMS Columbia, Lexington, Myrtle Beach, SC

Traumatic Stress and Law Enforcement	S.C. Law Enforcement Officers Association, S.C. Sheriff's Association, S.C. Department of Corrections, S.C. Criminal Justice Academy Columbia, Myrtle Beach, SC 1983 to present.
A Generic Approach to the Treatment of PTSD	International Society of Traumatic Stress Studies Atlanta, GA
Post Traumatic Stress	Regional Conference on Vietnam Veterans Columbia, SC
The Paradox of Survival	Third National Conference on PTSD Washington, D.C.
Cognitive Therapy in the Treatment of Vietnam Veterans	National Conference on Post-Traumatic Stress Disorder Chicago, IL
Pet Death	Columbia Area Veterinary Association Columbia, SC
Death Education and Counseling for Children	American Personnel and Guidance Association St. Louis, MO

OTHER ACTIVITIES

200 post trauma responses to organizations, business per year until 2012.

Responses to bank robberies, Bank of Clarendon, First Citizens Bank, Carolina First, NBSC, First Palmetto, others. Approximately sixty responses per year.

Coordinate, Trauma Response Services, Richland County (SC) Sheriff's Department.

Jefferson Institute of Justice Studies, Consultant on Criminal Mass Victimization, U.S. Department of Justice.

Trainer and Consultant, Staff Victimization in Corrections, National Victim Center, training in approximately twenty states to date.

Served as witness and/or expert witness before worker's compensation commission, circuit court, federal court, military court.

Consultant, S.C. Highway Patrol, State Law Enforcement Division

Grant review, U.S. Department of Justice, Office of Victims of Crime.

Developer and Consultant, Traffic Accident Victim Advocate Program (TAVA), Nation's first victim assistance program in a Highway Patrol, Missouri State Highway Patrol TAVA program.

Contract with S.C. Department of Mental Health, S.C. Department of Corrections, S.C. Highway Patrol, S.C. Department of Social Services, S.C. Department of Juvenile Justice to provide post-trauma services to employees.

Hurricane Hugo (September, 1989) services to include Charleston County School District, National Forest Service, S.C. Department of Mental Health, S.C. Department of Social Services, Family Service America, National Association of Social Workers, private businesses.

S.C. Crime Victims Advisory Board, appointed by Governor Jim Hodges, reappointed by Governor Nikki Haley, 2001 – 2017.

President, South Carolina Victim Assistance Network, 1991-3, Board Member 1986 to 1988, 1990 to 2009.

Leadership Columbia, Columbia Chamber of Commerce, 1985 - 1986.

Consultant and Trainer, Job Training Placement Act, Program for dislocated workers.

Developer and consultant, South Carolina Youth Attendant Program, Governor's Office, Criminal Justice Program, 1984.

Consultant, Office of the Governor, Safety Belt Use Campaign, 1984.

Board Member, Helpline of the Midlands, crisis intervention training line, 1981 - 1988.

Co-Founder and Board Member, Men's Resource Center, a counseling service for men who abuse their partners.

Consultant and Counselor, Lexington County Sheriff's Department, Chaplancy Program.

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Barnett-Queen & Bergmann, L.H. (1989) Survivors of trauma: Working with clients with psychological injuries. The Bulletin, Summer 26-29.

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Compilation of Notes — D. Parrott

Pre-Incident Factors

1. Palmetto Baptist 4/09
 - p1 delusional disorder
 - p12 suicidal due to delusions
 - p319 mild cognitive impairment
2. Sandpiper 2014
 - p5 history of depression
3. Acosta Deposition
 - p32/L18 pre-existing macular degeneration
 - p39/L25 pre-existing delusional parasitosis, 3 weeks inpatient
 - p82/L23 reported coins missing, no evidence
 - p91/L17 noted pre-existing anxiety
 - p132 before — independent, researched stocks, use computer, wrote checks, played bingo, went to thrift stores
4. Dr. Davidson Deposition
 - p10 frail before injury
 - p46/L21 no way to tell who will develop psychological symptoms
5. Dr. Mills Deposition
 - p22/L14 more frail before, death of husband took a little bit out of her

Incident Factors

1. Sandpiper 2014
 - Source — Carole Harvey - was a very traumatic experience, she yelled and banged for two days
2. Acosta Deposition
 - p103/L16 clothes ruined by urine and feces
 - p113/L13 after being found - had a very strong reaction, Please don't leave me
 - p122/L2 picture showing marks where pt was hitting to be heard
 - p123/L3 used socks to wipe up urine
 - p123/L22 in hospital crying in pain
 - p138/L7 a horrible event, she laid there, she wanted to end her life,

p165/L4 the pain was unimaginable
tried to open artery in left arm

3. Dr. Davidson Deposition

p19/L12 time on the ground is irrelevant
p52/L10 if pt was on floor 1 hour could be emotionally traumatic
p64/L13 would likely be in pain while on the floor
p67/L7 there are people who try to hurt themselves and then deny it
p74/L13 defecating and urinating on self could be emotionally impacting
p82/L17 "loss of will" could cause a bad rehab outcome

4. Dr. Mills Deposition

p12/L25 described pain during injury as very severe
p21/L23 an ongoing painful experience
p64/L10 longer period down would be worse, even if not down long
could still be traumatic

Post-Incident Factors

1. Sandpiper 2014

p55 slow response, abnormal affect
p79 poorly controlled pain
p106 required reassurance that she was not alone
p110 moderate depression, feels she will not be a happy person
again. I am not happy at all
p115 Ms. Merwin, noted depression, little energy, no suicidal plan

2. Ashley River Plantation

decline in cognitive functioning
confused, anxious, paranoid, anxiety, "evil spirits"

3. Roper St. Francis

p24 immediately after, crying, appears unkempt
p39 immediately after, remains confused
p77 immediately after, in extreme pain

4. Dr. Mills Deposition

p28/L5 after incident, more anxious, "her mental condition suffered",
not the same person
p32/L10 loss of mobility takes a toll
p34/L1 opinion that event was traumatic, triggered worsening of
her condition
p46/L1 event impacted her emotional state
p62/L14 not offering diagnosis but event triggers some psychological
problems

5. Acosta Deposition

p52 believed that there were criminals
p55 believed someone was trying to kill her, confused when waking up, auditory/visual hallucinations
p132/L2 psychologically, Mother never came back, did not write another check, did not watch TV, no interest, saw things, etc
p136/L22 after first reported hallucinations
p145/L16 Mother's life was hell, in her head after those three days on the floor
p165/L4 she stopped eating, she was giving up on life. The life she lived tormented her. Every night was filled with torment.

6. Dr. Davidson Deposition

p45/L8 possible that she could develop psychological symptoms
p47 reads records as not saying much psychological impact
p50/L5 he has no opinion concerning psychological impact
p53/L23 emotional well being would effect her prognosis

Materials Received and Reviewed Delila Parrott

Ms. Acosta notes related to medical records
Deposition of Dr. Scott Davidson - 8/5/19
Medical records of Dr. Richard Mills and other Roper St. Francis providers
Medical records of Hospice of Charleston
Incident report, contract from Sandpiper Village
Deposition of Brian Lancenese - 5/3/19
Medical bill from Sandpiper
Medical records from Palmetto Health Baptist
Medical records from FiveStar Senior Living
Deposition of Corrine Carrington 7/11/18
Deposition of Dr. Richard Mills 6/26/19
Photographs
Defendant's answers to plaintiffs first set of interrogatories
Defendant's responses to plaintiff's first set of requests for production of documents
Deposition of Joan Acosta 4/17/19
Answer to amended complaint by defendant
Deposition of Beth Auld 7/11/18
Medical records Roper St. Francis
Medical records from Sandpiper Rehab and Nursing
Summons and Complaint
Deposition of Lila Watters 2/2/17

Reviewed Article List

Simunovic N, Deveraux PJ, Sprague S, et al. Effect of early surgery after hip fracture on mortality and complications: systematic review and meta-analysis. CMAJ 2010; 182 (15): 1609–16.

found a statistically significant reduction in mortality in patients who underwent hip fracture surgery within 1–3 days of injury

Fleming, J. Inability to get up after falling, subsequent time on floor and summoning help, prospective cohort study in people over 90. BMJ, 2008

lying on the floor for over an hour was also strongly associated with moves to long term care

Those with cognitive impairments are more likely not to be able to get up.

Mundi et al Similar mortality rates in hip fracture patients over the past 31 years Acta Orthopaedica, 85:1 2019

review of literature

overall mortality 21% after 1999, going down

Magaziner et al, Survival experience of aged hip fracture patients, Am J of Public Health 1989.

17% mortality

male sex, advanced age, presence of at least one serious illness and delirium at the time of admission, more mortality

p.277 increased confusional state increased mortality possibly due to increased blood sugar, electrolyte aberration, others

Mosset. JM et al Determinants of recovery 12 months after hip fracture: The importance of psychosocial factors. AJP March 1989

poor cognitive status and post-surgical, self-related health were predictive of mortality.
Age, prefracture physical functioning and cognitive status were associated with recovery.
High post surgery depression score associated with poorer recovery.

Lincoln T.M. et al. Impact of stress on paranoia: an experimental investigation of moderators and mediator, Psychological Medicine Oct 2008
stress and vulnerability increase paranoid ideation

Weisath, L. Vulnerability and protective factors for PTSD Psychiatry and Clinical Neurosciences, 52,51
most people do not develop PTSD
perceived threat to life
maladaptive behavioral response
dissociation
early coping

female
family history
not age
early parental loss, death, early violence
childhood problems
prior trauma

personality plays a big role
insecure, dependent, passive, immature, narcissistic
pre-trauma psychiatric history/symptoms

Lobr, JB et al. Is PTSD associated with Premature Senescence? A review of the literature. Am J Geriatric Psychiatry 2015
review of 10 studies, seven showed earlier death
certain biological changes

supports accelerated aging

worse cognitive performance associated with PTSD

Books Used to Prepare for Deposition

American Psychiatric Association, DSM-IV

Determinants of Recovery 12 Months after Hip Fracture The Importance of Psychosocial Factors

JANA M. MOSSEY, RN, MPH, PhD, ELIZABETH MUTRAN, PhD, KATHRYN KNOTT, RN, AND REBECCA CRAIK, PhD, LPT

Abstract: The independent contributions to recovery from hip fracture of psychosocial factors including depression, personality, social connectedness, and self-rated health were studied in 219 women age 59 and older (mean age 78.5) who were community dwelling prior to fracture. Initial assessments were conducted shortly after surgery and follow up assessments 2, 6, and 12 months later. By 12 months, 15 patients had died and 15 had entered a nursing home. Substantial declines in physical functioning though not psychosocial status were observed. Only 21 per cent (compared to 81 per cent prefracture) reported walking independently; fewer than 30 per cent had regained reported prefracture levels of physical function. The proportion with elevated depression scores at 12 months was 20 per cent, down from 51 per cent following surgery; 64 per cent rated their

health excellent or good at 12 months, up from 43 per cent after surgery.

Poor cognitive status and post-surgical self-rated health were predictive of mortality. Among survivors, age, prefracture physical functioning, and cognitive status were associated with recovery in physical function but not psychosocial status. High post-surgery depression scores, but not the other psychosocial factors, were associated with poorer recovery in both functional and psychosocial status. These findings demonstrate the importance of depressive symptoms as one determinant of recovery from hip fracture and support the need to attend to the affective status of hip fracture patients following surgery. (*Am J Public Health* 1989; 79:279-286.)

Introduction

Fracture of the hip represents a public health problem of increasing magnitude. Annual incidence in the United States is estimated to be approximately 98 fractures per 100,000 population.¹⁻³ The majority of hip fractures (70-80 per cent) occur in females over 60 years of age, with the population at highest risk being White females 85 years or older.⁴ While there are sophisticated surgical procedures for hip fracture repair, full recovery has been elusive. Only 12 to 23 per cent return to prefracture ambulatory status and/or functional independence.^{5,6} Mortality rates in the first 12 months following fracture are 12 to 20 per cent higher than in comparable age/sex groups in the general population,^{3,7-9} and rates of institutional placement during the immediate post-hospital period are high and remain higher than average as the individual grows older.^{10,11}

Case series data^{6,9-11} consistently have shown prefracture physical and cognitive function and age to account for a substantial amount of the variance in hip fracture recovery. While there is evidence suggesting that psychological, social, and environmental factors influence recovery as well,^{6,12} evaluation of the contribution of a broad range of factors has been rare. Information regarding both physical functioning and psychosocial status, measured either before or after fracture, usually has not been available. Moreover, most studies have included both seriously debilitated, older individuals with limited potential for any recovery, and "healthier" elderly with a more positive prognosis. Consequently, even when psychosocial variables have been studied, there has been limited ability to evaluate the independent importance of these factors for recovery over and above the effects of the individual's health status.

We undertook a study designed to specifically investigate the role of psychosocial factors measured after surgery in the recovery of the "healthier" hip fracture patient. In this paper, we characterize their recovery status 12 months following surgery. We also present the findings of analyses to evaluate the independent contribution to recovery of four psychosocial factors measured during the initial, post-surgery assessments: self-rated health, depressive symptomatology, personality, and social supports. There is considerable evidence supporting the prognostic significance of these factors for the clinical course and/or recovery associated with diverse illnesses. The reader is referred to the excellent review by Kasl¹³ for a critical appraisal of this literature.

Methods

Study Sample

Subjects were recruited from among community dwelling, ambulatory White females over 59 years of age who were treated surgically for a fractured hip in one of 17 hospitals in the greater Philadelphia area between August 1, 1984 and January 15, 1986. Initial structured interviews were completed as soon after surgery as possible (usually the 7th-20th day). Follow-up interviews were obtained two and six months later and a final telephone interview was conducted 12 months after surgery. Clinical assessments of walking ability and neuromuscular status two and six months postsurgery were also made, and the patient's hospital record was systematically reviewed.

Seven hundred and thirty individuals meeting the above age, sex, race, and residence criteria were identified at the time of surgery; they represent an almost complete ascertainment of the patients treated during the surveillance period in each hospital. Additional study criteria included: ability prior to fracture to walk across a room with no greater assistance than a straight cane, absence of post-surgical cognitive impairment that would preclude completion of study assessments and absence of cancer or other health problems likely to cause a pathological fracture or to result in death during the year following hip fracture. Three hundred and sixty-two patients met these criteria and were asked to participate in the study; 219 of these consented.

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Editor's Note: See also related editorial p 269 and article p 274 this issue.

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The sample for this analysis, consists of the 211 individuals (96 per cent of those enrolled in the study) for whom complete post-surgical and follow-up data or documentation of death were available. Mean age of these individuals was 78.5 (s.d. 7.6). Prior to hip fracture, 55 per cent lived alone, 21 per cent lived with their spouse, and 24 per cent with friends or other relatives. Forty-eight per cent were of British or Irish ethnic origin; 25 per cent reported German descent, and 15 per cent and 11 per cent, respectively, were from Eastern Europe or were listed as other. Mean level of education was 11.6 years (s.d. = 3.4). Forty-three per cent of the study subjects sustained a fracture of the trochanteric or intertrochanteric region of the femur. An intercapsular fracture was reported for 36 per cent and a fracture of the subtrochanteric or femoral neck region was recorded for the remaining 21 per cent. For 65 per cent of subjects, hip fracture repair involved fracture reduction and fixation; for 35 per cent a partial or complete prosthesis was used.

Some information obtained during study enrollment was available for both the 211 patients in this analysis and those who refused the initial interview ($n = 143$) or who were excluded because of missing data ($n = 8$). In addition, survival status at 12 months was known for 94 per cent of the 143 refusers and 103 (72 per cent) completed the 12-month interview. Comparisons of study participants and non-participants revealed no differences ($p < 0.05$) between the groups in terms of: age, prefracture living arrangement, prefracture independence in ambulation, history of recent fracture, prefracture pain or observed physical or sensory impairments. At 12 months, there were no differences between participants and non-participants in terms of survival or any other recovery indices.

Study Variables

In addition to information on sociodemographic variables such as age, marital status, and education, variables pertinent to this report include:

- **Prefracture Health Status:** The number of health problems experienced in the preceding year was assessed during the initial post-surgical interview using a modified version of the health problems scale in the Multi Level Assessment Instrument (MAI).¹⁴ Two additional questions were included to assess the presence and constancy of pain prior to hip fracture. Information abstracted from the patient's hospital record included the number of hospitalizations in the two years preceding the hip fracture and the number and type of different diagnoses reported on the admission history. Data on the type of diagnoses were used to classify individuals according to the number of serious diagnoses reported.
- **Prefracture Functional Status:** Ability to perform self-care activities of daily living (ADL) such as bathing, and dressing, and instrumental activities of daily living (IADL) such as shopping and doing housework prior to hip fracture were assessed retrospectively during the initial post-surgical interview. An adaptation of the Multi-level Assessment Instrument was used.¹⁴ ADL and IADL scores were computed as the number of activities that the individual reported doing without any assistance. Difficulty in performing activities such as pushing, pulling, and carrying objects was measured with three items adapted from disability scales developed by Nagi.¹⁵ The presence and kind of assistance required in walking or

traveling distances were also determined.

Predictably, the above measures of prefracture functional status were correlated. To minimize potential problems resulting from multicollinearity and to simplify the analytic models, a principal components analysis that included the function scales was done. This yielded a single factor. Factor loadings were used to compute a summary prefracture physical function score. Scores ranged from -4.33 (poor function) to $.92$ (good function).

- **Cognitive Function:** The Short Portable Mental Status Questionnaire (SPMSQ)¹⁶ was administered during the initial interview to assess post-fracture cognitive function in terms of orientation, memory and abstraction ability. Of the 10 SPMSQ items, eight were asked; the questions on year of birth and age were omitted.
- **Psychosocial Variables:** Two subjective measures of global health status based on responses to the question, "How do you rate your health: excellent, good, fair or poor?", were obtained during the initial post-surgical interview. For one, individuals were asked to rate their health as they remembered it to be "just prior" to their hip fracture; for the other, a rating was obtained for current health status "today". The presence of depressive symptomatology experienced the week preceding the post-surgery interview was assessed with the Center for Epidemiological Studies Depression Scale (CES-D).^{17,18} Recent evaluation of this 20-item scale confirms its validity as a measure of depressive symptomatology with older individuals, even those who are physically ill or disabled.¹⁹ Scores range from 0 to 60 with a score of 16 or higher distinguishing those with a high probability of clinical depression.

Personality dimensions of neuroticism and extraversion were measured by the Eysenck Personality Inventory.²⁰ This instrument contains 52 "yes/no" questions of which 24 are markers for each personality trait. The Eysenck Inventory has been extensively used in personality research. Recent reviews confirm the validity of the neuroticism scale and, to a lesser extent, the extraversion scale in older populations.^{21,22}

Social support, defined in terms of the availability and usual frequency of contact with children, close relatives, close friends and a "special person" with whom intimacies are shared was assessed using questions adapted from the National Institute on Aging project "The Establishment of Populations for Epidemiologic Studies of the Elderly" (EPESE).²³

- **Treatment-Related Variables:** Fracture site (e.g., trochanteric, subcapital, intertrochanteric), repair type (pin or prosthesis), pre- or post-surgical medical events (e.g., fever, wound infection, pneumonia, congestive heart failure, decreased hemoglobin), number of days in hospital and discharge location (e.g. rehabilitation hospital, nursing home, home) were obtained from the patient's hospital record.
- **Recovery Parameters:** Recovery at 12 months was characterized in terms of survival status, physical functioning, self-rated health, presence of pain in the involved limb, extent of depressive symptomatology and return to prefracture level of physical functioning. Scales in the initial post-surgery interview to assess prefracture walking ability, ADL, IADL and physical

performance were readministered at 12 months with slight modifications to accommodate the telephone interview format. Again a principal component analysis was done to summarize the physical function scales. As before, a single factor emerged, and the associated factor weights were used in computing the 12-month physical function factor score. The global self-health rating referenced to "today", the pain questions and the CES-D were also readministered at 12 months. To accommodate the telephone format, a dichotomous response option, (never = 0; sometimes to always = 1) was used with the 20 CES-D items.

An additional recovery variable was constructed as a count of the number of seven different functional parameters on which the individual had returned to, or surpassed, prefracture levels. The criteria variables included return to prefracture: 1) residence location, 2) use of ambulatory aids, 3) ambulation in the home, 4) ambulation outside the home, 5) performance of self-care, 6) instrumental activities of daily living, and 7) participation in social and recreational activities.

Results

• **Prefracture Health and Functioning:** Although "healthier" hip fracture patients were enrolled, the study sample was not free of pre-existing medical conditions. Patients reported 3.5 (s.d. 2.2) health problems with a greater number of pre-existing medical conditions ($x = 6.3$, s.d. 3.1) recorded in the hospital record. Prevalent conditions noted in the hospital record included, coronary heart disease (60 per cent), hypertension (53 per cent), osteoporosis (51 per cent), and arthritis (46 per cent).

Most patients, however, reported independence in physical function prior to fracture. Only 19 per cent of the subjects reported requiring any assistance with ambulation. Most sample members (89 per cent) reported they were completely

independent in ADL activities and 65 per cent indicated they completed all IADL activities without assistance.

• **Initial Psychosocial Status:** As seen in Table 1, a large proportion of study subjects (57.6 per cent) rated their health on the interview day as fair or poor. This is substantially in excess of that reported in large samples of community dwelling elders.^{24,25} The retrospective ratings of health status (just prior to fracture) were much more likely to be positive. Over 50 per cent of the study sample scored 16 or above on the CES-D. Compared to most samples of community dwelling elderly, this proportion is extremely high. For example Berkman, *et al.*,¹⁹ report 15 per cent of women 65–74 years of age and 18 per cent of women ages 75+ enrolled in the EPESE study to have CES-D scores of 16 or greater. It is even in excess of the 28 per cent prevalence reported by Billig, *et al.*,²⁶ for the post-surgical hip fracture patients in their case series and the 20–38 per cent prevalence reported for older persons hospitalized for a medical problem.^{27,28}

• **Recovery at 12 Months:** Fifteen patients (7.8 per cent) died prior to the 12-month interview. One death occurred during the acute hospital stay and seven others before the six-month interview. This mortality experience is substantially lower than that reported previously,^{5,7–9,11,29} even by studies which used restrictive selection criteria similar to ours. For example, Cobey, *et al.*,⁶ and Jensen, *et al.*,³⁰ report six-month, not 12-month, mortality in comparable samples to be 7.4 per cent, and 5.8 per cent, respectively.

Descriptive statistics for the remaining recovery parameters are displayed in Table 2. Even in this selectively "healthy" sample, most individuals continued to experience a sustained decline in physical function 12 months after fracture. Fifteen individuals were permanent nursing home residents. Another 18.6 per cent were reported to be dependent on a caregiver for assistance in most activities of daily living. Indeed, while approximately 74 per cent indicated at 12 months they walked outside their home, only 21 per cent

TABLE 1—Descriptive Statistics for Selected Psychosocial Variables Measured during the Initial Post-Surgery Interview

	Excellent	Good	Fair	Poor
<i>Global Self-Rating of Health</i>				
% Today, day of interview	7.7	35.6	34.6	22.1
% Just before hip fracture	23.7	42.7	22.7	11.4
<i>Personality</i>				
Neuroticism scores:	mean 9.39	s.d. 5.3		
	standardized coefficient alpha	.96		
Extraversion scores:	mean 10.04	s.d. 3.5		
	standardized coefficient alpha	.92		
<i>Depression CES-D:</i>				
	less than 16	48.8%		
	16 or greater	51.2%		
	mean 16.41	s.d. 8.1		
	standardized coefficient alpha	.82		
<i>Social Connectedness:</i>				
Frequency of contact with "special person":		daily		%
		2-3 times a week		54.
		once a week		20.
		less than once a week		7.
		no special person		9.
		none		8.
Number of children, other relatives and friends reported being close to:		1-2		1.
		3-4		10.
		5-6		21.
		7 or more		25.
				40.

TABLE 2—Descriptive Statistics for Parameters of Recovery 12 Months Following Hip Fracture Surgery among Surviving Patients

<i>Residence:</i>	Private home: independent	62.7
	dependent	18.6
	Retirement Community	9.8
	Nursing Home	8.8
<i>Degree of return to prefracture functional status:</i>		
<i>Number indicators at prefracture levels or better:</i>		
	none	4.1
	1-3	27.5
	4-5	40.3
	6-7	28.1
<i>Walking ability:</i>	not ambulatory	9.7
	housebound	15.3
	walks in and outside home	
	uses walker	9.7
	uses quad cane	14.2
	uses straight cane	29.1
	independent, no aid	20.9
<i>Number of self-care activities for which no assistance was received:</i>		
	3	69.9
	2	14.3
	1	8.1
	none	7.7
<i>Number of instrumental activities for which no assistance was received:</i>		
	3	32.1
	2	16.3
	1	10.7
	none	40.8
<i>Self rated health:</i>	excellent	12.2
	good	51.5
	fair	27.6
	poor	8.2
<i>Pain in involved hip:</i>	none	45.9
	intermittent	44.7
	constant	9.4
<i>Depression score (CESD):</i>	less than eight	80.0
	eight or more	20.0
Mean	4.14	s.d. 4.3

reported they could do so without an ambulatory aid. This compares to 81 per cent who walked outside unassisted prior to hip fracture. Moreover, only 28.1 per cent had returned to their prefracture functional status in at least six of the seven functional indicators. Twenty-three per cent had failed to regain prefracture function in at least four criteria.

In contrast to physical functioning at 12 months, the distributions on self-rated health and the CES-D indicate considerable "recovery" in these areas. The proportion rating their health as excellent or good was almost identical to those rating their health status "just before fracture" in this manner. At 12 months only 20 per cent of the sample had elevated scores, ≥ 8 , on the modified CES-D scale. (Comparison of post-surgery scores on a dichotomized version of the CES-D with those on the full CES-D showed 93 per cent agreement in classification when cutpoints of ≥ 8 , and ≥ 16 , respectively, were used.) This proportion is similar to that reported in the total older female sample in the EPESE study¹⁹ and substantially less than that for women in the poorest health status strata.

Predictors of Mortality

The limited number of deaths precluded an extensive investigation of the predictors of mortality. Univariate analyses involved the examination of contingency tables, and the comparison of mean values between survivors and non-survivors on continuous variables using ANOVA proce-

TABLE 3—Adjusted Odds Ratios for Mortality in the 12 Months following Hip Fracture and 95% Confidence Intervals Computed from the Logistic Coefficients (B) and Their Standard Errors

Independent Variable	12-Month Mortality	
	AOR	95% CI
<i>Cognitive function</i>		
8	1	—
7	2.09	1.35, 3.25
5	9.15	2.44, 34.36
<i>Self-rated health</i>		
1	1	—
2	2.26	1.09, 4.68
3	5.09	1.19, 21.80
4	11.49	1.02, 101.79
<i>Age in years</i>		
60	1	—
70	.68	.32, 1.46
80	.47	.10, 2.31
<i>Years education</i>		
1	1	—
8	.93	.47, 1.83
12	.89	.40, 1.12
<i>Number days in hospital</i>		
14	1	—
21	2.54	.01, 588.16
28	6.44	.53, 3493.80

dures. An increased risk of dying was observed for individuals whose cognitive status score was 3 or less, for persons rating their health, referenced to "today", as fair or poor and for those who reported having completed high school or college. There were no mean differences ($p < 0.05$) between survivors and decedents in terms of age, prefracture physical functioning, number of recorded pre-existing health problems, number of diagnoses classified as serious, number of post-surgical medical complications, fracture site, type of fracture repair, or the psychosocial variables.* Individuals who died, however, did have significantly longer lengths of stay in the acute care hospital.

Multivariate analyses used the logistic model. Variables identified as risk factors during univariate analyses were included, along with age, as predictor variables. Adjusted odds ratios (with 95 per cent confidence limits) for each variable in the model tested are shown in Table 3. Only cognitive function following surgery and self-rated health are associated with risk of death. The importance of cognitive function measured after hip fracture for risk of post-fracture mortality has been well documented, even in studies including a similar selectively healthy population.^{6,8} Although not with hip fracture patients, other studies have demonstrated an association between self-rated health and mortality.^{24,25}

• *Predictors of Recovery among Survivors:* A two-stage analysis limited to study survivors was conducted for five recovery indices: 1) overall 12-month physical function; 2) degree of return to prefracture functional status; 3) self-rated health; 4) pain; and 5) level of depressive symptoms. In the first stage, univariate analyses between measures obtained during the post-surgery period and the recovery indices were conducted. Selected correlation coefficients are presented in Table 4. As expected, age was strongly related to all the physical function indices with recovery more limited as age increased. Predictably, as well, initial measures of health and physical functioning were strongly associated with the com-

*Data available from author on request.

TABLE 4—Correlation Coefficients between Ordinal or Continuous Variables Measured during the Initial Post-Surgery Interview Determined from the Hospital Record and Recovery Parameters at 12 Months among the Surviving Hip Fracture Patients

	Recovery Parameters				
	12 Month Physical Function	Degree of Return to Prefracture Functional Status	Self-Rated Health	Pain	Depressive Symptoms
Age	-.38**	-.28**	.09	.08	.08
Years education	.15*	.02	-.11	-.10	-.08
Years employed	.15	.04	-.13	-.11	-.12
Number self reported medical conditions	-.31**	-.25**	.26**	.07	.21**
Walking ability	.35**	-.15*	-.08	-.02	-.14
ADL	.30**	-.05	-.05	.07	.002
IADL	.45**	.22**	-.06	-.06	-.001
Physical performance	.54**	.32**	-.29**	.02	-.31**
Physical function factor score	.56**	.25**	-.20**	.03	-.19
Mental Status	.27**	.32**	-.12	-.02	-.10
Number pre-existing medical diagnoses	-.29**	.20**	.22**	.08	.11
Number medical diagnoses considered serious	-.16*	-.08	.19**	.01	.01
Number post-surgical complications	-.18**	-.19**	.11	.04	.08
Self-rated health (before fracture)	-.30**	.28**	.47**	.09	.34**
Self-rated health (now)	-.32**	.38**	.45**	.20**	.35**
CES-D score	-.24**	.26**	.39**	.29**	.47**
Neuroticism score	-.10	-.15*	.19**	.25**	.41**
Extraversion score	.11	.06	-.19**	.08	.08
Contact "special person"	-.09	-.07	.06	.14	.02
Number close children, friends and relatives	.01	.06	-.09	-.02	-.11

*p < .05 > .01

**p < .01

parable recovery parameters. To a lesser degree these variables were related to psychosocial functioning at 12 months. With the exception of scores on the extraversion scale and the measures of social connectedness, psychosocial variables measured shortly after surgery were consistently associated with both physical functioning and psychosocial functioning at 12 months. Univariate associations between the recovery indices and treating hospital, length of hospital stay, fracture site, type of fracture repair, number of post-surgical complications, discharge location, ethnic background, prefracture living arrangement and prefracture pain were also examined. Most of these associations were not of importance.*

Multivariate analyses using OLS regression procedures were conducted. Variables shown to be related to a recovery parameter or thought to be a potential confounding variable were entered into the regression equations first; included were: age, years of education, years of employment, number of self-reported conditions, number of medical conditions reported in the hospital record, number of post surgical complications, prefracture physical function score, cognitive status score, days in the acute care hospital, and pain prior to hip fracture. Dummy variables for type of fracture repair, prefracture living arrangement, the presence of pulmonary disease and cancer, and discharge location were also entered. Each psychosocial variable was entered on a second step yielding 35 separate regression equations. Analyses were also conducted in which a best fitting model containing only statistically significant ($p < 0.05$) terms obtained using backward elimination procedures³¹ was entered prior to the

psychosocial variable. The results of the two analyses were identical; the former are included here. Tables 5 and 6 present the beta coefficients and standard errors for the equations evaluating the importance of post-surgical depressive symptomatology for 12-month physical function and psychosocial status respectively. Data in Table 5 confirm the previously observed importance of age, cognitive status and prefracture physical function for recovery of physical function following hip fracture. As seen in Table 6, except for pre-fracture physical function, these factors are unrelated to psychosocial status at 12 months. The data also replicate previous studies in which pre-existing medical conditions unrelated to cognitive impairments were of limited importance to recovery.^{7,11} The type of hip fracture repair and post-surgical complications were also unassociated with recovery at 12 months.

In contrast, the associations between level of depressive symptoms and both the physical functioning and the psychosocial recovery indices stand out. In each case as level of depressive symptomatology following hip fracture surgery increases, outcomes 12 months later are less positive.

Comparable analyses not shown** here revealed the importance of the remaining psychosocial variables to be minimal. Specifically, the two measures of social connectedness and the measure of extraversion were unrelated to any of the recovery parameters. Self-rated health for the reference "just before you fractured your hip" and neuroticism were associated only with the psychosocial outcomes. While

**Findings from these analyses are available on request from the first author.

TABLE 5—Multiple Regression Analyses Showing the Relation between 12-month Physical Function Recovery Parameters and Selected Covariates and Depressive Symptoms (CES-D scores) Measured during the Initial Post-surgery Assessments among the Survivors at 12 Months

Independent Variables	Overall 12-Month Physical Function Beta (s.e.)	Degree Return to Prefracture Functional Status Beta (s.e.)
Age	-.034 (.008)***	-.071 (.017)***
Years educated	.030 (.017)	.063 (.037)
Years employed	.078 (.058)	.118 (.123)
Prefracture residence		
A (1 = lives alone)	.036 (.138)	-.344 (.294)
B (1 = lives with spouse)	.049 (.163)	-.198 (.349)
Type hip repair		
(1 = prosthesis)	.075 (.114)	.162 (.242)
Number self report conditions	-.042 (.030)	-.131 (.064)*
Number medical record reported conditions	-.015 (.022)	-.027 (.047)
Number post-surgical complication	-.063 (.087)	-.078 (.095)
Number recent hospitalizations	-.021 (.069)	-.083 (.148)
History of cancer		
(1 = yes)	-.074 (.139)	-.067 (.296)
History of pulmonary disease		
(1 = yes)	.269 (.140)	.609 (.299)*
Cognitive status	.097 (.048)*	.152 (.102)
Prefracture physical functioning	.465 (.062)***	.353 (.131)**
Depressive symptoms (CES-D score)	-.019 (.007)**	-.042 (.015)**
Constant	2.32 (.714)	10.764 (1.522)***
R	.72	.60
Adjusted R ²	.48	.31

*p < .05 > .01

**p < .01 > .001

***p < .001

there were associations between self-rated health for "today" and all five recovery indices, the associations between this health rating and all the recovery parameters except depressive symptomatology disappeared when the CES-D scores were added to the model.

The preceding assumes the presence of linear associations between post-surgery psychosocial variables and the recovery parameters and the absence of interaction effects. These assumptions were systematically evaluated. Analyses of residuals revealed no apparent non-linear associations. As well, none of the tested quadratic terms were statistically significant. Of the more than 100 separate analyses to evaluate the presence of interaction effects, only five achieved a p value < 0.05. Given the number of hypotheses tested, these associations may be due to chance.

Discussion

This study of the "healthier" hip fracture patient demonstrates again that older individuals who are frail have diminished reserves and are thus less able to regain losses in function following hip fracture. Impaired cognitive function as a risk factor for death or incomplete recovery of physical function is especially noteworthy. During study enrollment an experienced nurse researcher had evaluated all individuals as cognitively intact. The observed importance of cognitive status therefore reflects more subtle decrements identified by the inability to correctly respond to specific tasks on the SPMSQ such as naming the past president or subtracting from 20 by threes. Apart from the well known biomedical risk

factors, this study demonstrates for the first time the importance of level of depressive symptoms as a determinant of both functional and psychosocial recovery from hip fracture.

Several methodological features of this study make it unlikely that these observed findings simply reflect study artifacts. As noted by Kasl,¹³ serious methodological weaknesses of most previous studies of illness course include the inability to identify cohorts at the time of disease onset and to control for pre-existing, prognostically important aspects of health status. These problems have been minimized in this study. Hip fracture is an acute onset injury. Virtually all cases receive immediate medical attention and undergo a surgical repair. Although the initial interviews were conducted following the hip fracture and patient's responses may be affected by her convalescent status, correlations between self-rated health "just before hip fracture" and other retrospective measures such as ADL, IADL and the number of pre-existing medical conditions were substantially greater than those between these variables and self-rated health "today". Conversely, ratings of health today were more strongly correlated with other measures such as CES-D scores or cognitive status that had a post-surgery time reference. Moreover, a substantial amount of information concerning the individuals prefracture medical status was derived from her hospital record and reflected more objective assessments by the physician. Last, inclusion in the multivariate analyses of measures of pre-existing medical status, prefracture physical functioning and cognitive function minimized the possibility that the observed associations between depressive symptoms and the recovery indices simply reflect cross-sectional correlations between these prognostically important variables and depression.

The findings related to depression are in general agreement with those reported by Aneshensel, *et al.*³² Using longitudinal data from a community dwelling adult sample, they observed illness levels to be temporally related to increased levels of psychological distress and depression to have a smaller lagged effect on subsequent illness levels. They differ, however, from those reported by Casselith, *et al.*³³ who found no effect on differential survival or time to relapse among cancer patients due to any psychosocial factors studied including a measure of hopelessness. Casselith's study, however, was limited to individuals with advanced cancers where the inherent biology of the disease may override the influence of any other nonmedical factors. The results observed here were obtained in a patient cohort selected so that the individual's medical status was not likely to overshadow the effects of social or psychological factors.

While confirming the importance of level of depressive symptomatology, the study fails to demonstrate consistent associations between self-ratings of health and personality and achieved recovery. The apparent indirect pathways through depressive symptomatology for health ratings and neuroticism may reflect overlap in these psychosocial factors. Correlation coefficients between initial CES-D scores and neuroticism and health ratings "today" were .626 and .523 respectively. Although introduction of CES-D scores substantially modified the associations between these factors and the recovery parameters, the reverse did not occur. This suggests an importance of depressive symptomatology over and above that shared with either neuroticism or self-rated health. The absence of a detectable effect due to social supports may reflect inadequacies in the measurement of these variables. Only 1.4 per cent of study subjects indicated they had no person they felt very close to; thus most may

TABLE 6—Multiple Regression Analyses Showing the Relations between 12-month Psychosocial Recovery Parameters and Selected Covariates and Depressive Symptoms (CES-D scores) Measured during the Initial Post-surgery Assessments among the 196 Survivors

Independent Variables	Self-Rated Health	Depressive Symptoms	Hip Pain
	Beta (s.e.)	Beta (s.e.)	Beta (s.e.)
Age	.002 (.008)	.007 (.045)	-.007 (.007)
Years educated	-.009 (.017)	-.094 (.101)	-.018 (.017)
Years employed	-.019 (.058)	.004 (.319)	-.012 (.053)
Prefracture residence			
A (1 = lives alone)	-.151 (.137)	.686 (.801)	-.137 (.129)
B (1 = lives with spouse)	.005 (.163)	1.721 (.909)	.228 (.151)
Type hip repair			
(1 = prosthesis)	.149 (.114)	-1.012 (.637)	.039 (.105)
Number self report conditions	.031 (.030)	-.080 (.164)	-.019 (.028)
Number post-surgical complications	-.027 (.029)	-.029 (.034)	-.008 (.006)
Number medical record reported conditions	.019 (.022)	-.060 (.123)	.017 (.021)
Number recent hospitalizations	.049 (.069)	.436 (.371)	.010 (.062)
History of cancer (1 = yes)	-.074 (.139)	1.209 (.787)	.075 (.129)
History of pulmonary disease (1 = yes)	-.047 (.141)	-1.939 (.760)	-.168 (.126)
Cognitive status	.072 (.048)	-.2011 (.265)	.028 (.044)
Prefracture physical functioning	-.069 (.062)	-.899 (.407)*	-.002 (.067)
Depressive symptoms (CES-D score)	.036 (.007)***	.256 (.040)***	.029 (.007)***
Constant	1.749 (.714)*	1.721 (3.932)	1.810 (.658)
R	.49	.59	.44
Adjusted R ²	.24	.28	.19

* $p < .05$ > .01

** $p < .01$ > .001

*** $p < .001$

have exceeded a threshold distinguishing social isolates from those who are socially connected.

While the analyses reported here provide insight regarding variables that affect subsequent recovery, factors associated with the incidence of depressive symptomatology or the specific process by which recovery is affected have not been addressed. For example, we do not know if elevated post-surgery depressive symptomatology represents deterioration in affective state following hip fracture or an extension of a chronic state of depression. Likewise, we do not know if the importance of post-fracture level of depressive symptomatology is mediated through its effect on participation in a rehabilitation program, on one's ability to mobilize supportive resources or on associated biological factors that affect the capacity for recovery. Analyses of data obtained from informants and at the two- and six-month examinations are in progress and will permit further evaluation of some of these important issues.

Despite unanswered questions, the study findings emphasize the clinical relevance of routine evaluation of depression following surgery in hip fracture patients. Systematic assessment by staff nurses using one of the standard self report measures such as the CES-D or a staff rating scale such as the Raskin Scale³⁴ would require little time and could substantially reduce undetected depressive symptomatology. Psychiatric referral, when indicated, would permit evaluation and initiation of appropriate treatment. Although further research is required to determine the specific effect on recovery of treatment, reduction of depressive symptomatology alone is beneficial to the individual and is likely to have positive effects on those providing support and caregiving

assistance as well. In light of the relatively frequent occurrence of hip fracture and the high prevalence of post-fracture elevated levels of depressive symptomatology, these benefits could be substantial.

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Delta Omega Society Announces Essay Contest: Open to Public Health Students

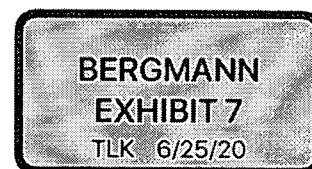
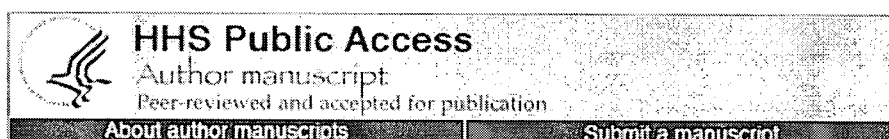
Delta Omega, the honorary society in public health, has announced a national essay contest on the topic of "Public Health as Social Justice." Any student currently enrolled in an accredited School of Public Health in the United States is eligible to enter. The deadline for entering contest is *April 15, 1989*.

Within the concept of "public health as social justice," the student may write about any aspect of public health in the United States or anywhere in the world. The essay may be based on empirical research, or literature review or interpretation, or on any other thoughtful approach to the subject selected. Essay length should not exceed 15 pages of text, typed double-space on 8½ × 11 inch paper. References, tables, and figures may occupy any additional five pages.

Winners will receive cash prizes and certificates from Delta Omega attesting to their awards. First prize is \$1500; second prize, \$1000; third prize, \$500. All three winners will be invited to present their papers during the 117th annual meeting of the American Public Health Association in Chicago, Illinois, October 22-26, 1989. Delta Omega will also contribute to the travel expenses of essay winners.

Selection of the winning essays will be made by a Delta Omega Committee of faculty members from at least three accredited Schools of Public Health. Send all essays by first class mail to:

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A consideration of select pre-trauma factors as key vulnerabilities in PTSD

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Abstract

Posttraumatic stress disorder (PTSD) is a pathological response to a traumatic event. A number of risk and vulnerability factors predicting PTSD development have been identified in the literature. Many of these variables are specific factors occurring during and after exposure to a traumatic event or are not measured prospectively to assess temporal sequence. Recent research, however, has begun to focus on pre-trauma individual differences that could contribute to risk for developing PTSD. The present review proposes that a number of biological and cognitive vulnerability factors place individuals at risk for PTSD development prior to the actual experience of trauma. Accordingly, this review provides a summary of evidence for a select number of these factors as pre-trauma vulnerabilities to PTSD. Included is a discussion of biological factors, including molecular genetic studies of systems regulating serotonin, catecholamines, and glucocorticoids as well as aspects of the neuroendocrine system. Specific cognitive factors are also considered, including intelligence, neuropsychological functioning and cognitive biases such as negative attributional style and appraisals. For each factor, the present review summarizes evidence to date regarding PTSD vulnerability and highlights directions for future research in this area.

Keywords: PTSD, trauma, vulnerability factors, risk factors

1. Introduction

Posttraumatic stress disorder (PTSD) is a pathological response to a traumatic event such as combat, natural disasters, or physical or sexual assault. PTSD occurs in approximately eight percent of the general population in America and seven percent in Europe, with higher rates in women than in men (de Vries & Olf, 2009; Glynn, Marshall, Schell, & Shetty, 2006; Kessler, Chiu, Demler, & Walters, 2005; see Kessler & Üstün, 2008 for international prevalence estimates). PTSD results in significant social and economic burden and puts individuals at increased risk for physical and mental health difficulties including depression and suicide (e.g., Hidalgo & Davidson, 2000). Although

epidemiological investigations indicate that as many as 74% of women and 81% of men will experience a stressful event that qualifies as a traumatic stressor according to the APA diagnostic criteria (Kessler et al., 2005; Stein, Walker, & Hazen, 1997), only a relative minority of trauma-exposed individuals goes on to develop PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McNally, Bryant & Ehlers, 2003). This suggests that individual differences present before, during, or after trauma may be important in understanding why some individuals go on to develop PTSD while others recover naturally.

Theoretical models describing the etiology and maintenance of PTSD emphasize cognitive and affective reactivity during and after trauma exposure. For example, schema-based theories posit that incompatibility of trauma-related information with pre-existing schemas leads to the affective and cognitive symptoms of PTSD until this information can be successfully incorporated into the individual's prior conceptualization of the world (e.g., Janoff-Bulman, 1989). Associative network models such as Emotional Processing Theory (Foa, Steketee & Rothbaum, 1989) describe dysregulation in the activation, connectivity, and responsiveness of fear-related representations in memory after traumatic experiences, leading to overgeneral and hyper-activated fear reactivity (e.g., fear structures). Other cognitive theories propose that maladaptive negative beliefs emerge after trauma about the self and symptoms, the world, and others, as do problems regulating memory systems that access sensory and autobiographical memory representations (e.g., perceptual priming in Ehlers & Clark, 2000; situationally and verbally accessible memories in Dual Representation Theory, Brewin, Dalgleish, & Joseph, 1996). Each of these models can account for the relationship between PTSD and many of the known risk factors for PTSD present during and after the traumatic event. These include characteristics of the event such as trauma severity (e.g., degree of life threat) as well as personal and environmental characteristics including peri-traumatic panic and dissociation, appraisals of symptoms, and post-trauma stress and social support (e.g., Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

Each of these models also point to factors that exist *before* trauma that may make some individuals more prone to developing PTSD than others. For example, in schema theories, the pre-existing schema held by an individual before trauma is critical to determining whether or not trauma will lead to psychopathology. In Emotional Processing Theory some individuals are thought to have a "potentiated" fear network, making them more inclined to develop symptoms. In cognitive models such as Ehlers and Clark's cognitive model and Dual Representation Theory, there are cognitive dysfunctions that presumably have some degree of pre-trauma etiology (e.g., pre-existing beliefs about safety; inability to inhibit sensory memory). Consistent with these models, empirical data also indicate that certain pre-trauma factors increase risk for psychopathology after trauma. Pre-trauma risk factors documented in extant literature include factors such as female gender, family history of psychopathology and prior trauma exposure (e.g., Brewin et al., 2000; Ozer et al., 2003).

This proposed interplay between pre-existing characteristics, traumatic experiences, and subsequent PTSD symptoms is consistent with a diathesis-stress conceptualization of PTSD. That is, certain constitutional factors pertaining to the individual (diatheses) are thought to predispose some individuals to developing psychopathology (PTSD) in the context of severe environmental stress (trauma; McKeever & Huff, 2003). Diatheses can be categorized into biological characteristics as well as ecological characteristics. Biological components may include factors such as genetic makeup or physiological reactivity, while ecological characteristics include environmental factors (e.g., social and developmental history), as well as psychological factors (e.g., cognitive variables, personality, pre-existing psychopathology).

Researchers evaluating risk factors for psychopathology propose that examination of *vulnerability* diathesis factors is especially critical (e.g., Ingram & Price, 2000). A vulnerability factor can be defined as an enduring, endogenous trait inherent in the individual that serves to increase the likelihood of

developing a particular disorder such as PTSD (Ingram & Price, 2009). By definition, then, vulnerability factors are typically characteristics observed in the individual before the onset of stress, and exclude characteristics found in the environment or otherwise outside the individual. Vulnerability factors are thought to point to mechanisms leading to the disordered state, in contrast to general risk diathesis factors that are associated with increased probability of psychopathology without indicating a direct causal relationship. Although a substantial body of evidence documents *risk* factors for PTSD (e.g., gender), growing empirical evidence also points to a number of characteristics that may be *vulnerabilities* to PTSD. Given the role of vulnerabilities as potential mechanisms of psychopathology development, critical examination of potential vulnerability factors in PTSD may point the etiology of problematic forms of cognitive and emotional processing outlined in current models of the disorder.

The present review describes research on a subset of factors that increase the likelihood that an individual will develop PTSD. In contrast to prior reviews discussing general risk factors, we focus on evidence for vulnerabilities in PTSD. That is, the present review focuses exclusively on a number of features that are stable (i.e., existing in the individual *prior* to trauma exposure), and endogenous (i.e., individual-level characteristics, rather than environmental factors). Consistent with diathesis stress model of the disorder, we differentiate between biological and ecological vulnerabilities. Within biological vulnerabilities, we provide a review of genetic factors related to systems regulating serotonin, catecholamines, and glucocorticoids, in addition to factors related to the neuroendocrine system. Moreover, within ecological vulnerabilities we focus specifically on cognitively-based psychological factors given the emphasis of conceptual (and treatment) models on cognitions. We specifically describe extant literature on intelligence, neuropsychological functioning, and cognitive biases as potential vulnerabilities for PTSD. Thus, the following sections will provide an overview of literature on the biological and cognitive factors existing *prior* to trauma exposure that may be implicated in the etiology and maintenance of PTSD.

2. Biological Vulnerability Factors

In this section we review a number of biologically-based characteristics that are observable in the individual prior to trauma exposure (or are not mutable by on trauma exposure, such as genetic factors) and subsequently associated with increased rates of PTSD development. We discuss research examining the role of genetic factors and heritability of PTSD risk and potential gene candidates thought to confer risk for diagnosis and/or increased symptom severity. In addition, work examining the physiological stress response is discussed, including potential pathways by which more distal biological dispositions turn into dysfunctional stress response after trauma.

2.1 Heritability of PTSD risk

Family studies indicate that risk for PTSD development after trauma exposure does appear to be genetically conferred. For example, twin studies report approximately 30% of the risk for developing PTSD is accounted for by genetic factors (Koenen et al., 2008; Skre, Onstad, Torgersen, & Lygren, 1993; Stein, Jang, Taylor, Vernon & Livesly, 2002; True et al., 2003; Xian et al., 2000, although see Sartor et al., 2011 for higher estimates). In addition, studies of offspring of parents with PTSD indicate that prevalence of PTSD is higher in these individuals than in the general population (Yehuda, Schmeidler, Giller, Siever, & Binder-Brynes, 1998; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998). This corpus of research suggests that genetic factors confer vulnerability to the development of PTSD after a traumatic stressor at a moderate level. These studies do have important caveats, such as the overlap of genetic factors accounting for PTSD and trauma exposure and the potential role of the environment in observed effects in family studies. Moreover, these general genetic vulnerabilities do not point to the mechanisms by which risk may be conferred.

2.2. Molecular genetics studies

The molecular genetics approach evaluates the effect of specific genes on variability in an observable trait, providing more specific information about potential mechanisms of action than general family studies. Consistent with a diathesis-stress approach to understanding PTSD, recent research specifically addresses the impact of genetic influence within the context of environmental stressors, including the experience of traumatic events and stressors during development (i.e., gene x environment interactions (GxE); [Koenen et al., 2009](#); [Mehta & Binder, in press](#)). GxE research in PTSD is proposed to be essential to understanding vulnerability and resilience after exposure to a traumatic event because it allows for direct examination of biological factors accounting for variability in response to a discrete identified stressor ([Koenen, Nugent, & Amstadter, 2008](#)). For example, one way that GxEs may confer vulnerability to PTSD is if certain genetic risk factors are “unmasked” by challenges to the individual during key developmental periods, hence altering the maturation of neural systems that control physiological and behavioral responses to stress and trauma. Here we will review the most recent findings, with an emphasis on replications of prior work when available (see also [Amstadter, Nugent, & Koenen, 2009](#); [Broekman, Olf, & Boer, 2007](#) for a full review of genes associated with PTSD).

2.2.1 Serotonin genes Based on the link between monoamine and catecholamine signaling with anxiety behaviors and the efficacy of drugs facilitating release of serotonin (5-HT) and norepinephrine to treat anxiety disorders, researchers have focused on a number of genes that regulate these systems ([Millan, 2003](#)). The most well studied gene encodes the 5-HT transporter (5-HTT), which tightly regulates synaptic 5-HT levels via active reuptake at the presynaptic membrane. A common variant with differential numbers of repeats in the promoter region of this gene (termed “5HTTLPR”) alters mRNA expression levels and thus function, with carriers of the “short” form (fewer repeats) exhibiting reduced expression and in some studies showing higher risk for PTSD compared to carriers of the long version ([Afifi, Asmundson, Taylor, & Jang, 2010](#); [Kilpatrick et al., 2007](#); [Koenen, Amstadter, & Nugent, 2009](#); [Kolassa, Kolassa, Ertl, Papassotiropoulos, & De Quervain, 2010](#), [Lee et al., 2005](#); although see [Grabe et al., 2009](#); [Mellman et al., 2009](#); [Thakur, Jooser, & Brunet, 2009](#)). Carriers of the low expression variant also exhibit reduced response to both pharmacological interventions (e.g., selective serotonin reuptake inhibitors; [Lesch & Gutknecht, 2005](#)) and cognitive behavioral therapy in PTSD ([Bryant et al., 2010](#)).

Consistent with diathesis-stress models, a number of studies demonstrate that having the low-expression variant of 5HTTLPR is associated with greater rates of PTSD, but only after exposure to high levels of stress (e.g., low social support; [Kilpatrick et al., 2007](#) or stressful life events; [Xie et al., 2009](#)). However, the relationship between 5HTTLPR and trauma is complex, and epigenetic modification of 5HTT gene may modulate PTSD risk. One form of epigenetic modification is DNA methylation, in which the promoter region of a given gene is methylated and gene expression is thus inhibited. One study found that high methylation (and thus less expression) potentially confers *protection* from PTSD in cases of high trauma burden ([Koenen et al., 2011](#)). This result is in opposition to the finding that carriers of the low expression 5HTTLPR allele show greater risk for development of PTSD. The 5HTTLPR variant is a fixed genetic mutation, whereas methylation changes can occur during development or even later in the life span. Thus, genetic vs. epigenetic modification of 5-HTT expression may have very different consequences on neural development and subsequent trauma risk. Taken together, there is evidence that genetic and epigenetic modulation of 5-HTT expression modifies risk for development of PTSD and this effect is dependent upon level of trauma exposure.

How reduction of 5-HTT expression alters PTSD risk is unclear, and may involve changes in maturation and 5-HT signaling in a number of brain circuits. Mice exposed to 5-HTT inhibitors exhibit increased anxiety-like behaviors in adulthood and mimicked stress-response phenotypes of mice lacking the 5-HTT gene ([Ansorge, Zhou, Lira, Hen, & Gingrich, 2004](#)). These data suggest that loss of 5-HTT function during development may be an important factor in the role of 5HTTLPR in risk for stress disorders. The low expression variant of 5HTTLPR is also associated with high reactivity in

circuits underlying stress response and emotional learning, including prefrontal cortex circuits, the orbitofrontal cortex, and amygdala ([Southwick, Rasmusson, Barron, & Arnsten, 2005](#), [Milad et al., 2005](#), [Southwick et al., 2005](#)). Thus, hyperactivity of emotional circuits in adulthood may also play a role in increasing risk for PTSD.

2.2.2. COMT gene Another gene that has been shown to be associated with PTSD risk is the gene encoding catechol-o-methyltransferase (COMT). COMT is an enzyme involved in the degradation of catecholamines: epinephrine, norepinephrine and dopamine. COMT mRNA is highly expressed in both prefrontal cortex and hippocampus, but has relatively low expression in striatum ([Matsumoto et al., 2003](#)). A single nucleotide polymorphism (SNP) was found in the human COMT gene (COMT-Met; [Lachman et al., 1996](#); [Tunbridge, Harrison, & Weinberger, 2006](#)) that decreases COMT enzymatic activity by 40% in prefrontal cortex tissue ([Chen et al., 2004](#)). This diminished activity reduces the dopamine clearance in the cortex and thus increases dopamine tone ([Tunbridge et al., 2006](#)). A number of studies suggest that the effects of this COMT-Met polymorphism may be a vulnerability for PTSD. In a Ugandan refugee sample (N=424) carriers homozygous for the Met allele were found to be significantly more likely to develop PTSD after relatively few trauma exposures compared to carriers of the Val allele ([Kolassa et al., 2010](#)). This study did not find that Met carriers were any more likely to experience trauma, suggesting that this finding is not an artifact of risk for trauma exposure. This finding was recently replicated in a smaller study of urban violence victims ([Valente et al., 2011](#)) as well as in a larger study (N=502) of PTSD associated with malignant pain ([Boscarino, Erlich, Hoffman, Rukstalis, & Stewart, 2011](#)).

Although a causal link for this polymorphism with PTSD has yet to be established, carriers of the Met allele have been shown to exhibit increased brain activation in the frontal cortex, amygdala and hippocampus in response to emotional or painful stimuli ([Drabant et al., 2006](#), [Smolka et al., 2005](#)). The COMT Met allele has also been associated with poorer fear extinction than Val carriers in healthy controls, as well as reduced response to exposure therapy in a small sample of panic disorder patients ([Lonsdorf et al., 2009, 2010](#)). Thus, one might speculate that Met carriers may have altered or “increased” function of neural circuits underlying emotion processing and memory, which could act as a vulnerability for PTSD symptoms via impaired fear extinction processes.

2.2.3 FKBP5 genes A number of studies have begun to show that both genetic and epigenetic differences in the FKBP5 gene interact with childhood trauma to effect vulnerability to PTSD ([Binder et al., 2008](#); [Boscarino et al., 2011](#); [Yehuda et al., 2009](#), [Xie et al., 2010](#)). FKBP5 is a co-chaperone peptide that negatively regulates bound glucocorticoid receptor translocation to the nucleus, thus inhibiting glucocorticoid signaling pathways including negative feedback. Polymorphisms in the FKBP5 gene have been linked to PTSD in trauma exposed individuals ([Binder, 2009](#); [Binder et al., 2008](#); [Xie et al., 2010](#)). Although the specific function of these mutations is unknown, they are associated with increased glucocorticoid resistance and increased FKBP5 expression in healthy controls, which is a logical consequence of increased inhibition of glucocorticoid signaling by FKBP5 ([Binder et al., 2004, 2008](#), [Ising et al., 2008](#)). In PTSD subjects, however, these polymorphisms are associated with increased glucocorticoid sensitivity and reduced FKBP5 expression ([Binder, 2009](#); [Mehta et al., 2011](#)). These data suggest that trauma, perhaps via epigenetic mechanisms that alter expression of FKBP5 or other HPA axis genes, change HPA function differently across FKBP5 genotype. The only way to test such a hypothesis is via a prospective study, predicting that carriers of the FKBP5 polymorphisms will reverse to low expression following trauma exposure. A recent prospective study in the Dutch military was unable to test this hypothesis due to a low number of PTSD cases; however, they did find that *low* plasma FKBP5 expression predicted high PTSD symptoms after combat ([van Zuiden, Geuze, Willemen, Vermetten, Maas, Amarouchi, Kavelaars, & Heijnen, 2011](#)). These data are similar to findings that PTSD subjects exhibit low peripheral FKBP5 expression ([Mehta et al., 2011](#), [Yehuda et al., 2009](#)).

Taken at face value these data suggest low FKBP5 expression predicts PTSD symptom development. One potential mechanism is through FKBP5 genotype altering HPA axis signaling and thereby impacting the maturation of key limbic circuits and/or the HPA axis directly. Or the reverse may occur, with trauma leading to developing circuits undergoing epigenetic changes in FKBP5 and related HPA axis genes that are already functionally at risk due to genetic variation, resulting in long term alteration of HPA axis signaling in these circuits.

2.2.4 Summary Findings using genetic methodology indicate that genetic and epigenetic factors (particularly in stress response gene pathways) existing prior to the experience of traumatic stress may influence the development of PTSD. Studies of the 5-HTT, COMT and FKBP5 gene variants are the most numerous with replications of at least some findings. Importantly variance in 5-HTT, COMT and FKBP5 may not only confer risk, but also modify pharmacologic or behavioral treatment responses; however, more studies in PTSD specific populations are needed to address this important question.

How and when these genes affect stress response systems during and after trauma, or how they may act via interactions with developmental traumas is unknown. For example, it is not yet clear how differences in FKBP5 levels may interact with childhood trauma to “direct” a developmental trajectory toward increased risk. Given the plasticity of the hippocampus (which develops significantly during early childhood) and prefrontal cortex (which develops heavily during adolescence), it is possible that experiencing early life trauma at a number of developmental periods could impact the function of these circuits, with the strength of this impact being modified by certain genotypes in the stress pathway. Alternatively these genetic factors may directly increase or decrease function of a particular circuit important for fear learning or emotional regulation (e.g. COMT and 5-HTT modulation of amygdala/frontal cortex activation and function). Animal models of 5-HTT and COMT function have been particularly helpful in establishing causal relationships between functional variants and related stress phenotypes as well as how these gene variants may alter neurocircuit development ([Harrison & Tunbridge, 2008](#), [Homberg & Lesch, 2011](#)). Establishing functional mechanisms of these polymorphisms will be critical to understanding how these polymorphisms alter gene function and ultimately response to trauma.

2.3 Neuroendocrine Response and Vulnerability to PTSD

The hypothalamic-pituitary-adrenal (HPA) axis allows the body to respond to the experience of stress. In this system, the paraventricular nucleus of the hypothalamus secretes corticotropin releasing factor (CRF), which activates CRF receptors at the pituitary. The pituitary subsequently releases adrenocorticotrophic hormone into the blood stream, which induces the adrenal glands to induce peripheral release of cortical glucocorticoids (e.g., cortisol). Glucocorticoids act to mobilize physiological changes such as release of glucose and lipid stores and increasing immune response ([Breedlove, Rosenzweig, & Watson, 2007](#)). They are also transported to the central nervous system and act to modify neural plasticity and behavior, as well as to shut off CRF release (negative feedback). Although this response is useful for mobilizing the body’s resources to cope with threat and typically terminates to return the body to homeostasis, chronic or particularly severe stressors, such as trauma, may lead to disruptions in this system. As a result, the body may be exposed to prolonged release of stress hormones and cortisol, leading to chronic inflammation and other negative consequences that can be conceptualized as “wear and tear” (referred to as allostatic load; [McEwen, 2004](#)).

Given that trauma is an extreme stressor, functioning of HPA components that regulate physiological reactions to stress may be a vulnerability to PTSD. Specifically, individuals with pre-existing tendency toward more sensitive or reactive HPA systems may demonstrate disruptions in the excretion of stress hormones or the negative feedback loop during and after the traumatic event, as well as increased hyperarousal and cognitive consequences of prolonged secretion of stress hormones. Cross-sectional literature on cortisol alterations in PTSD has been complex and somewhat inconsistent, but many

findings demonstrate hypocortisolism in PTSD, such that individuals with PTSD experience lower resting levels of peripheral cortisol and enhanced negative feedback mechanisms (see [Handwerker, 2009](#); [Meewisse, Reitsma, De Vries, Gersons, & Olf, 2007](#); [Mehta et al., 2011](#); [Yehuda, 2006](#); [Yehuda, Golier, Halligan, & Harvey, 2004](#)). These reduced basal cortisol levels in PTSD may be a consequence of specific genetic backgrounds associated with PTSD discussed previously (e.g. glucocorticoid receptor and FKBP5 genotypes, see [Mehta et al., 2011](#), [van Zuiden, Geuze, Willemen, Vermetten, Maas, Amarouchi, Kavelaars, & Heijnen, 2011](#)).

A number of longitudinal studies characterized the time course of cortisol adaptation soon after trauma to determine if cortisol response to trauma represents a vulnerability to subsequent PTSD development. These studies generally suggest that low cortisol responses early after trauma predicted increased risk for PTSD symptoms, potentially because this diminished response reflects the body's attempt to down-regulate high peri-trauma cortisol ([Delahanty, Raimonde, & Spoonster, 2000](#); [McFarlane, Barton, Yehuda, & Wittert, 2011](#); although see [Shalev et al., 2008](#)). Data from prospective studies also suggest that higher morning cortisol (presumably reflecting greater cortisol reactivity) prior to trauma predicts higher levels of peri-traumatic dissociation and acute stress symptoms after traumatic stress ([Inslicht et al., 2011](#)), although this finding is not consistently replicated ([van Zuiden, Geuze, Willemen, Vermetten, Maas, Heijnen, & Kavelaars, 2011](#); [van Zuiden, Kavelaars, et al., 2011](#); [Heinrichs et al., 2005](#)). A recent prospective study in Dutch military found that individuals with increased glucocorticoid binding capacity in leukocytes prior to military deployment were more likely to develop PTSD symptoms after combat exposure ([van Zuiden, Geuze, Willemen, Vermetten, Maas, Heijnen, & Kavelaars, 2011](#)). This same group found that reduced levels of FKBP5 also predicted PTSD symptoms (see FKBP5 section above - [van Zuiden, Geuze, Willemen, Vermetten, Maas, Amarouchi, et al., 2011](#)), suggesting that increased sensitivity to glucocorticoid signaling either via increased receptor levels or reduced negative modulation by FKBP5 confers risk for development of PTSD. Thus, although findings are still equivocal in some respects, pre-trauma features of the individuals' HPA functioning appear to comprise one potential vulnerability factor for PTSD after experiencing trauma.

The processes involved in HPA axis alteration development are not fully understood, but the resiliency of this system is likely a function of genotype, childhood trauma, trauma burden or an interaction between these factors ([Kearney, Weschler, Kaur & Lemos-Miller, 2010](#); [McCrorry, De Brito, & Viding, 2010](#); [Meaney et al., 1996](#); [Tarullo & Gunnar, 2006](#)). Indeed some studies suggest that HPA axis function may change in response to trauma depending on specific genotype and past trauma history ([Mehta et al., 2011](#)). Because of the clear interaction of multiple factors on these markers, careful evaluation of genetic polymorphisms, their functional effects across subjects with and without trauma and PTSD symptoms will be the standard for future studies in the field.

How HPA axis disruption might increase risk for PTSD is another open question with an extensive animal and human literature (for review see [Yehuda, 2009](#); [Mehta & Binder, 2011](#)). Glucocorticoid signaling facilitates fear conditioning as well as fear extinction ([Steckler and Risbrough, 2011](#)), and excess glucocorticoid signaling can severely disrupt cortical and hippocampal structure and function, which may in turn disrupt emotional regulation ([Acheson, Gresack, & Risbrough, 2012](#); [Conrad, 2008](#)). Again, large prospective studies that cut across multiple lines of inquiry (imaging, HPA markers, cognitive assessments, stress reactivity) will be needed to untangle which markers of dysfunction precede trauma-induced PTSD symptoms and other related disruptions (e.g. cognitive function, stress response). Moreover, these studies will need to evaluate whether or not stress effects on HPA development and subsequent alterations in HPA function actually *mediates* predisposition to psychopathology in adulthood, or if other effects, such as epigenetic changes in response to developmental stress play a larger role ([Yehuda et al., 2009](#)).

3. Cognitive Vulnerability Factors

Theoretical models of PTSD suggest that biases in cognitive processing are implicated in the maintenance of symptoms (e.g., [Brewin et al., 1996](#); [Ehlers & Clark, 2000](#); [Foa et al., 1989](#)). Cognitive correlates of PTSD can be divided into two domains: general cognitive functioning, which includes intelligence and neuropsychological performance on non-valenced tasks, and cognitive biases, which refer to distortions in the processing of emotional information. An emerging body of literature suggests that these cognitive characteristics may exist prior to the occurrence of the traumatic event and may be implicated in the etiology of the disorder. Below we review the extant evidence for the role of general cognitive functioning and biased cognitive processing as pre-trauma vulnerabilities for PTSD.

3.1 General Cognitive Functioning

3.1.1 Intelligence Extant data suggest a link between intelligence and PTSD symptoms after trauma (e.g., [McNally & Shin, 1995](#); [Vasterling, Brailey, Constans, & Borges, 1997](#)). A review by Brewin and colleagues (2000) concludes that intelligence may be a vulnerability above and beyond other pre-morbid conditions that accounts for a relatively small but significant portion of the variance in PTSD development (weighted average effect size of $r = .18$). Studies consistently demonstrate that lower intelligence prior to trauma exposure predicts subsequent PTSD development. One commonly used methodology for obtaining intelligence data on individuals before trauma exposure is the use of records from military personnel who were subsequently exposed to combat or other service-related traumatic events. In these studies, pre-trauma intelligence predicted PTSD diagnosis after exposure to trauma ([Boscarino, 2006](#); [Kaplan et al., 2002](#); [Macklin et al., 1998](#); [Pitman, Orr, Lowenhagen, & Macklin, 1991](#)), even when adjusting for the extent of combat exposure ([Macklin et al., 1998](#)). The link between pre-trauma intelligence and PTSD is also supported in longitudinal studies that assess children over the course of development; these demonstrate that intelligence assessed early in childhood is subsequently associated with PTSD in adolescent ([Breslau, Lucia, & Alvarado, 2006](#)) and adulthood ([Koenen, Moffitt, Poulton, Marin, & Caspi, 2007](#)).

Evidence for the link between intelligence and PTSD is also available indirectly from studies using samples of individuals with intellectual disability. If individuals with relatively diminished intellectual functioning are more likely to develop PTSD after trauma, this group will likely have greater rates of PTSD relative to individuals with average intelligence. Consistent with this hypothesis, a recent review suggested that PTSD may be more prevalent in individuals with intellectual disability ([Mevisen & de Jongh, 2010](#)), although as the authors note environmental factors and stressors may account for this relationship. For example, daily stressors associated with lower psychosocial functioning may lead to altered stress reactivity that also differentiate those with and without disability and may be differentially associated with PTSD development after trauma.

In summary, research using diverse samples and methodologies documents intelligence as a pre-trauma vulnerability factor for PTSD, although the effect size for this relationship is modest. The mechanisms by which intelligence confers risk for PTSD have yet to be empirically examined. One hypothesis is that those with higher intelligence are better able to use effective problem solving strategies to cope with symptoms ([Macklin et al., 1998](#)). Alternatively, the relationship between intelligence and PTSD may be accounted for by executive functioning abilities (i.e., cognitive systems that allow for planning and regulating goal directed behavior, including inhibition and working memory). That is, because intelligence is highly associated with executive functioning ability ([Engle, Tuholski, Laughlin, & Conway, 1999](#)), executive functioning may actually be the underlying vulnerability. By this account, an individual's executive functioning abilities may promote more efficient cognitive reactivity to trauma, thus modulating PTSD risk (e.g., [Verwoerd, Wessel, & de Jong, 2009](#); see section 3.1.2 below). We next turn to specific research utilizing neuropsychological assessment to examine aspects of executive functioning as potential vulnerabilities.

3.1.2 Neuropsychological Performance

PTSD is characterized by deficiencies on neuropsychological assessments of executive functioning in individuals with PTSD. For example, individuals with PTSD demonstrate diminished ability to maintain focused attention (Vasterling et al., 1998; [Vasterling et al., 2002](#)), poorer working memory performance (e.g., [Leskin & White, 2007](#); [Stein, Kennedy, & Twamley, 2002](#)), and poorer inhibitory control ([Falconer et al., 2008](#); [Yehuda, Keefe, Harvey, & Levengood, 1995](#)) relative to healthy individuals (for a review of cognitive functioning differences see [Buckley, Blanchard, & Neil, 2000](#); [Constans, 2005](#); [Mathews & MacLeod, 2005](#)).

Relative deficits in cognitive functioning in those with PTSD appear to pre-date trauma exposure. Twin studies have found that performance on neuropsychological tests in non-trauma exposed twins predicted cognitive performance in the twin with PTSD, suggesting that poor cognitive functioning is pre-existing vulnerability factor ([Gilbertson et al., 2006](#); [Kremen et al., 2007](#)). Moreover two studies to date found that cognitive functioning assessed prior to trauma predicts PTSD. In the first, [Parslow and Jorm \(2007\)](#) administered a battery of neuropsychological tests to a random sample of young adults before and after the occurrence of a natural disaster. Results indicated that those with lower performance on neuropsychological assessments, including memory, working memory, and attention, assessed during the first time point prior to the disaster independently predicted greater PTSD symptoms after the disaster. In a second study, [Marx, Doron-Lamarca, Proctor, and Vasterling \(2009\)](#) administered a neuropsychological assessment battery to active duty Army personnel prior to deployment and subsequently assessed psychopathology symptoms post-deployment. Results indicated that better immediate visual recall performance predicted more severe PTSD symptoms after combat exposure. Thus, in both cases neuropsychological performance predicted PTSD symptoms after trauma, although results differed in terms of the specific type of cognitive functioning that was predictive of PTSD.

Evidence using analogue methodologies also suggests that cognitive deficits may be pre-trauma vulnerability factors. In particular, the ability to control proactive interference (i.e., interference in memory for recently learned stimuli from previously learned stimuli) appears to be associated with re-experiencing symptoms after stress. For example, [Verwoerd, Wessel, de Jong, Nieuwenhuis, and Huntjens \(2011\)](#) demonstrated that performance on the proactive interference control index of the California Verbal Learning Test predicts re-experiencing symptoms following analogue traumatic stressors (i.e., a distressing film). Similar effects are documented in studies using other forms of proactive interference tasks in analogue samples ([Verwoerd et al., 2009](#); [Wessel, Overwijk, Verwoerd, & de Vrieze, 2008](#)). Thus, difficulty with proactive interference control may reflect a general failure of inhibitory control processes, which may lead to greater frequency of intrusive symptoms following trauma exposure.

In summary, data from longitudinal and analogue studies to date suggests that performance on neuropsychological assessments before trauma predicts PTSD symptom severity. Although studies differed in terms of which neuropsychological tests were predictive of PTSD, methodological differences, such as sample selection and statistical procedures, may have influenced this discrepancy (e.g., analogue versus actual traumatic events, use of full neuropsychological batteries versus single tests). Nonetheless, these studies together support the hypothesis that lower neuropsychological performance, including aspects of executive functioning, is a vulnerability factor for PTSD. Moreover, this relationship may be driven by inability to regulate re-experiencing symptoms such as intrusive memories after trauma.

Recent theoretical models of cognitive functioning in PTSD propose that deficits in aspects of executive functioning may be a neurobiological vulnerability for PTSD (e.g., [Koenen, 2006](#); [Verwoerd, Wessel, & de Jong, 2009](#)). Specifically, relatively diminished executive functioning may reflect poor prefrontal cortex functioning leading to decreased inhibition of amygdala reactivity to threat ([Koenen,](#)

2006). From a cognitive perspective, diminished executive functioning may lead to an inability to exert cognitive control over emotionally distressing thoughts and memories, reflected in greater re-experiencing symptoms (Verwoerd et al., 2009).

3.2 Cognitive biases

Another cognitive mechanism thought to contribute to PTSD is cognitive biases, including distorted or inaccurate beliefs, thoughts about one's self, the world, and others, and fear of emotional reactions. According to cognitive models, individuals with PTSD demonstrate cognitive biases that increase one's subjective sense of threat (e.g., perceptions of lack of safety in the environment) and prompt bias-consistent behavioral actions (e.g., avoidance; Foa et al., 1989; Ehlers & Clark, 2000). These biases are hypothesized to arise because individuals experience difficulty with adaptively integrating information from the traumatic experience with their understanding of the world, themselves, and other people. For example, trauma-related information may be inconsistent with positive beliefs about the safety and predictability of the world, or may be consistent with and confirm overly negative beliefs (Feeny & Foa, 2006). Cognitive biases including attributions, rumination, anxiety sensitivity, and looming cognitive style have been proposed to be vulnerability factors for PTSD (Elwood, Hahn, Olatunji, & Williams, 2009). Guided this earlier review, below we describe evidence for cognitive biases as vulnerabilities in each of the aforementioned domains. We also describe data regarding fear of emotions more generally, in addition to negative appraisals, based on the presence of empirical studies suggesting these may constitute vulnerabilities. As part of this review we specifically discuss evidence for each bias as a pre-trauma factor, emphasizing data from prospective designs assessing each bias prior to trauma exposure when available.

3.2.1 Negative attributional style and rumination Negative attributional style refers to an individual's likelihood of explaining events by attributing them to "internal, stable, and global" causes (Elwood et al., 2009). Rumination, or the tendency to mentally dwell on negative emotions and events, is theorized to serve an avoidance functioning by preventing the individual from cognitively processing the details of the actual traumatic stressor. Tendencies toward negative attributional style and rumination, assessed via participant self-report, have been identified in numerous cross-sectional studies of adults and children with PTSD. These studies indicate that individuals with posttraumatic stress symptoms tend to endorse less perceived control, and more global and/or stable attributions for negative events relative to those who experience no or few symptoms in adult (e.g., Ginzburg, Solomon, Dekel, & Neria, 2003) and child samples (Runyon & Kenny, 2002). The extent of this type of attributional style appears to be positively associated with symptom severity (e.g., Falsetti & Resick, 1995; Gray, Pumphrey, & Lombardo, 2003; Greening, Stoppelbein, & Docter, 2002; Joseph, Brewin, Yule & Williams, 1991; Palker-Corell & Marcus, 2004). Similarly, the tendency toward rumination about trauma-relevant information is associated with PTSD symptoms (e.g., Clohessy & Ehlers, 1999; Michael, Halligan, Clark, & Ehlers, 2007).

Longitudinal studies also suggest a relationship between cognitive biases and PTSD. Mikulincer and Solomon (1988) found that changes in attributional style after trauma (i.e., participant's self-reported increased attribution of negative personal events to stable, external and uncontrollable causes) were associated with increases in PTSD symptoms over time in a sample of war veterans. Moreover, high levels of rumination occurring after trauma predict later PTSD symptoms in adults (Kleim, Ehlers, & Glucksman, 2007; Mayou, Ehlers, & Bryant, 2002) and children (Ehlers, Mayou, & Bryant, 2003). This methodology (i.e., administering assessments closely following a traumatic event) provides additional information relative to a cross-sectional approach but is limited because it does not allow for an examination of the role of trauma exposure on the development of these types of negative attributions. To date, no published studies utilized pre-trauma assessment of these biases. In spite of

this limitation, this body of evidence suggests that these types of cognitions merit further study as potential vulnerabilities, including examination of whether these biases are latent traits that are activated by trauma or stable traits present in the individual before trauma exposure

Researchers have begun to use experimental designs to better elucidate the causal role of rumination. In these studies, the authors encourage participants to use a particular cognitive style in response to an analogue stressor to examine the effect on PTSD symptoms. Ehring, Fuchs, and Käsner (2009) asked participants to think about a negative personal experience and assigned participants to use rumination or distraction in response to that stressor (by priming rumination or distraction using items from a rumination questionnaire or distraction questionnaire, respectively). Results indicated that those using rumination continued to be distressed and have intrusive images after the stressor relative to the distraction condition. Zetsche, Ehring, and Ehlers (2009) obtained similar results using a distressing film rather than a negative personal memory. The results from these studies indicate that increasing or decreasing reliance on this type of cognitive process increases or decreases intrusive thoughts, respectively, and thus implies that rumination may be a causal factor in PTSD. Although future work is needed in clinical samples, these data indicate that one's tendency toward rumination may be a vulnerability factor that is activated by experiencing trauma, leading to increased tendencies toward recurrent intrusive cognitions.

3.2.2 Negative appraisals Cognitive models specifically emphasize appraisals about the self, others, and world in understanding problematic post-trauma reactions. Consistent with these theories, cross sectional studies confirm a relationship between negative appraisals and PTSD and suggest that PTSD is associated with negative beliefs about the individuals reactions during the trauma, the meaning of continued symptoms of PTSD, and subjective sense of current threat in the environment (e.g., Dunmore, Clark, & Ehlers, 1999; Engelhard, Macklin, McNally, van den Hout, & Arntz, 2001; Smith & Bryant, 2000). Longitudinal studies assessing appraisals soon after trauma also suggest that these traits increase risk for PTSD in adult (Dunmore, Clark, & Ehlers, 2001; Ehlers, Mayou, & Bryant, 1998; Ehring, Ehlers, & Glucksman, 2008; Halligan et al., 2003) and youth samples (Bryant, Salmon, Sinclair, & Davidson, 2007; Meiser-Stedman, Dalgleish, Glucksman, Yule, & Smith, 2009).

Data from studies assessing appraisals prior to trauma support the role of this factor as a vulnerability. Specifically, appraisals about the self (e.g., beliefs about one's inability to cope) prior to experiencing trauma predicted PTSD at four-year follow-up in a sample of firefighters (Bryant & Guthrie, 2007). Conversely, relatively higher evaluation of self worth prior to trauma has been associated with lower PTSD in a prospective study of police officers (Yuan et al., 2011). Taken together, these studies suggest that beliefs about the self, including appraisals about one's value or ability to cope, appear to predict PTSD symptoms even when assessed prior to the actual traumatic event. This is consistent with the proposed role of appraisals as a vulnerability factor. For example, an individual with negative beliefs about themselves may react to traumatic experiences with exaggerated predictions regarding the effects of trauma and subsequent symptoms (e.g., "I can't handle this", "if I don't control my symptoms I will go crazy"). These predictions likely drive an ongoing perception of threat combined with a sense of inability to cope, thus perpetuating anxiety symptoms (e.g., Bryant & Guthrie, 2007).

3.2.3 Fear of emotions Recent studies document an association between PTSD and fear of emotions. Specifically, increased fear of the experience or consequences of having or expressing emotions generally is associated with greater PTSD severity (Farnsworth & Sewell, 2011; Jacupcak, Farnsworth & Sewell, 2011; Price et al., 2006; Tull et al. 2007). Specific forms of fear of emotion studied in PTSD include anxiety and disgust sensitivity (i.e., high reactivity and aversion to the experience of consequences of feeling anxiety or disgust, respectively). Anxiety sensitivity has been linked to PTSD in a number of studies in adults (for a review see Elwood et al., 2009) and children (Kiliç, Kiliç, & Yilmaz, 2008; Storr, Jalongo, Anthony, & Breslau, 2007). Elevated disgust has also been associated

with PTSD in combat samples (Foy, Sipprelle, Rueger, & Carroll, 1984). At least one study has indicated that disgust sensitivity interacts with peri-traumatic reactions to predict PTSD development in combat exposed military personnel (Engelhard, Olatunji, & de Jong, 2010).

Fear of emotions may also be a pre-trauma vulnerability to PTSD, rather than a cross-sectional correlate of the disorder. Koegh and colleagues (2002) assessed anxiety sensitivity before childbirth and PTSD symptoms two weeks postpartum. Results indicated that anxiety sensitivity at the prenatal assessment predicted subsequent PTSD symptoms. Marshall, Miles, and Stewart (2010) assessed the time course of anxiety sensitivity and PTSD to determine the reciprocal relationship of the two constructs after trauma. The authors assessed each variable immediately after trauma then at 6- and 12-month follow-up points in a sample of individuals with physical trauma. Results revealed that these two factors reciprocally predict one another, suggesting that anxiety sensitivity at early time points predicts subsequent PTSD when controlling for earlier PTSD symptoms (although similar to the studies of negative appraisals and rumination, this study is limited due to the assessment of anxiety sensitivity immediately after trauma). Evidence for the role of disgust sensitivity in PTSD is more limited. However, one study using an analogue sample found that greater disgust reactivity assessed prior to viewing a distressing film predicted more re-experiencing symptoms immediately after the film (Bomyea & Amir, in press). Thus, preliminary evidence suggests that these variables may be pre-trauma factors increasing risk of PTSD development after trauma.

Continued research using longitudinal designs is needed to demonstrate that constructs pertaining to fear of emotion are present before trauma and to describe how these factors confer risk for PTSD. Nonetheless, researchers theorize that greater reactivity and aversion to bodily sensations may facilitate avoidance behaviors that exacerbate pathology after trauma (e.g., Elwood et al., 2009). In addition, negative appraisals about the ability to cope with physical sensations related to emotions (described above) may also contribute to patterns of avoidance that exacerbate symptoms (e.g., experiential avoidance; Boeschen, Koss, Figueredo, & Coan, 2001; Shenck, Putnam, & Noll, 2012).

3.2.4 Looming cognitive style Looming cognitive style refers to the tendency for individuals to pervasively predict threat in the environment combined with the sense that this threat is rapidly increasing (e.g., Reardon & Williams, 2007). Two studies indicate that self-report of greater looming cognitive style is modestly associated with PTSD symptoms (Reardon & Williams, 2007; Williams, Shahar, Riskind & Joiner, 2005). Research documenting information processing biases in PTSD also supports the looming cognitive style hypothesis. For example, individuals with PTSD endorse interpretations of ambiguous information as relatively more threatening support the contention that a threat-biased, negative schema consistent with the looming cognitive style may be present in these individuals (e.g., Amir, Coles, & Foa, 2002; Elwood, Williams, Olatunji, & Lohr, 2007). Similarly, individuals with PTSD demonstrate attention and memory biases toward threatening information (e.g., Constans, 2005; Yehuda, Stavitsky, Tischler, Golier, & Harvey, 2005), which is consistent with the presence of a threat-biased looming cognitive style (Riskind, Williams, Gessner, Chrosniak, & Cortina, 2000).

To date, one published study suggests that information processing manifestations of a looming cognitive style may be a vulnerability factor for PTSD. Beevers and colleagues (2011) assessed attention bias using eye tracking technology in a sample of military personnel prior to combat exposure to examine whether or not attentional bias may be a vulnerability to PTSD. In the initial assessment session participants were asked to attend to pictures of emotional faces while their gaze was monitored. These participants subsequently returned completed assessments of combat exposure, PTSD, and other mental health problems while deployed. Results revealed that those who demonstrated an attentional bias away from threatening information were more likely to develop PTSD symptoms after combat.

Additional evidence for attentional avoidance as a vulnerability for PTSD comes from a study by Wald and colleagues (2011), demonstrating that attentional avoidance soon after experiencing trauma predicted subsequent PTSD at 1 year follow-up.

This evidence suggests that patterns of attentional bias may constitute a vulnerability to PTSD. Although further research is needed to understand how this bias confers risk to PTSD, it is proposed that attention bias may reflect a cognitive manifestation of avoidance symptoms that are problematic in exacerbating and maintaining PTSD symptoms (e.g., Wald et al., 2011). Thus, individuals who are predisposed to use avoidance coping at the level of attention may also tend to use behavioral coping based on avoidance of perceived threat or negative emotion. Alternatively, difficulty attending to trauma stimuli may disrupt processing of trauma-related stimuli during the event, thus leading to disruptions in memory coherence and organization that proposed to contribute to PTSD development (Brewin, 2011). However, findings require further replication and other aspect of looming cognitive style have yet to be examined empirically as a pre-trauma predictor of PTSD,

4. Summary and Conclusions

A number of intrinsic and stable traits related to an individual's biology and cognitive functioning appear to increase the likelihood of developing PTSD. Evidence to date suggests that heritable biological factors may be vulnerability factors for subsequently developing PTSD. Although the exact mechanisms of transmission of this vulnerability are not known at this time, candidates include the 5-HTT, COMT, and FKBP5 genes. There is evidence suggesting that dysregulation in HPA axis function, particularly glucocorticoid sensitivity and reduced FKBP5 expression, may be a pre-trauma vulnerability factor for PTSD. General cognitive factors including intelligence and neuropsychological functioning also appear to be pre-trauma variables that are implicated in PTSD development. Moreover, forms of cognitive biases (i.e., negative attributions, rumination, negative appraisals, fear of emotion, and looming cognitive style) appear to interact with trauma exposure to predict PTSD symptoms. Table 1 presents a summary of reviewed studies that include prospective assessment of the purported vulnerability factor of interest (or assess a factor that is not altered by trauma exposure such as genetic makeup).

Table 1

List of reviewed studies that include assessment of vulnerability factor isolated from effects trauma exposure

Vulnerability	Subtype	Research Articles
Biological	Genetic Twin Studies	Twin: True et al. (1993) ; Stein et al. (2002) ; Skre et al. (1993)
	Molecular G x E Interaction (reviewed by Koenen et al. 2009 ; Mehta & Binder, in press)	5HTTLPR variations: Binder et al. (2008) ; Grabe et al. (2009) ; Kilpatrick et al. (2007) ; Koenen et al. (2009) ; Kolassa et al. (2010) ; Xie et al. (2009) . COMT: Kolassa et al 2010 ; valente et al. 2011 , Boscarino et al. 2011 FKBP5 genotype: van Zuiden, Geuze, Willemen, Vermetten, Maas, Amarouchi, Kavelaars, & Heijnen, 2011
	HPA Functioning	Amstadter et al. (2011 [CRF1]) ; Amstadter, Koenen et al. (2009 [NPY]) ; Binder et al. (2008 [FKBP5]) ; Mehta et al. (2011) ; van Zuiden, Geuze, Willemen, Vermetten, Maas, Heijnen, & Kavelaars (2011) ; van Zuiden, Kavelaars, et al. (2011) ; Yehuda et al. (2009)
Cognitive	Intelligence	Boscarino (2006) ; Breslau et al. (2006) ; Kaplan et al. (2002) ; Koenen et al. (2007) Macklin et al. (1998) ; Pitman et al. (1991)
	Neuropsychological Performance	Parslow & Jorm (2007) ; Marx et al. (2009) ; Verwoerd, Wessel, & de Jong, 2009 ; Verwoerd, Wessel, de Jong, Nieuwenhuis, & Huntjens (2011) ; Wessel, Overwijk, Verwoerd, & de Vrieze (2008)
	Cognitive Biases	Beevers et al. (2011) ; Bomyea & Amir (2011) ; Bryant & Guthrie (2007) ; Koegh et al. (2002) ; Yuan et al., 2011

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One question raised by empirical data in this area is *how* these particular factors confer vulnerability to PTSD. It is important to understand the mechanisms by which each vulnerability (or vulnerabilities jointly) lead to symptoms. Based on the evidence reviewed here, a model accounting for the effect of the vulnerability factors reviewed might specify two potential pathways to PTSD development. First, many of the vulnerability factors reviewed here are directly implicated in increased anxiety reactivity. These include variables such as molecular genetic variables that modulate neurobiological bases of anxiety (e.g., amygdala reactivity), as well as neuroendocrine responses that lead to chronic hormone-based stress reactivity and autonomic arousal, and cognitive biases that perpetuate a sense of current threat (e.g., negative appraisals). Second, other vulnerability factors appear to operate in part via decreased cognitive control over trauma-related cognitions. These include factors such as proactive

interference control and rumination, which appear to confer risk for PTSD by increasing the frequency of re-experiencing symptoms such as intrusive memories. In conjunction, these two pathways contribute directly to the increased anxiety reactivity and cognitive symptoms observed in those with PTSD, and may also lead to avoidance symptoms via operant conditioning processes (e.g., situations are avoided because this diminishes anxiety and triggered cognitive symptoms). Although these two pathways may be partially distinct, anxiety reactivity and cognitive control are likely interrelated and reciprocal, and some factors like operate via both mechanisms. Though plausible, empirical evidence is needed to explicitly test the hypotheses of this model and develop it further based on empirical evidence.

Moreover, research examining the interplay of the vulnerability diatheses described here with peri-traumatic factors is needed to more comprehensively model PTSD using a diathesis-stress conceptualization. Given that an individuals' response during trauma significantly impacts PTSD development (for a review of peri-traumatic risk factors see [Ozer, et al., 2003](#)), this approach may further integrate our knowledge of vulnerability factors with models of PTSD development that focus on peri- and post-traumatic reactivity. For example, biological predispositions may lead to greater anxiety and panic during trauma, leading to negative evaluations about one's reactions during trauma and more intrusive thoughts in the aftermath of the trauma. These consequences may then contribute to negative beliefs about the world on one's coping ability as outlined by models such as [Ehlers and Clark's cognitive model \(2000\)](#). Alternatively, greater intrusive thoughts as a result of diminished cognitive functioning may contribute to the development and over-accessibility of fear structures noted in [Foa and colleagues \(1989\)](#). Similarly, understanding the interaction of vulnerability factors may allow for more accurate conceptual models of PTSD given that each individual vulnerability is like to play only a small role in overall risk for PTSD ([Elwood et al., 2009](#)). Thus, research designed to examine competing models regarding the role of various vulnerability factors is also needed to better understand the pathways to PTSD development.

From a methodological perspective, further research is critically needed in this area using prospective, longitudinal study designs. Without proper sequential sequencing of assessment points it is impossible to disentangle effects of trauma exposure on assessments of factors such as HPA axis functioning or cognitive performance. The paucity of research in this area is undoubtedly due in part to the difficulties associated with identifying a large group of individuals to assess a disorder with relatively low prevalence. Without an adequate baseline group, lack of statistical power precludes analyzing potential relationships between baseline factors and PTSD. However, identifying high risk populations who are more likely to experience trauma (e.g., police officers) offers a viable alternative, with the caveat that these populations are likely to be different from a typical representative sample on many characteristics. For example, these groups differ on characteristics such as personality (e.g., [Salters-Pedneault Rueff, & Orr, 2010](#)) that may influence development of PTSD or other psychopathology after traumatic events. Evidence supporting and generating theoretical hypotheses may also be derived from experimental and analogue study designs, particularly when conducted in conjunction with studies in clinical populations.

In spite of potential limitations in our understanding of these factors, existing research in this area provides useful clinical information. Biological and cognitive vulnerability factors known to date may be useful in identifying those at risk for developing PTSD after trauma exposure. For example, those with relatives with PTSD may have a genetic "loading" predisposing them to PTSD under intense stress through neurotransmitter regulation or altered HPA reactivity. Similarly, those with lower intelligence or neuropsychological impairments appear more prone to PTSD development. Awareness of these factors may alert clinicians to those potentially most in need of preventative efforts or early intervention after exposure to trauma.

An understanding of the pre-trauma vulnerabilities outline here may also suggest intervention approaches, particularly once the mechanisms of the vulnerabilities are established. For example, identifying vulnerability factors within a specific individual may lead to greater personalized treatment (e.g., those with strong cognitive bias vulnerabilities may be amenable to cognitive approaches). In addition, understanding how risk for PTSD is conferred by vulnerability factors has the potential to improve current treatment approaches by distilling the critical components of physiological and cognitive change necessary for treatment success. Moreover, understanding these vulnerabilities may inform development of novel treatment approaches. For example, based on data suggesting cognitive functioning may be implicated in PTSD, a number of research groups have begun examining cognitive training programs as interventions for PTSD (see author notes in this manuscript and also [Schweizer & Dalgleish, 2011](#)).

In summary, a greater understanding of vulnerability factors that exist pre-trauma are critical to better develop theoretical accounts of PTSD and, eventually, for the development of prevention programs. Though further research is needed, the extant findings suggest that characteristics that pre-date trauma exposure operate to increase PTSD for specific individuals.

Highlights

- Vulnerability factors for PTSD may exist prior to experiencing trauma.
- Biological factors include genetics and physiological stress reactivity.
- Cognitive factors include neuropsychological ability and cognitive biases.
- Prospective research will further elucidate pre-trauma vulnerability factors.

Footnotes

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A traumatic event makes victims age biologically faster

Post traumatic stress disorder should no longer be thought of as only a mental illness after scientists found it causes major biological damage



A traumatic experience ages the body, causing disease and early death, scientists believe Photo: Alamy

By Sarah Knapton, Science Editor

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A stressful experience really can take years off you as scientists find that people with post-traumatic stress disorder (PTSD) are actually ageing faster

Researchers at the University of California looked at 64 studies which linked early death and illness to traumatic experiences.

Six studies looked at the length of telomeres – the protective caps at the end of chromosomes which stop DNA from becoming damaged. Telomeres shorten with every cell replication and so are considered a strong measure of the aging process in cells. They found that people who had suffered stress had shorter telomeres than would be expected given their age.

Other indicators of poor health and premature ageing, such as increased inflammation were also present.

People who had suffered post-traumatic stress disorder were also more likely to suffer from age-related diseases such as heart disease, type 2 diabetes, ulcers and dementia, indicating that they were ageing more quickly. They were also more likely to die earlier.

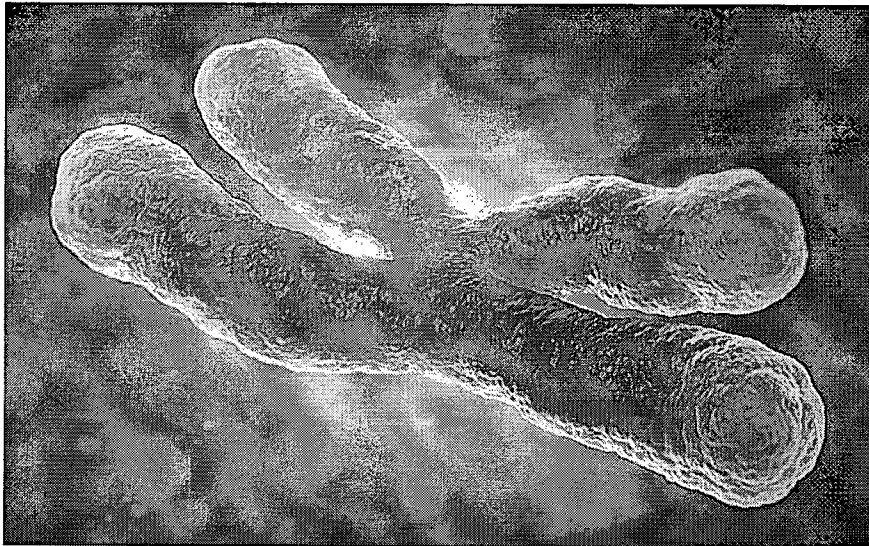
- Secret of healthy ageing discovered in ground-breaking 35-year study
- Ageing reversed as scientists discover how to turn clock back in animals

- Ageing does not have to bring poor health and frailty, say King's College scientists

PTSD can be brought on by a number of events including serious road accidents, sexual assaults, long term abuse, military combat or natural disasters. In Britain around three per cent of men and two per cent of women have been diagnosed with the condition.

It has already been found to heighten the risk of chronic depression, anger, insomnia, eating disorders and substance abuse, but it is the first study to show a link to premature ageing.

The researchers say that it shows PTSD should be classified as a biological not just a mental illness.



"This is the first study of its type to link PTSD, a psychological disorder with no established genetic basis, which is caused by external, traumatic stress, with long-term, systemic effects on a basic biological process such as aging," said Dr Dilip Jeste, Professor of Psychiatry and Neurosciences at the University of California.

Researchers had previously noted a potential association between psychiatric conditions, such as schizophrenia and bipolar disorder, and acceleration of the aging process.

"These findings do not speak to whether accelerated aging is specific to PTSD, but they do argue the need to re-conceptualize PTSD as something more than a mental illness," said Dr James Lohr, professor of psychiatry at the University of California.

"Our findings warrant a deeper look at this phenomenon and a more integrated medical-psychiatric approach to their care."

The research was published in the American Journal of Geriatric Psychiatry.

Survival Experience of Aged Hip Fracture Patients

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J. RICHARD HEBEL, PhD, AND JOHN E. KENZORA, MD

Abstract: Hip fracture has long been considered a major threat to survival in aged populations. This report describes the survival experience of 814 aged, community dwelling hip fracture patients treated in seven Baltimore hospitals between 1984 and 1986: 4.3 per cent died during hospitalization; 8.2, 12.6, and 17.4 per cent died within three, six, and 12 months after fracture, respectively. The mortality rate for the entire population approaches expected mortality approximately six

months post-fracture, but varies by age and sex. The most important factors predicting mortality are presence of serious concomitant illness and marked delirium (in the absence of dementia) at the time of hospital admission. The authors suggest that medical factors that may contribute to patient disorientation be investigated and treated, when possible, in an effort to improve the survival status of hip fracture patients. (*Am J Public Health* 1989; 79:274-278.)

Introduction

This report describes the survival experience of a recent series of hip fracture patients who entered one of seven Baltimore area hospitals between October 1, 1984 and April 30, 1986. While the survival experience of numerous series of hip fracture patients has been previously reported, the majority of these include patients treated in the late 1950s to mid-1970s,¹⁻²⁵ generally before the initiation of prophylactic anticoagulant and antibiotic treatment for surgical patients.¹³ Secondly, most recent hip fracture series involve patients treated outside the United States,²⁶⁻³⁴ where treatment principles and use of technology differ markedly from those in this country.³⁵ Moreover, most previous reports do not differentiate the mortality experience of individuals residing in nursing homes or other long-term care institutions at the time of fracture from that of community dwelling patients,^{1,3,5-11,13,15-17,19,20,22,24,25,31} and numerous studies^{1,2,5,6,8,9,11,13,17,19-23,31,32,36,37} include hip fracture cases younger than age 55 for whom the cause of fracture is often severe trauma and for whom the prognosis of recovery is generally excellent.^{3,24,25,37}

The present study provides more current information on the survival experience of aged hip fracture patients treated in the United States, and residing in the community at the time of their fracture, and determines at three, six, and 12 months following hip fracture the relative risk of mortality associated with selected demographic and medical indicators.

Methods

Subjects and Data Collection

Subjects consist of all patients aged 65 years or older, admitted to one of seven Baltimore area hospitals from the community with an acute fracture of the hip between October 1, 1984 and April 30, 1986. We identified the majority of patients (n = 698) through weekly calls to an established contact within each hospital, usually an orthopedic ward nurse or an admissions officer. To ensure complete enumeration of eligible cases,

we reviewed hospital discharge records for cases discharged with an ICD-9 code of 820 not previously identified. An additional 116 cases were located in this manner. Data on all patients (n = 814) were obtained from hospital charts by trained interviewers using a standard protocol.

The seven study hospitals were selected on the basis of the volume of patients treated using data from the Maryland Health Services Cost Review Commission. These hospitals treat approximately half of all hip fracture patients age 65 and older treated within the 27 hospitals in the Baltimore SMSA. Study hospitals comprise a broad range of practice settings, including urban, suburban, sectarian, and public hospitals. Three of the seven hospitals have orthopedic residency programs. Elderly hip fracture patients treated in the study hospitals compared with those seen in all Baltimore area hospitals are more likely to be older than 75 years (79 per cent versus 75 per cent), female (83 per cent versus 79 per cent) and discharged to nursing homes (39 per cent versus 34 per cent).

Measures

Predictors—The demographic factors examined in this study include: age, sex, and race. The medical predictors include: type of fracture (intracapsular or extracapsular), orientation on admission, and concomitant medical conditions. The measure of orientation on admission derives from physician chart notes regarding patient status on admission. If disorientation was noted, the patient was labeled confused; if unnoted, the patient was considered mentally clear.

To account for patients' medical status pre-fracture, we constructed a binary measure of general medical condition based on whether any of the following conditions were noted in the patient's chart: cancer; stroke and related conditions; heart, atherosclerotic, liver, bladder, pulmonary, or renal disease; chronic obstructive pulmonary disease (COPD); or Parkinson's disease. These conditions were selected on the basis of previous findings involving single disease entities and mortality following hip fracture^{1,9,16} and on clinician judgment. We constructed a binary measure of cognitive status based on whether or not senile dementia, Alzheimer's disease, or organic brain syndrome were noted in the hospital chart. Using this measure and an additional item concerning orientation on admission, we developed a three-category variable. The reference category includes patients with neither dementia nor noted delirium on admission; the second, consists of only patients with dementia; the third, includes cases with noted disorientation on admission, but who were not diagnosed as suffering from an organic brain syndrome. We chose to distinguish between chronic confusion due to dementia and acute confusional states or delirium

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Editor's Note: See also related editorial p 269 and article p 279 this issue.

as the latter often indicates the presence of a potentially serious biomedical condition or metabolic disturbance which can deleteriously affect patient outcome.^{17,38}

Outcome—We obtained the survival status of patients and date of death (when applicable) through follow-up interviews of the patient or a close friend or relative of the patient at two, six, and 12 months following hospital discharge. For 119 patients for whom we could not obtain follow-up interviews and the 116 patients identified through discharge diagnoses, the investigators searched the death records maintained by the Maryland Bureau of Vital Statistics for each patient's name and date of birth. When a match was found, staff recorded the date of death. If no death record was found, the patient was presumed still living.

Using the date of death for patients who died and the date of hospital admission, we calculated the number of days each patient survived since sustaining a hip fracture. Since hospitalization generally occurs within one or two days following a hip fracture,²² we used the date of hospital admission as a reasonable approximation of the date of fracture.

Data Analysis

We calculated the expected one-year mortality using 10-year age group-, sex-, and race-specific death rates published by the National Center for Health Statistics for the United States population in 1982.³⁹ We calculated the observed mortality rate for each month following fracture and compared this with the expected death rates. In plotting the expected survival curve and in calculating the expected monthly mortality, we assumed that change in mortality is directly proportional to time over the one year follow-up period.

To examine the relative predictive value of the demographic and medical factors, we first tested for the presence of an association between each variable of interest and mortality at three, six, and 12 months post-fracture, using Yates' chi square statistic for dichotomous measures and Mantel-Haenszel's test statistic for variables with three or more ordered categories. We performed logistic regression analyses with mortality as the outcome for each time period after fracture. Odds-ratios and 0.95 confidence intervals were calculated for each factor using the beta coefficients and standard errors generated by the regression procedure following the method prescribed by Schlesselman.⁴⁰

Results

Table 1 describes the demographic and medical characteristics of 814 patients followed for one year after sustaining hip fracture. The population consisted largely of White females with an average age of 80 years. Patients were relatively unhealthy with over 70 per cent having one or more serious concomitant illnesses and 8.6 per cent suffering from organic brain dysfunction. Thirty-seven patients (4.3 per cent) died before hospital discharge—all but one within 40 days of admission.

The proportion of patients dying within three, six, and 12 months following hip fracture is 8.2, 12.6, and 17.4 per cent, respectively. Figure 1 plots the observed and expected one year survival curves for the total population and for the population subgroups. Hip fracture patients clearly experience greater mortality than persons of similar age, race, and sex. The degree of excess mortality, however, varies by sex and age. At one year the difference between the observed and expected mortality rates is greater for males than females and greater in patients younger than 75 years than older patients. The point at which the observed survival curve parallels the expected survival curve also varies by age and by sex. The death rates for female patients and patients 85 years or older approach expect-

TABLE 1—Demographic and Medical Characteristics of 814 Hip Fracture Patients, Ages 65 and Older Admitted to Seven Baltimore Area Hospitals, October 1984 to April 1986

Characteristics	Per Cent (Years)
Gender	
Male	20.2
Female	79.8
Race	
White	93.5
non-White	6.5
Age	
Mean	(80.1)
65–74	24.2
75–84	45.3
85 or above	30.6
Type of Fracture	
intracapsular	45.2
extracapsular	54.8
Concomitant severe physical illness	70.6
Dementia noted in medical chart	11.8
Delirium on admission	19.3
Delirium on admission, exclusive of dementia	7.5

ed rates approximately six months post-fracture. Patients between 75 and 84 years of age experience similar mortality as expected at about 10 months after sustaining hip fracture. Elevated mortality for both males and the youngest patients appears to continue beyond the first year post-fracture.

Table 2 presents the relative risk of mortality at three, six, and 12 months following hip fracture associated with the seven demographic and medical factors examined. The presence of at least one life-threatening condition as noted in the patient's medical chart confers the greatest risk of mortality relative to the other factors examined at three and six months following fracture. This elevated risk diminishes with increasing time since fracture from 4.6 to 2.6 times the risk experienced by patients with no concomitant illness. Patients with dementia do not experience an increased risk of mortality following fracture; confidence intervals of any apparent protective effect of dementia are very wide, however. Patients with noted delirium on admission who had no history of dementia have 3.1 to 3.5 times the risk of dying as cases who were not disoriented when admitted to the hospital or who had a history of cognitive impairment.

Patients older than 84 years of age have 2.6 times the risk of dying within three months of hip fracture as patients between ages 65 and 74 years, decreasing by six months after fracture. Patients between ages 75 and 84 years do not experience an increased risk of mortality relative to patients between ages 65 and 74 years. These findings, with respect to age, are particularly noteworthy given that the expected death rate for persons 85 years of age and older is nearly six times the mortality rate for persons between ages 65 and 74 years (14.6 per cent versus 2.5 per cent) and the expected death rate in persons 75 to 84 years old is more than twice that of the rate for persons between ages 65 and 74 years (5.8 per cent versus 2.5 per cent). As expected the relative risk of mortality associated with male sex increases from 1.4 to 1.9 over time.³⁹ The small proportion of non-White cases (6.5 per cent) makes any finding, regarding race, difficult to interpret.

The relative risk associated with each factor after adjusting for the other factors in the models does not differ greatly from the unadjusted relative risk, except for a slight reduction in magnitude evident for each factor across all time periods.*

*Data available on request to authors.

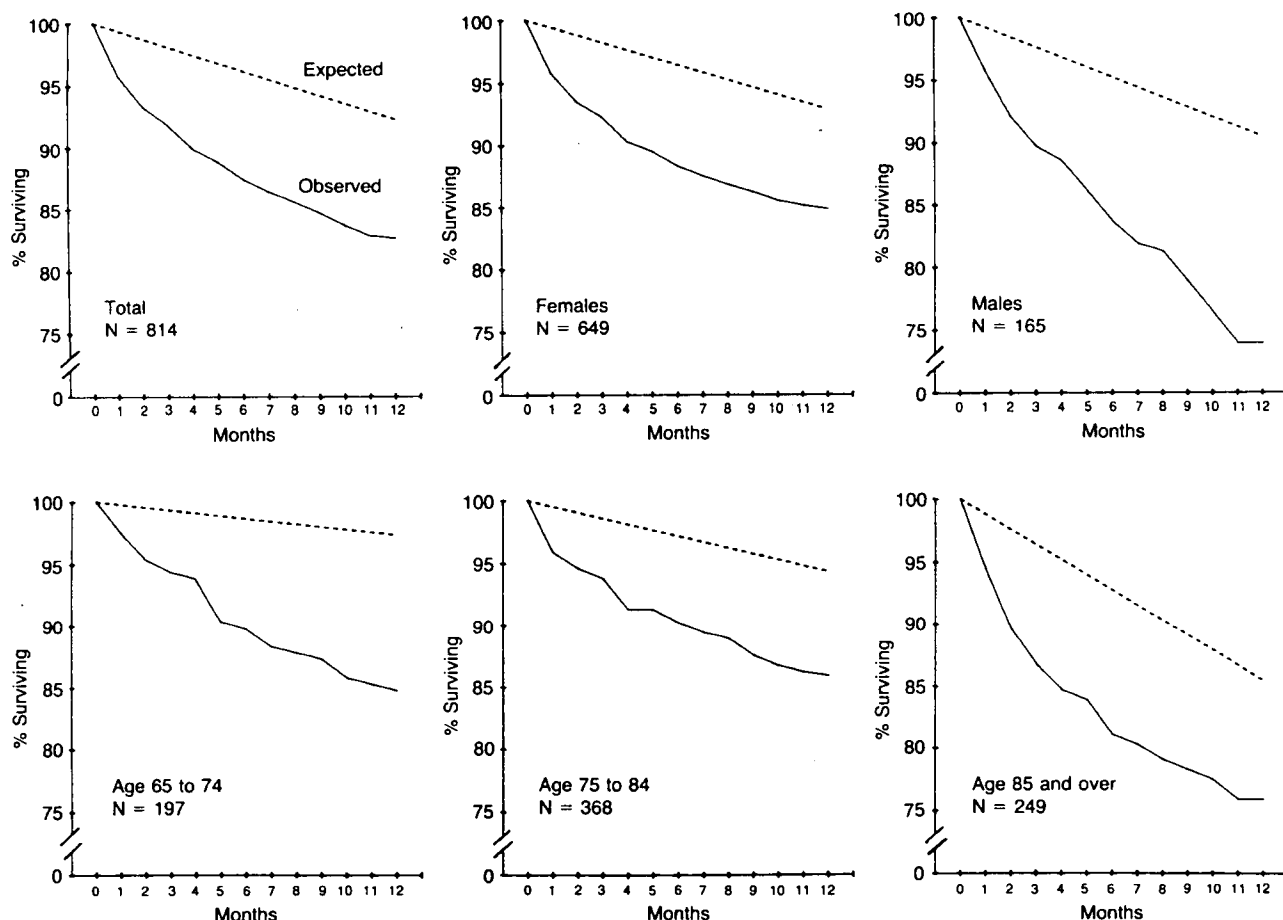


FIGURE 1—Observed and Expected Survival Curves by Sex and by Age Group for 814 Hip Fracture Patients, Ages 65 and Older, Baltimore 1984 to 1986.

Figure 2 presents the probability of one year survival given patient sex, age category, illness state, and orientation at the time of hospital admission independent of dementia. Delirium is present in a relatively small proportion of patients—7.5 per cent overall and no greater than 16.2 per cent in any subgroup. Patients older than 84 years and patients with at least one serious medical condition are more likely to become notably disoriented following their fracture than younger and healthier patients. In comparing subgroups similar in all respects except orientation on admission, we find that in all instances where valid comparisons can be made, patients with delirium on admission experience a lower probability of survival than patients with either normal orientation or a history of dementia. For female patients with no serious concomitant disease, the observed survival rate does not differ from the expected rate in either young or old patients. This relation does not hold for male hip fracture cases. Lastly, patients with serious medical problems have a lower probability of survival than patients without any serious medical conditions whether or not they become disoriented.

Discussion

Studies of mortality following hip fracture are characterized by diversity in patient populations, length of follow-up, and country of treatment. This diversity renders assessment of recent

secular trends in post-fracture survival difficult, although it appears that mortality rates among hip fracture patients have generally declined between the late 1950s and the mid-1970s.¹³ As such, the comparison of findings with previous work is limited to case series treated in the 1970s and later.

The in-hospital mortality rate of the current series of fracture patients is 4.3 per cent, considerably lower than the 18 and 21 per

TABLE 2—Unadjusted Relative Risk of Mortality at Three Points in Time Following Hip Fracture Associated with Selected Factors in 814 Patients Ages 65 and Older, Admitted to Seven Baltimore Area Hospitals, October 1984 to April 1986

Factors	Months Since Hip Fracture		
	Three	Six	Twelve
Sex (male)	1.4 (0.8,2.4)*	1.5 (0.9,2.4)	1.9 (1.3,2.9)
Race (non-White)	1.5 (0.6,3.6)	1.9 (0.9,3.8)	1.8 (0.9,3.3)
Extracapsular fracture	1.2 (0.7,2.0)	1.2 (0.8,1.8)	1.1 (0.7,1.6)
Ages 75 to 84**	1.1 (0.5,2.4)	1.0 (0.5,1.7)	0.9 (0.6,1.5)
Ages 85 and older**	2.6 (1.3,5.3)	2.1 (1.2,3.6)	1.8 (1.2,2.9)
Concomitant disease	4.6 (1.9,10.8)	3.6 (1.9,6.6)	2.6 (1.6,4.2)
Noted dementia	0.4 (0.1,1.7)	0.8 (0.4,1.7)	1.5 (0.9,2.5)
Delirium (exclusive of dementia)	3.2 (1.6,6.3)	3.5 (1.9,6.3)	3.1 (1.8,7.5)

*95% confidence interval in parentheses.

**relative to patients ages 65 to 74

Sex	Age (Years)	Serious Illness	Delirium on Admission	Probability of Survival (No. of cases)
Female	65-84	No	No	.95 (141)
			Yes	.83 (6)*
		Yes	No	.85 (283)
			Yes	.63 (16)
	85+	No	No	.88 (49)
			Yes	1.00 (5)*
		Yes	No	.78 (130)
			Yes	.58 (19)
Male	65-84	No	No	.86 (29)
			Yes	— (0)*
		Yes	No	.77 (82)
			Yes	.63 (8)*
	85+	No	No	.63 (8)*
			Yes	1.00 (1)*
		Yes	No	.68 (31)
			Yes	.50 (6)*

FIGURE 2—Probability of Survival One Year Following Hip Fracture Given Certain Characteristics

*Interpret probabilities with caution as these subgroups have fewer than 10 cases.

cent mortality found for two similarly aged patient series treated, respectively, in Great Britain²⁶ and in Ireland²⁷ in 1981. The length of hospital stay for those patients averaged over 30 days, however, compared with less than 20 days for the current series. Our in-hospital mortality rate (4.3 per cent), compares favorably to the 2.0³² and 5.8³⁶ found in two other recent series treated in Scandinavia that included patients as young as 50 years of age. Differences in in-hospital mortality across studies may reflect gross differences in treatment procedures, health status of patients, and/or age distribution of patients treated. While none of the case series described above include institutionalized patients, criteria for placement in and the definition of long-term care facility may vary greatly across cultures.

The one year mortality of patients in the current series (17.4 per cent) is similar to that found in two series, treated in Denmark between 1977 and 1978, that exclude non-elderly patients. One³⁶ had a six-month mortality of 11.1 per cent; the other,²⁸ 20 per cent. Differences in observed mortality reported in other studies^{29,32,37} appear strongly related to the age distribution of the respective patient populations reviewed.

The observed and expected survival curves for the current series become approximately parallel six months post-fracture, but this point varies by age and sex. This finding generally agrees with earlier studies which report that a substantial portion of excess mortality occurs in the first few months following fracture.³⁵ Estimates from other studies of patients hospitalized since the late 1960s^{5,24,28} of the point at which the mortality curve begins to parallel that for a cohort matched by age and sex range from three to 12 months.

Several investigators^{1,15,19} have found a secondary rise in mortality at varying points following hip fracture ranging from

four to six weeks to four to five months. Inspection of the survival curves and monthly mortality rates by age group in the current series suggests a similar phenomenon. This may reflect random variation in mortality rate rather than a true change in slope, but the possibility that a true secondary rise in mortality exists warrants exploration.

We found male sex, advanced age, presence of at least one serious illness, and delirium at the time of admission (exclusive of dementia) to represent threats to survival in the first year following hip fracture. Several previous studies report similar findings, with regard to sex, age, and concomitant disease.^{1,3-5,13,24,28,33} Contrary to our finding that dementia is not associated with a higher rate of mortality, other investigations^{1,24} find the presence of organic brain syndrome highly predictive of death within one year of hip fracture. These earlier reports, however, include patients from extended care facilities who may have had more advanced cases of dementia than the present community dwelling population; this difference could account for their higher death rates. While no previous reports examine the relationship between delirium at the time of hospital admission independent of dementia, the results from two prior studies are suggestive. Matheny and associates¹⁷ found that patients who became disoriented during their hospitalization experienced much higher in-hospital mortality than patients who remained mentally clear throughout their stay (20.7 per cent versus 1.1 per cent). Barnes, *et al.*,⁴ examined blood urea (whose elevated levels are associated with acute confusion)⁴¹ found the death rate among patients with elevated levels (>80 mg per 100 ml) died at five times the rate of patients with low levels (<40 mg per 100 ml).

How hip fracture contributes to delirium and why this

acute confusional state increases risk of mortality are important questions. While this area remains largely unresearched with respect to hip fracture cases, two reports offer some insight. Matheny, *et al.*¹⁷ contend that post-fracture and post-surgical delirium may signify blood sugar or electrolyte aberrations, renal failure, infection, drug intoxication, among other clinically relevant states. Kenzora and associates¹³ further suggest that patients who experience a delay in receiving medical attention may become dehydrated and that surgery before restoration of blood, fluid, and electrolyte balance may overwhelm the patient's capacity to make adequate physiologic adjustments. Taken together, these observations imply that mortality associated with patient disorientation may be amenable to treatment. Our findings tend to support this premise as marked disorientation on admission was found to make an independent contribution to patient mortality.

Several caveats are in order:

- The first concerns the dependence on medical chart notes for the measurement of dementia, confusion, and other significant medical conditions. The possible problems include: underreporting of serious medical problems, inability to evaluate the severity of various disease states, and mistaking delirium at the time of admission for dementia and *visa versa*.
- Second, the study population may not represent the universe of aged hip fracture patients residing in the community, as study hospitals were selected on the basis of the volume of patients treated and not for their case mix.
- Similarly, the exclusion of nursing home patients necessarily excludes patients in the poorest health. Thus, conclusions based on the current study population may not apply to all hip fracture cases.
- Fourth, the inability to determine the contribution of various disease conditions to mortality in the general population renders it impossible to distinguish the true contribution of hip fracture to patient mortality over that expected for a person with a similar health profile.
- Lastly, patient delirium noted on admission may have preceded the fracture—not followed from it.

Despite these limitations, our data indicate that excess mortality associated with hip fracture depends primarily on pre-fracture disease state and secondly on entering the hospital in an acute confusional state. Clearly, patients' pre-fracture medical status cannot be modified; however, fracture-related delirium is potentially treatable. This finding argues for careful investigation of factors that contribute to delirium as part of the standard treatment strategy.

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ALMONDEMOTION LONG LIE
TALKING AGEING & EMOTIONS



I was talking with the medical students yesterday.

They were presenting their 'long-cases' – this is when a student doctor or nurse reviews, examines and presents a patient's story to me.

In the world of medicine this is called a *long lie*.

As to how long you must be lying on the floor for your lie to become long, is I suspect relative.

Some long-lies can be very long.

One of the patients who fell, as described by a student, was on the floor for six hours before she could struggle to her feet; the other lay on the floor in his house for two days before neighbours alerted the police.

This says much about the place of older people in our society, and their associated frailty, fragility and vulnerability.

Two days.

That is a very long time.

I suspect there must have been times when he fell asleep, nodded-off on the carpet.

People who find themselves on the floor for this long experience several forms of trauma – the most significant which

die like this.'

Traditionally, those living in flats or semi-detached houses, will bang on the wall; that must offer some sense of determination – a hope, that someone will hear, respond.

If you are on the floor in a detached house or bungalow, what is the feeling?

The postman might come – how inquisitive are posties these days? Your son or daughter might phone; what if you don't have any family? What if the family you have don't bother with you or have the ability or interest to maintain close contact?

You are stuck.

Before long, you will be incontinent; you will either need to go to the loo and let go which will result in becoming wet then sore, or, you will not go and you will get stuck – a condition we call *urinary retention* – where you cannot go. At all. Urine is stuck inside your bladder and over hours your kidneys swell then stop working; if you are stuck for long enough, your skin and muscles will become damaged and break-down – this is a further trauma to your kidneys, which will then fail.

Wet and sore then cold.

Wet and cold and sore.

And they might bang or shout or cry or lie silently trying to work-out what to do, how to save themselves, for, no matter how old or frail, most people have a connection to life that is tenacious – the fight to live. Most take a while before giving-up.

At what point does your thirst become an issue?

Cold, hungry and thirsty and, your muscles and skin are breaking-down. And you are afraid and wet and you do not know when or if anyone will come to get you. Will you die like this?

Loneliness is not a new concept; some of us like being alone – we seek solitude; this is however different. Solitude is a choice. Thoreau walked into the woods of his own volition.

Loneliness, that is, social isolation, not seeing or talking to another person for days at a time is a modern construct, a symptom of our ailing society.

It is hard to conceive of a grandparent falling at home 100 years ago and being left.

tied-to falling and frailty, is a significant problem.

And the old man or woman, alone, isolated, long-lying; this perhaps adds a dimension of despair to the experience, to the trauma.

The consequences of a long-lie are significant – this can be the end of an older person living independently; the acute and post-trauma can have a devastating effect on an individual's sense of self, sense of worth and autonomy. The experience likely echoes throughout what remains of their life.

I suppose the question we must ask, after we have learned about long-lies, older people living alone and social isolation, is, what can we do?

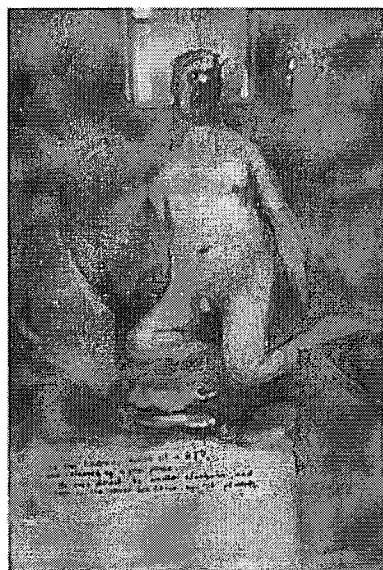
Just think; there is almost certainly an older person somewhere in the UK, possibly even along the road from you who is now stuck, trapped.

My friend Mike is helping to break-down some of the islands of isolation that are growing in our society – please check-out [B:Friend](#). This is not a panacea for loneliness, social isolation or long-lies it is however a significant position statement on society and the trajectory we should all be following if we choose to support a society that is loving, person-centred and kind.

ALMONDEMOTION LONG LIE

MENU

TALKING AGEING & EMOTIONS



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TALKING AGEING & EMOTIONS

POSTED IN HUMANISM, PERSON CENTRED CARE

B:FRIEND FALLS LONG-LIE OLDER PEOPLE

PREVIOUS POST

Delirium and numbers

NEXT POST

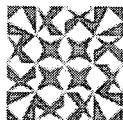
Alone (aka levadi*)



RODKERSH1948

Trying to understand the world, one emotion at a time.

3 COMMENT ON "LONG LIE"



1wenmac

MARCH 18, 2017 AT 1:29 PM

Great piece Rod. Reminded me of "A cream cracker under the settee" monologue by Alan Bennett.

★ Liked by 1 person

REPLY

rodkersh1948

REPLY

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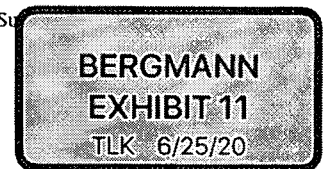
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Correlation of Psychosocial Factor with Functional Outcome: One Year after Hip Fracture Surgery

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Abstract

Objective: This study investigated the correlation of 8 domains of psychosocial factors with functional outcome one year after hip fracture surgery.

A prospective cohort study of patients who had unilateral hip fracture surgery was included. A total of 89 subjects were interviewed between 3rd to 7th day after the hip surgery using the short length Multi-level Assessment Instrument and followed up after 1 year. The functional outcomes were measured through the Harris Hip Score.

All of the psychosocial factors have little to no correlation on the functional recovery of the patient but the cognitive domain had a fair correlation in Harris Hip Score ($r=0.46$) and is significant ($p\text{-value}<0.0001$)

The study did not find strong correlation between psychosocial factors and functional outcome one year after unilateral hip surgery. Although statistics have shown little effect on psychosocial factors to functional outcome, it may still be prudent to consider every aspect that may contribute to the whole wellbeing of our patients, which includes their psychosocial background.

Key Words

Psychosocial Factors; Hip Fracture Outcome; Biopsychosocial; Hip Surgery; Psychosocial Background

Introduction

Disease is traditionally defined as deviation from normal function caused by injury, pathogen and developmental abnormality. This approach however has limitations and does not cater to all the needs of the patient¹. Paradigm shift into a holistic approach became more beneficial to patients as biopsychosocial model looks for potential psychological, physical, social, cognitive, affective and behavioural attributes causing the health problem. Moreover, it is important to the patient and health care provider to consider all aspects of this model to allow the patient to engage in health-promoting or treatment behaviours.

Injuries resulting from falls in older people are a major public health concern, representing the main cause of disability and death in this population. The prevalence of hip fractures among Filipino patients over 70 years and above was estimated to be 160 per 10 000. Based on this prevalence rate, it is estimated that there were about 28 000 hip fractures in 2003 and 34 000 in 2005. The numbers are expected to reach 65 000 by the year 2020 and almost 175 000 by the year 2050. In 2010, a total of 425 hip surgery was done at the Philippine Orthopaedic Center.

With the increasing magnitude of hip fracture, it is important to anticipate the necessary approach to treatment taking into consideration the factors that influence the recovery of geriatric patients with hip fracture. A study done by Mossey et.al. regarding the importance of psychosocial factor on hip fracture recovery in 219 women age 59 and older showed that poor cognitive status and post-surgical self-rated health and depression were predictive of mortality². While Jelcic et.al noticed that patients with fracture experienced a great deal of pain which had a great impact on patient's functional capacity and state of dependency. The research suggested that pain was influenced by psychological factors such as anxiety³. In addition, Howard et.al concluded that preoperative indicators of depression, anxiety, pain, and low self-efficacy relate directly to higher levels of pain and lower levels of function post operatively⁴.

A case control study of 387 participants by Peel et.al. suggested that psychosocial factors such as being currently married, living in present residence-, for more than 5 years, having private insurance, using proactive coping strategies and having higher level of life satisfaction have protective effect on hip fracture⁵.

A journal based on factors related to activity limitations in a group of Cuban Americans before and after hip fracture by Kirk-Sanchez showed that mental health status was related to more activity limitations prior to admission to the rehabilitation facility and early in the recovery process, but not later in the recovery process. Conversely, social support was related to activity limitations later in the recovery process, but not prior to admission or early in the recovery process⁶.

Wong et.al. studied the home readiness and recovery pattern of 50 patients after total hip replacement and found out that activities of daily living (ADLs), age and psychological status were significant factors related to home-readiness, whereas social support and hip function were significant determinants of recovery⁷.

Holmes et.al. found out that psychiatric illness was common after hip fracture and had significant effects on recovery⁸.

However, identifying psychosocial factors became difficult because of the numerous confounding factors present. Hence, with the development of different assessment tools like the Multilevel Assessment Instrument, the well-being of aged patients has been holistically considered. The tool helps clinicians gauge behavioural competence in the domains of health, activities of daily living, cognition, time use, social interaction and in the sectors of psychological wellbeing and perceived environmental stability. The present study investigated the psychosocial factors measured with short length Multilevel Assessment Instrument on 8 domains and correlated it with the functional outcome measured by the Harris Hip Score.

Materials and Methods

This is a prospective cohort study of 111 patients who had unilateral hip fracture surgery in our institution from May 2010 to April 2011. The study included patients aged 40 years and above, who, prior to sustaining a fracture, were able to walk at least 10 meters without assistance. Subjects with movement disorders such as Parkinson's disease, Huntington chorea, hemiballismus, spastic hemiplegia or quadriplegia and those with pathologic fractures were excluded.

Prior to surgery, consent was obtained from the subjects. Between the 3rd to 7th day after the surgery, an initial structured interview using the short length multilevel assessment tool was carried out by the investigator. The responses from the subjects were written out verbatim in some questions or recorded in codes beside the questions. After the interview, the codes were transferred to the hand tabulation worksheet for standard scoring procedure. The worksheet was available for scoring indices using a summing method. In the worksheet, the answer codes were copied in a sub-index from the questionnaire to the box in the "code" column and then recorded in the re-code column. The sub-index values were computed and entered in the double-lined box provided, while the domain index scores were entered in the thick black box and values recoded were summed up.

After the surgery, the subjects were advised a standard rehabilitation program. On the 12th month of follow up, Harris Hip scores were measured and recorded by another orthopaedic resident. The records were also reviewed for possible complications that could affect the functional outcome.

STUDY VARIABLES: **COGNITION:** reflects subject's mental process to recall recent and remote memories.

MOBILITY: evaluates the frequency the subject was able to go out of his/her household or neighborhood and means of transportation.

ACTIVITIES OF DAILY LIVING: activities in which subject could do on his own or with assistance.

PHYSICAL HEALTH: subject's perception of the general condition of the body which could affect the subject's activities in time of disability of diseased state.

TIME USE: how the subject spent his time and the degree of ego-involvement in various activities, persons or ideas.

ENVIRONMENT: reflected subject's evaluation of his surrounding including his household and neighbourhood.

PERSONAL ADJUSTMENT: subject's reaction to unfavorable life events such as depression, loneliness or sadness.

SOCIAL INTERACTION: subject's social network and its availability

HARRIS HIP SCORE: A standardized measurement of hip function after surgery

Data Analysis Data were entered into an access database (Microsoft Excel) then analyzed on StatsDirect version 2. Categorical (qualitative) variables were reported as frequencies and percentages and continuous (quantitative) variables as means and standard deviation. All independent variables were compared to the outcome (Hip Harris score) using student's t-test and ANOVA. The relationship of psychosocial factors to the functional outcome (Harris Hip Score, HHS) was subjected to multiple linear regressions. P-value < 0.05 is considered significant. All tests of significance are two-tailed.

Results

A total of 111 subjects were initially interviewed, fifteen subjects were considered drop out (five died within the study period, five lost to follow up and two sustained another injury from fall, three had different types of surgery) and were not included in the Statistical Analysis.

Table I shows the demographics of patients with hip fracture. Patients mean age was 74 years, ranging from 45 to 91 years. Most of the patient were female (87.6%), age 61 to 80 years - (73.0%) and had fracture of the femoral neck area (69.7%). Partial hip replacement (PHR) was performed on 77.5% of the patients.

Table I: Demographics of Patients with Hip Fracture

Demographics	N = 89
Age (Mean)	74.3 years $\pm$ 7.88 (45-91)
Age (Stratified)	
40-60	3 (3.4)
61-80	65 (73.0)
>80	21 (23.6)
Sex	
Male	11 (12.4)
Female	78 (87.6)
Type of Injury	
Femoral Neck	62 (69.7)
Peritrochanteric	27 (30.3)
Type of Surgery	
DHS	20 (22.5)
PHR	69 (77.5)

DHS – Dynamic Hip Screw; PHR – Partial Hip Replacement

Table I: Demographics of Patients with Hip Fracture

Most of the patients had poor Harris Hip Score 12 months after surgery (HHS < 70). Table II shows that in terms of age, patients whose age were below or equal to 60 had a higher Harris Hip Score compared to patients aged 61-80 or above 80 years old (67.7 vs 65.0 vs 62.9) and noted to be decreasing but not significant (p-value=0.79). Male patients had a higher HHS compared to female (70.5 vs 63.8) and was significant (p-value=0.01). Femoral neck fractures had a higher functional outcome than peritrochanteric fractures (66.5 vs 60.3) and was significant (p-value=0.03). Patients who underwent PHR had a higher functional outcome compared to those who had undergone dynamic hip screw (DHS) fixation (66.7 vs 57.7) and was significant (pvalue= 0.0032).

Table II: Functional Outcome using Harris Hip Score of Patients 1 year after Hip Fracture Surgery -

	Mean Harris Hip Score n (sd)	p-value
Age (Stratified)		0.79
40-60	67.7 (3.21)	
61-80	65.0 (12.65)	
>80	62.9 (11.88)	
Sex		0.01*
Male	70.5 (6.90)	
Female	63.8 (12.62)	
Type of Injury		0.03*
Femoral Neck	66.5 (11.48)	
Peritrochanteric	60.3 (13.02)	
Type of Surgery		0.0032*
DHS	57.7 (12.62)	
PHR	57.7 (12.62)	

DHS – Dynamic Hip Screw; PHR – Partial Hip Replacement.

Table II: Correlation of Psychosocial Domains with Functional Recovery 1 year after Surgery using Harris Hip Score

Table III shows the correlation of each psychosocial domains to functional recovery one year after surgery using Hip Harris Score. All of the psychosocial factors had little or no correlation with the functional recovery of the patient but the cognitive domain had a fair correlation on the Harris Hip Score ($r=0.46$) and significant ($p\text{-value}<0.0001$)

Table III: Correlation of Psychosocial Domains with Functional Recovery 1 year after Surgery using Harris Hip Score

Harris Hip Score vs.	Pearson's R	p-value
Cognitive	0.46	<0.0001*
Mobility	0.01	0.90
Physical	0.01	0.90
Activity of Daily Living	0.02	0.88
Time Use	0.15	0.17
Personal Adjustment	0.03	0.76
Social Interaction	0.02	0.87
Environmental	0.05	0.63

Table III: Functional Outcome using Harris Hip Score of Patients 1 year after Hip Fracture Surgery.

Discussion

Conventionally, some orthopaedic surgeons determine the success of a procedure by physical measurements or radiographic parameters. In spite of successful surgery, some surgeons failed to notice the good functional outcome and would still report a negative post-treatment result. Hence, most of research is directed to -discovering other contributing factors for the poor functional outcome.

Current trend in the management of patients are focused on biopsychosocial model - based on a holistic approach. Through this, the treatment is based not only on the injury itself but also on its impact on the psychosocial profile of the patient, thus opening new opportunities for the health care provider to understand the reasons for their patients' failure as gauged by functional outcome.

The results of this study have shown little to no correlation between the psychosocial factors measured and functional outcome after hip surgery. In addition, several other observed behaviours, including culture and tradition might be the reason.

The culture including the health beliefs of Filipinos are different compared to other races. As a health care provider, one has to be aware of this cultural diversity for better understanding of the health condition of the patients in catering for a more holistic approach to them. Some such beliefs and traditions were observed in this study which might have affected the result.

Majority of the subjects had reported mild to moderate pain especially during cold seasons but up to date there was no specific evidence published regarding this local experience. Hence, the subdomain score for pain resulted in a lower overall HHS rating.

The Filipino family tends to rely on direct home care rather than external health care facilities, which was observed among the subjects. This may have both negative and positive impacts on health and recovery. In cases of low income generating families, elderly patients are left unattended at home compromising the recovery from their illness. Some family members restrict elderly patients from doing household chores or even from walking because of fear of acquiring another injury, which contribute to poor functional outcome.

The Filipino people have always valued their religious virtues especially in matters of their health and well-being¹³. It gave them hope and strengthened their belief that they will be healed. But it could also bring hazards to their health especially if people ignored the practical measures for maintaining and treating their welfare. The "Bahala na ang Diyos" mindset is one of the beliefs that can cause harm in one's health; by totally relying on spiritual beliefs they forget that there are medical procedures that can help them. The spirituality of the Filipino people is not being undermined here, rather promoting the notion that medicine, and its appropriate medical doctors, can go hand-in-hand with a person's spiritual beliefs.

As age advances, there are numerous physiological declines that may contribute to poor functional outcome of patients who have undergone surgery. Factors such as retarded wound healing and altered muscle contraction due to synaptic remodeling were among them. Hence, this may explain the inverse relationship of age to functional outcome. This observation is also evident when the type of fracture and treatment were correlated to functional outcome. The patients with peritrochanteric fractures and patients who have undergone DHS fixation were older in this study (Mean Age: peritrochanteric 76.5yrs vs femoral neck 73.4yrs and DHS 75.2yrs vs PHR 74.1yrs). Moreover, there were five dropouts due to demise during the study period and were noted to be of extreme age.

The type of surgery has also been associated with different functional outcome as the metaanalysis done by Burgers et. al. which showed that patient who had partial hip arthroplasty (PHA) compared to total hip arthroplasty (THA) had less favorable functional outcome as weighted mean of the Harris hip score was 81 points after THA versus 77 after PHA. The subdomain pain of the HHS, the rate of patients reporting mild to no pain, quality of life measured with the EQ-5D and the score of WOMAC all favoured THA¹⁴. These may explain the reason for poor HHS score of 54% of the hemiarthroplasty group.

Conclusion

This study did not show strong correlation between psychosocial factors and functional outcome one year after unilateral hip surgery. Although statistics have shown little effect of psychosocial factors on functional outcome, it may still be prudent to consider every aspect that may contribute to the whole well-being of our patients which includes their psychosocial background. Through this method, the health care provider can find a way for the improvement of his patient's status. Therefore, assessment of patients with fracture should objectively see not only the physical or radiologic finding but also other factors that may contribute to their recovery. Thus, this study encourages every health care provider to consider the psychosocial background of his patients to maximize treatment strategies for better patient's satisfaction. The result of this study can also be used as a reference to other researches as basis of effect of psychosocial factors on overall recovery of the patients.

The discussion and arguments on the possible effect of psychosocial factors on overall recovery and outcome, as suggested in this study, could be prudently kept in mind in the evaluation of other similar researches.

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INTRODUCTION

Delusional disorder is characterized in DSM-5 as the presence of one or more delusions for a month or longer in a person who, except for the delusions and their behavioral ramifications, does not appear odd and is not functionally impaired [1]. Prominent hallucinations and other psychotic or marked mood symptoms are absent. Nonprominent hallucinations and odd behaviors related to the delusional theme may be present.

Delusional disorder is not well studied relative to other psychotic disorders, such as schizophrenia. Much of the information in the sections on epidemiology, course, and treatment is drawn from small samples or based on clinical experience. Longitudinal and population-based studies are needed to better characterize the disorder, and clinical trials are needed to identify effective treatments.

This topic discusses the epidemiology, pathogenesis, clinical manifestations, course, diagnosis, and treatment of delusional disorder. Clinical manifestations, differential diagnosis, and initial management of psychoses are discussed separately. The epidemiology, pathogenesis, clinical manifestations, course, diagnosis, and treatment of delusional parasitosis, a delusional disorder of the somatic type, are described separately. (See "[Clinical manifestations, differential diagnosis, and initial management of psychosis in adults](#)" and "[Delusional infestation: Epidemiology, clinical presentation, assessment and diagnosis](#)" and "[Treatment of delusional infestation](#)".)

EPIDEMIOLOGY

Prevalence — The lifetime morbid risk of delusional disorder in the general population has been estimated to range from 0.05 to 0.1 percent [2-4], based on data from various sources including case registries, case series, and population-based samples. The epidemiology of delusional disorders has not been studied in large, community-based samples. These findings and the DSM-5's estimated lifetime prevalence of delusional disorder (0.2 percent) [1] are far lower than the estimated lifetime prevalence for other major psychotic disorders, such as schizophrenia (0.3 to 0.87 percent) and bipolar I disorder (0.24 to 0.6) [5]. Rates of delusional disorder reported in samples of patients receiving mental health treatment have ranged from 0.5 to 1.2 percent [2,6,7].

Attempts to quantify incidence estimates (0.7 to 3.0/100,000) have been based on hospital admission data of uncertain accuracy [2].

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DSM-5 and Psychotic and Mood Disorders

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Abstract

The criteria for the major psychotic disorders and mood disorders are largely unchanged in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), with a few important exceptions: a new assessment tool for the psychotic disorders based on dimensional assessment, a new scheme of specifiers for the mood disorders, the addition of three new depressive disorders, and recognition of catatonia as a separate clinical entity. In addition, subtle changes to the diagnostic criteria for longstanding disorders may have important ramifications. There are forensic implications to these changes in the psychotic and mood disorders, but in most cases, these implications should be relatively modest, as the DSM-5 Work Groups ultimately adopted a cautious approach to changes in the psychotic and mood disorders.

This article will consider the forensic implications of the changes in the diagnostic criteria for the psychotic and mood disorders contained in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),¹ which was published by the American Psychiatric Association (APA) in May 2013. DSM-5 includes modest changes to the criteria and descriptive text for nearly every psychotic and mood disorder, some more significant than others. New developments in the psychotic and mood disorders in DSM-5 include the recognition of catatonia as a clinical state and the addition of three new disorders: disruptive mood dysregulation disorder, persistent depressive disorder, and premenstrual dysphoric disorder.

Forensic clinicians routinely encounter psychotic and mood disorders when performing forensic evaluations and while caring for patients in correctional settings. Psychotic disorders are particularly common in criminal forensic evaluations, as they are the primary reason for requests for evaluation of competence to stand trial² and sanity at the time of the offense.³ The psychotic disorders may also be seen in civil forensic evaluations, particularly in civil

commitment and disability evaluations. Mood disorders are less frequent than psychotic disorders in criminal forensic evaluations, but may be pertinent to competence-to-stand-trial and insanity evaluations. They are more common in civil forensic evaluations, particularly in disability evaluations.

The members of the DSM-5 Task Force and Work Groups reviewed the results of the abundant neuroscience research published over the past two decades and realized that “the boundaries between many disorder ‘categories’ are more fluid over the life course than DSM-IV recognized” (Ref. 1, p 5) and considered the implementation of a dimensional approach to diagnosis, which would have dramatically changed the focus of the DSM. However, the Task Force “recognized that it is premature scientifically to propose alternative definitions for most disorders” (Ref. 1, p 13). DSM-5 thus continues to use the categorical approach to clinical diagnosis familiar to clinicians and to most consumers of forensic evaluations. Forensic clinicians may experience challenges to DSM-5 diagnoses, based on the widely published criticisms by the chair of the DSM-IV Task Force⁴ and the current Director of the National Institutes of Mental Health (NIMH), who in 2009 launched the research domain criteria project to “develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures.”⁵ Familiarity with the extensive review process that led to DSM-5, which included extensive literature reviews, field trials, and public and professional review before final publication (Ref. 1, pp 6–10), should allow for effective rebuttal of such challenges.

The Psychotic Disorders

The Psychotic Disorders Workgroup decided that DSM-IV criteria for the psychotic disorders “do not accurately capture the considerable variability of symptom profile, response to treatment, and most importantly, social function and outcome”; however, despite considerable pressure to move to a dimensional approach to the diagnosis of psychotic disorders, “the DSM-5 does not represent such a paradigm shift” (Ref. 6, p 11).

There is subtle evidence of the dimensional approach in the chapter entitled “Schizophrenia Spectrum and Other Psychotic Disorders,” which begins with a description of “five domains” of psychotic symptoms (Ref. 1, p 87), the names of which are identical to the five symptoms listed in Criterion A for the diagnosis of schizophrenia in DSM-IV. In addition, the work group developed a rating instrument, the Clinician-Rated Dimensions of Psychosis Symptom Severity, to evaluate eight dimensions of psychosis, “which may help with treatment planning, prognostic decision-making and research” (Ref. 1, p 89), but placed it in Section III, “Emerging Measures and Models” (Ref. 1, pp 743–4). This instrument is mentioned in the last section of the criteria for each of the psychotic disorders, under the heading “Specify Current Severity”; clinicians are referred to the instrument after the statement “quantitative assessment of the primary symptoms of psychosis ... may be rated for its current severity ... on a 5-point scale” (Ref. 1, p 91). This tool appears to be easy to use, could easily be adapted for inclusion in an electronic medical record, and may prove valuable in correctional and other treatment settings where continuity of care is difficult to achieve due to clinician turnover and movement of patients within the system. However, each section ends with a note, which states “diagnosis of [the disorder] can be made without using the severity specifier,” which certainly

implies that the use of this instrument is not required. A PubMed search of the phrase “clinician-rated dimensions of psychosis symptom severity” returned no items; thus, this instrument appears not to have been validated, which may make it vulnerable to challenge in court.

Overall, the criteria for diagnosis of psychotic disorders in DSM-5 are little changed from those in DSM-IV. All of the psychotic disorders found in DSM-IV are present in DSM-5, and catatonia was added, as a semiautonomous clinical entity. Schizotypal personality disorder is listed at the beginning of the section, “because this disorder is considered part of the schizophrenia spectrum of disorders” (Ref. 1, p 90). However, because “only a small proportion” (Ref. 1, p 657) of people with schizotypal personality go on to develop another psychotic disorder, the diagnostic criteria and explanatory text for schizotypal personality disorder, which are essentially identical to those in DSM-IV, remain in the section on Personality Disorders. The recognition in DSM-5 of schizotypal personality as part of the schizophrenia spectrum may have implications for sanity evaluations, which typically hinge on the presence or absence of psychosis, even though people with schizotypal personality do not show persistent symptoms of psychosis, such as hallucinations or delusions.

Delusional Disorder

In DSM-5, people who show bizarre delusions are now eligible for the diagnosis of delusional disorder, which is a significant change. The criteria also include a more modest change, as course specifiers are now more detailed. The subtypes of delusions are unchanged from DSM-IV, but clinicians may now also specify if the person's delusions show “bizarre content.” The addition of bizarre delusions to the diagnostic criteria may increase slightly the frequency of this uncommon diagnosis, which DSM-5 estimates has a lifetime prevalence of 0.2 percent (Ref. 1, p 92). In a recent article, bizarre delusions were rarely (<2%) identified as the sole reason for a DSM-IV diagnosis of schizophrenia,⁷ so the number of people whose diagnosis would change from schizophrenia to delusional disorder is likely to be low. It is hard to predict how the shift of bizarre delusions to the criteria for delusional disorder will affect treatment; the small research literature on the treatment of delusional disorder suggests that long-term treatment with antipsychotic medication may lead to a modest decrease in the intensity of delusions.^{8,9} It is unknown whether people who have delusional disorder with bizarre content will show a similar response to antipsychotic medication. Given the strong likelihood of persistent symptoms in a person with delusional disorder, assessment of the risk of violence based on bizarre delusions will require, as always, a careful evaluation of the individual and his symptoms, particularly if the delusions involve an identifiable individual (e.g., a family member or neighbor) or a group of people (e.g., police officers), thus putting that person or group at risk of violence.

Brief Psychotic Disorder

The core diagnostic criteria for brief psychotic disorder are essentially unchanged: the symptoms must persist for one month or less, and the person must recover fully after the psychosis ends. The criteria now require the acute onset of at least one symptom: delusions, hallucinations, or disorganized speech. Grossly disorganized or catatonic behavior remains as a fourth possible symptom but is not sufficient alone to make the diagnosis. The impact of this minor revision on forensic psychiatry is likely to be minimal.

Schizophreniform Disorder

The diagnosis of schizophreniform disorder is little changed. The A, B, C, and D criteria are identical to those in DSM-IV. The text for the specifier “with good prognostic features” has been slightly revised (Ref. 1, p 97). Schizophreniform disorder remains intermediate in symptom duration between brief psychotic disorder and schizophrenia. It has no corollary in the International Classification of Diseases (ICD) scheme,¹⁰ in which a diagnosis of schizophrenia may be made after one month of symptoms of psychosis. The forensic impact of the minor changes in the criteria for schizophreniform disorder in DSM-5 should be minimal.

Schizophrenia

Critics have described the DSM-5 criteria for schizophrenia as an evolution, not a breakthrough.^{11,12} The DSM-IV criteria for schizophrenia were quite reliable and diagnoses made with these criterion were stable over time, so only modest changes were made in DSM-5.¹³ The five symptoms of the A criterion, which are familiar to clinicians, have been retained, but one of the two symptoms needed to diagnose schizophrenia must be delusions, hallucinations, or disorganized thinking and speech. Schneiderian first-rank symptoms (i.e., bizarre delusions or auditory hallucinations, either conversing among themselves or providing a running commentary) are no longer sufficient to qualify a person for a diagnosis of schizophrenia. Research on these symptoms found that they had no prognostic relevance and were not linked to a family history of schizophrenia; removing the Schneiderian symptoms from the A criteria was estimated to affect fewer than 2 percent of diagnoses.¹¹ In another change based on recent research, the negative symptoms have been limited to two choices: “diminished emotional expression or avolition” (Ref. 1, p 99). Negative symptoms are often overlooked in criminal forensic evaluations, which typically focus on the link between positive symptoms of psychosis and behavior, but a lack of volition may have important implications for deciding whether a defendant possessed *mens rea* at the time of the alleged offense. In civil forensic evaluations, negative symptoms are well known as a primary cause of disability in schizophrenia.¹⁴

DSM-5 does not identify any subtypes of schizophrenia (e.g., paranoid or disorganized), due to the frequent comorbidity among the DSM-IV subtypes and their poor reliability, low stability, and limited prognostic value.¹³ In contrast, the course specifiers for schizophrenia in DSM-5 are almost completely new. There are two main categories of course specifiers, first episode and multiple episodes, each of which may be described as acute, in partial remission, or in full remission; the specifier continuous is the only holdover from DSM-IV (Ref. 1, pp 99–100). These specifiers should allow clinicians to describe accurately the present clinical status of a person with schizophrenia. The specifiers are likely to see regular use in correctional psychiatry, where ongoing treatment is the norm, and in civil forensic evaluations, where the specifiers may be helpful in commitment and disability evaluations. The course specifiers are not as likely to be a factor in criminal evaluations of competence or sanity.

The connection between a given mental disorder and a risk of violence is not prominent in the psychosis and mood disorders sections of DSM-5. The closest DSM-5 comes to this topic is in the description of “associated features supporting diagnosis” of schizophrenia, which includes the observation that “hostility and aggression can be associated with schizophrenia, although spontaneous and random assault is uncommon. Aggression is more

frequent for younger males and for individuals with a history of violence, non-adherence with treatment, substance abuse and impulsivity” (Ref. 1, p 101). Beyond this statement, DSM-5 has little to say about the risk of violence associated with psychosis. The “Cautionary Statement for Forensic Use of DSM-5,” which precedes the sections of diagnostic criteria, does not mention risk of violence.

Schizoaffective Disorder

Schizoaffective disorder was considered for removal from DSM-5, in favor of a dimensional approach to the diagnosis of the psychotic disorders. This proposal was based on the low reliability of this diagnosis compared with other psychotic disorders, recent research that suggested that schizoaffective disorder is intermediate between schizophrenia and bipolar disorder and may not be a separate diagnostic entity, and the limited clinical utility of a diagnosis that practitioners make without adhering to criteria.¹⁵ However, because the available research findings “are not yet compelling enough to justify a move to a more neurodevelopmentally continuous model of psychosis” (Ref. 16, p 131), schizoaffective disorder was retained, with revised criteria. In particular, the requirement for the presence of a mood episode was strengthened, such that “mood symptoms sufficient to meet criteria for a mood episode must be present for at least half of the total duration of the illness from the onset of the first psychosis” to make a diagnosis of schizoaffective disorder (Ref. 15, pp 23–4). Schizoaffective disorder diagnosed with DSM-IV criteria has been shown to be an unstable diagnosis.¹⁷ Field trials of the DSM-5 criteria for schizoaffective disorder showed good test-retest reliability when rigorously applied,¹⁸ so it is possible the new criteria will also lead to a more stable diagnostic entity.

The forensic implications of the changes in the criteria for schizoaffective disorder in DSM-5 are not clear. A proper diagnosis of schizoaffective disorder requires that a person meet all of the criteria for schizophrenia and all of the criteria for an episode of bipolar disorder or depression, with the exception of impaired function. DSM-5 estimates the prevalence of schizoaffective disorder to be one-third that of schizophrenia (Ref. 1, p 107), so it should be an uncommon disorder. Although it is important to make as accurate a diagnosis as possible to treat effectively, the alternatives to schizoaffective disorder (i.e., schizophrenia with a mood component or a mood disorder with psychosis), should also lead clinicians to treat with appropriate classes of medication. Otherwise, the forensic implications of the changes to schizoaffective disorder should be modest; the main concern will continue to be appropriate and consistent use of the criteria.

Catatonia

In DSM-5, catatonia is recognized as a separate clinical entity, though not as an independent disorder. It can be diagnosed whenever it is present, but only in the context of a mental disorder, a medical disorder, or an unspecified condition. If a person meets 3 of the 12 criteria, the specifier “with catatonia” should be added to diagnoses of most of the serious mental disorders in DSM-5 (Ref. 1, pp 119–120), to “facilitate its appropriate recognition and specific treatment.”¹⁹ Catatonia was once considered a common presentation of schizophrenia, but its reported prevalence in schizophrenia declined over the course of the 20th century^{20,21}; in recent research, though, catatonia was found in up to 10 percent of people with an acute psychiatric disorder, nearly half of whom had a mood

disorder and only a quarter of whom had a psychotic disorder.²² Improved awareness of catatonia could have implications for forensic practice. In the criminal realm, catatonia could certainly contribute to a finding of incompetence to stand trial, but it is unlikely to be an element of an insanity defense, as only one of the 12 symptoms, agitation, might be a precursor to illegal activity. The primary outcome of recognition of catatonia, though, would be the impact on the person with catatonia, as this condition can be treated effectively.²²

Attenuated Psychosis Syndrome and Shared Psychotic Disorder

The Psychotic Disorders Work Group considered adding attenuated psychosis syndrome as a new diagnosis to DSM-5, but instead decided to place it in Section III as a condition for further study, after field trial data showed that it was not diagnosed reliably by clinicians.²³ Attenuated psychosis syndrome is meant to describe people who show “recent onset of modest, psychotic-like symptoms and clinically relevant distress and disability” (Ref. 23, p 32). In addition, the person who experiences the symptoms must recognize them as unusual and experience sufficient distress or disability to seek clinical evaluation. Despite the clear guidance in the DSM-5 that conditions in Section III are not intended for clinical use, this syndrome is not just in Section III, but is also specifically identified in “Other Specified Schizophrenic Spectrum and Other Psychotic Disorder” as one of four examples of alternative presentations of a psychotic disorder; where it is labeled “other psychotic disorder, attenuated psychosis syndrome” (Ref. 1, p 122).

The diagnosis of attenuated psychosis syndrome may contribute to a finding of incompetence to stand trial, as young adults are at highest risk for this disorder and are at highest risk for arrest, but it is unlikely to be the single reason for such a finding, given the absence of overt psychosis. Attenuated psychosis is also unlikely to be a precursor to an insanity verdict, as this syndrome is meant to identify people with symptoms that are “psychosis-like but below the threshold for a full psychiatric disorder” (Ref. 1, p 783). Attenuated psychosis may appear more frequently in civil forensic evaluations, in the context of employment and disability assessments.

Shared psychotic disorder (*folie à deux*), which was present in DSM-IV as a separate disorder, exists in DSM-5 only in the section on other specified schizophrenic spectrum and other psychotic disorders, as “delusional symptoms in partner of individual with delusional disorder” (Ref. 1, p 122). The presence of shared psychotic disorder in DSM-5 will allow continued recognition of this disorder, which, although rare, is occasionally seen in forensic cases, both criminal and civil.

Mood Disorders

The DSM-IV section on Mood Disorders has been replaced in DSM-5 with separate sections for the Bipolar Disorders and the Depressive Disorders. The section on Bipolar Disorders is placed between the Psychotic Disorders and the Depressive Disorders in DSM-5, “in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history and genetics” (Ref. 1, p 123). Three new depressive disorders are included in DSM-5: disruptive mood dysregulation disorder, persistent depressive disorder, and

premenstrual dysphoric disorder; the first of these will not be discussed in this article but will be considered in the review of “Neurodevelopmental and Other Disorders of Childhood and Adolescence.”²⁴ The number of bipolar disorders is unchanged; they consist of bipolar I, bipolar II, and cyclothymic disorders, as well as bipolar disorder due to medications, drugs, or a medical condition. The criteria for episodes of mania, hypomania, and major depression are generally unchanged from DSM-IV, with a few important exceptions, which are discussed below. Missing from DSM-5 is the DSM-IV entity of mood disorder NOS, which has been replaced with unspecified bipolar disorder and unspecified depressive disorder; people who present with an unclear pattern will have to be designated as one or the other.

Specifiers for Mood Disorders

DSM-5 includes multiple specifiers to describe the Bipolar and Depressive Disorders (Ref. 1, pp 149–54, 184–8), as part of a mixed categorical-dimensional approach.²⁵ The specifiers are meant “to define a more homogeneous subgrouping of individuals with the disorder who share certain characteristics ... and to convey information that is relevant to the management of the individual's disorder” (Ref. 1, pp 21–2). The presence of new and more detailed descriptive specifiers for the bipolar and depressive disorders may have some impact on forensic psychiatry. The specifiers are intended to be used to describe the course of a person's disorder and should not affect the frequency of the underlying diagnosis, but some specifiers may have implications for suicide risk. In addition, these specifiers may be useful in forensic contexts where a prediction of future course may be helpful, such as sentencing, civil commitment, and child custody.

The specifier of “with anxious distress” (Ref. 1, p 149) is the only entirely new one. It was added to account for the high prevalence of symptoms of anxiety in both manic and depressed states and because “a substantial body of research conducted over the past two decades points to the importance of anxiety as relevant to prognosis and treatment decision-making” in bipolar and depressive disorders.²⁶ The addition of this specifier should encourage the identification of anxiety in people who have a bipolar or depressive disorder, which should lead to improved management of suicide risk, as anxiety is a risk factor for suicide.²⁷ Conversely, a lack of recognition of anxiety in the medical record or treatment plan could have implications for malpractice liability in cases of attempted or completed suicide.

The DSM-IV specifier of postpartum onset has been replaced in DSM-5 by “with peri-partum onset,” which may be applied if the mood episode occurs during pregnancy or within four weeks of delivery. The explanatory note for this specifier makes it clear that it was added to improve the recognition of bipolar and depressive episodes during pregnancy, in order to prevent postpartum psychosis, which is often linked to a mood disorder and is a major risk factor for infanticide (Ref. 1, pp 152–3). The addition of peri-partum onset will thus have forensic implications, both for the management of bipolar and depressive disorders in pregnancy and for the review of cases of infanticide.

The DSM-IV entity of a mixed episode of bipolar disorder has been replaced with the specifier “with mixed features” (Ref. 1, p 149–50), which can be applied to bipolar I, bipolar II, major depressive, and persistent depressive disorders. Thus, a person with hypomania or mania who shows some symptoms of depression and a

person with depression who shows some symptoms consistent with hypomania or mania should be designated as “with mixed features.” Although the mixed-features specifier will “better account for the highly prevalent subsyndromal presentations” (Ref. 28, p 30) of both manic and depressed states, its addition does not solve the problems of the overlap between unipolar and bipolar depression or the gray zone of the boundary between bipolar disorder and schizoaffective disorder.²⁸ As a result, debate on the applicability of this specifier to a particular person could be vigorous. The DSM-5 criteria for the specifier of mixed features have also been criticized for including euphoria and excluding agitation and irritability, thus moving away from Kraepelin's original concept of mixed depression as a fairly common clinical entity.²⁹ Overall, the impact this specifier will have on forensic practice is unclear.

The specifier “with seasonal pattern” now includes all mood episodes (mania, hypomania, and depression) in the introduction and the criteria, instead of being limited, as in DSM-IV, only to episodes of depression. However, the explanatory note makes it clear that “the essential feature is the onset and remission of major depressive episodes at characteristic times of the year” (Ref. 1, p 153), which retains the intent of the DSM-IV criteria.

The criteria for the specifiers “with melancholic features” and “with atypical features” are largely unchanged from DSM-IV, but a detailed note on the use of each specifier has been added to the text for each. The criteria for the specifier “with psychotic features” are essentially unchanged and have no explanatory note. The criteria for “with rapid cycling” are also unchanged, but a second explanatory note was added to clarify that each of the four episodes needed in one year to qualify for this diagnosis must be marked by full remission or a switch of polarity.

Bipolar I Disorder

The Mood Disorders Work Group introduced the criteria for the bipolar disorders by noting “the bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder” (Ref. 1, p 123). There are two changes in the criteria for bipolar I disorder in DSM-5. First, a person with mania must show elated or irritable mood or both and increased energy or activity, which modestly tightens the criteria for a manic episode. Second, “excessive involvement in activities” no longer requires these activities to be pleasurable, just to have “a high potential for painful consequences” (Ref. 1, p.134), which can be seen as a modest loosening of the criteria. The work group also clarified that mania induced by treatment with antidepressant medication counts as a manic episode for the purpose of diagnosing bipolar I disorder. The DSM-5 criteria for bipolar disorder are unlikely to have a significant impact on forensic psychiatry and are unlikely to solve the debate over whether bipolar disorder is overdiagnosed³⁰ or underdiagnosed.³¹

The prevalence of self-reported bipolar disorder in correctional populations is likely to remain high so long as people who report mood swings are given a prescription for a mood-stabilizing medication and a diagnosis of some form of bipolar disorder by clinicians. If the DSM-5 criteria for the diagnosis of bipolar disorder are used appropriately, the frequency of this phenomenon should decrease. However, even though the DSM-IV diagnosis of bipolar disorder NOS has been removed, DSM-5 has added “other specified bipolar and related disorders” (Ref. 1, p 148) and “unspecified bipolar disorder” (Ref. 1, p 149), which are likely to be used to describe people who report

subjective mood instability that does not meet criteria for bipolar I or bipolar II disorder. In particular, the choices under other specified bipolar and related disorder include four variant presentations, including one that is also listed in Section III (depressive episodes with short-duration mania), which could account for several bipolar presentations that do not include a true manic or hypomanic episode. The report of a prior diagnosis of bipolar disorder in a forensic evaluation should prompt thorough, open-ended questioning of the person's psychiatric history, searching for evidence of true manic or hypomanic episodes.

Bipolar II Disorder

The DSM-5 diagnosis of bipolar II continues to require at least one episode of current or past hypomania and at least one episode of current or past major depression, with no history of an episode of mania. There is a new focus in the criteria on the functional impact of the symptoms of depression in bipolar II, as the section on the diagnostic features notes that this disorder often presents with major depression and urges clinicians to ask for a history of hypomania in people who are depressed (Ref. 1, p 135). In addition, because people who have bipolar II disorder often experience repeated or prolonged episodes of depression, DSM-5 makes a point of describing bipolar II disorder as not less severe than bipolar I disorder. The observations made above regarding the prevalence of diagnoses of bipolar I disorder also apply to bipolar II disorder.

Cyclothymic Disorder

The diagnosis of cyclothymic disorder requires a two-year history of many episodes of not-quite hypomania and not-quite major depression. DSM-IV permitted this diagnosis to remain active if an episode of mania, hypomania, or major depression occurred after the first two years of subsyndromal symptoms. The DSM-5 criteria hold that "criteria for a major depressive, manic or hypomanic episode have never been met." In addition, the DSM-5 criteria clarify that hypomanic or depressive symptoms must be present at least half of the time during the required two-year period (Ref. 1, pp 139–40). These changes in the criteria will further restrict the prevalence of this relatively rare disorder, but their impact on forensic practice is likely to be minimal, as this disorder is uncommon in criminal forensic evaluations and is not a major cause of disability.

Major Depressive Disorder

The primary criteria for the diagnosis of major depression in DSM-5 are largely unchanged from DSM-IV, with one potentially significant exception. DSM-IV permitted a diagnosis of depression in a bereaved person only if the symptoms had been present for more than two months or if they had caused marked functional impairment. However, research on bereavement and depression found little reason for such a distinction. The Mood Disorders Work Group therefore proposed that symptoms of depression in the context of bereavement or other significant loss would qualify for a diagnosis of major depression, which would have removed the "normal bereavement" exception for depression found in DSM-IV and present in the ICD.³² This proposal was met with strong criticism by many clinicians and the public, who felt that the new disorders inappropriately turned a normal psychological reaction to loss into a form of psychopathology.

The Mood Disorders Work Group did not reinstate the bereavement exception, but instead added a note to the depression criteria to explain that “responses to a significant loss ... may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode ... should also be carefully considered” (Ref. 1, p 161). This change to the criteria for major depression could have an impact on civil forensic psychiatric evaluations. If bereavement is no longer a barrier to a diagnosis of depression, this diagnosis can be made in survivors of wrongful or negligent deaths, which could increase claims for damages.

A more subtle change in the criteria for depression in DSM-5 can be found in the description of depressed mood, where a person who is depressed is “sad, empty or hopeless”; in DSM-IV the phrase was “sad or empty.” Thus, a feeling of hopelessness alone is enough to meet the criterion for depressed mood, which could increase the frequency of the diagnosis of depression.³² Hopelessness has long been recognized as a risk factor for suicide,^{33,34} so the recognition of this symptom as characteristic of depression should encourage clinicians to inquire about hopelessness and then to take it into account in their suicide risk assessment.

A major concern for all clinicians who use the DSM is the reliability of the disorders described in the manual. Major depression does not fare well in this regard; the inter-rater reliability of DSM-5 major depression showed a κ coefficient of 0.28, well below the coefficients for the DSM-III³⁵ (between 0.60 and 0.80) and DSM-IV (between 0.40 and 0.80) criteria.³²

Persistent Depressive Disorder (Dysthymia)

The diagnosis of persistent depressive disorder is new to DSM-5 and is meant to combine the DSM-IV disorders of dysthymia and chronic major depression, defined as two or more years of continuous major depression. The decision to merge these diagnostic concepts was based on research that suggested that chronic depression was prevalent in the community and could be distinguished from nonchronic depression.³⁶ The A, B, and C criteria for persistent depressive disorder are unchanged from the DSM-IV criteria for dysthymia, but the D criterion now reads “criteria for a major depressive disorder may be continuously present for two years” (Ref. 1, p 168). The relationship between persistent depressive disorder and major depression in DSM-5 is somewhat confusing and leads to conflicting recommendations. For example, a person “whose symptoms meet major depressive disorder criteria for two years should be given a diagnosis of persistent depressive disorder as well as major depressive disorder” (Ref. 1, p 169), whereas for a person who meets criteria for persistent depressive disorder, “if the symptom criteria are sufficient for a diagnosis of a major depressive episode at any time during this period, then the diagnosis of major depression should be noted, but it is not coded as a separate diagnosis but rather as a specifier” (Ref. 1, pp 170–1). The proper diagnosis of a person with chronic depression may thus become a fruitful area for cross-examination, given the multiple ways a person with chronic symptoms of depression could be coded. The impact of persistent depressive disorder in clinical practice may be modest, outside of the possible confusion of proper diagnosis, as people who have dysthymia or chronic depression respond to similar treatment.

Premenstrual Dysphoric Disorder

This disorder was in Appendix B of DSM-IV (Ref. 37, pp 715–18) but has been moved to the main text in DSM-5. The research criteria laid out in DSM-IV have been modified for DSM-5. This diagnosis is based on the presence of specific symptoms in the week before onset of menses followed by resolution of the symptoms after onset. The symptoms must include one or more of marked affective lability, irritability or anger, depressed mood or hopelessness, and anxiety or tension, as well as one or more of an additional seven symptoms, with a total of at least five symptoms. The criteria specifically note that “Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles” (Ref. 1, p 172), which means it will be difficult to make this diagnosis on the basis of a single evaluation; although two cycles of daily ratings are technically not required, it will be easy to challenge a diagnosis made without these data. The addition of premenstrual dysphoric disorder to DSM-5 may open up new avenues in civil forensic evaluations, most likely in the area of disability evaluations, and may make an appearance in criminal evaluations if affective instability and anger due to this disorder contribute to an individual's violent behavior.

Conclusion

Overall, because many of the changes in the criteria for these disorders are minor, the forensic implications of the DSM-5 criteria for the diagnoses of psychotic and mood disorders appear to be modest, with a few exceptions. Forensic clinicians should review the DSM-5 criteria for the mood and psychotic disorders carefully and consider how the new criteria may affect their evaluations and practice.

Footnotes

- Disclosures of financial or other potential conflicts of interest: None.

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RESEARCH ARTICLE

Open Access

The effect of early surgery after hip fracture on 1-year mortality



Paola Colais^{1*}, Mirko Di Martino¹, Danilo Fusco¹, Carlo Alberto Perucci² and Marina Davoli³

Abstract

Background: Hip fracture injuries are identified as one of the most serious healthcare problems affecting older people. Many studies have explored the associations among patient characteristics, treatment processes, time to surgery and various outcomes in patients hospitalized for hip fracture. The objective of the present study is to evaluate the difference in 1-year mortality after hip fracture between patients undergoing early surgery (within 2 days) and patients undergoing delayed surgery in Italy.

Methods: Observational, retrospective study based on the Hospital Information System (HIS). This cohort study included patients aged 65 years and older who were residing in Italy and were admitted to an acute care hospital for a hip fracture between 1 January 2007 and 31 December 2012. A multivariate Cox regression analysis was used to assess the effect of early surgery on the likelihood of 1-year mortality after hip fracture, adjusting for risk factors that could affect the outcome under study. The absolute number of deaths prevented by exposure to early surgery was calculated.

Results: We studied a total of 405,037 admissions for hip fracture. Patients who underwent surgery within 2 days had lower 1-year mortality compared to those who waited for surgery more than 2 days (Hazard Ratios -HR-: 0.83; 95 % CI: 0.82–0.85). The number of deaths prevented by the exposure to early surgery was 5691.

Conclusions: This study is the first to evaluate the association between time to surgery and 1-year mortality for all Italian elderly patients hospitalized for hip fracture. The study confirmed the previous reports on the association between delayed surgery and increased mortality and complication rates in elderly patients admitted for hip fracture. Our data support the notion that deviating from surgical guidelines in hip fracture is costly, in terms of both human life and excess hospital stay.

Keywords: Hip fracture, Timing surgery, Administrative data, Postoperative complications

Introduction

Hip fracture injuries are identified as one of the most serious healthcare problems affecting older people. Many studies have explored the associations among patient characteristics, treatment processes, time to surgery and various outcomes in patients hospitalized for hip fracture [1, 2].

Some studies reported that preoperative delay might lead to an increase in mortality and adversely influence other clinical outcomes such as infection and pressure sores [3–6]. Clinical guidelines recommend immediate reparative surgery within 24–48 h of hospital admission [7, 8]. A meta-analysis published in 2010 investigating

the effect of surgical delay on mortality at various follow-up times found significantly higher all-cause mortality in patients treated surgically more than 24, 48 and 72 h from admission [9]. A recent meta-analysis published in 2012 found that patients who underwent early surgery had significantly lower odds of death and pressure sores than those whose surgery was delayed (OR 0.74; 95 % CI 0.67 to 0.81; OR 0.48, 95 % CI, 0.38–0.60, respectively) [10].

Despite remarkable benefits of early surgery after hip fracture on outcomes and clinical guideline recommendations, optimal care is not always made available to all eligible patients.

Therefore, the proportion of surgery within 48 h after hip fracture is one of the most frequently used indicators of healthcare quality. Hospitals, and more generally

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healthcare systems, may be compared on the basis of this indicator, with the implicit assumption that higher proportions reflect more appropriate healthcare practice.

Public reporting of hospital performance has become increasingly common and may influence hospital performance through two related pathways [11, 12]. In the first pathway, patients or general practitioners use performance data to choose better performing providers (which may motivate providers to improve performance). Evidence supporting this pathway is scant [13]. In the second pathway, providers respond to performance data because of professional pride, competitiveness and sensitivity to their reputation among peers and implement internal improvement projects [13, 14].

The proportion of surgery within 2 days after hip fracture is an indicator that measures quality in the orthopaedic specialty and is included in the National Outcome Program, which is currently active in the Italian Health System. This program, introduced in 2010, performs comparative analyses of hospital care, and approximately 130 outcome indicators of inpatient care are evaluated [15]. The results provided by the National Outcome Program are updated every year and are publicly available, including the data analysed in this study [16].

The objective of the present study is to evaluate the difference in 1-year mortality after hip fracture between patients undergoing early surgery (within 2 days) and patients undergoing delayed surgery in Italy.

Methods

Data sources

This study is based on information from the Hospital Information System (HIS) [17]. Discharge abstracts for all hospitals are routinely collected by the HIS and contain patient demographic data (gender, age), admission and discharge dates, up to 6 discharge diagnoses (International Classification of Disease, 9th Revision, Clinical Modification [ICD-9-CM]), medical procedures or surgical interventions (up to 6), and status at discharge (alive, dead, transferred to another hospital).

Moreover, the National Tax Registry was used to collect information regarding vital status and out-of-hospital deaths.

Study population

We conducted a retrospective cohort study of patients aged 65 years and older who were residing in Italy and were admitted to an acute care hospital for a hip fracture (ICD-9-CM diagnosis codes 820.0–820.9 in any position) between 1 January 2007 and 31 December 2012. We excluded admissions of patients:

hospitalized for hip fracture in the previous 2 years;

who had multiple significant traumas (DRGs 484–487); who had a principal or secondary diagnosis of malignant neoplasm (codes 140.0–208.9) at the index admission (current admission for hip fracture) or at previous hospitalizations during the last 2 years.

transferred from another acute care hospital; died within 2 days of admission.

Patients who died within 2 days of admission were excluded in order to give all subjects the same “probability of exposure” and avoid any kind of time related bias. Additionally, patients with hip fracture who did not undergo surgery were excluded because they had different clinical characteristics and 1-year mortality compared to the surgical patients.

Exposure

The exposure of interest is the surgery within or after 2 days of hospital arrival (difference between date of surgery and date of admission less than or equal to 2 days). The surgeries were identified by the following ICD-9-CM codes: total or partial hip replacement (codes 81.51, 81.52) and reduction of fracture (codes 79.00, 79.05, 79.10, 79.15, 79.20, 79.25, 79.30, 79.35, 79.40, 79.45, 79.50, 79.55).

Outcome and follow-up

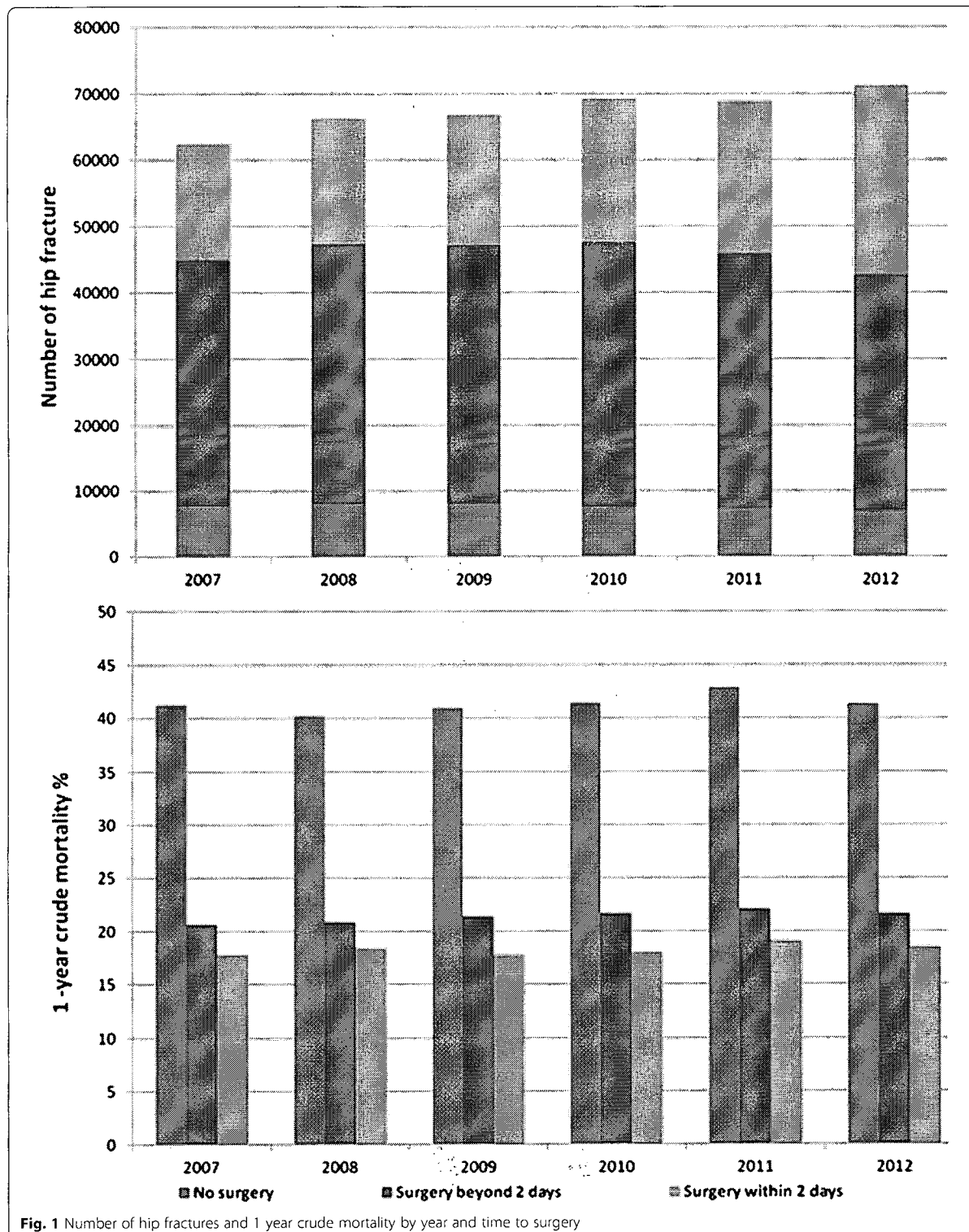
The outcome under study is 1-year mortality. The follow-up period started two days after admission to give all patients the same opportunity of receiving early surgery and was continued until one year.

Comorbidities

Risk factors potentially associated with the outcome under study were chosen among the conditions identified in the literature [1, 2, 5]. Comorbidities were identified on the basis of ICD-9-CM codes registered either at the index hospitalization or at previous hospital admissions during the last 2 years [18]. Acute events that occurred during the index admission that could be considered complications of care were not included. Details and ICD-9-CM codes are reported in the Additional file 1.

Statistical analysis

The proportions of surgery performed within 2 days of hospital arrival were calculated. We stratified the patients into seven age groups: 65–69, 70–74, 75–79, 80–84, 85–89, 90–94 and 95–100 years. The multivariate Cox regression analysis was used to assess the effect of early surgery on the likelihood of 1-year mortality after hip fracture, adjusting for other factors (age, gender and comorbidities) that could affect the outcome under



study. In particular, age and gender were considered a priori risk factors and were thus included in the risk-adjustment models. For the co-morbidities, a bootstrap stepwise procedure that assigned an importance rank for the predictors in the logistic regression was implemented to identify the set of conditions that significantly predicted the risk of the outcome and optimized the trade-off between the goodness-of-fit of the final model and parsimony. Using this approach, the logistic regression with all predictors was run 1000 times on random samples drawn with replacement from the original data set. Only the risk factors identified as significant ($p \leq 0.05$) at least 30 times in at least 30 % of the procedures were included in the predictive model [19]. The adjusted hazard function for both groups of patients (patients with versus patients without early surgery) was calculated. A slight violation of the proportional hazards assumption was detected for the exposure variable (early surgery) using the Schoenfeld Residuals test. We addressed this violation using interactions with time. Therefore, time-dependent effects of early surgery were calculated estimating its effect in the first and in the last six months of follow-up. Time-dependent effects were estimated for the entire population and by age groups.

The absolute number of deaths prevented by exposure to early surgery were calculated. After adjusting the mortality rate among exposed by means of direct standardization, the number of prevented deaths among exposed was calculated as follow: rate among unexposed adjusted rate among exposed. This absolute effect, referring to one person-year, was subsequently multiplied by the total number of person-years among the exposed.

All analyses were undertaken using SAS Version 9.2 and STATA 12.

The data used for the study are not openly available. The Department of Epidemiology has been authorized by the Ministry of Health to use the data.

The study was conducted with the permission of the Department of Epidemiology of Lazio Regional Health Service, the regional referral centre for epidemiological research who has full access to anonymized hospitalization data therefore ethics approval was not required.

Results

We studied a total number of 405,037 admissions for hip fracture in Italy between 1 January 2007 and 31 December 2012. The number of hip fractures and 1-year crude mortality for time to surgery and year is reported in Fig. 1. Overall, only 11 % had no procedure recorded, the mortality rate of non-operated patients was twice the mortality of the total population, and comorbidities were more frequent in non-operated patients compared with surgical patients. The distribution of risk factors for operated and non-operated patients is reported in Table 1. Therefore, in

the further analyses, we only considered 359,529 surgical patients.

The risk factors included in the predictive model were the following: age, gender, diabetes, nutritional deficiencies, obesity, blood disorders, dementias, Parkinson's disease, hemiplegia and other paralytic syndromes, hypertension, other forms of chronic ischemic heart disease, heart failure, rheumatic heart disease, cardiomyopathy, other heart conditions, cardiac arrhythmias, cerebrovascular disease,

Table 1 Distribution of risk factors for operated and non-operated patients

Risk factors	Operated patient %	Non operated patients %
Age groups (years)		
65 69	4.9	4.0
70 74	9.2	8.0
75 79	16.9	15.5
80 84	26.2	24.9
85 89	26.4	26.9
90 94	12.1	14.5
95 100	4.3	6.2
Gender		
Male	21.8	30.2
Female	78.2	69.8
Diabetes	5.9	9.3
Nutritional deficiencies	0.4	1.1
Obesity	0.3	0.4
Blood disorders	4.2	6.9
Dementias including Alzheimer's disease	8.3	12.5
Parkinson's disease	2.4	3.0
Hemiplegia and other paralytic syndromes	0.6	0.8
Hypertension	13.0	17.3
Other forms of chronic ischemic heart disease	7.9	13.5
Heart failure	4.9	9.0
Rheumatic heart disease	0.9	1.6
Cardiomyopathy	0.9	2.2
Other heart conditions	0.7	1.0
Cardiac arrhythmias	7.1	10.6
Cerebrovascular disease	10.0	15.7
Vascular disease	2.8	4.8
COPD	4.7	8.4
Chronic renal disease	4.8	9.1
Other chronic disease (liver, pancreas, intestine)	1.9	3.8
Rheumatoid arthritis and other inflammatory polyarthropathies	0.4	0.4

vascular disease, COPD, chronic renal disease, other chronic disease (liver, pancreas, intestine), rheumatoid arthritis and other inflammatory polyarthropathies. All comorbidities included in the predictive model increased the likelihood of 1-year mortality with the exception of hemiplegia and other paralytic syndromes and hypertension. The likelihood of 1-year mortality was reduced in female patients.

As shown in Fig. 2, patients who underwent surgery within 2 days had lower 1-year mortality compared to those who waited for surgery more than 2 days (Hazard Ratios (HR): 0.83; 95 % CI: 0.82-0.85). There was a significant interaction between exposure to early surgery and age group ($p < 0.001$); HRs progressively increased with age, ranging from 0.68 (95 % CI: 0.58-0.78) in the age group 65-69 up to 0.88 (95 % CI: 0.83-0.92) in the age group 99-100 (Table 2).

By each age group, the number of deaths observed in the entire cohort of surgical patients, the number of deaths among the exposed (early surgery) and the number of deaths prevented by the exposure among the exposed patients are reported in Table 3. In regard to the population of patients who underwent surgery, the number of deaths prevented by exposure to early intervention was 5691 in the entire follow-up period and increased over time rising from 776 in 2007 to 1255 in 2012 (Fig. 3).

The time-dependent effects (the first 6 months versus the last 6 months of follow-up) of early surgery on 1-year mortality for the entire population of surgical patients and by age groups are shown in Fig. 4. The beneficial

effect of early surgery decreased from the first six-month follow-up period to the second six-month period.

Discussion

The study evaluated the difference in 1-year mortality after hip fracture between patients undergoing early surgery (within 2 days) and patients undergoing delayed surgery in Italy, with the implicit assumption that higher proportions reflect more appropriate healthcare practice.

This study is the first to evaluate the association between time to surgery and 1-year mortality for all Italian elderly patients hospitalized for hip fracture in the recent past, using a large national dataset and routinely collected data on hospital admissions.

We found that patients who underwent surgery within 2 days had lower 1-year mortality compared to those who waited for surgery more than 2 days (HR: 0.83; 95 % CI: 0.82-0.85), conditional on survival to two days after admission and excluding those that did not undergo surgery, even after considering potential confounding factors. The number of deaths prevented by exposure to the early intervention was 5691.

Our data confirm the previous reports on the association between delayed surgery and increased mortality in elderly patients admitted for hip fracture repair. In fact, Simunovic et al. reported a relative risk equal to 0.81 (CI 95 %: 0.68-0.96) whereas Moja et al. an odds ratio equal to 0.74 (CI 95 %: 0.67-0.81) [9, 10].

Novack et al. showed that the length of surgery delay had a gradual effect on increasing both short-term and

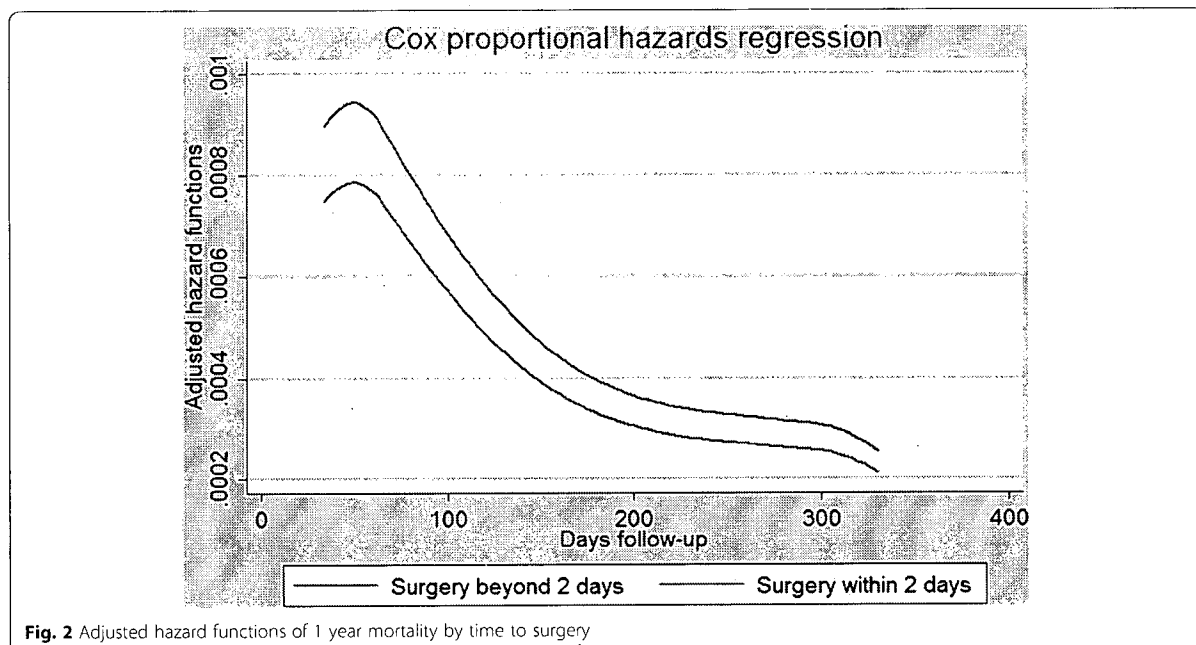


Fig. 2 Adjusted hazard functions of 1 year mortality by time to surgery

Table 2 One-year mortality in patients operated within 2 days versus patients operated beyond 2 days by age group

Age groups (years)	N	H R ^a	95 % C.I.
65 69	17500	0.68	0.58 0.78
70 74	32976	0.72	0.66 0.78
75 79	60697	0.79	0.75 0.84
80 84	94357	0.84	0.81 0.87
85 89	95076	0.84	0.82 0.86
90 94	43468	0.87	0.84 0.90
95 100	15455	0.88	0.83 0.92
Total	359529	0.83	0.82 0.85

^aAdjusted for age, gender, diabetes, nutritional deficiencies, obesity, blood disorders, dementias, Parkinson's disease, hemiplegia and other paralytic syndromes, hypertension, other forms of chronic ischemic heart disease, heart failure, rheumatic heart disease, cardiomyopathy, other heart conditions, cardiac arrhythmias, cerebrovascular disease, vascular disease, COPD, chronic renal disease, other chronic disease (liver, pancreas, intestine), rheumatoid arthritis and other inflammatory polyarthropathies

long-term mortality [4]. Similar findings were also reported from Casaletto and Gatt [20], Zuckerman et al. [21], and Elliott et al. [22].

Delay in hip fracture surgery is significantly associated with increased risk of mortality and complication. Therefore, we support the initiatives to reduce waiting times for hip fracture surgery as a measure to improve local healthcare quality of patients with hip fracture. In Italy, the proportions of surgery within 2 days after hip fracture were included in the National Outcome Program to measure quality in the orthopaedic specialty [23]. However, there are many initiatives in other countries. The Scottish Intercollegiate Guidelines Network suggests that medically fit patients should receive surgery as soon as possible within safe operating hours after presenting to hospital [24]. The British Orthopedic Association guidelines also state that surgical fixation should not be delayed for more than 48 h after

Table 3 Number of deaths in the entire population, among the exposed and number of prevented deaths by exposure among the exposed per year by age group

Age groups (years)	N	N of observed deaths in the population	N of observed deaths among the exposed	N of prevented deaths by exposure among the exposed
65 69	17500	967	251	165
70 74	32976	2737	715	387
75 79	60697	7292	2021	696
80 84	94357	17005	5120	1275
85 89	95076	23715	7657	1808
90 94	43468	14759	5340	1017
95 100	15455	6478	2608	460
Total	359529	72953	23712	5691

admission unless there are clearly reversible medical conditions [25]. The Royal College of Physicians recommends that hip fracture operations should be performed within 24 h by senior staff [26]. As a result, some hospitals, governments, and administrators have set this time point as a target, making hip fracture a performance indicator in the quality of healthcare delivery.

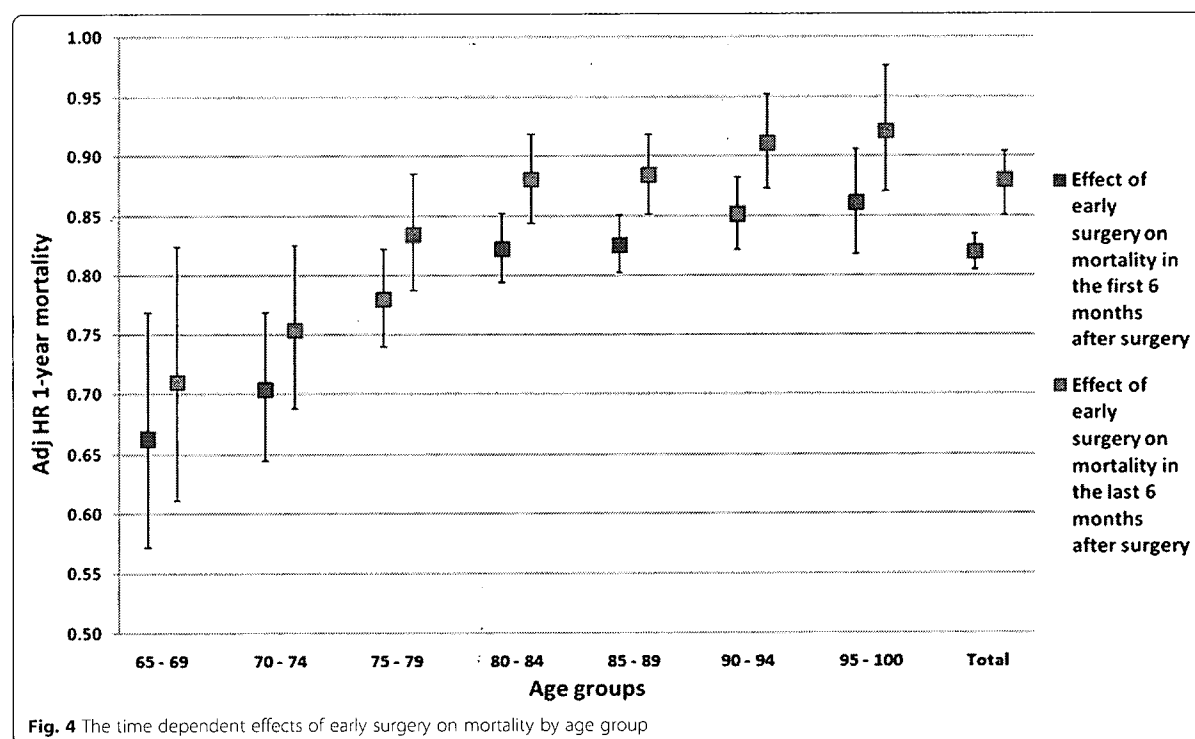
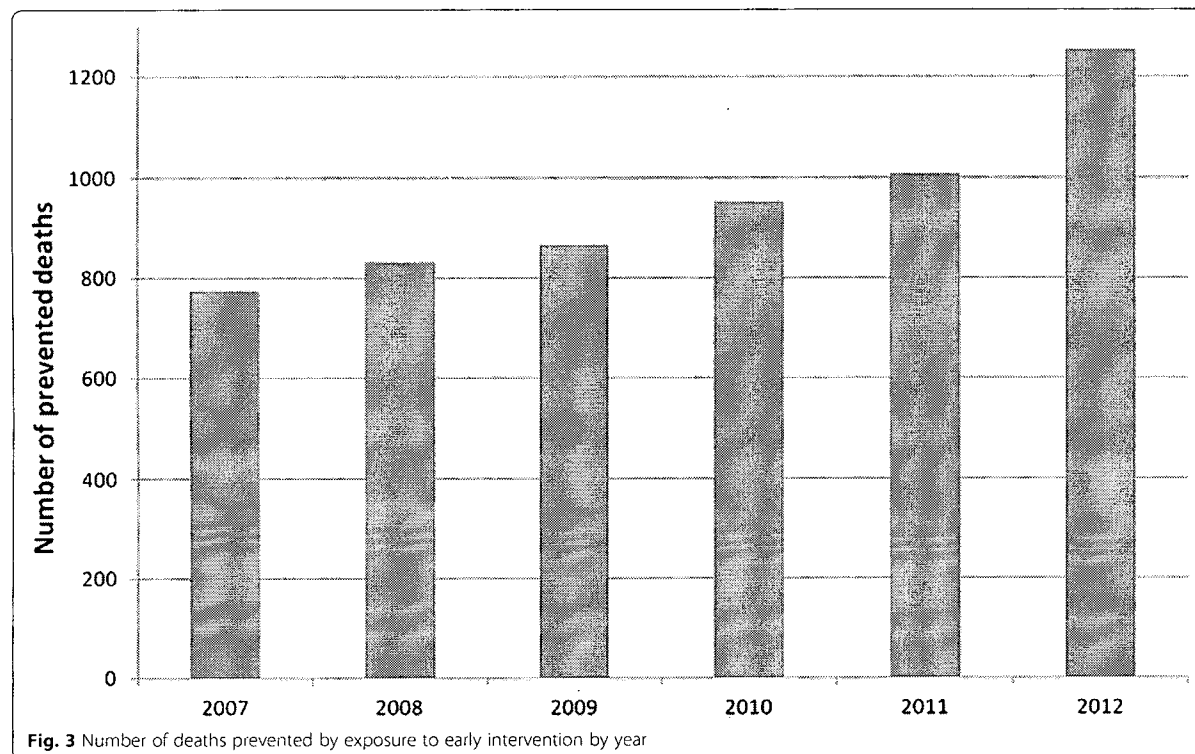
The strengths of this study include the large data sample available for analysis, the validated algorithm for cohort selection and variable definitions, and the robust outcome. However, our study has some potential limitations. Time to surgery was computed based on the dates of hospital admission and surgery and was not refined to the actual hour of surgery and to access in the emergency room, which might introduce a bias into the estimation of the operative delay effect. Emergency room data are not yet available to all Italian regions; however, it was possible to verify the bias introduced in 10 regions for which data were available. For these 10 regions, the proportions of surgery within 2 days were calculated using both the date of admission to hospital and the date of admission in emergency room; in 90 % of cases, no differences in operative delay were observed.

In addition to validating the date of surgery as part of the National Outcome Program, we activated a clinical audit to verify the quality of data reported in the hospital discharge records.

This study relies entirely on administrative data, and despite the broad and valued use as a source for healthcare research, hospital discharge data have several limitations that have been recognized repeatedly [18]. Additionally, although several covariates were included in the models to adjust for differences in patient characteristics, unmeasurable or unmeasured covariates that might affect both the likelihood of 1-year mortality and the delay in surgery after hip fracture, such as cognitive impairment and delirium, may not have been considered. We lacked data on socio-economic status and functional status prior to admission, two factors that may have affected patient selection for surgery, time to surgery, and the outcome of these elderly patients.

Conclusion

In conclusion, we demonstrated that delaying surgery after hip fracture is associated with worse outcomes. Medical organizations should improve performance according to guidelines and use surgery for hip fracture as a quality improvement measure. Our data support the notion that deviating from surgical guidelines in hip fracture is costly, in terms of both human life and excess hospital stay.



Additional file

Additional file 1: List of comorbidities used for risk adjustment.
(DOC 41 kb)

Competing interests

The authors declare that they have no competing interests.

Data used for the study

The data used for the study are not openly available. The Department of Epidemiology has been authorized by Ministry of Health to use the data. The study was conducted with the permission of the Department of Epidemiology of Lazio Regional Health Service, the regional referral centre for epidemiological research who has full access to anonymized hospitalization data therefore ethics approval was not required.

Authors' contributions

CP: study conception and design, data analysis, interpretation of data. MDM: study conception and design, data analysis, interpretation of data. FD: study conception and design, interpretation of data. PCA: study conception and design, interpretation of data. DM: study conception and design, interpretation of data. All authors read and approved the final manuscript.

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