IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

DAVID DELOACH,

Plaintiff,

-vs-

JUDGE BQYLE
CASE NO. 394340

UNITED PARCEL SERVICE, et al.,

Defendants.

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Deposition of JOHN P. CONOMY, M.D., taken as if upon cross-examination before Kenneth F. Barberic, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Nurenberg, Plevin, Heller & McCarthy, First Floor, 1370 Ontario Street, Cleveland, Ohio, at 10:20 a.m., on Thursday, October 19, 2000, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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ALSO PRESENT:

David G. Lightman, Videotape Operator

P R O C E E D I N G S

MR. JACOBSON: Why don't we mark this Plaintiff's Exhibit 1.

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(Thereupon, Plaintiff's Exhibit 42 was mark'd for purposes of identification.)

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MR. JACOBSON: All set?

VIDEOTAPE OPERATOR: Just one minute.

We're on the record.

JOHN P. CONOMY, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF JOHN P. CONOMY, M.D.

BY MR. JACOBSON:

Q. Good morning, doctor.

A. Good morning.

Q. Can you state your name, please?

A. My name is John Conomy.

Q. And your profession?

A. I'm a neurologist.

Q. And today's date is?
A. Am I being quizzed as to orientation this morning, Mr. Jacobson?
Today, I believe, is the 19th, is it, of October in the year of our lord or common era 2000.
Q. Doctor, we are here today in my office and with you is counsel, John Rasmussen, one of the attorneys representing United Parcel Service in this matter, is that correct?
A. That's correct.
Q. You've been retained by Mr. Rasmussen on behalf of United Parcel Service to evaluate Mr. David Deloach, is that correct?
A. I have.
Q. And that is in connection with injuries sustained by Mr. Deloach on August 21st, 1999, correct?
A. Yes.
Q. Doctor, have you been retained by Mr. Rasmussen in the past to perform neurological evaluations?
a. I have on one or two occasions. I can't remember the specifics or the names of people, but, yes, I have been retained by him to examine persons at his request.
Q. And have you been retained in the past by other

members of his firm, the law firm of Jan Saurman, to perform neurological examinations?

A. I may well have indeed, yes.

Q. Doctor, what is the nature of your current medical practice?

A. Well, I'm a neurologist. I am a member of a neurology, neurosurgery group, that includes members of other, other specialties dealing with one or another aspect of nervous system disease and treatment. I see a variety of patients, both, 80 percent of them are adults, 15 or 20 percent are children generally above the age of two.

I schedule patients three days weekly, generally on Mondays, Wednesdays and Fridays. I see patients in hospitals and in a variety of other settings, either patients of my own or persons whom I have been asked to see by other, other physicians. That occupies roughly 80 or 85 percent of a scheduled week.

Q. Doctor, do you currently have any academic appointments?

A. Yes.

Q. And what are they?

A. I'm professor of clinical neurology at Case

Western Reserve University, at the medical school, and University Hospitals.

Q. Doctor, you are also a board certified neurologist, is that correct?

A. I am.

Q. Looking through your CV I see that you were the chairman of the Department of Neurology at The Cleveland Clinic for approximately 18 years, is that correct?

A. 19 and a glorious experience it was, Mr. Jacobson.

Q. Doctor, you were also the director of the, pardon me, the training program director at the Department of Neurology at The Cleveland Clinic for that period of time. What is that, doctor?

A. Well, I was director of the resident, neurology residency program, and several fellowships derivative. I also held that position at University Hospitals of Cleveland for about three years prior to the time I went to The Cleveland Clinic.

Q. Doctor, I also see from your CV that you have written a number of book chapters and articles, a few hundred?

A. Yes.

Q. And lectured over a hundred times nationally and internationally as well, is that correct?
A. That's correct.
Q. Doctor, when did you see Mr. Deloach?
A. I saw him on the 6th of October of this year.
Q. And that was, once again, at the request of Mr. Rasmussen on behalf of UPS, correct?
A. Correct.
Q. Doctor, did you prepare a report, medical/legal report for Mr. Rasmussen?
A. I did. It's dated October 6th, 2000. I believe you have it in your hand.
Q. Okay. And that would be what's been marked as Plaintiff's Exhibit 42, correct?
A. Yes.
Q. Doctor, did you prepare any other reports?
A. Yes, I did. I followed this up with a summary report after reviewing a variety of medical records and associated documents which I can name for you if you'd like. That was sent on October 14th, 2000.
Q. Doctor, can we go off the record so that I can have an opportunity to review that report?
A. Certainly.
Q. Thanks.

VIDEOTAPE OPERATOR: Off the record.

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(Thereupon, a discussion was had off the record.)

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(Thereupon, Plaintiff's Exhibit 43 was mark'd for purposes of identification.)

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MR. JACOBSON: Back on the record.

VIDEOTAPE OPERATOR: We're back on the record.

Q. Doctor, thank you for allowing me the opportunity to review this report and the subsequent report of October 14th, 2000 we've now marked as Plaintiff's Exhibit 43, is that correct?

A. That's correct.

Q. Doctor, you had an opportunity to evaluate the records from the initial hospitalization at University Hospitals of Cleveland, is that correct?

A. That's correct.

Q. Those records indicate that Mr. Deloach sustained, amongst other things, a bilateral basilar skull fracture in the left petrosal bone

with especially separated pneumocephaly throughout the subarachnoid space, is that correct?

A. That's correct.

Q. Can you tell me or can you explain to me, doctor, what that is?

A. Well, a basilar skull fracture refers to a fracture crossing not the towering parts, the so-called calvarium of the skull, but the base, the parts below the nose and below the ears and above the neck.

And his fractures were more than one and extended through that area of his head. Now, the evidence that that fracture occurred was, was multiple. He had bleeding from the ears when he was taken from the site of this accident to the Meridia Health, pardon me, Southwest General Hospital. That continued when he was brought over to University Hospitals. He had deafness as part of that. Actually the fractures through the temporal bones, through the petrosal area, the temporal bones cracks through the organs of hearing and those were impaired.

When that communication exists, that is a fracture in that particular area of the head,

there are ways through the caverns and the canyons of the head to allow air from the nasal passages and from the throat or from the ears itself to gain entry into the head so that when an x-ray of the head is taken you see not only the head as would be seen in an x-ray but outlines of certain brain structures because of air contrast within the head. This can be seen with CT scans and other forms of imaging as well. These are common consequences of a basilar skull fracture.

Q. Doctor, when you saw Mr. Deloach did you take a history from him?

A. I did.

Q. All right. And, doctor, what I'd like you to do now, if you would, and I apologize because this is going to take a little time, is to relate that history to us here by reading your report into the record, if you would, doctor.

A. Do you want me to read it verbatim?

Q. That would be fine.

A. All right. Fine. Excuse me. I'm losing portions of my electronics here from time to time.

I'm going to omit the introductory

business. There was a representative of your firm, Mr. Jacobson, a Miss Vicky Leath, who accompanied Mr. Deloach throughout this exercise and it took place over an hour.

I say in the history that Mr. Deloach is a native of Cleveland, Ohio. He is one of four siblings, all the others residing in Cincinnati, Ohio along with his mother at this time. He has a life long history of quite good health and has never been seriously injured or seriously ill he tells me in his entire life. At the time of his injury he resided with a friend and is still in a residential arrangement based on friendship rather than kinship. He has completed eleven years of education and at the time of his injury was three days away from beginning his senior year of high school at South High School in Cleveland. He also attended Lincoln-West High School where he excelled in athletics, being a tailback on the football team, a member of the basketball team and he enjoyed playing many other sports including baseball. He led a healthy, vigorous and active life.

He's been employed through his teenage years in a variety of summer jobs and after school

jobs. He has, for instance, worked as a food service attendant at Jacob's Field.

Now, these are things that he told me. The history is obtained from him. It's not obtained from Miss Leath for from the pile of medical records that are in front of me. What I'm reading to you are, is what he, what he told me.

He's done some factory work he tells me. At the time he was injured he was employed by the United Parcel Service at a facility in Middleburg Heights, Ohio. He was in the process of removing a lock from the back of a trailer on a UPS truck when he was hurt. A dolly was attached to the back of the trailer. As he proceeded about his work the truck moved. He was caught in the movement, pushed beneath the dolly which ran over him. He remembers this, and I'm quoting him now, as being sucked up like I was inside of a vacuum cleaner. He remembers the sensation, again and I quote, of drowning in my own blood. He attempted to stand up and actually made it to his feet but then fell to the ground again smashing the left side of his head against the ground. His memory thereafter for the next couple of days is spotty and foggy. He remembers EMS people transporting

him to University Suburban Hospital. He was -- actually that's the name he gave me. It was not quite correct. But hardly a fault or failing. He was evaluated there and placed in the intensive care unit for a period he believes to be about three days. He's not correct on the, on the time. He does not recollect all of the events going on about him, but he does remember pain in his head, his left shoulder, both of his legs, and then he had difficulty speaking, swallowing and moving his face. He was aware *of* numbness on the left side of his face as well.

He was subsequently hospitalized for a period of about 42 days at University Hospitals of Cleveland, attended there by neurosurgeons, neurologists, ear, nose and throat specialists and trauma specialists. He does not recollect having any surgical therapy. He does remember, however, prolonged periods of physical, speech and occupational rehabilitation. Over that period of hospitalization the numbness in his face slightly receded, but he has never completely resolved his legs were weak and he needed a cane in order to walk. He was discharged from the hospital to his current

residence where he now lives in a semi-independent fashion.

As an effect of his injuries he claims these things: He has a constant swimming feeling in his head and periods of dizziness particularly aggravated by movement. His vision is double and blurred from time to time. His sense of smell and his sense of taste have both been impaired. The left side of his face is largely numb and both sides of his face are weak, particularly the left side. While his facial weakness has improved, he still has difficulty chewing food and food catches in his mouth and he must remove it with his fingers because his face and lips are weak. His speech is improved and is intelligible and is of a much better quality now than the time shortly after his injury. He has occasional difficulties with choking. His ears are, in his words, messed up. He has difficulty hearing in his right ear particularly and a constant buzzing or whizzing sound in that ear as well.

He has difficulty controlling his legs, particularly his left foot. He has frequency and precipitancy of both urination and bowel control. I did not inquire into his sexual

function. I know about it from reading the observations of others. I just felt that under the circumstances and dealing with him as a person and attempting to respect his privacy and sensitivities that I would not, that would not have benefited this exercise for me to persist with that line of questioning or pursue it.

He walks with a cane because of imbalance.

In terms of functional effects of these injuries he lays out the following picture: He can stand on his feet for a period of at least several minutes and walk about 500 feet without assistance, but does so slowly. Let me tell you how, he lives actually on my old paper route, on Eddy Road, the Glenville area of Cleveland. So I'm quite certain of the distances. He can walk from his house, which is up near Larchmont and Sellers, down to St. Clair. He has to stop a couple of times. He has to sit down and he can make it to the corner. But it takes him ten minutes to, to get down there. It's a five minute walk for the rest of us I would think. At the end of that time he must rest for a few minutes to go on his way again.

He's become largely homebound, largely out

of a sense of embarrassment. When he attempts to eat, food falls from his mouth or he chokes. His face moves little and does so asymmetrically. His hobbled condition and his facial appearance cause him to be embarrassed and he simply stays at home. He claims his short term memory is impaired and he must struggle to remember the day's events and even common things. His energy level is small and he must rest frequently. Because of his inability to blink his eyes he uses lubricant eye drops which tend to smear upon his face, his appetite is diminished and he has lost 15 pounds in weight since his injury. He cannot participate in sports and again largely from embarrassment over his disfigurement and avoids groups of unfamiliar people and does not eat in restaurants or go to a movie theater any longer. He is distressed by prickly feelings in both sides of his face and on the lower left side of his face particularly. His neck is frequently stiff and, quote, cracks when he moves it, quote. He is troubled by headaches and has difficulty hearing, stating that the doctors tell me I have loose bones in my head. And he's, he's correct. What he has is dislocation of the, of

the small bones, the hammer, the anvil and the stirrup, the little, very fine, almost fish bone like ossicles that are in the middle ear that allow one to hear.

His change in bowel and bladder habits necessitate being near toilet facilities less an accident happen. He simply doesn't get much warning,

He's not been able to return to school. He spends much of his time attending doctors' appointments. He is cared for primarily by Dr. Donald Mann, neurologist. He's on no medication at the time save Lacril, eye drops, which are a lubricating ointment for the eyes.

All of this has taken an emotional toll as well. He has become relatively reclusive and saddened over his state of being impaired as it is, as he is at a relatively young age. He does, however, remain hopeful about the future stating I am only 20 years old and I can go on for another 60 years.

That's what I learned from him.

Q. Doctor, after you took a history did you then proceed to do a complete neurologic examination?

A. Yes.

Q. Doctor, I'm going to ask you to discuss and explain your findings on that examination and to the extent that they incorporate your opinions I will ask you to confine your opinions to those which you are certain of, at least to a reasonable degree of medical certainty. Do you understand that, doctor?

A. Yes.

Q. All right. I will also ask you to confine all opinions that you give in this deposition to those which you are certain of to a reasonable degree of medical certainty. Okay, doctor?

A. Yes, it is.

Q. Doctor, with respect to the history that Mr. Deloach gave you, was it for the most part borne out by your examination?

A. Yes, it was.

Q. Did you, did there appear to be any embellishment or exaggeration on his part?

A. None.

Q. Doctor, can you then take us through your examination, please?

A. Yes. Again, do you want me to read it all or do you want me to touch on those things that are relevant and important to what's wrong with him?

Q. Well, I have some specific questions that I'm going to ask you about that, doctor. But to the extent that you want to do that extemporaneously please feel free to do so.

A. Yeah. You know, in the interest of time it may save some time because there are things in here that, that are, are part of a statement of an ordinary examination that are probably somewhat extraneous.

A complete examination was done. Now, I don't want to take the next two days telling you what a complete examination is. I want to tell you what was wrong with him.

I say that based on his examination and based on his complaints I cannot exclude some element of memory failure and suspect that if a defect does exist it will take formal neuropsychologic tests to demonstrate it. That is when I talked to him he was able to give a well ordered, concise history. He spoke to the point of things. He had necessary information He considered his responses and articulated them in a thoughtful way. Now, since I've read his neuropsychologic tests and I'm aware of what they have to say.

He's unable to detect the odor of cloves in his left nostril but does so in his right. His sense of smell was impaired on the side of his head. His visual acuity with corrective lenses is normal. He's wearing a pair of glasses and, you know, he could read the ordinary hand held eye chart. He has a partial left sixth nerve palsy. That means that when he attempted to look with both eyes to the left side the right eye moved all the way to the left, but the left eye did not. It stopped part way over. That produces double vision.

He had prominent sustained shimmering nystagmus on conjugate gaze to the left and a slightly lesser degree of the same on conjugate gaze to the right. Now, this is an involuntary disorder of eye movement in which the eyes when moved throughout the planes of gaze, you can imagine those planes shaped like an asterisk, it would be with six points. His when they move laterally, that is in the horizontal plane, a plane parallel to the ground, wiggle and shimmer and shake in his head. That has the effect of doing two things, blurring vision and making objects that should be steady jump. Persons with

a complaint of jumping or blurred vision,, he complains of both. He didn't to me, but again it's in Dr. Bardenstein's records that this is the case and it's consistent with what's wrong with him.

Q. Doctor --

A. Yes.

Q. Before we go on there, doctor. Before you saw Dr. Bardenstein's records or any of the records you were able to deduce a nystagmus on your own, is that correct?

A. Yeah. I didn't see any of these records until after I saw him and dictated this. So that is habitually a next step exercise with me.

Q. Now, the, the movements of the eyeballs, the nystagmus, are involuntary, correct?

A. That's correct,

Q. And that was something that you were able to observe on your own, is that correct?

A. That's correct.

Q. So there's objective evidence of nystagmus, correct?

A. Yes, sir. Everything I'm telling you is what I observed on my own.

Q. Okay. Now, doctor, you indicated in your report

that he has a shimmering nystagmus on conjugate gaze to the left and a slightly lesser degree of the same on conjugate gaze to the right, correct?

A. Correct.

Q. Are those common eye movements, doctor?

A. Well, that's a common abnormality of eye movement. Particularly in persons with injuries to the brainstem, to nuclear centers of gaze within the brainstem, and the way those things are connected to a part of the brain called the cerebellum. Common for me, yes. For you, no. And I would see it in the course, I see somebody with nystagmus during the course of a day every day.

Q. No. Doctor, I didn't make myself clear. In other words, for an individual to look to the left and look to the right, those are common eye movements for an individual?

A. Oh, yes.

Q. All right. So Mr. Deloach is going to have the sensations produced by this nystagmus on a, on a fairly regular basis, correct?

A. Usually the jumping of vision gets damped over time and there are compensations for it. But he will have, in my opinion, abnormal eye movements,

abnormal nystagmus. There's a normal kind, too. I don't think we need to get into it. It's a long talk.

By my opinion is that he's going to have this evidence of brainstem and eye coordination damage forever.

Q. Now, doctor, can you explain to me physiologically what has occurred in his head to cause this?

A. I'll try to be brief about it.

Two things have occurred. He has weakness due to nerve damage in the nerves coming from the brain to the eye muscles that will not sustain his eyes in a constant position. Imagine trying to pick up a heavy dumbbell with a weak arm. One kind of gets a shake and a tremor in it. That's one aspect of it.

The other is this, the way the brain fixes on an image to hold it constant so you can appreciate what it is and size it up, if you will, and measure it, requires that eye movements be directed and held in one place. Now, that's a combination of the nuclear centers that move the eyes within the brainstems acting properly, the nerves that connect those things and centers

within the brain that coordinate the movement of the eyes to hold the eyes affixed on an object. His anatomic damage has impaired all of those systems.

Q. And, doctor, an individual with a sixth nerve palsy and nystagmus is going to experience problems with balancing, correct?

A. They may. But it's not why he has trouble with balance.

Q. Okay. He has another reason for that problem, doctor?

A. Yes.

Q. All right. I'll get into that in a moment, doctor.

Doctor, the sixth nerve palsy, the double vision and the nystagmus, is that something that will interfere with his ability to read from time to time?

A. From time to time it may. There are ways around that. For him occluding, putting a patch over his right eye is going to help things. Over time the quality of his eye movements is going to improve to the point where he can indeed read. He did reading for, particularly for his neuropsychologic testing. So he can read. It

doesn't impair him entirely.

I would admit in response to your question that this particular combination of things that he has wrong with his eyes, the abnormality of movement, the doubling of vision and because of other nerve damage some tendency toward irritating the lower part of his corneas may make reading a, a, let me say a less comfortable exercise than it would have been without those damages.

Q. Well, doctor, that's something you would expect to occur in this individual, correct? In other words, he's going to have some difficulty reading and he will tire from reading quicker than you, than you or I, is that a fair statement?

A. Yeah, he may. I think it's fair enough. It's a bit speculative, but it's not an unfair statement.

Q. Is it a probability, doctor?

A. I, I really can't answer it. It's, it can and does occur, but yet there are other people with the same combination of things that, that don't express difficulty. I don't, let me put it this way, I don't think it's an unreasonable probability.

Q. All right. Let me just move on then, doctor.

You were going to explain, doctor, the reason for his difficulties in balance? Or are we getting ahead of ourselves here?

A. Well, by your lead. I'll answer whatever questions you have.

Q. Well, why don't we just go in an orderly fashion, doctor. You were, you were moving on with your examination.

A. He has diminished sensation in all modalities, that is to touch, to temperature and to pain sensation in the second and third divisions of the left fifth cranial nerve. That means that the lower part of the left side of his face is, in a word, numb and he has mild weakness of the masseter muscles, the muscle that forms this ball at the bottom of the jaw is weak as well. Now, that's, all of that is from damage to the fifth cranial nerve on that side of his head. There was a time when he had bilateral damage in this regard. But some of it has been repaired. This is what remains, at least at the time I saw him.

He has facial diplegia. That means that both sides of his face are weak. He has the facial appearance of placidity and it's because

the muscles of his face are weak and in fact sag. His lids are sagged a little bit, the bottom 1ids are sagged, he does not blink his eyes completely. As one just sits and watches him. And when he's asked to move the muscles of his face to create facial expressions, smiling, scowling, and so forth, these things can't be done completely. They can be done, but they're done in an abnormal and incomplete fashion.

I'll go forward. He has diminished hearing bilaterally particularly in the right ear.

Q. Doctor, let me just interrupt you for a moment.

A. Sure.

Q. Okay. You indicate in the, in the examination facial diplegia of a moderately severe degree and can close neither of his eyes, wrinkle his forehead, whistle or corrugate his lips, correct?

A. Correct.

Q. His platysma is bilaterally weak. What muscles is the platysma, doctor? What does that control?

A. If I were to growl at you it's this muscle that connects the chest to the jaw and wrinkles up like that.

Q. Doctor, the platysma also assists in depression of the jaw as well, is that correct?
A. Well, it assists in a number of things. In people who lose their jaw depressors it may. In people who lose their neck flexors. And it is preserved. It can be used to bring the head down into the chest. The importance with respect to him is not in those regards. It is, its absence of function is evidence of injury to both facial nerves because that's what innervates it.
Q. Doctor, the masseter weakness would affect his ability to eat certain foods, correct?
A. Not necessarily. I don't think his masseter weakness at this point is interfering with his inability to eat. It's, it's a legitimate physical finding, but it is not of a degree that he'd have to, say, use manual assistance on one side of his jaw in order to chew. It is somewhat weaker than the other side. Persons with this degree, a mild degree of masseter weakness, not to discount its importance as a clinical finding because it is important, generally don't have trouble chewing up the food and it does not involve swallowing that way.
Q. All right. Doctor, the findings that you made in

the face, do they follow along well known nerve distribution patterns?

A. All of them do.

Q. Does that assist you in determining the legitimacy of your findings, doctor?

A. Yes, it does.

Q. And can you explain that, please?

A. Well, he's had a basilar skull fracture and everything I'm telling you about, that you've asked me about involve nerve structures that run through the basilar portions of the skull. They run through the petrous area, they run through the temporal bone, they run through the posterior fossa.

Q. Okay. All right. Doctor, going back to some of the complaints that Mr. Deloach expressed to you in the history, he indicated some time food gets caught in his mouth, he has to pull it out, that type of thing. Is that consistent with your findings, doctor?

A. Yes, it is. The way he pulls it out, by the way, is to put his finger around his lips and mouth in front of his teeth because that's where it gets caught. The muscles about the side of the face are weak and food gets caught as it were in

pouches between his, what did the people who use to advertise, say between the cheek and the gum and that's where it gets caught. So he has to use his hand and clean it out.

Q. Mr. Deloach also complains of excessive drooling. Is that consistent with the laxity of his facial muscles, doctor?

A. Yes, it is.

Q. Go on, please, if you would. You were discussing his hearing, doctor.

A. Well, he has hearing loss on both sides. It's worse on the right side where he has ossicular fractures and dislocations. He hears, I can't tell what he hears out of that ear. Little or nothing is my conclusion from office testing. And his hearing on the left side is not normal, it's reduced. But it's of much better quality than it is on the right.

He didn't have any weakness in the movements of his tongue or palate. The areas that involve swallowing, at least at the time that I saw him, though I would take it he had that and it has been improved.

I go on to say he's very atactic --

Q. Doctor, let me just back up.

A. Yeah.
Q. One more time. You also mentioned that his speech is of good quality but his articulation is impaired by weakness and laxity of his facial muscles, correct?
A. Yes.
Q. All right. Go ahead, doctor.
A. Yes.
Q. You had -- he's atactic. *Go* ahead.
A. He's very atactic when he walks and changes in posture produce prompt nystagmus on left gaze particularly, and a sensation that the world is spinning around, and an inability to walk for a period of about 30 seconds as he regains his bearings.

This is a complicated business and I don't wish to under or over complicate it. He actually wobbles when he stands or sits a little bit. It's called titubation and it's evidence of cerebellar damage. He is impaired beyond that act of balancing himself by knowing just how far or how fast he has moved. That is due to damage from structures within the inner ear that connect the inner ear to the brain and a part of the brain itself related to the eighth nerve and to

the cerebellum. What he lacks is the inability to judge or measure or control his acceleration. That is something, you know, we just don't think about it unless we have trouble with it.

That is fraught with another difficulty, the system that would act in all of us as a gyroscope to keep us upright or steady and let us know where we are in relation to the rest of the universe. In him it's damaged. It is tripped off with too little stimulation and it over reacts and it produces a hallucination of movement in him where there is none in reality. Hence, when he stands up, an act which in you or in me, assuming that we're both normal today, will have a, if at all the most minuscule and unnoticed unsteadiness for a time so brief that it probably can't be measured. In him that same act sets off what would be a roller coaster trip or an experience of spinning or having the world spin about him until the system responsible for those things, which is intact and works but not normally, takes over and lets him know that he's standing still. The effect of this is that he has the sensation of movement where there is none and his ability to direct his limbs while walking

or reaching or whatever it is is done in a drunken like way, although he is not drunk.

Q. Doctor, is there a connection between what you just described and the changes in posture producing the prompt nystagmus or involuntary movement of the eyeballs?

A. Yes. These are all part and parcel, the function of the same system. Now, the findings that one elicits depends on what you're looking for when you do these things. But at the same time that he's developing nystagmus if he's also moving or changing his posture while he's shifting his gaze he'll get all of this stuff.

Q. Now, doctor, you indicated that you observed that he was atactic when he walked. And ataxia, doctor, is a failure of muscular coordination, is that correct?

A. Yes But it's not due to anything wrong with muscles,

Q. It's due once again to the inner ear problems which you discussed, correct?

A. Well, the inner ear is connected. It's the inner ear and brain problems. It's just not the inner ear.

Q. Okay. All right, doctor. *Go* ahead on, if you

would, please.

A. I've talked about the titubation, this shaking that he has, and his inability to coordinate the movement of his limbs. I'm going on to the next paragraph.

Q. Doctor, the titubation, the shaking of his head when he sits, why does that occur? What is causing that?

A. That's reflex cerebellar damage. Damage to the area of the brain that is in the end responsible for holding it steady.

Q. Okay. Go ahead, doctor.

A. I go on to say his stretch reflexes are hyperactive everywhere, including his jaw jerk, which is of three plus quality. Now, the significance of this is that for a clinician this connotes damage to certain specified known and named tracts within the brain that flow from the brain eventually to voluntary muscles.

The same with the next abnormality I'm going to describe, his left plantar reaction is abnormal and inconsistently his left toe extends. The so-called Babinski response. He does, however, have considerable weakness of extension of all of his toes and to a lesser

degree of his left foot. He has bilateral impairment of rapid alternating movement of his feet and he lacks clonus at this time. I'm looking at the quality of his movements. So his, the stretch reflexes being hyperactive by itself has no functional significance to him. It doesn't change the way he does things. It's a clinical sign. The weakness, however, does. He, he's slow in his ability to voluntarily move his limbs, particularly the parts farthest away from him, the distal parts, the feet and the toes. And this is prominent on his left side.

Q. Doctor, in other words, he has some demonstrable nerve damage in his lower extremities, correct?

A. That's from brain damage actually. It is demonstrable, yes.

Q. Okay. And it occurs, doctor, once again along those lines of nerve distribution, correct?

A. Yes, it does.

Q. Doctor, what are the, the practical problems that he will experience as a result of the neurological difficulties in his lower extremities?

A. The weakness and slowness of movement. But that again reflects what he had to tell me about his

ability to walk, the speed with which he can do things and his need to use a cane.

Q. Okay. Go ahead, doctor.

A. I, I say that save for defective facial sensation he's able to perceive cutaneous sensibility everywhere on his body and position and vibration senses are intact. That means he hasn't lost, if you will, deep or superficial feeling anywhere on his body outside of his head and his face.

He complains of difficulty in the use of his left arm and shoulder, but formal examination is normal in terms of motility, strength and muscle bulk at this time. He did complain about that to me but I couldn't find a reason for it when I examined him.

So that summarizes the examination.

Q. All right. Let me just go over a few things, doctor.

First of all, we can agree that this is an individual who is severely limited in his mobility or his ability to ambulate, get around, correct, doctor?

A. Well, he does not ambulate independent. I don't want to quibble words. You know, severe means you can hardly walk at all. That's not him. He

is impaired in his ability to walk and he needs a cane to do it safely. He does it slowly and he can't do it with his former robustness or the way a normal person would.

Q. Okay. Doctor, can you read your impression, please, if you would?

A. Yes. Now, this is at the end of, of the examination. I say that flowing from an injury in which his body was partially crushed and his head injured, Mr. Deloach demonstrates signs of closed head injury with multiple cranial nerve defects as well as injury to his brainstem long tracts and cerebellar connections. He claims a cognitive defect in terms of memory and he is depressed.

Q. Doctor, you have discussed now a number of abnormal findings for Mr. Deloach. Doctor, are those abnormal findings which we have discussed here, each and every one of them, in your opinion, to a reasonable degree of medical probability, caused by the accident at UPS on August 21st, 1999?

A. Yes, they are to the extent that I've, I've described them.

Q. Okay. Doctor, are they permanent?

A. Yes.
Q. Mr. Deloach is not going to get any better at this point? He will learn to cope or perhaps compensate, but the injuries, the nerve damage themselves, doctor --
A. Well, coping and compensating are forms of getting better because it means doing better. Now, I don't think his physical findings are going to change. Will he always have the same degree of impairment with respect to that? I don't think that's the case either. But the findings themselves are permanent and the injuries to the tissues of his nervous system and its derivatives are also permanent.
Q. Now, doctor, your statement that he may not have the same degree of impairment, that relates once again to his ability to learn how to cope with the problems that he has, physiological and structural problems that he has and to compensate for them, correct?
A. In essence, yes.
Q. All right. Doctor, let me then turn to your second report and that is the report of October 14th, 2000. Doctor, there are a number of statements that you make regarding your analysis

and opinions, the first one being that Mr. Deloach was involved in a gruesome accident on August 21st, 1999 in which he incurred serious injuries to his head and brain.

Is that correct, doctor?

A. That's correct.

Q. Doctor, you also indicate that as a result of this accident David Deloach has experienced bilateral hearing loss, bilateral facial weakness, impairment of facial movement, eye closure, speech and swallowing, impairment of taste, positional vertigo, ocular impairment, urinary discontrol, limb weakness, bodily incoordination and easy fatigue. These deficits are permanent and unlikely to improve substantially, even with medical and rehabilitative treatment. They have heavily degraded the quality of his life.

Is that your statement and your opinion, doctor?

A. Yes, it is.

Q. Doctor, with respect to his inability to close his eyes, is that something that will indeed interfere with his sleep patterns?

A. No, it's not going to interfere with his sleep.

It may interfere with his vision and the protection of his cornea and vulnerability to ocular injury. It's not going to interfere with his sleep.

Q. Can you explain, doctor, the importance of one's ability to close one's eyes to the protection of the eye itself?

A. Well, lack of that closure allows, allows things to fall into the eye. When that happens an ordinary person will blink and wake up. Now, he retains sensation in his cornea so he will blink and wake up should that happen to him. However, his corneas can become dried, dried out, if you will, and that leads to vulnerability to other kinds of injuries, to infections, to tissue reactions that reflect the dryness. He has had some of that. Dr. Bardenstein's notes reflect that and he's on treatment to try to obviate that.

Q. Doctor, you indicate also as a further result of his sentinel injuries, David Deloach has experienced substantial but not severe cognitive impairment affecting mental alacrity and, to a lesser degree, memory. He is very substantially emotionally depressed. His cognitive deficits

are permanent and unlikely to be bettered by prolonged treatments. He requires psychiatric treatment for his derivative depression.

Is that your statement and your opinion, doctor?

A. Yes, it is.

Q. Doctor, with respect to his employability, doctor, and certainly, doctor, in the course of your profession you are called upon from time to time to determine the extent of a patient's employability, correct?

A. Yes.

Q. His impaired mobility, doctor, that is something that can from time to time be an obstacle to employment, correct?

A. I think it's safe to say that everything that we've described is wrong with him is to one degree or another a barrier to employability.

Q. And that would include, doctor, his depression as well, correct?

A. It would.

Q. Doctor, it is your opinion that Mr. Deloach is not employable, is that correct?

A. Yes. Now, if I may, that statement reflects what I know of those ordinary guidelines that govern

entities with which I'm familiar, some corporations, some companies, the military, the Social Security administration and so forth as those entities will lay out those things that are required to be employed at all.

Now, when he's compared in his current state of disability, and I distinguish disability from impairments or deficits, when those things are lined up against those parameters it is my opinion that he is not employable. Does this mean that such persons are never, never employed? Well, it does not mean that at all. The former head of the veteran's administration, formerly a senator from Georgia, was more disabled and very successful. Not that I would ever want this to happen to Mr. Gates, but I think if Bill Gates had the same degree of injury he'd find a way of going back and running Microsoft.

What I've reflected in this is my knowledge of what it generally takes to be employed vis-a-vis his disabilities and then looking at these guidelines relative to him. In that sense he is not employable. That's my opinion.

Q. Well, doctor, doctor, we can only look at things

in terms of probabilities here, of course, and the likelihood is that Mr. Deloach may perhaps not be quite as intelligent and capable as Mr. Gates. Knowing what he we know, doctor, it is your opinion that David Deloach will probably never be employed, correct?

A. That's what I've stated, yes.

Q. He's probably not employable and he is probably unable to maintain employment, correct?

A. Correct.

Q. Once again, doctor, on a permanent basis, correct?

A. Yes.

Q. Now, doctor, you indicate in your report that based upon his academic performance, which we can agree on was poor, you indicate that it is probable to you that Mr. Deloach would have had a successful career as a law enforcement offer, officer or a member of the military service. That was your opinion which you stated to Mr. Rasmussen in the letter, correct?

A. That's right.

Q. Okay. Now, you're aware that this was an individual, doctor, whose mother left him at age 16, he was able to go to school and work and care

for himself?
A. I can only speculate and actually conjure up and imagine what his life must have been like. He was on his own. I think he was 15. I remember him telling me that or been kind of living off on his own and going to school and working and so forth. I really don't know what his social circumstances have been or the contribution of whatever those circumstances might have been to things like his academic performance and after school history. I don't know. All I can suspect, and I think with, with great confidence, is that it was in many ways disruptive and impoverished.
Q. Doctor, from the circumstances it appears that Mr. Deloach was a somewhat motivated individual, was able to get by on his own, in spite of his mom's abandoning him, he worked and went to school, correct?
A. Well, I'll assume that, sure, yeah, fine.
Q. Doctor, there's no question in your mind that Mr. Deloach would have been able to obtain some employment and maintain that employment had this accident not occurred, is that right?
A. Oh, sure. He was already doing that. I have no

doubt that that's the case.
Q. All right. Let me just move on then, doctor. It's also your opinion that Mr. Deloach should never drive, is that correct?
A. That's correct.
Q. And why is that?
A. Well, he doesn't see well. His vision is blurred, double and jumps. His reflexes are impaired. He's weak and his head swims when he moves. So were he a patient of mine, which he is not, but I certainly care for people like him, my advice is not to drive a car or truck or van or anything else with four wheels on it that goes down the highway.
Q. All right. Let me move on then, doctor. Mr. Deloach is able to ambulate with the use of a cane at the moment, correct?
A. Yes.
Q. And in spite of the vertigo problems, the neurological problems in his lower extremities, his nystagmus, double vision, blurriness, he is able with the use of a cane to go from Point A to Point B, correct?
A. Well, provided Point A and Point B are not greatly distant, yes.

Q. Okay. One of the, one of the ways he's able to do that is he uses his strength and his muscles to assist in balancing and getting him around, correct?
A. We all do, yes. You're correct.
Q. As he ages, doctor, will his ability to compensate for the deficits which we discussed become somewhat reduced?
A. I don't think so. That's, I think that's speculative. Once, as I see him, the kinds of compensatory things he would need to do over time will just as probably sustain him. I don't see him falling apart because he walks slowly or uses a cane or on some birthday, at some time he's going to become, by virtue of what's wrong with him now completely and utterly disabled in the way that he won't retain the kind of independence that he has now. I don't think that I share that feeling.
Q. Okay. Doctor, certainly this is an individual who's going to require assistance in some of the day to day affairs of life, for example, transportation, correct?
A. Absolutely.
Q. All right. And maintaining a household, doctor,

and doing certain things around the household Mr. Deloach is an individual who is going to require daily assistance on a permanent basis to do some of those things, correct?

A. That's correct.

Q. All right. Doctor, you're not a certified life care planner, correct?

A. No. But I, you know, i clean the house, I do the wash and that kind of stuff. I think, you know, I have a good feeling for what you're talking about and I agree with you. He's going to need assistance to do a number of things in his own domicile.

MR. JACOBSON: All right. Let's go off the record for a moment.

VIDEOTAPE OPERATOR: Off the record.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

MR. JACOBSON: Back on the record.

VIDEOTAPE OPERATOR: We're back on the record.

Q. Doctor, have you had an opportunity to review the

life care plan of Dr. Wilhelm?
A. Yes.
Q. Okay. Dr. Wilhelm indicates that from ages 20 to 40 based on Dr. Mann's report that she believes that Mr. Deloach will require approximately six to eight hours a day of supportive care in terms of transportation or assistance in the home. Does that seem reasonable, doctor?
A. It doesn't seem unreasonable to me. I'm looking not over 9:00 to 5:00 but over 24 hours. You know, including things like doing the wash, getting things up the stairs, having somebody help get his shopping done, you know, it snows in Cleveland, that kind of business. So, yes.
Q. All right. Dr. Wilhelm indicates that from ages 41 to 65 that the amount of care will probably increase the necessity of supportive care, transportation, supervision, those sorts of things, to approximately ten to sixteen hours a day?
A. I don't see why that should occur.
Q. Will it increase as he ages, doctor?
A. Not necessarily. I don't know why it should. I'm assuming that, you know, the things that are going to come his way are those things that

befall all of us, are not products of this injury, and there may be reasons for that to happen to him. I just don't know. But I don't see him crossing the threshold of youth to middle age by increasing by a factor of two the amount of assistance he needs in the course of a day.

Q. Will it, will it increase by some factor?

A. I don't know. I don't see why it should increase beyond eight hours quite frankly. I do not.

Q. Doctor, what about when he reaches age 66, would it be reasonable for it to increase at that point?

A. By virtue of what's wrong with him now?

Q. Yes

A. Beyond eight hours a day?

Q. Yes.

A. No.

Q. Let me just go over some of the other particulars of the life care plan with you, doctor.

A. Can I turn to it?

Q. Please.

A. I've got a copy of it. Thank you.

Yes, please.

Q. Beginning with Page 26.

A. Yes.

Q. Dr. Wilhelm sets forth the frequency of treatment for Mr. Deloach by physiatrists, neuropsychiatrist, orthopedist, neurologist, ophthalmologist, neuropsychological evaluation, audiologist, ENT, physical therapy evaluations, speech therapy evaluation, occupational therapy evaluation. Do you disagree with any of that, doctor?

A. No. I went over all of these last night and I think they are all reasonable.

Q. All right. Also, doctor, the, the need for treatment with the psychologist, conditioning program, a case manager, reasonable, doctor?

A. Yes.

Q. All right. And that would be with respect to the frequency, doctor, the cost is something that you're probably not as familiar with as she is, is that a fair statement?

A. That's, that's also a fair statement. I think the kinds of people and the frequencies as I see them are not unreasonable.

Q. Okay. Let's move on to Page 28. You've already indicated that you don't feel a wheelchair is necessary for Mr. Deloach, is that correct?

A. A power wheelchair.

Q Okay
A. I don't think so.
Q All right A manual wheelchair would be something that would be helpful for him to have if he's going to travel long distances on occasion?
A Well, it's a matter of his convenience It may not even be a long distance He just may find it convenient to, you know, go to a restaurant or a movie theater or a shopping mall in a wheelchair rather than without one.
Q The rest of the costs on the page, doctor, and the, pardon me, the rest of the items and the frequency, reasonable, doctor?
A The tips for the cane He's a pretty mobile guy I'd get him a few more tips for his cane
Q Okay But everything else?
A Everything else is fine
Q Everything else other than what's related to the wheelchair you feel is reasonable, correct, doctor?
A. Right.
Q. Doctor, the next page, Page 2, with respect to the glasses and hearing aids, is that reasonable, doctor, with respect to frequency?

A. I don't believe his hearing is going to be improved by hearing aids.
Q. All right.
A. He's got nerve damage and ossicular damage. I'm not sure why he needs new glasses every year.
Q. Okay. So those items --
A. These are small things, Mr. Jacobson.
Q. All right. Doctor, let's --
A. The adaptive van on the list I already addressed.
Q. Doctor, let's turn to Page 31. The medications, doctor, do you feel those are reasonable?
A. Yes.

MR. JACOBSON: Let's go off the record for a moment.

VIDEOTAPE OPERATOR: Off the record.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

MR. JACOBSON: Back on the record.

VIDEOTAPE OPERATOR: We're back on the record.

Q. Doctor, on Page 33 of the life care plan?

A. Yes.
Q. Dr. Wilhelm indicates that she feels that it would assist Mr. Deloach in having some architectural changes to his place of residence. Do you feel that's reasonable as well, doctor?
A. Yes, I do.
Q. All right. Dr. Wilhelm also indicates that, on Page 31, that amongst the potential complications for Mr. Deloach are orthopedic injuries related to falls, neurological disorders, dementia, rheumatological disorders, arthritis, psychiatric disorders, neural behavioral disorders and increased audiological and visual problems. Do you agree with those, doctor?
A. Yes.
Q. All right.
A. The dementia I take an exception with. I think by itself his current cognitive difficulties will have some permanency but it should not be progressive. So if dementia here connotes a progressive decline then I would not agree with it.
Q. All right. Doctor, for the most part you agree with this life care plan part and parcel except for supportive care as he ages, is that a fair

statement?
A. Support care as he ages and the business about driving a van.
Q. Okay. Certainly, doctor, you feel that eight hours of supportive care on a daily basis for the rest of his life is reasonable, correct?
A. Yes. But I don't think it's going to be filled by somebody standing there for eight hours. I think they're, it's going to be a distributive kind of thing.
Q. I understand. Doctor, is there anything about these injuries that would alter Mr. Deloach's life expectancy?
A. No.
Q. And --

MR. JACOBSON: All right. I think I'm done, doctor. Just give me a moment. Can we go off the record, please.

VIDEOTAPE OPERATOR: Off the record.

- - - -

(Off the record.)

- - - -

Q. Doctor --

VIDEOTAPE OPERATOR: Back on the

record.

Q. You indicated, doctor, that the assistance that Mr. Deloach will need will be from time to time, it won't be one solid period of time, correct?

A. Correct.

Q. He will need to travel at different times, he will need meal preparation assistance from time to time, help with the laundry, heavy work around the house, those types of things, and you don't all do them at the same period of time?

A. That's right.

Q. All right. If it can be done -- well, strike that.

Doctor, would it then facilitate Mr. Deloach to have, or would it be reasonable for Mr. Deloach to have some sort of home health aid during the waking hours of the day rather than having somebody come on a piecemeal basis?

A. Well, I, you know, you cannot get people to do things on a piecemeal basis predictably. So, yes, it would, you know, it would be helpful to him have somebody there at a predictable time to get these things done.

Q. Okay. Helpful of course it would be. The question is, doctor, would it be reasonable for

Mr. Deloach --

A. Yes, it would.

Q. -- to have somebody during the waking hours of the day?

A. Yes. Because I think the heavy things that he can't do, for instance, are predictable and they could be done at predictable times by predictable people.

MR. JACOBSON: All right. Thanks so much, doctor. I have nothing further.

MR. RASMUSSEN: Doctor, no questions for you at this time.

MR. CLIMER: I have no questions.

MS. SAMMON: I have no questions

MR. JACOBSON: Can we get a waiver?

THE WITNESS: Do you want a waiver?

MR. JACOBSON: Yeah.

THE WITNESS: You got a waiver.

(Signature waived.)

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Kenneth F. Barberic, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named JOHN P. CONOMY, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of Oct A.D. 20 00.

Kenneth Barberic, Notary Public, State of Ohio
14237 Detroit Avenue, Cleveland, Ohio 44107
My commission expires October 18, 2003

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PRESIDENT

October 6, 2000

John V. Rasmussen, Esq.
Law Offices of Jan A. Saurman
14650 Detroit Ave. – Suite 450
Lakewood, OH 44107-4210

RE: *Independent Neurological Evaluation, David DeLoach*
DOI: 21 August 1999

Dear Mr. Rasmussen:

It was my pleasure today to meet and examine David DeLoach of Cleveland, Ohio. I saw him at your request for the evaluation of the effects of injuries he has received from involvement in an accident occurring in the course of his work on 21 August 1999. He was accompanied to the examination today by Vicki Leath, a representative of the firm of Nurenberg, Plevin, Heller & McCarthy who are Mr. DeLoach's representatives in this matter. Today's evaluation took place over a one hour period.

HISTORY

Mr. DeLoach is a native of Cleveland, Ohio. He is one of four siblings, all the others residing in Cincinnati, Ohio along with his mother at this time, He has a life long history of quite good health and has never been seriously injured or seriously ill 'he tells me in his entire life. At the time of his injury he resided with a friend and still is in residential arrangement based on friendship rather than kinship. He has completed eleven years of education and at the time of his injury was three days away from beginning his senior year of high school at South High School, Cleveland. He also attended Lincoln West High School where he excelled in athletics, being a tailback on a football team, a member of the basketball team and he enjoyed playing many other sports including baseball. He led a healthy, vigorous and active life.

He has been employed through his teenage years in a variety of summer and after school jobs. He has for instance worked as a food service attendant at Jacob's Field.

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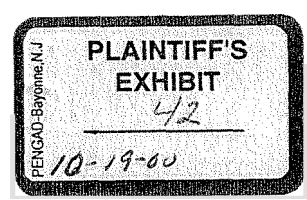

History continued...
He has done some factory work he tells me as well. At the time he was injured he was employed by the United Parcel Service- at a facility in Middleburg Heights, Ohio.

He was in the process of removing a lock from the back of a trailer on a UPS truck when he was hurt. A dolley was attached to the back of the trailer. As he proceeded about his work the truck moved. He was caught in the movement and pushed beneath the dolley which ran over him. He remembers this as "being sucked up like I was inside of a vacuum cleaner. He remembers the sensation of "drowning in *my* own blood." He attempted to stand up and actually made it to his feet but then fell to the ground again smashing the left side of his head against the ground, His memory thereafter far the next couple of days is spotty and foggy. He remembers EMS people transporting him to University Suburban Hospital. He was evaluated there and placed in the Intensive Care Unit for a period he believes to be about three days. He docs not recollect all of the events going on about him but does remember pain in his head, his left shoulder, both of his legs and that he had difficulty speaking, swallowing and moving his face, He was aware of numbness OR the left side of his face as well.

He was subsequently hospitalized for a period of about forty-two days at University Hospitals of Cleveland attended there by neurosurgeons, neurologists, ear, nose and throat specialist and trauma specialists. He does not recollect having any surgical therapy. He does remember however prolonged periods of physical, speech and occupational rehabilitation. Over that period of hospitalization the numbness in his face slightly receded but has not ever completely resolved. His legs were weak and he needed a cane in order to walk. He was discharged from the hospital to his current residence where he now lives in a semi-independent fashion.

As an effect of his injury he claims these things: He has a constant swimming feeling in his head and periods of dizziness particularly aggravated by movement, His vision *is* double and blurred from time to time. His sense of smell and his sense of taste have both been impaired. The left side *of* his face is largely numb and both sides of his face are weak, particularly on the left side. While his facial weakness has improved he still has difficulty chewing and food catches in his mouth and he must remove it with his fingers because his face and lips are weak. His speech is improved and is intelligible and is of a much better quality now than *the* time shortly after his injury. He has occasional difficulties with choking. His ears are "messed up." He has difficulty hearing in his right ear particularly and a constant buzzing or whizzing sound in that ear as well..

He has difficulty controlling his legs particularly his left foot. He has frequency and precipitancy of both urination and bowel control. I did not inquire into his sexual function. He walks with a cane because of imbalance.

In terms of functional *effects* of these injuries he lays aut the following picture: He can stand an his feet for a period of at least several minutes and walk about five hundred feet without assistance but does so slowly. At the end of that time he must rest for a few minutes in order to go on his way again-

History continued...

He has become largely homebound, largely out of a sense of embarrassment, When he attempts to eat, food falls from his mouth or he chokes. His face moves little and does *so* asymmetrically. His hobbled condition and his facial appearance cause him to be embarrassed and he simply stays at home. Me claims his short term memory is impaired and ha must struggle to remember the days events and even common things. His energy level is small and he must rest frequently. Because of *his* inability to blink his eyes he uses lubricant eye drops which tend to smear upon his face. *His* appetite is diminished and he has lost fifteen pounds in weight since his injury. He cannot participate in sports and again largely from embarrassment over his disfigurement avoids groups of unfamiliar people and does not eat in restaurants or go to the movie theater any longer. He is distressed by "prickly feelings" in both sides of his face particularly on the lower left side af his face. His neck is frequently stiff and "cracks when he moves it." He is troubled by headaches and has difficulty hearing stating that "the doctors tell me I have loose bones in my head." (I take it to mean he has suffered ossicular ear damage). His change *in* bowel and bladder habits necessitate being near toilet facilities less "an accident" happen.

He has not been able to return to school. He spends much of his time attending doctors appointments. He is cared for primarily by Dr. Donald Mann, Neurologist. He is on no medications at the time saw Lacril eyedrops.

All of this has taken an emotional toll as well, He has become relatively reclusive and saddened over his state being impaired as he is at a relatively young age, He does however remain hopeful about the future stating "I am only twenty years old and I could go on another sixty years,"

EXAMINATION

General examination shows a lithe young man. He has several tasteful and artistic tattoos over his left shoulder and the word "dirty" emblazoned over his right deltoid. His blood pressure is 120/80 in his left arm. The examination of his heart, lungs, abdomen and extremities are normal. He is thin and muscular.

A complete neurologic examination was done today including mental status, speech, spine, cranium, cranial nerves, motor, sensory, vascular, reflex, autonomic and cerebellar examinations. These are remarkable for the following: He gives a well-ordered, cohesive and chronologic history and does not appear to me to have a behavioral or cognitive defect.

Based upon his complaints however I cannot exclude some element of memory failure and suspect that if a defect does exist it will take formal neuropsychologic tests to demonstrate it. He appears to me moderately depressed. He is unable to detect the odor of cloves in his left nostril but does so in his right. His visual acuity with corrective lens is normal. He has a partial left sixth nerve palsy and he has very prominent and sustained shimmering nystagmus on conjugate gaze to the left and a slightly lesser degree of the same on conjugate gaze to the right. He has no upward or downward nystagmus.

Examination continued...

He has diminished sensation to all modalities in the second and third divisions of the left fifth cranial nerve and be has some mild masseter weakness on that side: as well. He has a facial diplegia of moderately severe degree and can close neither of his eyes, wrinkle his forehead, whistle or corrugate his lips. His platysma is bilaterally weak. He has diminished hearing bilaterally, particularly in his right ear. Speech is of good quality but articulation is impaired by weakness and laxity of his facial muscles. He has no defect in the movement of his tongue or pallet at the moment.

He is very atactic when *be* walks, and changes hposture produce prompt nystagmus on left *gaze* particularly, a sensation of "the world spinning around" and inability to walk for a period of about *thirty* seconds until he regains his bearings. His gait thereafter is wide-based and he is hardly capable of tandem walking. He has titubation of his *head* and his trunk as he sits, He has mild bilateral finger to nose and heel to shin ataxia.

His stretch reflexes are hyperactive everywhere including his jaw jerk which is of 3+ quality. His left plantar reaction is abnormal and inconsistently his left toe extends. He does have however considerable weakness of extension of all of his toes and to a lesser degree of his left foot. He has bilateral impairment of rapid alternating movement in his feet. He lacks clonus at this time.

Save for defective facial sensation he is able to perceive cutaneous sensibility everywhere on his body and position and vibration senses are intact.

He complains of difficulty in the use of his left arm and shoulder but formal examination is normal in terms of motility, strength and muscle bulk at this time.

IMPRESSION: Flowing from an injury in which his body was partially crushed and his head injured, Mr. DeLoach demonstrates signs of a closed head injury with multiple cranial nerve defects as well as injury to brain stem long tracts and cerebellar connections. He claims a cognitive defect interms of memory and he is depressed.

I will be pleased to review medical records sent in his behalf and I will be in further contact with you regarding him once that review is completed.

Yours truly,

John P. Conomy, M.D., J.D.
JPC/cf
DeLoach, David – IME.doc

CompEval
A system providing comprehensive evaluation of disabilities

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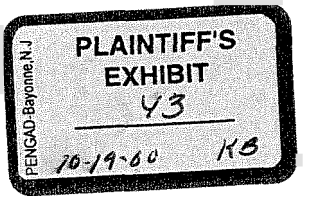
John P. Conomy, M.D., J.D.
PRESIDENT



John V. Rasrnussen, Esq.
Law Offices of Jan a. Saurman
14650 Detroit Avenue – Suite 450
Lakewood, Ohio 44107 – 4210

October 14, 2000

Re: David Deloach v. United Parcel Service, et al.
(David Deloach, DOI: *August* 24, 1999)

Dear Mr. Rasmussen,

I have been pleased to review medical records and associated documents sent to me regarding David Deloach and the injuries he suffered as result of an accident in which he was involved on August 21, 1999. These include the following:

- Police Report
- Records of Southwest General Health Center
- Records of University Hospitals of Cleveland
- Partial Records of Ohio Bureau of Workers Compensation
- Records and Reports of Dr. Donald Mann, Neurologist
- Records and Reports of Dr. David Bardenstein, Ophthalmologist
- Report of Dr. Barry Layton, Neuropsychoiogist
- Report of Cynthia Wilhelm, Life Care Planner (Written Portion)
- David Deloach's Academic Records, South High School
- David Deloach's Answers to Interrogatories

These documents contain inclusions, opinions, findings and recommendations made by persons other than those specifically cited in the tabulation. In addition I have reviewed my own Independent Neurological Evaluation of Mr. Deloach performed on October 6,2000 which has been sent to you. All of these sources taken together form the factual basis of opinions I offer you in this matter, all of them stated to a reasonable degree of medical certainty.

P. OBox 269 Chagrin Falls, Ohio 44022
☎(888) 929-8885 or (216) 621-6751 E-✉ 2BR02B@msn.com
FAX (216) 360 - 9329

CompEval Corporation
John P. Conomy, MD, JD

Analysis and Opinions

1. David Deloach was involved in a gruesome accident on August 21, 1999 in which he incurred serious injuries to his head and brain. This occurred in the course of his employment.

2. As a result of this accident, David Deloach has experienced bilateral hearing loss, bilateral facial weakness, impairment of facial movement, eye closure, speech and swallowing; impairment of taste; positional vertigo, ocular impairment, urinary dyscontrol, limb weakness, bodily incoordination and easy fatigue. These deficits are permanent and unlikely to improve substantially, even with medical and rehabilitative treatment. They have heavily degraded the quality of his life.

3. As a further result of his sentinel injuries, David Deloach has experienced substantial but not severe cognitive impairment affecting mental alacrity and to a lesser degree, memory, He is very substantially emotionally depressed. His cognitive deficits are permanent and unlikely to be bettered by prolonged treatment. He requires psychiatric treatment for his derivative depression.

4. While one may argue that David Deloach may one day be capable, with training, of sedentary employment, it is my opinion that this argument is not realistic. I do not believe he will ever be gainfully employed.

5. Based upon his academic performance, it seem very improbable to me that David Deloach would have a successful career as a law enforcement officer or a member of the military service.

6. I consider the life care plan reasonable based upon the portions I have read with these modifications:
    a. Mr. Deloach does not require a modified van. It is my opinion that Mr. Deloach should never drive. I say this without respect to trade-off costs of alternative means of transportation.
    b. Mr. Deloach does not require a mechanized wheelchair, and should not at the age of 55 years.
    c. Mr. Deloach is capable of living semi-independently now and into the future and does not require institutional care.

7. Mr. Deloach is indeed able to read. This is no small point, given the capacity of this gift to enhance the quality of his life.

If further medical material become available in this matter, I would be pleased to review them.

Yours truly,

John P. Conomy, MD, JD

File: rasmussen-deloach rpt cEv 14 oct 00 inspiron

LAWYER'S NOTES

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