you to put your uniform back on and head to so and so.

APPEALS OFFICER MORGANDO: I guess I'm a little confused because you're scheduled to work a particular -- from 2:30 in the afternoon to 12:30 in the morning.

THE CLAIMANT: Yes.

APPEALS OFFICER MORGANDO: So on a regular day you would leave at 12:30 in the morning, whether or not you were in uniform or not, and you're headed home.

THE CLAIMANT: Yes.

APPEALS OFFICER MORGANDO: You're not technically on your shift during that time period, are you?

THE CLAIMANT: If it's after 12:30?

APPEALS OFFICER MORGANDO: After 12:30.

THE CLAIMANT: I am not on my shift.

APPEALS OFFICER MORGANDO: Maybe I wasn't clear. Okay. But the night that you were headed home you were let go early.

THE CLAIMANT: I was still on my shift.

APPEALS OFFICER MORGANDO: And I think -- counsel, correct me. Did the accident occur at 12:25?

THE CLAIMANT: 22.

APPEALS OFFICER MORGANDO: 12:22?

THE CLAIMANT: I believe.

MR. SCHWARTZ: That's what the -- one of these documents said.

APPEALS OFFICER MORGANDO: I saw --

MR. SCHWARTZ: Via --

APPEALS OFFICER MORGANDO: -- military time.

MR. SCHWARTZ: Right. The C-1 form says the accident happened at 1513.

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: There was another one. The C-3 form says it happened at 1513. The C-4 form doesn't have a --

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: Oh, wait.

MR. MILLS: That can't -- that can't be right.

APPEALS OFFICER MORGANDO: I can't read it.

MR. MILLS: That's the afternoon.

MR. SCHWARTZ: Oh, the wrong one. My fault. Hold on.

APPEALS OFFICER MORGANDO: 1:30 p.m.

MR. SCHWARTZ: Hold on. I'm sorry. That's what happens when I look at somebody else's --

APPEALS OFFICER MORGANDO: Oh, no. That's the wrong injury. Hold on.

MR. SCHWARTZ: Right. Exactly.

APPEALS OFFICER MORGANDO: Because the one

that I saw, the C-3 for this incident, is at A-13.

MR. SCHWARTZ: Yeah, the C-4 form, which is on Page 12 of Exhibit 1, doesn't have a time. The C-3 form, which is on Page 13 of Exhibit 1, says 0025.

APPEALS OFFICER MORGANDO: Which would --

MR. SCHWARTZ: 12:25.

MR. MILLS: At 12:25.

APPEALS OFFICER MORGANDO: 12:25 a.m. Correct?

MR. SCHWARTZ: And the C-1 form, which is on Page 14, says 0025. Reported at 0028.

APPEALS OFFICER MORGANDO: Okay. All right. Sorry. I just wanted -- is anyone ordering a transcript? I didn't want to interrupt so much. I just wanted --

MR. SCHWARTZ: We had talked about -- we're not done yet, but we had talked earlier about doing briefs.

APPEALS OFFICER MORGANDO: Right.

MR. MILLS: Yeah.

MR. SCHWARTZ: If we're going to do briefs, then I will order a transcript.

MR. MILLS: So will I unless your Honor --

MR. SCHWARTZ: Excuse me. You don't need -- I mean, I'll order it. Because I'm assuming you want me

to submit it?

APPEALS OFFICER MORGANDO: Yes.

MR. SCHWARTZ: So I'll submit it as an evidence packet. There's a cost associated with it.

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: So we're okay paying for it. He doesn't have any money, "he" meaning Jason.

APPEALS OFFICER MORGANDO: All right. So are we finished with Mr. Figueroa?

MR. MILLS: Yes, your Honor.

APPEALS OFFICER MORGANDO: Okay. Sir, thank you very much. You may be seated.

THE CLAIMANT: Thank you.

APPEALS OFFICER MORGANDO: Mr. Mills, do you have any further witnesses?

MR. MILLS: No, your Honor. No, ma'am.

APPEALS OFFICER MORGANDO: Mr. Schwartz?

MR. SCHWARTZ: I'm going to call Jeff briefly.

APPEALS OFFICER MORGANDO: All right. Counsel, does anybody --

MR. SCHWARTZ: Do you care if he stays?

APPEALS OFFICER MORGANDO: Does anybody object if he stays at counsel table?

MR. MILLS: I don't.

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: Will you let us know if we're not talking loud enough into the microphone?

APPEALS OFFICER MORGANDO: And actually, it's close enough. You're sharing it. I think you should be fine. I will let you know though.

MR. SCHWARTZ: Okay.

APPEALS OFFICER MORGANDO: All right. Sir, raise your right hand.

Do you solemnly swear or affirm the testimony you're about to give in this matter shall be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

APPEALS OFFICER MORGANDO: State your name, please.

THE WITNESS: Jeff Roch, R-O-C-H.

APPEALS OFFICER MORGANDO: Okay. Thank you. Mr. Schwartz.

DIRECT EXAMINATION

BY MR. SCHWARTZ:

Q And, Mr. Roch, where do you currently work?

A I work for Las Vegas Metropolitan Police Department.

Q And how long have you worked at the Las Vegas Metropolitan Police Department?

A 20 years.

Q What's your current job title at the Las Vegas Metropolitan Police Department?

A I'm currently the director of risk management.

Q Okay. And is that primarily a desk job?

A Yes.

Q Prior to being the director of risk management what was your -- what other experience have you had at Las Vegas Metropolitan Police Department?

A Prior to this position I was assigned to the Traffic Bureau.

Q And what did you do at the Traffic Bureau?

A I was a motorcycle officer until I was involved in an accident.

Q And how long were you a motorcycle officer?

A One year.

Q And so you've been the director of risk management for 19 years?

A Actually, I was in risk management -- well, I was three years in patrol and traffic, two years in risk management before I became the director.

Q Okay. So you were a motorcycle officer and you were also a non-motorcycle officer?

A Yes.

Q Okay. Are you familiar with the -- as the

risk manager with the Las Vegas Metropolitan Police Department policies about letting officers go home early?

A Yes, more procedures than policies.

Q Okay. So wrong term. It should be procedures?

A Well, I'm not aware of a written policy on when an officer would leave, particularly in this case.

Q But you're aware of the procedures?

A Yes.

Q Okay. You've heard Mr. Figueroa testify that his sergeant called him in and said, "You can leave early."

Is that uncommon within the Las Vegas Metropolitan Police Department?

A No.

Q And why do supervising officers allow subordinate officers to leave early?

A Well, sometimes it will be that they came in early. Sometimes it will be that they stayed late within the previous couple of days. Sometimes it's a reward for a good case. It's commonly referred to as what we call EO or an early out.

Q Okay. And do they continue -- do the officers continue to get paid up until the time their shift

ends?

A Yes.

Q Are they subject to any -- I don't want to talk about recall yet because I'll get there in a second, but once they're let go, an EO, are they free to do whatever they want to do?

A Yes, within reason.

Q What's the reason? I mean, what's the within reason?

A It wouldn't be real wise to start drinking or have alcohol if you're still on the clock.

Q Okay. You've heard Officer Figueroa talk about potentially having to be called back --

A Yes.

Q -- when you get an EO. Is that correct according to the procedures?

A I'm not aware of it ever happening. Generally when we're talking about EO or a time frame, it is within the last hour of the shift. Sometimes it's been a couple of hours. I think I've been the benefit of that over the years.

But generally it's within that last hour where nothing much is going to happen. The shift is done, particularly near the end of the week on what we call a Friday, whatever day of the week that lands for folks,

but sometimes as a reward or if the other shift has come and taken over the calls for service and they were slow, sometimes the sergeant would be -- particularly in traffic what they would call it is the wave. Whenever the paperwork was done, all checked and turned in, you would get what they called the wave, and that would be anywhere from 12:15 to 12:30 to 12:45 depending on when your shift ended.

Q Okay. You've heard Officer Figueroa testify about a bag that he would pick up that would have his police radio, some other -- handcuffs and some other department items in it.

Are they -- are officers prohibited from taking department items home with them when their shift is over?

A No.

Q Are they allowed to take items home with them when their shift is over?

A Yes.

Q What about service weapons? Are they required to leave those at their place of employment or are they allowed to take those home?

A No requirement. They can take it wherever they want to take it.

Q Okay. To the best of your knowledge do

officers generally leave it in their lockers or do they take them home?

A I think it's a personal preference, but I think most officers transport it with them.

Q Okay. How about their badges? Is that something that they're allowed to take home with them or are they required to leave those wherever they're stationed?

A No. You're allowed to take them anywhere you want.

Q Okay. You've also heard Officer Figueroa testify about a duty to assist implicit in his oath.

Is there -- as the director of risk management is there something in policies or procedures for Las Vegas Metropolitan Police Department that an officer off duty -- we'll start there -- must assist if they see something happening?

A There's not a "must." The policy doesn't call for "must." It actually gives guidance. There is no mandatory carrying of a weapon off duty. However, if in the event something happened in front of you, the expectation is that you would be a good witness. You would call it in, and your obligation would stop at calling it in.

It becomes a personal preference whether you

wish to involve yourself in that, in which case you would identify yourself and take police action, but it really is dictated by the threat or the situation that's presented.

Q But what is required is that you be a good witness and that you call whatever's going on in?

A Yes.

Q And this is 24/7; correct? I mean, this is not during those 15 minutes or 20 minutes when you're let go early. This is as an officer this is a requirement?

A Correct.

Q We've talked a little bit with Officer Figueroa about being called back in even after his shift has ended.

What's -- I'm not sure what the right term is to ask you this, but is what Officer Figueroa said correct, that any officer can be called in at any point in time during any day? Is that a fair way of saying it?

A Well, I believe what he's referring to is A/B roster activation if we had a large scale event.

Q Okay. Can you say that slower?

A Yes.

Q So we can make sure we get the record.

A I'm sorry. We call that A, B, and C roster. And so officers are set up, and if we had a large scale activation for, say, a terrorist event or -- our last time that we did it was in June of 2014 when we had both of our officers killed.

We would move to a 12-hour shift, but they would take a rotation. So our on-duty officers would work to stabilize. Anybody that would be normally on call for their position would be called first. We would stabilize, and then over the course of a 12 to 24-hour period we would begin to activate the A, B, C roster which would put officers on mandatory seven days a week, 12-hour shifts on, 12-hour shifts off, and we would split -- it's all pre-planned. So we would split who would be on from 6:00 a.m. to 6:00 p.m. and then from 6:00 p.m. to 6:00 a.m. so that there would be coverage on both events.

Q And that's something that is put into place only in the event of certain catastrophic events?

A Yes.

Q So again, in Officer Figueroa's case, if his supervising officer just didn't have enough manpower, he doesn't have the ability to call Officer Figueroa on his day off and say come in or does he?

A Not -- well, on his day off there would be a

reason for why we would call him on his day off. I think the testimony on this one, what they narrowed it to was the last hour or 45 minutes of the shift that he would have been, and I think it would be fairly tough to bring folks back that were within that last 45 minutes of just completing their shift.

So I'm not aware of it happening. Can it happen? I'm sure anything could happen.

Q I guess my question is, if Officer Figueroa -- if this was Friday, meaning he's not working the next two days, is there anything within the policies or procedures that you're aware of that his supervising officer, just Officer Figueroa, not a catastrophic event, can call up Officer Figueroa on his day off and say, "I just want you to come into work today"?

A I'm not aware of that.

Q Okay. Officer Figueroa answered these questions, but just again, on behalf of the Las Vegas Metropolitan Police Department, do you provide any vehicles, personal vehicles? Do you have anything to do with personal vehicles for the officers traveling to and from work?

A No.

Q Do you provide any kind of stipend for their travel to and from work?

A No.

Q Do you provide them with gas money for their travel to and from work?

A No.

Q How about insurance for their cars?

A No.

Q Do you have a say -- and by "you" I mean the Las Vegas Metropolitan Police Department -- in what an officer like Officer Figueroa drives to or from work?

A No.

Q Can you mandate that he get a motorcycle because he drives a motorcycle for work?

A No.

Q There's nothing in your policies or procedures that allow you to do that?

A No.

MR. SCHWARTZ: Okay. I don't have any other questions, your Honor.

APPEALS OFFICER MORGANDO: Mr. Mills.

MR. MILLS: Yes.

CROSS-EXAMINATION

BY MR. MILLS:

Q So you said that usually when they're given time off it's an early out? Is that what you called

it, an EO?

A Yes.

Q And that's usually done for what reasons?

A It could be any number of reasons. We could be at the end of the week and everybody worked hard. It could be that somebody stayed over a shift or was early or it just could be a reward from the supervisor for a good case or hard work during the week.

Q So it could be for a number of reasons?

A Yes.

Q You heard him testify what the reason was that he was given an early out for this; correct?

A Yes.

Q And that was to get additional seat time because he was getting transferred back to motors?

A That's what I heard.

Q Would that make sense?

A I've never heard it quite like that where they say go get seat time, but if he represents that the sergeant said that, I don't know. I wasn't there.

Q That's not against company policy or Metro policy to do that?

A I don't -- it would be because I don't know why you would mix personal with work, but seat time on a personal bike is a whole lot different than seat time

on a Metro bike.

Q Yeah, that's not my question.

I'm asking you is it against company policy to allow someone to leave early out and instruct them to go get extra seat time?

APPEALS OFFICER MORGANDO: If you know.

THE WITNESS: I don't. I don't know if there's a policy on that or not.

BY MR. MILLS:

Q Okay. Is it accurate to say while he was still -- during his shift and his supervisor called him back, not whether or not it's normal, but if he would have done that, could he have refused him and said, "Absolutely not, I'm not coming back" and subject himself to no discipline?

A I don't know for certain, but I would venture to say that there would be an internal affairs investigation, and they would look at the totality of the event. And there would be a conclusion after Officer Figueroa was provided his rights and provided his statement.

Q Okay. That would be during his shift?

APPEALS OFFICER MORGANDO: I'm not understanding.

THE WITNESS: I don't understand the question.

MR. SCHWARTZ: I understand what he's saying.
BY MR. MILLS:
Q He had an early out that evening.
A Okay.
Q Right?
A Yes.
Q And he was paid till 12:30 because his shift was till 12:30.
A Yes.
Q So he was released early, whether it's a half hour or 45 minutes.
A Okay.
Q Right?
A Yes.
Q If his supervisor had called him back during that time period and he received that call, would he be able to tell him, "Absolutely not, I'm not coming back," and it would be in his discretion to do that and he would receive no discipline whatsoever?
A I don't think I could answer that because I think it depends on multiple factors.
Q And those factors would be?
A Would be -- well, in this particular case, the accident happened at 12:25. So had his supervisor called him at 12:25, would he have had a right to

refuse it? He was probably more than five minutes away from the station, and that would have put him towards the end.

So I think the answer is it would be based on a totality of circumstances, and that's why I think it would be appropriate for internal affairs to just do their investigation. I mean, it's a hypothetical. I can't say for certain that a supervisor would or would not discipline him in the time frame that we were talking.

Q But internal affairs would get involved?

A Yes. If they started a complaint, yes, they would.

Q And they would have the right to initiate a complaint if he refused during his shift hours?

A Yes.

Q Okay.

MR. MILLS: Nothing further, Judge.

REDIRECT EXAMINATION

BY MR. SCHWARTZ:

Q And just to follow up on that, you've already identified that there are times when officers who are not on duty as a group are required to come on duty; correct?

A Yes.

Q Like the unfortunate situation that happened in 2014?

A Yes.

Q If they called an officer when that happened and the officer said, "I'm not coming in," what would happen?

A There would be an internal affairs investigation.

Q So it doesn't really matter if they're on duty or off duty. If they're called in and they say no, someone is going to -- has the right to file or to initiate a complaint?

A Yes.

MR. SCHWARTZ: Do you want to jump in? I don't mind.

MR. MILLS: May I.

MR. SCHWARTZ: I mean, I'm not quite done, but if you have a question, let's just keep him on the same area.

BY MR. MILLS:

Q You had indicated that if he was off duty and the supervisor did call him, then he would have no duty to respond.

So why would an internal affairs investigation

begin?

MR. SCHWARTZ: Maybe you didn't understand my question. Maybe I can ask it better.

MR. MILLS: Okay.

MR. SCHWARTZ: I was asking in the situation that he had described with the two officer fatalities where they actually called in groups of people.

APPEALS OFFICER MORGANDO: With the A, B, C rosters.

MR. SCHWARTZ: Right.

MR. MILLS: I understand.

MR. SCHWARTZ: And I was asking if in that scenario where they're not on duty but they're called in because of some kind of tragedy or catastrophic event and they say -- and a specific officer says, "No, I'm not coming in," if that could or would lead to the same potential discipline.

APPEALS OFFICER MORGANDO: You know, and I mean no disrespect by this. I'm not sure we have the right witness for that. I don't know. I mean, in terms of internal investigations or something like that are there written policies regarding this or is it just generally known?

THE WITNESS: Regarding a return to --

APPEALS OFFICER MORGANDO: Right, the refusal

to come in, whether it's -- the refusal to come back or come in. I mean, I don't know if --

MR. SCHWARTZ: Do you want me to find out if there's a written policy? Is that what you're asking? I don't know the answer, your Honor.

APPEALS OFFICER MORGANDO: Okay. Yeah, but I mean, actually -- but, I mean, what if somebody is -- you know, they get the call on their personal phone. I don't know if that's normal but -- and they're in New York on vacation, and they say, "I'm in New York on vacation. I'm not coming back."

Does that result in an internal affairs investigation? I mean, I don't know.

MR. SCHWARTZ: I think there has to be a complaint by a supervising officer.

APPEALS OFFICER MORGANDO: Oh.

MR. SCHWARTZ: In order to do an internal affairs investigation.

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: It's not just some dispatcher called me and said come in, and I said I can't come in, and then you're suddenly subject to --

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: I think Mr. Roch has used the term "complaint."

APPEALS OFFICER MORGANDO: Got it. Okay.

MR. SCHWARTZ: I think there has to be a complaint.

APPEALS OFFICER MORGANDO: Okay.

MR. SCHWARTZ: But if you want more backup documentation, your Honor, I don't mind looking for it.

APPEALS OFFICER MORGANDO: No, I don't think -- that answers my question, actually, as to how the IA investigation starts. It has to be based on a complaint. Okay.

MR. SCHWARTZ: Did I --

MR. MILLS: Yeah, that's fine.

MR. SCHWARTZ: Is your question good now?

MR. MILLS: Yes.

MR. SCHWARTZ: Okay. I'm not being facetious.

MR. MILLS: No, no, no. I'm good.

BY MR. SCHWARTZ:

Q And I just have one other question because you said something in cross-examination that kind of puzzled me.

So Officer Figueroa's shift was scheduled to end at 12:30 a.m. according to the documents we have.

A Yes.

Q So that means he's done at 12:30 a.m.

Is that a fair statement?

A Fair.

Q This accident, according to the documents we have, happened somewhere around 12:25 a.m.

A Yes.

Q Are they -- I'm trying to figure out if he's more than five minutes away and he gets a call, it's going to take him more than five minutes to get back to the command which means he's now working overtime; correct?

A Yes.

Q Okay. So in order for them to call him back if he has -- if it takes him longer to get back and it goes beyond his shift, he's now being paid overtime?

A Yes.

Q Is that --

A Yes.

Q Okay. So if your shift ends at 12:30 and you have to work up until 12:35, you're getting five minutes of overtime?

A Well . . .

Q Assuming you've --

A Five minutes is probably not. That's where they would do an adjust or something along that line. They wouldn't pay you five minutes of overtime. I think the overtime goes in increments of 15 minutes.

So they would either say 15 minutes or no overtime or "I'll help you out down the road."

MR. SCHWARTZ: Okay. I don't have any other questions.

MR. MILLS: I have one other, Judge.

RECROSS-EXAMINATION

BY MR. MILLS:

Q You also indicated that you shouldn't -- until your paid shift ends you shouldn't drink. That wouldn't be reasonable.

Is that accurate to say?

A That's accurate.

Q So up until 12:30, even though he's out 45 minutes, he shouldn't be drinking alcohol?

A Well, I guess better said is if he's going to be armed, it is a misdemeanor to be intoxicated and be in possession of a firearm. So whether you're on your shift or off your shift, we've had some issues in the past where folks are intoxicated with their firearm. So if you're going to have your firearm, whether you're on duty or off duty, never a good idea to drink if you're going to have a firearm.

Q No, I -- without a firearm.

APPEALS OFFICER MORGANDO: There's no

question -- there's no issue of this officer having consumed anything.

THE WITNESS: No.

APPEALS OFFICER MORGANDO: This is more a question of protocol.

MR. SCHWARTZ: And just so we're clear for the record, your Honor, absolutely not. There's no allegation of --

APPEALS OFFICER MORGANDO: I don't -- I didn't see anything in the records.

MR. SCHWARTZ: No, and I don't think Mr. Mills is making that statement.

MR. MILLS: No. The Tighe case had drinking involved.

MR. SCHWARTZ: Right.

MR. MILLS: That's why I'm --

APPEALS OFFICER MORGANDO: Right, right, right. Okay.

MR. SCHWARTZ: I just want to make sure your Honor is clear for the record that there's no allegation on our side, and I'm assuming not on Mr. Mills' side either.

APPEALS OFFICER MORGANDO: That's where I thought you were going with this. So I just wanted to make sure I didn't miss something in the medical

records.

MR. MILLS: No, Judge.

APPEALS OFFICER MORGANDO: Okay.

MR. MILLS: No.

APPEALS OFFICER MORGANDO: All right.

BY MR. MILLS:

Q So again, when an officer's shift -- during his scheduled shift, he's expected not to drink during his scheduled hours of work?

A Yes.

Q Correct?

A Correct.

MR. MILLS: Okay. Nothing further.

MR. SCHWARTZ: I don't have any follow-up, your Honor.

APPEALS OFFICER MORGANDO: I don't have anything else.

All right, Mr. Roch. Thank you very much for your testimony.

THE WITNESS: Thank you.

APPEALS OFFICER MORGANDO: Mr. Schwartz?

MR. SCHWARTZ: I don't have any other witnesses, your Honor.

APPEALS OFFICER MORGANDO: Okay. We're running about two to three weeks, I think, right now on

transcripts, unless you know of anything differently.

MR. SCHWARTZ: That's if you're lucky.

APPEALS OFFICER MORGANDO: Okay. So if we're not lucky, we're thinking a month.

MR. SCHWARTZ: I was going to say, I was told yesterday that if I wanted a transcript expedited, because in a particular case I wanted it expedited, that it's five days for expedited. Because whoever the transcript service is that's being used is one woman. I mean, it could be one man. I don't mean to say because it's a woman, but it's one person, and apparently she has a lot of transcript orders so . . .

APPEALS OFFICER MORGANDO: News to me.

MR. SCHWARTZ: I was told this yesterday because I had the same question. I was a little fired up and wanted a transcript very quickly and was told --

APPEALS OFFICER MORGANDO: News to me. Okay.

MR. MILLS: That it's going to take a month?

MR. SCHWARTZ: It will probably take two to three weeks to get the transcript.

APPEALS OFFICER MORGANDO: Okay. I'm just trying to set your briefing schedule.

MR. SCHWARTZ: If we're -- I mean conservatively.

MR. MILLS: Okay. And I'm gone June 15th to

July 15th.

MR. SCHWARTZ: He's doing transcripts.

MR. MILLS: No, I'm just saying --

MR. SCHWARTZ: Just kidding.

APPEALS OFFICER MORGANDO: I'm thinking --

MR. MILLS: Yes. I'm going to get a second job.

APPEALS OFFICER MORGANDO: June 15. I don't know how to type so help me. June 15th you're -- it's going to be really difficult if we --

MR. SCHWARTZ: I don't mind -- I don't want Mr. Mills to have to either, A, worry about doing a brief while he's on vacation.

APPEALS OFFICER MORGANDO: On vacation? We're not that cruel.

MR. SCHWARTZ: Or B, kill himself the day before he leaves to get the brief done. So if it's okay with Mr. Mills, we can do it after he gets back.

APPEALS OFFICER MORGANDO: And when do you come back? I'm sorry.

MR. MILLS: The 15th of July.

APPEALS OFFICER MORGANDO: End of July?

MR. MILLS: 15th.

APPEALS OFFICER MORGANDO: No, no, no. I'm thinking aloud for when it would be due.

MR. MILLS: Oh, yeah, that's fine.

APPEALS OFFICER MORGANDO: Do you want simultaneous or do you want opening --

MR. MILLS: Yes. I'm fine with simultaneous.

MR. SCHWARTZ: Simultaneous is fine. If you want to do the end of July, that's fine.

MR. MILLS: I'm fine.

APPEALS OFFICER MORGANDO: First week of August. I'll pick a date in there.

MR. MILLS: Perfect.

APPEALS OFFICER MORGANDO: And I'll just issue a briefing order.

MR. SCHWARTZ: Okay.

MR. MILLS: Perfect. And, Dan, you're going to get the transcript and you'll file it?

MR. SCHWARTZ: I'll submit it as an exhibit.

MR. MILLS: And you're going to get me --

MR. SCHWARTZ: I'm going to get you Lisa's packet which just has two little marks on it.

MR. MILLS: Okay. Cool.

APPEALS OFFICER MORGANDO: All right. Counsel, thank you very much. The matter will stand submitted upon receipt of your briefs. I will issue my decision within 30 days. Thank you.

(Proceedings concluded at 3:12 p.m.)

CERTIFICATION

TITLE: DAVID FIGUEROA

DATE: May 10, 2017

LOCATION: Las Vegas, Nevada

The below signature certifies that the proceedings and evidence are contained fully and accurately in the tapes and notes as reported at the proceedings in the above referenced matter before the Department of Administration, Appeals Office.

Kelly Paulson — 05/16/2017

KELLY PAULSON — DATE

CERTIFIED COURT REPORTER #628

Signature Certificate

Document Reference: TEWEPMJTVKUXVLUKBZPBKF

RightSignature
Easy Online Document Signing

Kelly Paulson
Party ID: 34HH3SIDE2WFXZWEUTGVU8
IP Address: 68.7.171.222
VERIFIED EMAIL: keltypaulson@gmail.com

Kelly Paulson

Multi-Factor Digital Fingerprint Checksum: 76d50f68a84f7c9733485807142efcd0f88a27c4

Timestamp	Audit
2017-05-16 20:21:19 -07:0	All parties have signed document. Signed copies sent to: Kelly Paulson.
2017-05-16 20:21:17 -7:00	Document signed by Kelly Paulson (keltypaulson@gmail.com) with drawn signature. - 68.7.171.222
2017-05-16 20:20:11 -7:00	Document viewed by Kelly Paulson (keltypaulson@gmail.com). - 68.7.171.222
2017-05-16 20:20:11 -7:00	Document created by Kelly Paulson (keltypaulson@gmail.com). - 68.7.171.222

This signature page provides a record of the online activity executing this contract.

NEVADA DEPARTMENT OF ADMINISTRATION

FILED
JUL 25 2018
APPEALS OFFICE

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim of DAVID FIGUEROA 6831 HILLSTOP CREST CT. LAS VEGAS, NV 89131, Claimant.	Claim No.: 15D34E72969 Hearing No.: 1510632-TH Appeal No. : 1511793-MM Employer: LAS VEGAS METROPOLITAN POLICE DEPARTMENT 400B S MARTIN LUTHER KING #435 LAS VEGAS, NV 89106

DECISION AND ORDER

The above-captioned appeal came on for hearing before Appeals Officer MICHELLE L. MORGANDO, ESQ. The claimant, DAVID FIGUEROA (hereinafter referred to as "claimant"), was represented by JASON D. MILLS, ESQ. The Employer, LAS VEGAS METROPOLITAN POLICE DEPARTMENT (hereinafter referred to as "Employer"), was represented by DANIEL L. SCHWARTZ, ESQ., of LEWIS BRISBOIS BISGAARD & SMITH LLP.

On April 9, 2018, claimant was informed that his industrial insurance claim was denied. Claimant appealed that determination and the parties agreed to bypass the Hearing Officer and proceed before this Court. This hearing followed.

After carefully reviewing the evidence, hearing the testimony of the witness, and considering the arguments of counsel, the Appeals Officer finds and decides as follows:

FINDINGS OF FACT

1. The claimant has multiple prior industrial claims. Upon information and belief, the first of these claims has a date of injury of August 27, 2010.

2. The claimant had another industrial injury which occurred on March 15, 2011, when he was involved in a motor vehicle accident (hereinafter referred to as "MVA") at Las Vegas Blvd. and I-95 intersection where he incurred head, neck and back injuries. (Exhibit A at 1.)

3. Dr. Quaglieri performed a permanent partial disability (hereinafter referred to as "PPD") evaluation for that injury on September 6, 2012 and determined that the claimant had an eleven percent (11%) whole person impairment. Based upon this impairment rating, the claimant was notified on September 28, 2012 that his claim was being closed with an eleven percent (11%) PPD award. (Exhibit A at 2-3.)

4. The claimant filed another Form C-4 for his elbows, knees and arm. The alleged injuries occurred from a motorcycle accident the claimant was involved in on September 21, 2011. Dr. Quaglieri performed a PPD evaluation addendum for the injury on March 5, 2013. (Exhibit A at 4-9.)

5. The claimant filed another Form C-4 for his back on December 17, 2012. The claimant listed the date of injury as March 15, 2011 and was diagnosed with low back pain. (Exhibit A at 10.)

6. The Employer completed a Form C-3 on December 18, 2012 and indicated that the claimant had stated that he was bending over to pick up a flashlight and felt pain in his lower back. (Exhibit A at 11.)

7. In the instant matter, on March 7, 2015, according to the Form C-4 form, the claimant was "driving" and was in an "MVA." (Exhibit A at 12.)

8. The Employer completed its Form C-3 upon receiving the Form C-4. (Exhibit A at 13.)

9. An Injury Report was also completed on March 7, 2015. This report indicated the claimant was not in the normal course of his work or duties as a police officer at the time of the incident. (Exhibit A at 14.)

10. The claimant was notified on April 9, 2015, that his claim was being denied. (Exhibit A at 15-16.)

11. The claimant appealed the determination letter of April 9, 2015, regarding claim denial, to the Hearing Officer. (Exhibit A at 17.) This appeal was transferred directly to the Appeals Office. (Exhibit A at 18.)

12. This matter came on for hearing before the Appeals Officer on May 10, 2017. Claimant and Employer's Director of Risk Management, Jeff Roch (hereinafter "Mr. Roch"), gave testimony. Salient facts from this testimony will be discussed below. (Exhibit B at 151-226.)

13. Claimant provided eighty-one (81) pages of evidence which was reviewed and duly considered. (Exhibit 1.)

14. These Findings of Fact are based upon substantial evidence within the record.

15. Any Finding of Fact more appropriately deemed a Conclusion of Law shall be so deemed, and vice versa.

CONCLUSIONS OF LAW

1. It is the claimant, not the Employer, who has the burden of proving his case, and that is by a preponderance of all the evidence. State Indus. Ins. Sys. v. Hicks, 100 Nev. 567, 688 P.2d 324 (1984); Johnson v. State ex rel. Wyoming Worker's Comp. Div., 798 P.2d 323 (1990); Hagler v. Micron Technology, Inc., 118 Idaho 596, 798 P.2d 55 (1990).

2. In attempting to prove his case, the claimant has the burden of going beyond speculation and conjecture. That means that the claimant must establish the work connection of his injuries, the causal relationship between the work-related injury and his disability, the extent of his disability, and all facets of the claim by a preponderance of all of the evidence. To prevail, a claimant must present and prove more evidence than an amount which would make his case and his opponent's "evenly balanced." Maxwell v. SIIS, 109 Nev. 327, 849 P.2d 267 (1993); SIIS v. Khweiss, 108 Nev. 123, 825 P.2d 218 (1992); SIIS v. Kelly, 99 Nev. 774, 671 P.2d 29 (1983); 3, A. Larson, The Law of Workmen's Compensation, §80.33(a).

///

///

3. NRS 616A.010 makes it clear that:

> A claim for compensation filed pursuant to the provisions of this chapter or chapter 617 of NRS must be decided on its merits and not according to the principle of common law that requires statutes governing worker's compensation to be liberally construed because they are remedial in nature.

4. Under NRS 616C.150(1), the claimant has the burden of proof to show that the injury arose out of and in the course and scope of his employment. The claimant must satisfy this burden by a preponderance of the evidence. Further, NRS 616B.612 mandates that an employee is only entitled to compensation if he is injured in the course and scope of his employment. Here, the claimant was not in the course and scope of his employment when the alleged injury occurred while claimant was on his commute home while driving his personal motorcycle.

5. NRS 616A.030 defines an accident as "... an unexpected or unforeseen event happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury." Furthermore, NRS 616A.265 defines an injury as "... a sudden and tangible happening of a traumatic nature, producing an immediate or prompt result which is established by medical evidence ..."

6. The Nevada Supreme Court has held that:

> An award of compensation cannot be based solely upon possibilities and speculative testimony. A testifying physician must state to a degree of reasonable medical probability that the condition in question was caused by the industrial injury...

United Exposition Services Co. v. SIIS, 109 Nev. 421, 851 P.2d 423 (1993).

7. This holding has been affirmed and bolstered in the Horne v. SIIS, 113 Nev. 532, 936 P.2d 839 (1997) case, which held that "mere speculation and belief does not rise to the level of reasonable medical certainty."

8. Further, the Court has held that:

> An accident or injury is said to arise out of employment when there is a causal connection between the injury and the employee's work ... the injured party must establish a link between the workplace conditions and how those conditions caused the injury ... a claimant must demonstrate that the origin of the injury is related to some risk involved within the scope of employment.

Rio Suite Hotel v. Gorsky, 113 Nev. 600, 939 P.2d 1043(1997).

9. The same Court further stated that the "Nevada Industrial Insurance Act is not a mechanism which makes Employers absolutely liable for injuries suffered by employees who are on the job." (Id.).

10. Here, the claimant has not established that his injury arose out of and in the course and scope of his employment. The accident in question occurred while claimant was on his commute home while driving his personal motor cycle. (Transcript pp. 20:25-21:1) Claimant was wearing civilian clothes and although he was carrying service items such as his department issued radio, duty weapon, handcuffs, and badge (Transcript p. 20:20-24), Employer did not require that claimant have any of those items with him. Mr. Roch testified that claimant could have those items on his person if he wanted, but he was not required to have them. (Transcript pp. 54:9-55:10) Further, claimant testified that it was merely his own personal habit to take those items with him. (Transcript pp. 32:6-33:16)("My radio I have an option to leave it in my locker if so be.")

10. At the time of the incident, claimant was not performing his job as a police officer, was on his commute home, and was driving his own personal vehicle. Based on these facts alone this claim is not compensable. There is no "causal connection between the injury and the employee's work." Gorsky, Id. Indeed, this is a going and coming rule scenario.

> Nevada looks to whether the employee is in the employer's control in order to determine whether an employee is acting within the scope of employment when an accident occurs outside of the actual period of employment or off the employer's premises. Thus, we have embraced a 'going and coming' rule, precluding compensation for most employee injuries that occur during travel to or from work. This rule frees employers from liability for the dangers employees encounter in daily life.

MGM Mirage v. Cotton, 121 Nev. 396 (2005).

11. The going and coming rule provides that employers are not liable for injuries sustained by employees while commuting to and from work. Tighe v. Las Vegas Metropolitan Police Dept., 110 Nev. 632, 877 P.2d. 1032 (1994). However, there are exceptions to the rule recognized in

Nevada. In Evans v. Southwest Gas Corp., 108 Nev. 1002, 842 P.2d 719 (1992), the Nevada Supreme Court held that an employee may still be within the course and scope of his employment when the travel to or from work confers a distinct benefit upon the employer or the employer exercised significant control over the employee.

12. In Evans, the employee was provided a hand held radio and a radio in his van. The employee was allowed to take the van home in order to respond to emergencies. He would be notified of those emergencies via the radio or the hand held radio. The employee was required to take the van home to respond to emergencies.

13. A second case which is of particular import to the current matter is Tighe. In that case, the claimant, an undercover narcotics officer, was commuting home and was involved in a traffic accident. At the time of the accident, the officer was driving an unmarked undercover vehicle provided by the police department. The vehicle in question was equipped with a radio and the officer was carrying a beeper provided by the police department as he was "on call." The claimant's claim was denied under the going and coming rule. The Appeals Officer reversed and then the District Court reversed the Appeals Officer. The claimant appealed to the Supreme Court. The Supreme Court found the claim compensable and noted that two exceptions to the going and coming rule applied to this case.

14. The first exception is satisfied "when the travel to or from work confers a distinct benefit upon the employer." Id., 110 Nev. at 635, 877 P.2d at 1035 (citing Evans). The Court found it dispositive that the officer was driving a vehicle provided by the employer, was "on call" as evidenced by the beeper and radio, and that the employer benefited from having an officer out driving an undercover vehicle. Therefore the Court concluded that the officer in Tighe was providing a "distinct benefit" to the employer.

15. Second, the Tighe Court adopted the "law enforcement exception." The Court reasoned that "police officers are generally charged with a duty of law enforcement while traveling on public thoroughfares" and therefore injuries sustained on the commute "may be compensated." (Id.)(citing Hanstein v. City of Ft. Lauderdale, 569 So. 2d 493, 494 (Fla. Dist. Ct. App. 1990).

16. However, the Court made it clear that the law enforcement exception "is not sufficiently broad and all-inclusive to justify the conclusion that all law enforcement officers are *always* excluded from the general rule that injuries sustained while traveling to or from work do not arise out of and in the course of employment."(Emphasis in original)(Id.) The Court specifically concluded that Tighe satisfied the law enforcement exception because "Tighe was on call and driving a police vehicle equipped with a police radio, and he was prepared to respond to any public emergency he may have encountered."

17. The instant case is distinguishable from Tighe. To begin with, claimant was operating his own personal vehicle at the time of the incident while wearing civilian clothes. Claimant would have been indistinguishable from any other civilian motorcycle rider. The Employer received no benefit by claimant simply being on the road, unlike Tighe. Further, although he had a radio with him, he was not required to have it and only carried it out of his own personal habit. Therefore, the two things which the Tighe court found dispositive (i.e. an employer provided vehicle and a mandatory form of radio from the employer) are not present in this case. Claimant even testified that he is *never* required to use his personal motorcycle while he is on duty (Transcript p. 41:19-22) and only carries his radio out of personal habit. At the time of the accident, claimant was not providing any distinct benefit to his employer and was simply driving home just as any non-law enforcement employee would.

18. On March 7, 2015, claimant was employed as a traffic Police Officer by LVMPD. The claimant was assigned to the Bolden Area Command in a re-acclimation program due to injuries he suffered as a result of a prior industrial injury. The claimant was scheduled to work from 2:30p.m. to 12:30a.m. On that date, claimant was informed by his supervisor that the re-acclimation program was ending and that the claimant would be returned to his previous area command and resume his motorcycle traffic duties.

19. At approximately 11:45p.m. on May 7th, the claimant was given an "early out" by his sergeant. The claimant testified that this sergeant told him to leave early to get some "seat time" on the claimant's motorcycle. After changing his clothes, the claimant left on his personal motorcycle and was involved in an accident about two miles from the area command at approximately 12:25a.m. The claimant was still on the clock at the time of the accident.

20. Though Mr. Roch was not present for this alleged conversation between claimant and his sergeant, Mr. Roch questioned the same, stating that "I don't know why you would mix personal with work, but seat time on a personal bike is a whole lot different that seat time on a Metro bike." (Transcript pp. 60:23-61:1)

21. Furthermore, it should also be noted that claimant's co-worker, Tyler McMeans, was working the exact same shift as claimant, had been released at the exact same time, was also driving his personal motorcycle, and was traveling close enough to claimant at the time of the incident to both witness the incident and speak with the driver who caused the accident. (Transcript pp. 39:13-41:7) This draws claimant's testimony into question. Mr. McMeans was not released early from his shift because claimant was ordered to "get some seat time."

22. Employer does not doubt that claimant's sergeant said something to the effect that claimant should "get some seat time" referring to claimant riding his personal motorcycle on the day in question. There is no evidence to the contrary. However, in no way was claimant's commute

from work on the day in question any different than his commute on any other day. Nor is there any evidence that claimant's sergeant explicitly required him to "get some seat time" as a condition of his employment.

23. It was claimant's choice to have a personal motorcycle to commute to and from work. Claimant could have chosen to drive a sedan, a van, a truck, or literally any other type of vehicle that he wanted for his commute. The fact that claimant drives an employer provided motorcycle for work and also drives a different personal motorcycle for his commute is irrelevant to this case. Claimant's choice to drive his personal motorcycle to and from work does not confer any benefit upon Employer and does not extend the workplace to his commute where he is subject to "the dangers employees encounter in daily life." Cotton, Id.

24. It must also be noted that the fact that this accident happened while claimant was still technically "on the clock" does not somehow render this claim compensable. Indeed, it is a mainstay of the Nevada workers' compensation law that a claimant must establish more than the fact that they are getting paid at the time of an injury to make out a compensable claim: "an injured employee is not entitled to receive workers' compensation 'unless the employee . . . establishes by a preponderance of the evidence that the employee's injury arose out of and in the course of his employment.'" Mitchell v. Clark Cty. Sch. Dist., 121 Nev. 179, 181, 111 P.3d 1104, 1105 (2005)(citing NRS 616C.150(1))

25. Just as with the claimant in Mitchell, the fact that claimant was "on the clock," by itself, does not render this claim compensable. Claimant must establish a workplace connection to his injury. Here, as established above, there is no work place connection. Claimant was on his personal motorcycle in civilian clothes while commuting home and happened to be involved in a traffic accident. Claimant's employment did not contribute to his accident in any way.

26. Claimant testified that it was only his personal belief that he should intervene and he could not cite to any rule, regulation, or policy which mandated that he take police action while he was not then currently within the course and scope of his duties as an officer. (Transcript pp. 14:10-19).

27. Mr. Roch confirmed the same:

> Q: Is there -- as the director of risk management is there something in policies or procedures for Las Vegas Metropolitan Police Department that an officer off duty -- we'll start there -- must assist if they see something happening?
>
> A: There's not a "must." The policy doesn't call for "must." It actually gives guidance. There is no mandatory carrying of a weapon off duty. However, if in the event something happened in front of you, the expectation is that you would be a good witness. You would call it in, and your obligation would stop at calling it in.
>
> It becomes a personal preference whether you wish to involve yourself in that, in which case you would identify yourself and take police action, but it really is dictated by the threat or the situation that's presented.
>
> Q: But what is required is that you be a good witness and that you call whatever's going on in?
>
> A: Yes.
>
> Q: And this is 24/7; correct? I mean, this is not during those 15 minutes or 20 minutes when you're let go early. This is as an officer this is a requirement?
>
> A: Correct.
>
> (Transcript pp. 55:13-56:12)

28. Mr. Roch, in his twenty years of service, has never heard of someone getting called back after an "early out" (Transcript p. 53:12-53:8), the shear logistics of claimant getting called back are impossible. Claimant himself testified that he was ten minutes away from the operations center when his accident occurred and he only had five minutes left before his shift technically ended. Even if Employer had called claimant a minute before the accident happened and requested claimant to come back and finish his shift, it would be physically impossible for him to make it back in time.

29. Further, Mr. Roch testified that the only time claimant would be called in to work when he is off the clock is during a catastrophic scenario whenever the entire force is put on what he referred to as an "A, B, and C roster activation" whereby the officers would rotate on twelve hour shifts until the situation stabilized. (Transcript at pp. 56-58) Furthermore, Mr. Roch was entirely unaware of any other scenario which would allow claimant's supervising officer to simply "call him in" during claimant's scheduled time off. (Id.)

30. In summation, it is true that claimant's subject accident/injury occurred while claimant was still technically on the clock. However, simply being on the clock is not enough to render a claim compensable; there must be a workplace connection to the accident/injury. Claimant was simply commuting home on his personal motorcycle just as he would on any other day and just as any non-law enforcement employee would. He was not being paid for his commute time nor was he performing any employment related tasks at the time. There is no workplace connection and claimant was not conferring any benefit on his employer at the time of the incident. The claimant left in civilian clothes on his personal motorcycle. The claimant was not instructed to take a LVMPD motorcycle or to go get some "seat time" at a designated employer-owned location. There is no evidence that the claimant's commute when he left on May 7th was any different than any other time he left work to go home. One of claimant's co-workers Tyler McMeans, also was given an early out and left on his own personal motorcycle at the same time as the claimant.

31. Further, there is no "police" connection to claimant's accident/injury. Unlike the officer in Tighe, claimant was driving his own personal vehicle and had been released from service for the day. Though he was still technically "on the clock" at the time of the incident, it would have been impossible for claimant to be called back in prior to his shift's conclusion and the only reason claimant would be called in while he is off-duty is for a catastrophe such as a terrorist attack. Finally, the fact that he had his radio on him at the time of the incident is inconsequential as claimant made the

personal choice to carry it with him and was in no way required to have it while he was off duty. Claimant does not satisfy the law enforcement exception to the going and coming rule.

DECISION AND ORDER

The claimant, DAVID FIGUEROA, has failed to establish a compensable industrial claim.

IT IS HEREBY ORDERED that Administrator's April 9, 2015 determination to deny the claim is AFFIRMED.

IT IS SO ORDERED.

DATED this 25th day of July, 2018.

APPEALS OFFICER

MICHELLE L. MORGANDO, ESQ.

NOTICE: Pursuant to NRS 616C.370, should any party desire to appeal this final decision of the Appeals Officer, a Petition for Judicial Review must be filed with the District Court within thirty (30) days after service of this Order.

Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____
DANIEL L. SCHWARTZ, ESQ.
Nevada Bar No. 5125
2300 W. Sahara Avenue, Ste. 300, Box 28
Las Vegas, NV 89102
Attorneys for Employer

CERTIFICATE OF MAILING

The undersigned, an employee of the State of Nevada, Department of Administration, Hearings Division, does hereby certify that on the date shown below, a true and correct copy of the foregoing **DECISION AND ORDER** was duly mailed, postage prepaid **OR** placed in the appropriate addressee runner file at the Department of Administration, Hearings Division, 2200 S. Rancho Drive, #220, Las Vegas, Nevada, to the following:

DAVID FIGUEROA
6831 HILLSTOP CREST CT
LAS VEGAS NV 89131

JASON MILLS ESQ
JASON D MILLS & ASSOCIATES LTD
2200 S RANCHO DR STE 140
LAS VEGAS NV 89102

LVMPD - HEALTH DETAIL
ABIGAIL BUCKLER - HEALTH MGR
400 S MARTIN L KING BLVD STE B
LAS VEGAS NV 89106

DANIEL SCHWARTZ ESQ
LEWIS BRISBOIS BISGAARD & SMITH LLP
2300 W SAHARA AVE STE 300 BOX 28
LAS VEGAS NV 89102-4375

CCMSI
C/O JULIE VACCA
P O BOX 35350
LAS VEGAS NV 89133-5350

Dated this 25th day of July, 2018.

Zoe McGough

Zoe McGough, Legal Secretary II
Employee of the State of Nevada

Electronically Filed
4/30/2019 4:34 PM
Steven D. Grierson
CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA

DAVID FIGUEROA, Petitioner(s), vs. CANNON COCHRAN MANAGEMENT SERVICES, INC., LAS VEGAS METROPOLITAN POLICE DEPARTMENT and THE DEPARTMENT OF ADMINISTRATION, APPEALS OFFICE, an Agency of the State of Nevada, Respondent(s).	Case No.: A-18-779790-J Department 28

ORDER REVERSING THE APPEALS OFFICER'S DECISION AND ORDER

This matter was set for a hearing on April 23, 2019; however, the parties requested the hearing be continued and the Court set it for a decision in chambers on May 16, 2019. As this decision is made in chambers, the Court did not hear arguments on the matter. The Court, having reviewed and considered the briefs filed by the parties and the papers on file herein, including the record on appeal, hereby finds as follows:

FACTS & PROCEDURE

Since approximately November 5, 2006, David Figueroa ("Appellant" or "Petitioner") was employed as a traffic police officer with the Las Vegas Metropolitan Police Department ("LVMPD" or "Respondent"). LVMPD's workers' compensation administrator is Cannon Cochran Management Services, Inc. (collectively with LVMPD "Respondents"). On March 7, 2015, Appellant, riding his personal motorcycle, got into an accident shortly after leaving the Bolden Area Command where he was assigned. Prior to the crash, Appellant was a motorcycle officer, but due to an industrial accident he was

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

240

Case Number: A-18-779790-J

assigned to the re-acclimation program at Bolden Area Command. On or about March 7, 2015, Appellant's supervisor informed Appellant that he did not need to complete the 12-16 week re-acclimation program and Appellant was being returned to his regular working division and traffic duties effective his next shift or two. The reassignment to his old command would require Appellant to ride and operate a police motorcycle again. On the evening of March 7, 2015, Appellant was working a 2:30 p.m. to 12:30 a.m. shift at the re-acclimation unit. That night Appellant's supervisor instructed Appellant to leave at approximately 11:45 p.m. and to get some extra "seat time" on his motorcycle in preparation for his return to motorcycle duties. Appellant left, and at approximately 12:25 a.m., about 2 miles from Bolden Area Command, Appellant was involved in the aforementioned collision.

On March 7, 2015, the C-4 employee compensation form process was completed. On April 9, 2015 Appellant's claim was denied. Appellant appealed and on July 25, 2018, the Appeals Officer filed a Decision and Order affirming the insurer's claim denial.

On August 21, 2018 the Petitioner David Figueroa filed a Petition for Judicial Review, contesting an Appeals Officer's July 25, 2018 Decision and Order. On November 16, 2018, Petitioner filed his Opening Brief. On December 17, 2018, Respondents filed their Answering Brief. On January 16, 2019, Petitioner filed his Reply Brief and Petitioner's Request.

FINDINGS OF FACT AND CONCLUSIONS OF LAW AND ORDER

This Court conducts judicial review of a final agency decision under NRS 233B.135, which states as follows:

1. Judicial review of a final decision of an agency must be:

(a) Conducted by the court without a jury; and

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

241

(b) Confined to the record.

In cases concerning alleged irregularities in procedure before an agency that are not shown in the record, the court may receive evidence concerning the irregularities.

2. The final decision of the agency shall be deemed reasonable and lawful until reversed or set aside in whole or in part by the court. The burden of proof is on the party attacking or resisting the decision to show that the final decision is invalid pursuant to subsection 3.

3. The court shall not substitute its judgment for that of the agency as to the weight of evidence on a question of fact. The court may remand or affirm the final decision or set it aside in whole or in part if substantial rights of the petitioner have been prejudiced because the final decision of the agency is:

(a) In violation of constitutional or statutory provisions;

(b) In excess of the statutory authority of the agency;

(c) Made upon unlawful procedure;

(d) Affected by other error of law;

(e) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or

(f) Arbitrary or capricious or characterized by abuse of discretion.

4. As used in this section, "substantial evidence" means evidence which a reasonable mind might accept as adequate to support a conclusion.

Under NRS 616C.150(1), to receive compensation for an injury a claimant must show by a preponderance of the evidence that the injury arose out of and in the course and scope of his or her employment. "Nevada looks to whether the employee is in the employer's control in order to determine whether an employee is acting within the scope of employment when an accident occurs..." *MGM Mirage v. Cotton,* 121 Nev. 396 (2005).

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

242

Generally, "injuries sustained by an employee while going to his regular place of work are not deemed to arise of and in the course of his employment." *Tighe v. Las Vegas Metropolitan Police Dept.*, 110 Nev. 632, 635 (1994) (citing *Crank v. Nevada Indus. Comm'n*, 100 Nev. 80, 675 P.2d 413 (1984). The "going and coming" rule precludes compensation for most employee injuries that occur during travel to and from work. *MGM at 396.* However, there are three exceptions to the "going and coming" rule that apply here. The first exception is when "the travel to or from work confers a distinct benefit upon the employer." *Tighe at* 635 (citing *Evans v. Southwest Gas Corp.*, 108 Nev. 1002, 842 P.2d 719 (1992). The second exception is when the employer exercised significant control over the employee. *Id.* The third exception is the "law enforcement exception" adopted by the *Tighe* Court, which reasoned that because "police officers are generally charged with a duty of law enforcement while traveling on public thoroughfares" their injuries may be compensated. *Id.* at 636.

Here, the decision reached by the appeals officer is affected by error of law and clearly erroneous in view of the reliable, probative and substantial evidence on the whole record. The appeals officer significantly omitted in the Findings of Fact[1] that the Appellant was still on the clock at the time of the accident. This is an undisputed fact and integral to the legal error in deciding the law that applies to the case. This Court is well aware of its limitations in not deciding facts, but when a crucial fact, that is not contested is omitted from the Findings of Fact, the Court also needs to look to see whether the decision was also arbitrary and capricious and not supported by substantial evidence.

The second fact that was also left out of the Findings of Fact is that Respondent concedes the Appellant's superior requested that the Appellant get additional practice

[1] It was briefly mentioned in the Conclusions of Law.

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

riding a motorcycle, as he called it "seat time." The request was supposedly the reason why he was given an "early out," since he was going to return to motorcycle duty the next shift.

The appeals officer analyzed the *Evans* and *Tighe* cases in relation to this case. The appeals officer states, "The employer received no benefit from "claimant being on the road..." This is an incorrect statement of fact. There is no question the Appellant was on the clock at the time of the accident and, therefore, under the control of LVMPD unlike an off-duty officer returning home. Unlike the officer in *Tighe* who was just "on-call" on his drive home, here, it was not disputed that Appellant was still "on the clock" until 12:30 a.m. and carrying out the instruction to get more "seat time" on a motorcycle. Appellant could have been called back to some other duty or task prior to 12:30 a.m., however unlikely that may have been. LVMPD derived the benefit of Appellant obtaining additional "seat time" as instructed.

Finally, it is further undisputed that because Appellant was on the clock at the time of the accident, he was subject to all the rules and regulations of an officer and could be punished or even terminated for any violations. LVMPD exercised a level of control over and derived benefit from Appellant at the time of the accident. The above reasons are combined with the fact that Appellant had his radio and the general duty of law enforcement while traveling on public thoroughfares under *Tighe*.

Therefore, COURT ORDERED, the appeals officer's decision is REVERSED.

DATED this 30 day of April, 2019.

RONALD J. ISRAEL
DISTRICT JUDGE
DEPARTMENT 28

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

I hereby certify that on or about the date signed, a copy of this Order was electronically served per the attached Service Contacts list and/or placed in the attorney's folder maintained by the Clerk of the Court and/or transmitted via facsimile and/or mailed, postage prepaid, by United States mail to the proper parties as follows:

Jason D. Mills, Esq.
Via Facsimile: (702)822-4440
Not listed in E-Service per *N.E.F.C.R.9(b); E.D.C.R. 2.02*

Sandra Jeter, Judicial Executive Assistant
A-18-779790-J
ORDER

RONALD J. ISRAEL
DISTRICT JUDGE
DEPT XXVIII
LAS VEGAS, NV 89155

245

A-18-779790-J

DISTRICT COURT
CLARK COUNTY, NEVADA

Worker's Compensation Appeal	**COURT MINUTES**	**May 23, 2019**

A-18-779790-J David Figueroa, Petitioner(s)
vs.
Cannon Cochran Management Services, Inc., Respondent(s)

May 23, 2019 **Chambers** **Motion** **Respondents' Motion to Alter Judgment, to Amend Findings, and For Oral Argument; or in the Alternative Motion for Stay Pending Supreme Court Appeal and Motion for Order Shortening Time**

HEARD BY: Israel, Ronald J. **COURTROOM:** RJC Courtroom 15C

COURT CLERK: Kathy Thomas

PARTIES PRESENT: None

JOURNAL ENTRIES

- After reviewing the Motion and Opposition, the Order, the briefs, the record on appeal, and the other documents on file, the Court finds as follows:
Respondents' Motion to Alter Judgment, to Amend Findings, and for Oral Argument; Or in the Alternative Motion for Stay Pending Supreme Court Appeal and Motion for Order Shortening Time is DENIED.
First, the Court does not find oral arguments are warranted for this Motion. Second, a stay is not appropriate because Respondent has not demonstrated a reasonable likelihood of success on the merits for the reasons stated below.
This Court's decision was not a manifest error of law or fact, nor did it misapprehend the Appeals Officer's Decision and law governing this case.
Respondents reliance on the boilerplate "catch-all" phrase that "[a]ny Finding of Fact more appropriately deemed a Conclusion of Law shall be so deemed, and vice versa." is misplaced. The Appeals Officer's failure to include in the Findings of Fact that Appellant was told to leave early and "get some seat time" indicates the Appeals Officer did not find it as a material fact, regardless of the Appeals Officer's analysis in the Conclusions of Law. Additionally, this Court's decision stated the fact that Petitioner was on the clock was just one of several factors that supported the conclusion that

246

Petitioner's injuries arose out of and in the course of his employment. In addition to being on the clock, this Court's Order noted that at the time of the injury Petitioner was carrying out a supervisor's instruction to "get more seat time," that act conferred a benefit to Petitioner's employer, and "the above reasons are combined with the fact that Appellant had his radio and the general duty of law enforcement while traveling on public thorough fares under Tighe." This Court clearly considered multiple factors and understood that Tighe did not hold that law enforcement officers are always excluded from the travel-to-or-from rule. Likewise, this Court considered multiple factors beyond just petitioner being on the clock.

Based on the foregoing, the arguments raised in the briefs, and the documents on file Respondents' Motion is DENIED.

This Decision sets forth the Court's intended disposition on the subject but anticipates further Order of the Court to make such disposition effective as an Order. Such Order should set forth a synopsis of the supporting reasons proffered to the Court in briefing and argument.

Counsel for Petitioner to prepare the Order and submit to Chambers for consideration in accordance with EDCR 7.21. Said order then must be filed in accordance with EDCR 7.24.

CLERK'S NOTE: A copy of this minute order was e-served to counsel. kt 05/28/19.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONICOLL, CHRISTOPHER
Order Number: 6914224
Order Date: 03/11/2015

Interpreting Radiologist: HSU, FRANK
Dictated on: 03/11/2015 at 02:58
Signed and Finalized by: HSU, FRANK on 03/11/2015

Exam Charge Date: Mar 11 2015 2:58AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6914224

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 3/10/2015

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Cardiac and mediastinal silhouettes are unchanged from the previous examination. Endotracheal tube is at the level of the head of the clavicles . Nasogastric tube is visualized. Distal tip is not visualized on this study. . Right-sided central venous line catheter projects over the SVC. Diffuse ill-defined bilateral lung opacities are again noted without significant interval change.

IMPRESSION:

1. No significant interval change in the bilateral ill-defined lung opacities.

141

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: BCUN:1316-01
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MCNICOLL, CHRISTOPHER
Order Number: 6915572
Order Date: 03/13/2015

Interpreting Radiologist: MUIR, BENJAMIN
Dictated on: 03/13/2015 at 00:03
Signed and Finalized by: MUIR, BENJAMIN on 03/13/2015

Exam Charge Date: Mar 13 2015 12:03AM
PROCEDURE: RAD 0020 - CHEST PORTABLE -- 6915572

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 11/13/2015.

TECHNIQUE: Portable chest, 1 view AP.

IMPRESSION/FINDINGS:

Interval extubation and removal of enteric catheter compared to prior study. Right subclavian catheter, tip projects over SVC region.

Low lung volumes. Pulmonary vascular congestion. Improved aeration at left lung base compared to prior study.

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 11/13/2015.

TECHNIQUE: Portable chest, 1 view AP.

IMPRESSION/FINDINGS:

Interval extubation and removal of enteric catheter compared to prior study. Right subclavian catheter, tip projects over SVC region.

Low lung volumes. Pulmonary vascular congestion. Improved aeration at left lung base compared to prior study.

140

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6918391

Order Date: 03/16/2015

Interpreting Radiologist: HYER, KEVIN
Dictated on: 03/16/2015 at 12:48
Signed and Finalized by: HYER, KEVIN on 03/27/2015

Exam Charge Date: Mar 16 2015 12:48PM
PROCEDURE: SUG 3010 - OR ANKLE LIMITED (LEFT) -- 6918391

History: Left ankle fracture.

Findings: 7 spot images of the left tibia and fibula obtained in the OR demonstrates intraoperative ORIF surgery. Fluoroscopy time was 56.1 seconds. Please refer to the surgical note.

IMPRESSION: \

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: BCUN:1316-01
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6918392

Order Date: 03/16/2015

Interpreting Radiologist: TOPHAM, STEVEN
Dictated on: 03/16/2015 at 12:48
Signed and Finalized by: TOPHAM, STEVEN on 03/16/2015

Exam Charge Date: Mar 16 2015 12:48PM
PROCEDURE: SUG 0030 - OR ELBOW LIMITED (LEFT) -- 6918392

INTRAOPERATIVE FLUOROSCOPY: 3/16/2015 12:48 PM PDT

CLINICAL HISTORY: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 5 spot image(s) were submitted.

Fluoroscopy time: 8.6 seconds.

IMPRESSION:

Intraoperative fluoroscopy.

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

ADMITTED: 03/07/2015

TRANSFERRED: 03/20/2015

ADMISSION DIAGNOSES:
1. Status post motorcycle crash.
2. Multiple left-sided pelvic fractures with hip dislocation and femoral head fractures.
3. Left-sided comminuted tibia and fibular fracture with diastasis of the tibia-fibular joint near the knee, open fractures.
4. Significant loss of tissue and degloving injury to the anterior aspect of the left knee.
5. Left humerus fracture and olecranon fracture in conjunction with laceration of the left elbow.
6. Left 5th rib fracture.
7. Focal sigmoid fat stranding on CT scan.
8. Injury to the left popliteal artery at the level of the posterior knee dislocation.

DIAGNOSES AT TIME OF TRANSFER:
1. Status post motorcycle crash.
2. Left pelvic fractures including acetabulum, femoral head, inferior pubic, status post ORIF.
3. Left posterior knee dislocation with popliteal artery injury, status post vascular artery repair.
4. Left comminuted tib-fib fracture with proximal tib-fib diastasis with anterior tibial artery injury, status post ORIF on March 8th.
5. Left 5th rib fracture, stable.
6. Left humerus and olecranon fracture, open, status post ORIF on March 9th and revision on March 18th.
7. Degloving injury of the left knee with open fracture, status post reduction.
8. Sigmoid fat stranding with benign abdominal exam. No evidence of bowel injury.
9. Paresthesias of the left lower extremity, likely secondary to severe injury, stable.

DIAGNOSTIC STUDIES:
1. A CTA of the lower extremity, march 7, 2015, showing traumatic occlusion of the left popliteal artery with reconstitution detailed above, left anterior tibial artery traumatic occlusion.
2. A CT of the abdomen and pelvis with IV contrast, on March 7, 2015, showing transverse T-shaped left acetabular fracture, posterior left hip dislocation, mild left sacral iliac diastasis, mild sigmoid mesenteric fat stranding, may represent contusion. No discrete hematoma identified.
3. A CT of the cervical spine, without contrast, March 7, 2015: No cervical spine fracture or malalignment noted, mild degenerative disc disease at C2-3 through C6-7, moderate-to-severe left C3-4,

145

mild right C4-5, and mild right C5-6 neural foraminal stenosis.
4. CT of the chest, with contrast, March 7, 2015: Fracture noted in the left lateral 5th rib. Bilateral lower lobe atelectasis noted.
5. CT of the brain, without contrast, March 7, 2015: Unremarkable CT of the brain without contrast.
6. CT of the thoracic spine, March 7, 2015: No evidence of thoracic spine fracture or malalignment noted.
7. CT of the lumbar spine, March 7, 2015: No evidence of lumbar spine fracture. Postoperative changes at L5-S1 noted.
8. Left humerus x-ray, March 7, 2015: Humeral diaphyseal fracture and fracture in region of the elbow and ulna.
9. Pelvis x-ray, March 7, 2015: Fractures with malalignment on the left, with presumed associated hematoma.
10. X-ray of the left tib-fib, March 7, 2015: Comminuted distal tibial shaft fracture, comminuted distal fibular shaft fracture, lateral femorotibial compartment diastasis.
11. Portable chest x-ray, March 7, 2015: Minimally displaced left 5th rib fracture.
12. Femur x-ray, March 7, 2015: Left acetabular fracture, left hip dislocation, winding of the proximal tibiofibular articulation compatible with traumatic subluxation/dislocation.
13. Left foot x-ray, March 7, 2015: No definite fracture identified.
14. Left forearm x-ray, March 7, 2015: Mildly displaced proximal ulnar fracture.
15. Left hand x-ray, March 7, 2015: No evidence of acute osseous abnormality. Lucency projecting over proximal portion of the distal phalanx of the 1st digit as described.
16. CT pelvis reconstruction, March 7, 2015: Comminuted T-shaped left acetabular fracture with posterior hip dislocation.

HOSPITAL PROCEDURES:
1. Open left knee dislocation with femoral head fracture, left tib fracture with multiple comminuted distal left tib-fib fractures, reduction and splinting of left lower extremity with a long leg splint, March 7, 2015.
2. Reduction of left humerus fracture, application of splint, and placement of moist gauze over left elbow laceration, March 7, 2015.
3. Closed reduction left knee, external fixation application femur to tibia, open reduction and internal fixation of left fibula, preliminary external fixation open tib pilon fracture, irrigation and debridement, left leg primary closure, March 7, 2015, per Dr. Monroe.
4. Left popliteal artery repair with reverse saphenous vein interposition graft, open vein harvest from right lower extremity, March 7, 2015, per Dr. Quynh Feikes.
5. Close reduction IM rodding left humeral shaft, open reduction and internal fixation left olecranon fracture, March 9, 2015, per Dr. Michel Monroe.
6. Open reduction and internal fixation of left acetabular fracture, open reduction, internal fixation of left femoral head fracture, open reduction, internal fixation of left trochanteric fracture, March 8, 2015, per Dr. Gerald Mark Sylvain.
7. Open reduction and internal fixation of left tibial pilon fracture, external fixator removal from tibia and fibula, revision open reduction, internal fixation of left olecranon, hardware removal of left olecranon, March 16, 2015, per Dr. Michael Monroe.

HOSPITAL COURSE: Mr. Figueroa is a very pleasant, 44-year-old gentleman who was involved in a motorcycle crash. He was brought to our facility as a full activation. Upon arrival to our facility, it was noted that he had an extensive injury to his left upper and left lower extremity. He reported that another vehicle turned left and into him while he was traveling approximately 35 miles per hour on his motorcycle. He was thrown from his bike approximately 30 yards. He was found lying in a prone position at the scene. He did have loss of consciousness. He complained of left foot pain and significant pain to his left lower extremity. He was evaluated by the trauma team and had the above diagnostics completed. The patient was severely injured and had risk of losing his left lower extremity. He had vascular repair and extensive orthopedic repair, per orthopedic surgery and vascular surgery. The patient was admitted into our intensive care unit initally. After he stabilized, the patient was transferred to our floor service where he has remained stable. He has had surgery to remove his external fixators while on the floor service. We have had difficulty managing his pain. Therefore, we consulted our pharmacy team to assist with pain management. At this point, the patient is stable. He has been immobilized by Physical Therapy and Occupational Therapy. At this point, the patient is not independent with mobility due to the fact that he is not able to use his left upper and left lower extremities at this time. He was deemed a candidate for rehabilitation on March 13th and is pending a rehab bed. At this time, he is tolerating a regular diet. His pain is controlled on oral pain medication. When a rehab bed is available, the patient will be transferred with explicit orders that patient is not to have any rehabilitation in his left upper and left lower extremity as he is still pending further reconstructive surgery.

DISPOSITION: Transfer to rehab when bed available.

CONDITION: Stable.

ACTIVITY LIMITATIONS: Nonweightbearing left upper extremity and left lower extremity.

HOSPITAL MEDICATIONS:
1. Tylenol 650 milligrams oral q.6 hours p.r.n.
2. Lovenox 40 milligrams subcutaneously before bed for DVT prophylaxis.
3. MiraLAX powder 17 grams by mouth daily. While on narcotics.
4. Zofran 4 milligrams IV q.4 hours p.r.n. nausea.
5. Robaxin 1000 milligrams by mouth q.i.d. for muscle spasms.
6. Oxycodone 15 milligram tablets q.4 hours p.r.n. breakthrough pain.
7. Hydroxyzine 25 milligrams q.6 hours p.r.n.
8. Oxycodone 12-hour release 20 milligrams by mouth 3 times a day, scheduled and 40 milligrams before bed.
9. Gabapentin 200 milligrams by mouth t.i.d.
10. Nexium 20 milligrams by mouth before breakfast.
11. Aspirin 81 milligrams by mouth daily.

DIET: Regular as tolerated.

FOLLOWUP:
1. Patient is to follow up with Dr. Monroe in 2 weeks.
2. Patient is to follow up with Dr. Quynh Pelkes after discharge from rehab facility.
3. Patient is to follow up with trauma surgeon, Dr. Deborah Kuhls,

147

in 1-2 weeks after discharge from rehab facility.

4. Patient is to return to our emergency department if he has severe pain, fevers, chills, loss of sensation of his extremities or any concerns.

Transfer planning of this patient was discussed with attending rounding physician, Dr. Nichole Ingalls.

EC/MedQ
DD: 03/19/2015 10:00:57
DT: 03/19/2015 11:06:18

ESMERALDA CLARK, APN

NICHOLE INGALLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001905211
ADM DATE: 03/07/2015
JOB#: 759119/648132663
PHYSICIAN: NICHOLE INGALLS, MD
DICTATED BY: ESMERALDA CLARK, APN

TRANSFER SUMMARY

Edited by:
Esmeralda Clark, APN On 03/19/2015 02:13 PM PDT
Electronically Authenticated and Edited by:
Esmeralda Clark, APN On 03/20/2015 11:10 AM PDT
Electronically Authenticated by:
Nichole K Ingalls, MD On 03/24/2015 11:59 AM PDT

146

OneContent Generated By UMC\kpark Generated On: 03/30/2015 16:14

UMC

1TRHRCD

ACCT: 0029043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MR# 0001986211 ADM: 03/07/15

TRAUMA TELEMETRY RECORD

MRU01263 (07/31/14) Page 1 of 1

0040

1. DOES PATIENT MEET TRAUMA FIELD TRIAGE CRITERIA? ☐ Yes ☐ No 3. INTER-FACILITY TRANSFER? ☐ Yes ☐ No
2. CHOOSE ONE: ☐ Full ☐ Intermediate ☐ Burn Activation ☐ ED Eval 4. BEDSIDE ACTIVATION? ☐ Yes ☐ No

DATE: 3/7/15 TIME: 0941 ETA: 7
UNIT: 697

Arrived via:
☐ AMR ☐ MW ☐ LVFR ☐ HPD ☐ CCFD
☐ NLVFD ☐ Mercy Air ☐ Guardian Air
☐ Other:

AGE: 44 SEX: ☐ Male ☐ Female

PRE-HOSPITAL CARE

☐ C Spine ☐ Back Board
☐ O2 via: @ L/min
☐ IV:
☐ Medication(s):
☐ Other:

VITAL SIGNS

BP: 7 P: 122 R: 18 O2Sat: 100% GCS: 15

MECHANISM OF INJURY

☐ MVC - Versus: / mph
☐ Ext Damage > 18 inches PCI & Location:
Apparatus: ☐ Restrained ☐ Unrestrained ☐ Air Bag deployed ☐ Car Seat
Victim Location: ☐ Driver ☐ Passenger → ☐ Front ☐ Back
Impact Type: ☐ Rear-ended ☐ Rollover ☐ T-Boned (driver side) ☐ Front End ☐ Head On ☐ T-Boned (passenger side)
☐ AUTO vs. PEDESTRIAN - mph → ☐ at least 20 mph
☐ MOTORCYCLE ☐ ATV ☐ BICYCLE ☐ WATERCRAFT
☐ Versus: @ mph ☐ Operator ☐ Helmet
☐ FALL - Distance: On to: 3RD
☐ PENETRATING INJURY - ☐ GSW ☐ Stab Wound
☐ Other:
☐ ASSAULTED - With / By:
☐ AMPUTATION: ☐ CRUSH:
☐ INHALATION INJURY: ☐ BURN: %
☐ OTHER: LOC + -

CHIEF COMPLAINT

☐ Head ☐ Abdominal ☐ Neck ☐ Back ☐ Chest ☐ Extremities Lt leg ☐ Anticoagulants

BURN ACTIVATION CRITERIA

☐ Patient 15 years of age or older - 2nd DEGREE BURNS OR GREATER WITH AT LEAST 20% TBSA

FULL ACTIVATION CRITERIA

PHYSIOLOGICAL CRITERIA (Attributable to Trauma)

☐ Glasgow Coma Score is 12 or less
☐ Confirmed Systolic BP is 90 mmHg or less at any time in adults and age specific for children
☐ Respiratory Rate is < 10 or > 29 breaths/minute with respiratory compromise, obstruction and/or intubation
☐ Children < 12 years old with uncertain physiologic condition

ANATOMIC CRITERIA

☐ Flail Chest
☐ Penetrating injury to head, neck, chest, abdomen or pelvis
☐ Traumatic paralysis
☐ Obvious skull or pelvic fracture (due to blunt trauma)
☐ Amputated, crushed, de-gloved or mangled extremity proximal to wrist or ankle

RECEIVED
JUN 10 2015
CCMSI Las Vegas

INTERMEDIATE CRITERIA

☐ Ejection of patient from motor vehicle
☐ Passenger compartment intrusion (12 inches on patient side OR 18 inches any other area within the passenger compartment)
☐ Pedestrian or cyclist hit by vehicle traveling greater than 20 mph
☐ Fall of greater than 20 feet
☐ Fall of > 3 times a child's height (age < 14 years)
☐ Rollover, patient unrestrained
☐ Motor vehicle crash with death of same vehicle occupant
☐ Motorcycle or personal watercraft crash greater than 20 mph
☐ Combination trauma with burns greater than 10% or inhalation injuries
☐ Prolonged extrication (20 minutes or longer)
☐ Penetrating injuries to the extremities, proximal to the knee or elbow

Additional Information:

ER Physician Name: Dr Berkeley Physician / RN Signature:
☐ Conferred with Dr: regarding Activation Status

ORIGINAL: Chart COPY: Registrar

149

002932 001
002989

UMR Care Management
P.O. Box 8042
Wausau, WI 54402-8042

UMR
A UnitedHealthcare Company

March 13, 2015

002952

Umc Hospital
1800 West Charleston Blvd.
Las Vegas, NV 89106

Dear Umc Hospital,

Patient Name: David Figueroa
Admission/Start Date: 3/7/2015
Reference Number: 20150309-000393

We received a request to review inpatient services for you. This letter is notification regarding the review of clinical information necessary to determine if they are *medically necessary*, as defined in your plan document. Based on the information submitted, we have determined the following treatment is medically necessary.

3/7/2015 to 3/16/2015

The information in this letter does not guarantee payment or benefits.

Please note payment is based on the submitted claim, the actual health care services received, the medical guidelines and policies in place at the time of service and the member's plan of benefits when the services are received.

To confirm benefits, please call your customer service representative at the toll-free number listed on your member ID card.

If more treatment is necessary, another medical review will be required.

Sincerely,

Care Management
UMR

cc: David Figueroa
Deborah Kuhls

RECEIVED
JUN 10 2015
CCMSI ~ Las Vegas

150

ORIGINAL

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim, of DAVID FIGUEROA, Claimant.	Claim No.: 15D34E72969 Appeal No.: 1511793-MM

TRANSCRIPT OF PROCEEDINGS

BEFORE THE

HONORABLE MICHELLE L. MORGANDO

APPEALS OFFICER

Wednesday, May 10, 2017

2:04 p.m.

2200 South Rancho Drive, Suite 220

Las Vegas, Nevada 89102

Ordered by: Daniel L. Schwartz, Esq.
Lewis, Brisbois, Bisgaard & Smith
2300 W. Sahara Avenue, Suite 300, Box B
Las Vegas, Nevada 89102

A P P E A R A N C E S

On behalf of the Claimant:

Jason Mills, Esq.
Neeman & Mills Ltd.
1201 South Maryland Parkway
Las Vegas, Nevada 89104

On behalf of the Employer:

Daniel L. Schwartz, Esq.
Lewis, Brisbois, Bisgaard & Smith
2300 W. Sahara Avenue, Suite 300, Box B
Las Vegas, Nevada 89102

Also Present:

Jeff Roch

I N D E X

EXAMINATION	DIRECT	CROSS	REDIRECT	RECROSS
DAVID FIGUEROA	6	23	44	
JEFF ROCH	50	59	63	69

EXHIBITS	IDENTIFIED	IN EVIDENCE
CLAIMANT'S 1	4	5
CLAIMANT'S 2	5	5
EMPLOYER'S A	5	5

* * *

P R O C E E D I N G S

APPEALS OFFICER MORGANDO: Counsel, we're on the record. This is the time and place set in the matter of the contested industrial insurance claim of David Figueroa, Claim No. 15D34E72969, Appeal No. 1511793.

The Claimant is present and is represented by counsel Mr. Mills. The Employer, Las Vegas Metropolitan Police Department, is represented by counsel Mr. Schwartz.

Who's seated with you today at counsel table, please?

MR. SCHWARTZ: This is Jeff Roch, R-O-C-H, last name.

APPEALS OFFICER MORGANDO: Thank you.

MR. SCHWARTZ: From Las Vegas Metropolitan Police Department.

APPEALS OFFICER MORGANDO: Thank you. This is the Claimant's appeal and a stipulation to bypass regarding the Insurer's determination letter dated April 9, 2015.

All right. Mr. Mills, prior to going on the record you indicated you will be offering the evidence packets submitted by former counsel; is that correct?

MR. MILLS: Yes, Judge.

APPEALS OFFICER MORGANDO: All right. Mr. Schwartz, you don't have any objections, do you?

MR. SCHWARTZ: No, your Honor.

APPEALS OFFICER MORGANDO: All right. That will be marked and entered as Claimant's Exhibit 1.

I also received on behalf of the Claimant and filed by Mr. Mills' office a list of -- excuse me -- a list of exhibits filed November 2, 2016, containing 69 pages.

Have you received that?

MR. SCHWARTZ: I have, your Honor. No objection.

APPEALS OFFICER MORGANDO: Thank you. That will be marked and entered as Claimant's Exhibit 2.

Mr. Mills, I have an index of documents filed by the Employer on August 28, 2015, containing 150 pages.

Have you received that?

MR. MILLS: Let's see. I believe, yes.

APPEALS OFFICER MORGANDO: Any objections?

MR. MILLS: No, Judge.

APPEALS OFFICER MORGANDO: Thank you. And that will be marked and entered as Employer's Exhibit A.

Okay. You're Mr. Figueroa; correct?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Okay. Raise your right hand.

Do you solemnly swear or affirm the testimony you are about to give in this matter shall be the truth, the whole truth, and nothing but the truth?

THE CLAIMANT: I do.

APPEALS OFFICER MORGANDO: Thank you. State your name.

THE CLAIMANT: David Figueroa.

APPEALS OFFICER MORGANDO: Okay. Mr. Figueroa, I have a current mailing address of 6831 Hillstop Crest Court, Las Vegas, Nevada 89131; is that correct?

THE CLAIMANT: It is.

APPEALS OFFICER MORGANDO: Thank you. Mr. Mills.

MR. MILLS: Yes.

DIRECT EXAMINATION

BY MR. MILLS:

Q Mr. Figueroa, are you the Claimant in this action that's going today?

A I am.

Q Okay. Where are you currently employed?
A Las Vegas Metropolitan Police Department, Traffic Bureau.
Q And how long have you been employed in that capacity?
A Just over ten years.
Q And how long have you been with the force? The same?
A Same time frame.
Q So in the same division the entire time period?
A No, sir.
Q What were you -- where were you previously to that?
A I was -- previous to that I was Convention Center Area Command.
Q Okay. What are your current duties with Las Vegas Metropolitan Police Department?
A Traffic detail, fatal unit.
Q Do you -- what type of vehicle do you operate?
A I operate my personal vehicle to and from work.
Q Okay. I want to talk to you a little bit about your accident back in March of 2015.
Do you recall the date?

A I do.

Q What was it?

A March 15, 2015.

Q March 15th?

A March 7th. I'm sorry.

Q March 7th, 2015, what happened?

A I was headed home traveling on Camino Al Norte entering North Las Vegas traveling down the roadway in the left two travel lanes. Next thing I knew I was -- my body was flipping in the air. I landed on the ground and at that point realized I was in a traffic accident.

Q Okay. So on that date -- what were your job duties on that date prior to the accident earlier in your shift?

A I was assigned to a re-acclimation program with Bolden Area Command, swing shift patrol unit.

Q And why were you assigned to a re-acclimation unit?

A I was out for a prior surgery that I had, and policy was implemented that based on the number of -- the time that you were away from the job, you had to be put in a re-acclimation detail to get re-acclimated as a police officer.

Q So you had -- did you have a prior accident

prior to this one or --

A I did.

Q That caused you to have surgery or something?

A Correct.

Q Could you tell the Court?

A Yes. I had back surgery prior to that, and I was out some time.

Q On an industrial basis?

A It was.

Q Okay. Was that claim still open when this accident opened?

A Yes.

Q Okay. Did you receive a compensation award for that accident?

A I did.

Q Okay. What procedure was done for that prior accident, if you recall?

A A fusion of my lower lumbar, L5/S1 disc area.

Q Okay. Prior to you going to the re-acclimation unit, what was your job duty with Metro?

A I was assigned to Traffic Bureau. I rode a motorcycle, marked motorcycle, and performed traffic enforcement, traffic duties, traffic accident investigation.

Q Okay. Do you recall on March 7th, 2015, what

your assigned shift duty was, if there is such a thing?

A General patrol duties involving patrol-related calls, citizens that call 911, and enforcement, general enforcement that patrols are responsible for.

Q What hours were you slated to work that particular day, March 7, 2015?

A 2:30 to midnight 30.

Q So 2:30 in the afternoon until 12:30 a.m. the following day?

A Correct, swing shift.

Q Swing shift. Ten-hour shift?

A Correct.

Q Okay. Did you leave prior to the ending of your shift that evening?

A Yes.

Q Do you recall what time you left prior to the end of your scheduled shift?

A Approximate, 2345. 11:45 p.m.

Q And is there a reason that you left prior to the end of your shift?

A There is.

Q What is that reason?

A I was told by my supervisor that I was to be -- the re-acclimation program for me initially was to run an approximate 12 to 16 weeks, and that is based

on the time you are away. They have a time frame that you need to be re-acclimated.

I was advised by my supervisor that they didn't feel, him as well as the captain of the Bolden Area Command, that I needed to be there for that long of a time frame because I was well up to speed as to what the requirements are needed to be as a police officer. And so I was to be released early from that 12 to 16-week period, and I was to be reassigned back to my bureau which is the Traffic Bureau.

Q And did he let you go early that evening for any particular purpose?

A He did.

Q What was that purpose?

A He stated that he wanted me to get re-acclimated on my motorcycle because effective the next following shift or the shift after, I was to be -- to report back to my assignment which was at the Traffic Bureau.

Q So you were going to go back to the motorcycle division?

A Correct, and then there was a training that had to be done at the Traffic Bureau.

Q To get back on motorcycles?

A Correct.

Q Okay. I'm going to ask you about your duties now.

When you leave your shift early at your Employer's instruction are you still being paid?

A Yes.

Q Until when?

A Until midnight 30.

Q Until the end of your shift?

A Correct.

Q Even though he's released you is it within his power to call you back until the end of your shift?

A It is.

Q Do you have any authority to say no to that?

A No.

Q Did you have any police equipment on you during that ride on the motorcycle when you were leaving your --

A I did.

Q What was it?

A I had my duty weapon. I had my police department issued radio. I had my handcuffs and other miscellaneous items in my bag that I carry.

Q Was your badge with you as well?

A It was.

Q Are you allowed to consume alcohol while

you're on duty?

A No.

Q If you left work at 11:45 -- let's put it this way.

If you left work prior to 12:30, which the supervisor, you indicated, did that, you're not in the building anymore; correct?

A No.

Q But you're free to leave?

A Yes.

Q Would you be able prior to 12:30 to go to a bar and drink alcohol while you're on duty?

A Absolutely not.

Q Even though you've been released?

A Correct.

Q Would you be allowed to do it after 12:30?

A Yes.

Q After your shift ends, after 12:30, is there an ability for Metro to call you back to work?

A There is.

Q During the time frame that you're not scheduled to work?

A There is.

Q In what scenarios would that happen?

A God forbid, terrorist activities, any extreme

volatile situation that requires immediate police presence and staffing is limited to handle that situation, they will contact and kind of a mandatory type of police presence.

Q Okay. If you're off duty and you receive one of these summons and you receive it, not a question of whether you did or didn't receive it, do you have any discretion to refuse that callback?

A No.

Q What about on your journey home and you encounter a severe traffic accident where it's obvious there's problems, people in distress, requires emergency care, requires police? Do you have any duty to do anything as a police officer?

A I do.

Q Even if you're signed out from work?

A I do. It's the oath that I took when I took this job, the responsibility I have to my community, of course my morality. I have a duty to intervene.

Q What about the -- do you have a call sign, for lack of a better term, when you're working as opposed to when you're not working that you use on the radios?

A A call sign when I'm working? I do not have a call sign when I'm not working, but I do have a designated verbiage, if you will, off duty to identify

myself to dispatch of who I am and what's taking place.

Q So there's a difference when you're on duty. You have one particular call sign, so to speak?

A That is correct.

Q And then off duty it's something else and what is that?

A It's a -- you provide the letter 'U' in front of your 'P' number. The 'U' indicates to the call taker that you are off duty, and your 'P' number identifies who you are, and they know that the call is being generated by off-duty police officer so and so.

Q And 'P' number, is that your badge number?

A That is. Personnel number --

Q Personnel number?

A -- is what it stands for.

Q What it stands for. And when you're on duty you're assigned a different call -- or you have a call sign when you're on duty?

A You do.

Q Where do you get that?

A It's generated by the area of assignment, the shift that you work, and so each area of assignment, each shift, has a designated call sign that is recognized department-wide.

Q So in a scenario where you're released from

the building prior to your shift ending but you're still on the clock, had you encountered any incident on the public roads or out there while it was still during your shift time, would you call in to dispatch?

A Absolutely.

Q What call sign, again, for lack of a better term, would you use if it's before your shift ends?

A Before my shift ended I would utilize the call sign, on-duty call sign, and state the situation or emergency that's taking place.

Q Would the dispatcher be able to know that you were within your on-duty time but you were released but you're not off duty yet?

A She would run the call sign and see that I was logged on as Officer David Figueroa, and she would be able to identify me as such.

Q Okay. And that would be true right until your shift ends till 12:30?

A I would say she has the ability to do it afterwards.

Q Okay.

A You know, for research purposes months later, days later, but yes.

Q With regard to this particular accident, do you have a recollection what happened in the accident?

A The only recollection I have is, as I stated earlier, I was flipping in the air. I was trying to process what just happened. I hit the ground. I feel tremendous pain. I'm conscious the whole time.

I land on my stomach with my arms bracing my fall, and I was able to look to the left and see that the motorcycle was on fire. And at that time I realized that I was involved in an accident.

I also had another police officer who was assigned to the squad that I was re-acclimating on, he was behind me. And so he and I had a discussion, and he explained what happened because he was behind me and he observed the accident.

Q Were you transported to the hospital?

A UMC Trauma, yes.

Q And were you hospitalized? Did they check you in?

A They checked me in, yes.

Q And were you there -- how long were you there?

A I was placed in a medically induced coma for six days. When I was brought out of the medically induced coma, I had no idea where I was at, what was going on. And I had family from back East, my brother was standing above me, and he explained to me what was going on.

Q How long were you in the hospital, if you recall?

A 47 days. Between UMC Trauma, Summerlin Hospital, a total of 47 days.

Q Were you released after Summerlin Hospital to any type of home -- or any type of health care place other than the two hospitals?

A UCLA Medical Center.

Q Okay. How long were you there?

A I was there as an outpatient until surgery was done. So I didn't stay -- I didn't leave Summerlin Hospital to UMC -- or UCLA Medical Center for a stay. I was released to home, and then we made our way down to UCLA Medical Center, the family and I.

Q To perform --

A For corrective surgery that was needed.

Q And the records, I'm sure, speak for themselves, but what is your recollection to the injuries that you sustained in this accident?

A I broke everything from my left shoulder, femur, elbow, ribs -- this is all left side -- hips, pelvis, thigh, tib-fib, tibia-fibula. Sorry. And so pretty much from the ankle up to the shoulder and everything in between was broken.

Q Were you out of work for some period of time

following the March 7, 2015, accident?

A Yes, sir.

Q From when to when, if you remember?

A Approximate year and a half-ish. Maybe a little shorter. Then I was able to be assigned to a modified duty position.

Q And what was that position?

A The position was at the Traffic Bureau front desk office.

Q Do you recall when you went back to work?

A The modified duty?

Q Yeah, when you went back to work after this accident.

A Date, I do not.

Q Do you recall the month?

APPEALS OFFICER MORGANDO: Mr. Mills, if I order the claim to be accepted, it's going to be remanded for a new determination on --

MR. MILLS: I understand, Judge.

APPEALS OFFICER MORGANDO: -- on retro benefits so . . .

MR. MILLS: Understood, Judge.

APPEALS OFFICER MORGANDO: I mean, it's my understanding in listening to this and looking at it, this is really a course and scope.

MR. MILLS: Going and coming, yes, Judge.

APPEALS OFFICER MORGANDO: Right.

MR. MILLS: Yes, Judge. I'll move along.

APPEALS OFFICER MORGANDO: Okay.

MR. MILLS: I get it.

APPEALS OFFICER MORGANDO: All right. And I just want to clarify one or two things, and I don't know if Mr. Schwartz was going to or not. I'm a little confused.

You were let go early by your supervisor who basically said you've acclimated enough in the patrol unit?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Correct?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Okay. Were you driving a motorcycle at that time or were you in a patrol car?

THE CLAIMANT: I was in a patrol car.

APPEALS OFFICER MORGANDO: Okay.

THE CLAIMANT: But I was -- I'm sorry.

APPEALS OFFICER MORGANDO: No. When he told you to -- did he tell you to go home when you left on the 7th?

THE CLAIMANT: No. I was commuting from -- to

and from the area command on my personal motorcycle.

APPEALS OFFICER MORGANDO: Okay. But when you -- when you were in the accident you were leaving where and intending to go where?

THE CLAIMANT: Intending to go home.

APPEALS OFFICER MORGANDO: You were intending to go home. Okay. And that was your personal motorcycle. You intended to start back up with your re-acclimation with your regular unit the next day or so?

THE CLAIMANT: Right. He stated that he wanted me to re-acclimate on the motor- -- on my personal motorcycle because -- which was news to me because my intention was that I was going to stay longer. He released me because he advised me that I will be reassigned back to my bureau of traffic.

APPEALS OFFICER MORGANDO: So he wanted you to finish your shift on your regular motorcycle? I guess I'm just --

THE CLAIMANT: No.

APPEALS OFFICER MORGANDO: -- a little confused.

THE CLAIMANT: No. So he released me early.

APPEALS OFFICER MORGANDO: Okay.

THE CLAIMANT: He said, "Go get some practice

time on your motorcycle because effective" -- I don't recall if it was the next shift or the following shift -- "but you will be sent back to traffic because there's no reason you should be here to re-acclimate because" --

APPEALS OFFICER MORGANDO: Okay. So you were just told to go practice?

THE CLAIMANT: Correct.

APPEALS OFFICER MORGANDO: On your personal motorcycle?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Is it the same type of motorcycle that you ride?

THE CLAIMANT: Very similar.

APPEALS OFFICER MORGANDO: Okay. And so you were only going to practice until your shift ended or you just were practicing on your way home?

THE CLAIMANT: Well, practicing on my way home, and I live quite a ways away.

APPEALS OFFICER MORGANDO: Okay. Sorry, Mr. Schwartz.

MR. SCHWARTZ: That's okay.

APPEALS OFFICER MORGANDO: I just was a little confused about what he was riding and where he was going. Thank you.

MR. MILLS: Yes. Let me see if I have any other questions.

BY MR. MILLS:

Q Even though you were released to go home, you were still on the clock though. They were still paying you?

A I was.

Q And when you're on the clock, your duties are different than when you're not on the clock regardless of whether you're released or not?

A Well, we're told that, "Hey, you're still on the clock, and if we need you, have your phone close." And I have my department issued radio with me for those purposes as well.

Q And had the same supervisor that released you called you back prior to 12:30 would you have discretion to say no?

A No.

MR. MILLS: Okay. Nothing further, Judge.

APPEALS OFFICER MORGANDO: Thank you. Mr. Schwartz.

CROSS-EXAMINATION

BY MR. SCHWARTZ:

Q Had the same supervisor called you at 2:30 in

the morning that morning and said, "The aliens have invaded" -- and I'm being overly dramatic.

A I understand.

Q "We need you to come back," could you say no?

A I'd like to say no. I would be obligated to say yes.

Q Okay. I want to go back to the beginning just to ask a couple questions to clarify a few things that maybe I just made bad notes on, but when Mr. Mills was first asking you about vehicles, you said something about operating a personal vehicle.

So I'm clear -- and I only want to ask you questions about March 7, '15, and backwards. Is that okay?

A Sure.

Q So I don't -- today you could be -- I mean, you're working today; correct?

A I am.

Q And are you driving a vehicle?

A Yes.

Q Is it a sedan or a motorcycle?

A It's a sedan. Well, a jeep.

Q Okay. So it's yours?

A It is.

Q And are you actually working as a police

officer right now?

A I am, modified duty.

Q Okay. Are they allowing you to use your vehicle as part of your job when you're out patrolling or you're not patrolling yet?

A No, I'm not patrolling.

Q Okay.

A In the office.

Q Back in March of 2015 during the period of time after you came back from your prior industrial surgery, you were working where? What's the name of the command you were at?

A I was at the Traffic Bureau.

Q Okay. And then after you came back they sent you somewhere else; correct?

A I was advised that you have to report to Bolden Area Command for this re-acclimation program.

Q Okay. Can you say that just slow enough so we get it in the record?

Which command did you go to?

A Traffic Bureau.

Q And then where did they send you?

A Bolden Area Command.

APPEALS OFFICER MORGANDO: Would you spell -- for the record, spell it, please.

THE CLAIMANT: Okay. B-O-L-D-E-N.

APPEALS OFFICER MORGANDO: Thank you.

BY MR. SCHWARTZ:

Q And where is Bolden Area Command located?

A It's on the south side of the valley, just off of Martin Luther King.

Q Okay. How long were you at the Bolden Area Command prior to your injury, the injury we're discussing today in March of 2015?

A Four weeks-ish.

Q Okay. And during that period of time did you report to the Bolden Area Command to begin your shift?

A Yes.

Q And then at the end of your shift you were let go from the Bolden Area Command location; correct?

A Correct.

Q You didn't go back to the Traffic Bureau during those four weeks?

A In the capacity of what? I did go back to the Traffic Bureau.

Q Probably a poor question. Let me ask it again.

You would start your day during those four weeks leading up to your injury at the Bolden Area Command?

A Yes.

Q And then you would go elsewhere during the course of your shift?

A Correct.

Q And then your day would end at the Bolden Area Command?

A Correct.

Q Okay.

APPEALS OFFICER MORGANDO: But you were doing patrol?

THE CLAIMANT: I was doing patrol work, yes.

APPEALS OFFICER MORGANDO: Okay.

THE CLAIMANT: Well, traffic.

APPEALS OFFICER MORGANDO: Traffic. That's --

THE CLAIMANT: Traffic work as well.

APPEALS OFFICER MORGANDO: Okay.

BY MR. SCHWARTZ:

Q Okay. Where do you live?

A Northwest side of the valley.

Q And let me back up. Sorry again.

In March of 2015 where did you live?

A I lived at 5207 Sparkling Vine Avenue which is northwest.

Q Sparkling Vine Avenue?

A Yes.

Q Okay. During your time at the Bolden Area Command -- the Appeals Officer just asked it, but I have some follow-up questions.

You were out -- you would be out patrolling during your shift; correct?

A Correct.

Q And what would you be in while you were patrolling?

A A patrol vehicle.

Q A squad car?

A SUV, yes.

Q Okay. When you leave your house back then at Sparkling Vine Avenue and you would get to the Boulder Command what -- Bolden Command, excuse me, what would you do when you first got there? What do you do?

A I'm sorry. Could you repeat?

Q Back in March of 2015, and that's the area of time I'm focusing on, when you would leave your home on Sparkling Vine Avenue and go to the Bolden Command, once you got there what do you do? What's the first thing you do?

A I would change out into uniform.

Q Okay. So you would ride from your home to the Bolden Area Command in civilian clothes?

A Sometimes.

Q Is that the right term? Am I --
A Yes, that's the proper term. Sometimes civilian clothes. Sometimes in full uniform.
Q Okay. And is there an area for you to change when you get there?
A There is.
Q You would then change sometimes into your uniform?
A Correct.
Q And then what happens next?
A Then you attend a briefing.
Q Okay. And does the briefing -- I'm not a police officer.
A Sure.
Q So is it like the things we see on TV where somebody speaks to a whole group of individuals and kind of gives you an idea of what's going for that day?
A Yeah. We're briefed with -- dependent on the day it is, if we had our days off, of all the prior activities that took place and police-related issues that -- outstanding suspects and things of that nature.
Q And then after the briefing what happens?
A Then you hit the streets.
Q Okay. So you get into your patrol SUV and go out and do your job in essence?

A Correct.

Q Okay. Then at the end of your shift you come back -- I'm assuming you come back to the Bolden Area Command?

A Yes.

Q And what's the general way that your shift ends?

A Generally you get -- you have a debriefing.

Q Okay. And is that kind of the opposite of the beginning? It's just you telling someone what happened during the day?

A Not necessarily. You're handing in paperwork. The supervisor is taking a count to make sure that he has all of his police officers back, and any pertinent information that needs to be exchanged at that point is exchanged and then you're released.

Q Okay. And at that point are you free to leave?

A Depends.

Q Okay. Depends on what?

A If there's a training that has to be done, if there's computer work that has to be done, paperwork that is not properly filled out or corrections need to be made, if there's dictations, a number of things.

Q Okay. Once you get all your paperwork and

training in order are you then free to leave?

A Yes, if you're told to by your supervisor.

Q Okay. So your supervisor can tell you to stay or tell you to go?

A "I need you to stay," yes.

Q And if he needs you to stay beyond the time frame that you were scheduled to work, you're going to actually get paid overtime; correct? Are you supposed to get paid overtime?

A Today's time, no. It's -- well, it depends. They have different ways of compensation.

Q Okay. Is one of those ways that they'll then let you go early another day, kind of catch up on the time?

A Possibly, if that's an agreement that you and the supervisor agree to.

Q Okay. Once the supervisor says it's okay for you to -- and I'm still focusing back in March of 2015.

A Sure.

Q At the Bolden Command. Once the supervisor says it's okay for you to leave, then you personally, what do you do next?

A Personally it depends. I'll change out if -- or if I need to get home and time is -- because I stayed longer, I'll leave in uniform. So you have

options that you can do.

Q Okay. How about on March 7th? Did you change out?

A I did.

Q Okay. You said that on March 7th that you had a bag with you; is that correct?

A Correct.

Q And in that bag you said was your handcuffs and some other assorted items?

A Handcuffs, police radio, and assorted items police related.

Q Okay. Would you normally take that bag back and forth from work to home every single day?

A Yes.

Q So that's something that you -- as part of your routine you would take the bag to work and then from work to home?

A Well, you have the option to leave it in your locker, but me being a motorcycle police officer, I have a habit, if you will, and I grab what I need. Just in the event that something happens, I have a police radio with me and I have handcuffs with me, that if I have to act upon a situation that requires a police officer, I have the necessary items.

Q Okay. But you could leave it at the Bolden

Command back then?

A With the exception -- yes, I guess, with the exception of my service weapon and my radio. My radio I have an option to leave it in my locker if so be.

Q But your service weapon I'm assuming you keep with you at all times?

A Absolutely.

Q And probably your badge as well; correct?

A Correct.

Q So that's not something you'd leave in your locker no matter what you were doing; correct?

I mean, if you were leaving -- let's assuming you were leaving to go on vacation. You still wouldn't leave your service revolver and your -- your service weapon and your badge in your locker, would you?

A Depends. Maybe if I'm leaving on vacation.

Q Okay. On this particular day you said your supervisor told you you could leave early; correct?

A Yes.

Q Okay. Did he radio you? Were you already in the Bolden Command building? How did he tell you that logistically?

A Inside the area command building.

Q So you had already come back from patrolling?

A We had came back early, and he advised us to

go.

Q Okay. And just so I understand, he and the captain also told you that you had done enough acclimation from your injury to go back to traffic. Is that --

A So I was on a call that he showed up on, a patrol-related call.

Q Okay. Which "he"?

A I'm sorry. My sergeant.

Q Okay.

A And so he advised me that he had a conversation with the captain. He said that you were telling my guys who -- in this re-acclimation program you were being -- kind of overseeing, is I guess the word that I would use, by a field training officer, and he said that you are telling my guys things that they should know. There's no reason you should be here.

"So the captain and I had a conversation, and he signed your release papers effective" -- I don't recall if it was the shift or the shift after, but it was in close proximity -- "that you will be reporting back to the Traffic Bureau, and there's no reason you should be here for the 12 to 16-week duration."

Q And are those two individuals, your sergeant and the captain, are they the ones who have the

authority to release you back to your old position?

A I don't know for sure in terms of the sergeant. I would assume that he has to go through his chain of command, but the captain of that bureau is the -- I guess would make the decision based on the information he receives from my immediate supervisor.

Q Okay. And just so I understand, in essence he was saying to you that you know more than the people who are supposed to be supervising you?

A I don't want to word it that way.

Q I'm wording it that way.

A Okay.

Q Is that fair to say? I'm not trying to breach the chain of command for you. I just want to understand.

A I would like to put it that there's nothing for you to re-acclimate to.

Q Okay.

A You are up to speed and you shouldn't be here.

Q Okay. And so then you're already in the command building; correct?

A I am. Well, this conversation --

APPEALS OFFICER MORGANDO: No, no.

BY MR. SCHWARTZ:

Q This was -- okay. You're right. This

conversation happened on a call?

A Correct.

Q You then come back to the command building at some point later. I'm not saying --

A He advises me to come back.

Q Oh, okay. So he actually told you after this call to come back?

A "Go in early. Go get some seat time," is what we call it on a motorcycle which -- because effective the next shift or the shift after, I don't recall, and that's when he explained to me that I had been released from this program.

Q Okay.

APPEALS OFFICER MORGANDO: I'm sorry. Did you say "seat"?

THE CLAIMANT: Seat.

APPEALS OFFICER MORGANDO: S-E-A-T?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Okay.

THE CLAIMANT: On a motorcycle it's a jargon.

BY MR. SCHWARTZ:

Q So then you're --

APPEALS OFFICER MORGANDO: It's kind of like time in the saddle.

MR. MILLS: Euphemism.

THE CLAIMANT: Yes, ma'am.

BY MR. SCHWARTZ:

Q You're back at the command building?

A Yes, sir.

Q And he tells you you can leave early?

A He says, "Go get time in. If we need you, be close to your phone." And I had my radio with me as well.

Q Okay. And you have a -- do you have a personal cell phone? Is that what you mean by "phone"?

A Yes, sir.

Q Or was there a work cell phone?

A Personal cell phone, sir.

Q Okay. And the same question I asked you about the radio earlier. I just want to make sure I'm clear.

If you were to get a call at 2:30 in the morning, which is clearly not your shift time, on your personal cell phone that you need to come back, you don't have a choice but to come back; correct?

A If my supervisor says, "We need you back," I am going.

Q In your ten years on the force how many times has that happened?

A Count on one hand. Five maybe.

Q Okay.

A Ish.

Q Mr. Mills asked you some questions about consuming alcohol, and he asked you up until 12:30 when your shift ended you were -- you're not allowed to consume alcohol; is that correct?

A Correct.

Q Okay. After your shift ends are you free to consume alcohol?

A I am.

Q What is the policy, if you know, if -- you said a handful of times you got a call after hours to come back. What happens if you've been drinking? What's your response supposed to be when you get that call?

A If I've been drinking, I will advise my supervisor of the fact that I've been drinking.

Q And do you have any idea what happens if you do that?

A I have never been in that position to know.

Q Okay. Are you told by your supervisor that you are to advise them of that fact if that occurs or is this just something you would do?

A I don't know if it's something you're told. It's just -- it's kind of an unspoken rule. I guess I would say, "Hey, you know, just so you know, I've been

drinking."

Q Okay. How long approximately after you left, if you know, that night on March 7th did this accident occur?

A At what time did this accident --

Q How long after you had left the command center, the Bolden Command?

A The general -- the location of the accident is, I would say less, than two miles, a mile and a half from the Bolden Area Command. So ten minutes, five, ten minutes. Well, not five minutes. Maybe ten minutes, closer to.

Q And you said there was another officer who was behind you who later told you what had happened?

A I knew I was involved in an accident, and he explained what had happened. And he was able to make contact with the driver of the vehicle who hit me.

Q Okay. What is that Tyler McMeans? Is that his name?

A Yes.

Q Was Officer McMeans on a motorcycle when this happened?

A Yes.

Q Was he on a police motorcycle when this happened?

A No.

Q He was on his own motorcycle?

A Yes.

Q Okay. Was he also going through an acclimation process with you?

A No.

Q Do you know why he was on his own motorcycle at that particular time?

A No.

MR. MILLS: Objection; calls for speculation.

APPEALS OFFICER MORGANDO: If he knows.

THE CLAIMANT: No, I don't. It was his transportation.

BY MR. SCHWARTZ:

Q To and from work?

A Or to point A and point B, wherever he was going.

Q Was he working at the Bolden Command at the same time you were?

A He was.

Q Okay. Did he work the same shift that you did at the Bolden Command?

A He was assigned at the time to the same squad and shift that I was in this program.

Q Okay. So would that mean that if he was there

when your accident happened -- by "there" I mean in the same general vicinity -- he must have been let go early as well?

A Yes.

Q Because he was on his -- your recollection is he was on his own personal motorcycle?

A Yes.

Q Okay. And you don't -- do you ever ride your own personal motorcycle while on shift?

A In Bolden Area Command when I was working?

Q Let's start within the Bolden Area Command.

A Sometimes I've taken a motorcycle. Sometimes I drove a vehicle, car.

Q Okay. Maybe I'm not -- I don't understand your answer. So maybe I'll re-ask the question.

When this accident happened you were on your personal motorcycle; correct?

A Correct.

Q Okay. As part of your job duties are you ever required to use your personal motorcycle while, we'll call it, on duty and not released early?

A No.

Q Okay. Do you know if Officer McMeans, because you were working with him at that time, was required to use his personal motorcycle while on duty and not

released early?

A No.

Q No, you don't know, or no, you --

A No, he was not using his personal motorcycle for on duty.

Q Does the department have anything to do with your selection of your transportation from the command to your home? Do they provide you with anything?

A No. A vehicle, no.

Q Okay. So can you pick any kind of motorcycle that you want?

A No. To go home?

Q Let me start again. Your transportation to and from work.

A Uh-huh.

Q Can you drive in any type of motorcycle you wish?

A Sure.

Q Can you drive in any type of car you wish?

A Sure.

Q Does the department pay for any part of that commuting expense, cost of the car, cost of insurance, cast of gas, anything like that?

A No.

Q So you could live in St. George and commute

back and forth if you wanted to?

A Sure.

Q You talked a little bit about a duty to assist, and Mr. Mills asked you and you said that's your moral duty. That's your duty as a police officer.

Is that -- do you remember saying that?

A Something along those lines. I said that that's my oath that I took to protect and serve this community that I am a part of.

Q Would that extend to at any point in time during any day or do you think it's only during certain times when you're not technically in a police vehicle?

A You're a police officer 24 hours a day, seven days a week.

Q Okay. So you believe you have a duty to assist -- again, if we're going back to your shift at the time this happened, your shift ends at 12:30.

At 3:30 in the morning if you hear something outside your house, you have a duty to assist as a police officer?

A I wouldn't say -- it's a case-by-case basis, but I have a duty to assist. There are exceptions, and those exceptions for me are if my family's present.

Q Okay. When you say there are exceptions, is any of this actually in a handbook or a rules or

regulations that the department makes you follow or is this just you believe as a police officer you have this duty?

A I don't know if it's in any handbook, as you put it, but I'm speaking from my personal belief and the oath that I took to serve the community that I am a part of.

MR. SCHWARTZ: Okay. I don't have any other questions, your Honor.

APPEALS OFFICER MORGANDO: Mr. Mills, anything further?

MR. MILLS: Just briefly.

REDIRECT EXAMINATION

BY MR. MILLS:

Q I don't know if I asked you this on direct, but if you're being paid and on the clock and anyone from Metro superior team summons you, in that instance do you have the discretion to refuse?

A I do not.

Q Okay.

MR. MILLS: Nothing further, Judge.

APPEALS OFFICER MORGANDO: I think I only had one question. I looked at my notes, and I don't know if anybody asked it.

When you were working your re-acclimation assignment --

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: -- when did your shift begin, when you arrived at Bolden or when you left your home?

THE CLAIMANT: My shift began when I arrived at Bolden.

APPEALS OFFICER MORGANDO: Okay. And your shift ended when you left Bolden?

THE CLAIMANT: My shift ended --

APPEALS OFFICER MORGANDO: And on a normal day.

THE CLAIMANT: On a normal day my shift ends at midnight.

APPEALS OFFICER MORGANDO: 12:30 in the morning?

THE CLAIMANT: Yes, ma'am.

APPEALS OFFICER MORGANDO: Right, but once you -- once you leave Bolden and you're headed home, you're not considered on the clock, correct, except the day of your accident?

THE CLAIMANT: Right. We're on the hook. So, in other words, because my shift is still ongoing, I can be called back, This has happened or, Hey, we need

OneContent Generated By UMC\kpark Generated On: 03/30/2015 16:13
DL/MedQ
ID: 03/07/2015 21:41:39
DT: 03/08/2015 07:52:36

DANIEL LEE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 353563/646668155

DICTATED BY: DANIEL LEE, MD

CONSULTATION REPORT
Electronically Authenticated by:
Daniel Lee, MD On 03/08/2015 02:24 PM PDT

87

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

CONSULTANT: Michael Monroe, MD

REQUESTED BY: DEBORAH A KUHLS, MD

Date: 3/10/2015

REASON: Left pelvic fracture, left olecranon fracture, left humeral shaft fracture, left acetabular fracture with left hip dislocation, tibial shaft fracture with fibular shaft fracture.

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old male who presented after a motorcycle accident. He was wearing a helmet, traveling at 25-30 miles per hour when a car turned left in front of him and he struck him. He was thrown approximately 40 feet and found in a prone position with his legs apart. The patient denies any loss of consciousness during this event. He had immediate pain in his left upper and lower extremity.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: L5-S1 fusion.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: He denies any tobacco, alcohol, or illicit drug use.

FAMILY HISTORY: Not contributory to this issue.

REVIEW OF SYSTEMS:
A 12-point review of systems was obtained and was negative except for the above-mentioned complaints.

PHYSICAL EXAMINATION:
GENERAL: The patient is intubated when I see him.
HEAD: Pupils are equal and reactive to light. There is no facial trauma noted.
ENT: External appearance of ears and nose is normal. No exudates or erythema.
CARDIOVASCULAR: Pulses are brisk. Capillary refill is brisk in the bilateral upper and lower extremities.
LUNGS: Normal respirations without evidence of flail chest on the ventilator.
MUSCULOSKELETAL: There is a laceration over the knee with deformity and open distal tib-fib pilon fracture. The pelvis feels unstable on compression in AP and lateral plane on the left. There is gross deformity and angulation of the humeral shaft.

IMAGING: Radiographs of the left forearm reveal a transverse

88

olecranon fracture. Radiographs of the left foot reveal no fracture. Left femur reveals a left acetabular fracture, left hip dislocation. Left tibia and fibula show a comminuted distal tibia intra-articular fracture with distal fibular fracture. Also showing left knee dislocation. Bilateral acetabular fractures with pubic rami fractures. Left humerus shows a diaphyseal humeral fracture. CT of the pelvis reveals posterior left hip dislocation with mild sacroiliac diastasis on the left with left inferior pubic ramus fracture, ischial tuberosity fracture, iliac fracture, acetabular fracture. This appears to be a T-type left acetabular fracture.

IMPRESSION:
1. Left acetabular fracture.
2. Left hip posterior dislocation.
3. Left sacroiliac diastasis.
4. Left humeral shaft fracture.
5. Left transverse olecranon fracture, mildly displaced.
6. Open left pilon fracture.
7. Left knee dislocation.

TREATMENT AND PLAN: Our plan at this time is to perform closed reduction of the left knee dislocation, place an external fixator from the femur to the tibia for the dislocation, and then perform open reduction and internal fixation of the left fibula with preliminary external fixation of the open tibial pilon fracture. We plan to perform irrigation and debridement of all the open areas. For the left humerus, we would recommend humeral intramedullary nail, and for the olecranon, a large intramedullary screw. We will proceed with these procedures as medical clearance and OR schedule allows.

RJ/MedQ
DD: 03/10/2015 12:13:32
DT: 03/10/2015 16:39:22

ROSS JONES, MD

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 734247/646969650
PHYSICIAN: MICHAEL MONROE, MD
DICTATED BY: ROSS JONES, MD

CONSULTATION REPORT
Electronically Authenticated by:
Michael Monroe, MD On 03/11/2015 02:53 PM PDT
Electronically Authenticated and Edited by:
ROSS JONES, DO On 03/13/2015 05:53 PM PDT
Electronically Authenticated by:
Michael Monroe, MD On 03/20/2015 11:05 AM PDT

89

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9928043215
Medical Rec. Number: 0001908211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Vital Signs/Data

Time	Staff	Temperature	Pulse	Respiration	Blood Pressure	Pulse Oximetry	Pain
03/07/2015 02:40	MP24	98.0 F	80 /min	22 /min	133/99 mm Hg.	98%	10/10

Allergies

NKA (03/07/2015 01:17)

Chief Complaint

MVA (MP24 03/07/2015 02:40)

Triage

Activation Level - Full. (MP24 03/07/2015 02:40)
2 - Emergent (MP24 02:40)
Domestic violence survey shows NEGATIVE risk for this patient. (MP24 02:40)
mco (MP24 02:40)
Mentation - Patient is alert, oriented x3. Score = 0 (MP24 02:40)
Mobility - Patient is able to ambulate with no assistance. Score = 0 (MP24 02:40)
Elimination - Patient has independent elimination. Score = 0 (MP24 02:40)
No prior fall history. Score = 0. (MP24 02:40)
Patient is not at risk for falls. (MP24 02:40)
Patient has no thoughts of suicide. (MP24 02:40)
INFECTIOUS DISEASE/ CDC SCREENING: No risk factors for infectious disease. (MP24 02:40)
INFECTIOUS DISEASE/ CDC SCREENING: Pt has not been outside the US nor lives with anyone that has been outside the US in the last 6 months. (MP24 02:40)

Height/Weight

Hgt: 188 cm at 02:40 (MP24 03/07/2015 02:40)
Wgt: 109.1 kg at 02:40 (MP24 02:40)
BMI: 30.9 (MP24 02:40)
BSA: 2.39 sq. m (MP24 02:40)

Patient Problems

Multiple closed fractures of pelvis with disruption of pelvic circle (03/07/2015 03:02)

90

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9928043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Med Orders

albuterol soln for neb [VENTOLIN] 2.5 MG NEB RT Q4H PRN ROUTINE AEROSOL TX SVN Bronchodilator Protocol: Yes
Indications: dyspnea
albuterol soln for neb [VENTOLIN] 2.5 MG NEB RT QID ROUTINE AEROSOL TX SVN Bronchodilator Protocol: Yes

sodium chloride 0.9% 1000 ML IV 125 ml/hr CONTINUOUS ROUTINE

fentaNYL inj [SUBLIMAZE] 100 MCG IV Q1H PRN ROUTINE
Indications: Pain
midazolam inj [VERSED] 0.5 MG IV Q4H PRN ROUTINE
Indications: agitation
ondansetron inj [ZOFRAN] 4 MG IV Q8H PRN ROUTINE
Indications: nausea Comments: PO preferred, IV if NPO or unable to tolerate PO
famotidine inj [PEPCID] 20 MG IV BID ROUTINE

diphenhydrAMINE inj [BENADRYL] 25- 50 MG IV HS PRN ROUTINE
Indications: insomnia
acetaminophen [TYLENOL] 650 MG ORAL Q8H PRN ROUTINE
Indications: temp >= 38.5 C
chlorhexidine 0.12% oral rinse [PERIDEX] 10 ML SWISH_SPIT QID ROUTINE

chlorhexidine 0.12% oral rinse [PERIDEX] 10 ML SWISH_SPIT PRN ROUTINE
Indications: oral care
potassium chloride [KLOR- CON] 40 MEQ ORAL PRN ROUTINE If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
KCl 40 mEq rider 40 MEQ IVPB 10 MEQ/HR PRN ROUTINE If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders Central Line
Indications: per Electrolyte Protocol (PROT #383)
potassium- sodium phosphate packet (8 mmol phos) [PHOS- NAK] 2 PACKET ORAL PRN ROUTINE If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
KPhos inj 40 MMOL IVPB 7 MMOL/HR PRN ROUTINE Peripheral Line If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
magnesium sulfate 2 gm rider 2 GM IVPB 30 MIN PRN ROUTINE If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
NaPhos inj 40 mmol IVPB 7 MMOL/HR PRN ROUTINE If serum creatinine is >= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)

91

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929049215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

TR CT BRAIN W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CERVICAL SPINE W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT ABDOMEN AND PELVIS IV ONLY ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CTA LOWER EXTREMITY ONCE STAT Left
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Completed By (01:26)
TR CHEST PORTABLE ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 00:56) Ordered By (00:56) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR PELVIS 1 VIEW ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 00:56) Ordered By (00:56) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
CBC/AUTOMATED ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:12) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
BASIC METABOLIC PANEL ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:18) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
ABO RH TYPE ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Completed By (01:47) MD Sign (JDM1 MD 01:01)
ANTIBODY SCREEN - GEL TECHNIQUE ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:47) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
TR HUMERUS (LEFT) ONCE STAT trauma
Entered By (MK23 RN 03/07/2015 01:10) Ordered By (01:10) Completed By (01:26)
TYPE AND SCREEN ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Order Cancelled (02:21)
REQUEST THAWED PLASMA ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Completed By (01:38)
REQUEST RED BLOOD CELLS (BLOOD PRODUCT) ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Completed By (01:38)
TR CT CHEST WITH CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:09) Ordered By (01:09) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CERVICAL SPINE W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:09) Ordered By (01:09) Order Cancelled (01:10) Comments: ...recon
TR CT THORACIC SPINE RECONSTRUCT ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT LUMBAR SPINE RECONSTRUCT ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Results Back (01:26) Notes: Portable X- ray at bedside. Returns from CT. Taken to CT. (CJE1 02:43)
TR CT ABDOMEN AND PELVIS IV ONLY ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Order Cancelled (01:13) Comments: ...thin outs
HEMATOLOGY SLIDE REVIEW ONCE LIFE THREATENING
Entered By (03/07/2015 01:16) Ordered By (01:16) MD Sign (01:16) Order Cancelled (01:33)
TIBIA + FIBULA (LEFT) ONCE ROUTINE mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:27)
FEMUR (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:27)
ANKLE LIMITED (LEFT) ONCE STAT mcc

92

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001908211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non-Med Orders

Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:26)
TR ANKLE LIMITED (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:26) Ordered By (01:26) MD Sign (01:26) Order Cancelled (01:28)
TR FEMUR (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:27) Ordered By (01:27) Results Back (01:27) MD Sign (01:27) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR TIBIA + FIBULA (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:32)
TR ANKLE LIMITED (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:34)
TR FEMUR (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:34)
TR TIBIA + FIBULA (LEFT) ONCE ROUTINE mcc
Entered By (03/07/2015 01:27) Ordered By (01:27) Results Back (01:27) MD Sign (01:27) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR FOOT LIMITED (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:28) Ordered By (01:28) Results Back (01:32) MD Sign (01:28) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
ABO RH TYPE ONCE STAT
Entered By (03/07/2015 01:38) Ordered By (01:38) MD Sign (01:38) Order Cancelled (02:23)
ANTIBODY SCREEN - GEL TECHNIQUE ONCE STAT
Entered By (03/07/2015 01:38) Ordered By (01:38) MD Sign (01:38) Order Cancelled (02:24)
CROSSMATCH ELECTRONIC ONCE LIFE THREATENING
Entered By (03/07/2015 01:46) Ordered By (01:46) Completed By (CJE1 RN 02:43) MD Sign (01:46)
TR HAND LIMITED (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 02:24) Ordered By (02:24) Results Back (02:29) MD Sign (02:24) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR FOREARM (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 02:24) Ordered By (02:24) Results Back (02:29) MD Sign (02:24) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
PT + APTT ONCE STAT
Entered By (BD99 UNIT CLERK 03/07/2015 02:33) Ordered By (02:33) Results Back (02:42) MD Sign (02:33) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
HOLD CLOT FOR BLOOD BANK ONCE ROUTINE
Entered By (BD99 UNIT CLERK 03/07/2015 02:33) Ordered By (02:33) MD Sign (02:33) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
Surgery Admit Order (basic requirements) ONCE ROUTINE Inpatient TICU Standard multiple extremity fractures with vascular injury KUHLS, DEBORAH A [CRITICAL CARE MED, SURGICAL CRIT CARE, GENERAL SURGERY, TRAUMA] (2294)
Entered By (03/07/2015 03:02) Ordered By (03:02)
Measure Height ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Measure Weight EVERY DAY ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Incentive Spirometry - NSG Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: X 10 Breaths
INCENTIVE SPIROMETER- RT to Instruct ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Admission Nasal MRSA Colonization Screen- ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Initiate Influenza Vaccine Assessment- CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: - Switch to influenza vaccine order if indicated
Initiate Pneumococcal Vaccine Assessment- CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: - Switch to pneumococcal vaccine order if indicated

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001806211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

Intake & Output Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE Urine Output < 0.5 ml/kg/hr Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE HR<50 or >130 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE RR<10 or >30 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE SaO2 <90% Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE Temp >38.5C Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE SBP <80 or >180 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE DBP <50 or >110 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RD May Modify / Clarify Diet Orders CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Physician Consult CONTIN ROUTINE MONROE, MICHAEL TODD [ORTHOPAEDIC SURGERY, ORTHOPAEDIC SURGERY] (1917)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Intensivist is: CONTIN ROUTINE KUHLS, DEBORAH A [CRITICAL CARE MED, SURGICAL CRIT CARE, GENERAL SURGERY, TRAUMA] (2294)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Physician Consult CONTIN ROUTINE FEIKES, QUYNH N [GENERAL SURGERY, THORACIC SURGERY, THORACIC SURGERY] (20175)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Activity CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Cervical Collar CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Neurovascular Checks Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: Site for NV checks: LLE
NPO MEALS
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Sequential Compression Device CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Nurse to Follow Protocol: CONTIN ROUTINE Print and follow PROT #383 (Electrolyte Protocol), place in chart
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RN to Order: CONTIN ROUTINE Repeat K level 2 hr after KCl, Phosphorous level 2 hr after KPhos/NaPhos/PhosNaK, Magnesium 2 hr after magnesium
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: per Electrolyte Protocol (PROT #383)
ABG LINE CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: Obtain ABG and call MD with results for sudden acute resp. distress
EKG 12 LEAD ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE for any questionable arrhythmia (and obtain 12 lead EKG with rhythm strip) Admin Coordinator and House Officer
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
CBC/AUTOMATED IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RENAL PANEL IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
MAGNESIUM LEVEL IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)

94

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

NUTRITIONAL CONSULT ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
SOCIAL SERVICES CONSULT ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
CPK ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Order Cancelled (03:10)
CPK ONCE LIFE THREATENING
Entered By (03/07/2015 03:11) Ordered By (03:11) MD Sign (03:11)

Disposition

NOT SEEN BY ER ATTENDING (see RN chart). (CJE1) 03/07/2015 03:12 Disposition status is Admit. Admitted to Operating Room. RN accompanied patient. MD accompanied patient. Monitor used during transport. Valuables inventoried and collected by UMC Public Safety. Patient physically left department and was removed from Tracking Board by CARLOS JUSTIN ESPARZA RN. (CJE1) 03/07/2015 02:59 Electronically signed by CARLOS JUSTIN ESPARZA RN. (CJE1) 03/07/2015 03:12

Discharge Summary

Chief Complaint: MVA.. Primary Diagnosis: NO DATA AVAILABLE.. Disposition Notes: NOT SEEN BY ER ATTENDING (see RN chart).. Discharge Prescriptions: NO DATA AVAILABLE. (03/07/2015 03:12)

Staff Legend

BD99	BRENDA DERLEIN UNIT CLERK
CJE1	CARLOS ESPARZA RN
MK23	MARTIN KOVACIK RN
MP24	MARITA PEREZ RN
RW4	ROBERT WILSON RN

95

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

TIME: Approximately 12:50 a.m.

SENIOR RESIDENT: Zachary VanWagoner.

FELLOW: Dr. Alistair Chapman.

JUNIOR RESIDENT: Benjamin Fox.

This is a full activation.

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old male status post motorcycle collision. The patient had another vehicle turn left and into him while he was traveling approximately 35 miles an hour. Patient was thrown from his bike with approximately 30 yards of separation. He was found lying in prone position at the scene. Positive LOC. Negative loss of consciousness. The patient is complaining of no sensation in the left foot and also significant pain in the left lower extremity and left leg and left hip.

REVIEW OF SYSTEMS:
Ten-point review of systems is significant for loss of sensation in the left lower extremity and significant left arm, left hip, and leg pain.

PAST MEDICAL HISTORY: Patient denies.

PAST SURGICAL HISTORY: Significant for fusion of L5-S1 for a prolapsed disk.

MEDICATIONS: None.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Patient is a police officer. He denies any tobacco or alcohol or illicits.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

PRIMARY SURVEY: AIRWAY: Patent, phonating.
BREATHING: Clear to auscultation bilaterally. No wheezes, rhonchi, or rales.
CIRCULATION: Pulses: Radial 2+ bilaterally. Femoral 1+ on the left, 2+ on the right. Carotid 2+. Pedal pulses: Right 2+, _____ pulses on the left foot.
DISABILITY: Eye 4, verbal 5, motor 6. GCS of 15.
EXPOSURE: Patient has a very large degloving injury of the left knee with exposed proximal tibia and fibula and femur with obvious dislocation of the knee joint. The patient also has an obvious

deformity of the left humerus, laceration near the left elbow, and superficial abrasions over the right hand and knee.

SECONDARY SURVEY: VITAL SIGNS: Heart rate 90, blood pressure 135/92, respiration rate 22, temperature 96, O2 saturation 99%. IV access: Patient had a 16-gauge in the right hand and 16-gauge in the right AC.
HEENT: No step-offs or deformities. NCMI. PERRLA.
MAXILLOFACIAL: No step-offs or deformities.
NECK: C-collar is in place.
CHEST AND LUNGS: Clear to auscultation bilaterally.
CARDIOVASCULAR: Normal sinus rhythm. S1, S2. No murmurs, rubs, or gallops.
ABDOMEN: Soft, nondistended, nontender to palpation.
PELVIS: Significant pain on palpation of the left hip. Otherwise, appears stable.
BACK: T- and L-spines nontender to palpation. No step-offs or deformities.
RECTAL: Normal tone. No abnormality. No blood noted. Prostate in normal position.
EXTREMITIES: Decreased pulses in the left lower extremity with an exposed femur and knee and exposed proximal tib-fib. The left upper extremity also has a deformity with a laceration near the left elbow.
NEUROLOGIC: Mental status AAO x3. Cranial nerves 2-12 grossly intact. Bilateral motor is diminished in the left upper and left lower extremity secondary to pain and fractures. Sensation is diminished in the left foot at approximately the level of the left knee.

RADIOLOGY REPORTS: CT of the brain shows no abnormality. CT of the C-spine shows no abnormality. CT of the chest demonstrates a fracture of the left 5th rib, bilateral lower lobe atelectasis. CT of the abdomen and pelvis demonstrates a left acetabular fracture, posterior left hip dislocation, left SI diastasis, mild sigmoid mesenteric fat stranding. CT of the T-spine demonstrates no acute fracture. CT of the L-spine demonstrates no acute fracture. X-ray of the pelvis demonstrates multiple left pelvic fractures including pubic rami at 2 points, acetabular fractures, malalignment of the left hip with proximal migration of the femur and a femoral head fracture. X-ray of the left femur demonstrates the above-listed fractures. In addition, widening of the proximal tibial-fibular articulation compatible with a traumatic subluxation and dislocation. X-ray of the left tib-fib shows a left comminuted distal tib-fib fracture with the aforementioned diastasis of the tibiofibular articulation. X-ray of the left foot demonstrates no fracture. X-ray of the left humerus shows a diaphyseal fracture and fracture of the elbow and ulna. X-ray of the chest demonstrates minimally displaced left 5th rib fracture. CT of the left lower extremity shows injury to the left popliteal and anterior tibial arteries. There is 3-vessel reconstitution going into the leg; however, the anterior tibial ends abruptly at the level of the distal comminuted tibia and fibular fractures, and there is runoff of the posterior tibial vessel all the way to the foot.

LABORATORY DATA: WBC 10.0, RGB 15.7, hematocrit 47.9, platelets 214.

Sodium 138, potassium 3.8, chloride 108, CO2 19, BUN 22, creatinine 1.4, glucose 148.

CONSULTANTS: Dr. Monroe with Orthopedics and Dr. Quynh Pelkas with Vascular Surgery.

97

PROBLEM LIST/MANAGEMENT: Multiple left-sided pelvic fractures with hip dislocation and femoral head fracture, left-sided comminuted tibia and fibular fracture with diastasis of the tibia-fibular joint near the knee. All of these fractures are open with significant loss of tissue and degloving injury to the anterior aspect of the knee. Dr. Monroe with Orthopedics was consulted, personally came and evaluated the patient, evaluated all films, and will be taking the patient to the operating room for washout with possible fixation of these fractures. The patient also sustained a left humerus fracture and olecranon fractures in conjunction with the laceration of the left elbow, likely represents an open fracture, which will also be taken by Dr. Monroe to the operating room for washout and possible fixation. Patient has a left rib fracture. He will be monitored for possible signs of pulmonary compromise; however, no major abnormalities on the CT scan were observed with exception of the rib fracture and a small amount of atelectasis. The patient also has a small amount of sigmoid fat stranding. We will perform serial abdominal evaluations to rule out the possibility of an occult bowel injury. Patient has an injury to the left popliteal artery at the level of the posterior knee dislocation. Dr. Quynh Feikes with Vascular Surgery was consulted. She is awaiting the results of Dr. Monroe's orthopedic procedure with fixation for further recommendations. We will follow up her recommendations. Dr. Monroe with Orthopedic Surgery was given a number to contact Dr. Quynh Feikes upon the completion of his procedure. Patient also has superficial abrasions to the right hand and right knee for which we will perform local wound care. Following the operation, the patient be sent to the ICU for serial neurovascular checks.

Dr. Deborah Kuhls was present for this activation, directed all patient care and procedures.

ZDV/MedQ
DD: 03/07/2015 02:56:04
DT: 03/07/2015 04:07:09

ZACHARY D VANWAGONER, MD (RESIDENT)

DEBORAH A KUHLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 352100/646608958
PHYSICIAN: DEBORAH A KUHLS, MD
DICTATED BY: ZACHARY D VANWAGONER, MD (RESIDENT)

TRAUMA CENTER HISTORY AND PHYSICAL

98

UMC

Surgical Services - Implant Log

Patient: ACCT: 5926048215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL
MR# 0001908211 44Y M ADM: 03/07/15

Date of Procedure: 3/16/17

Circulator Signature: [signature]

Procedure: ORIF left ankle
Synthes plate 3.5mm

Product Sticker	Product Sticker
241.453 13 holes 226mm (L)	
Product Name: x(1)	Product Name:
Lot and Serial Number / Quantity	Lot and Serial Number / Quantity
Product Sticker: 3.5mm locking screws 212.101 x1 22mm	Product Sticker:
Product Name: 212.112 x3 ?mm	Product Name:
Lot and Serial Number: 212.114 40mm x1 / Quantity	Lot and Serial Number / Quantity
Product Sticker: 212.130 ?mm x2 212.134 44mm x1	Product Sticker:
Product Name: 212.136 46mm x1	Product Name:
Lot and Serial Number / Quantity	Lot and Serial Number / Quantity
Product Sticker:	Product Sticker:
Product Name:	Product Name:
Lot and Serial Number / Quantity	Lot and Serial Number / Quantity
Product Sticker:	Product Sticker:
Product Name:	Product Name:
Lot and Serial Number / Quantity	Lot and Serial Number / Quantity
Product Sticker:	Product Sticker:
Product Name:	Product Name:
Lot and Serial Number / Quantity	Lot and Serial Number / Quantity

POOR ORIGINAL

RECEIVED
JUN 10 2015
CCMSI ~ Las Vegas

UMC
UNIVERSITY MEDICAL CENTER

Surgical Services - Implant Log

ACCT: 99230432216 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MRN 0001806211 ADM: 03/07/15

Date of Procedure: 3/8/15

Circulator Signature:

Procedure: Left
ORIF: Acetabular & Femoral Head Fractures
Synthes Implants.

Product Sticker: 3.5mm Pelvic Cortex Screws Product Name: 204.610 x 2 (40mm) Lot and Serial Number: 204.605 x 1 (105mm) 804.605 x1 Quantity	Product Sticker: 4.5mm Headless Compression Product Name: 02.226.740 x 2 Lot and Serial Number Quantity
Product Sticker: 3.5mm Cortex Screws Product Name: 204.820 x 3 (20mm) Lot and Serial Number Quantity	Product Sticker: 4.5mm Headless Compression Product Name: 02.226.746 x 1 Lot and Serial Number Quantity
Product Sticker: 3.5mm Low Profile Recon. Plates Product Name: 245.024 x1 (53mm) Lot and Serial Number Quantity	Product Sticker Product Name Lot and Serial Number Quantity
Product Sticker: 3.5 mm Low Profile Recon Plates Product Name: 245.036 x 1 (104mm) Lot and Serial Number Quantity	Product Sticker Product Name Lot and Serial Number Quantity
Product Sticker: 6.5mm Cannulated Screws Product Name: 208.436 x 1 Lot and Serial Number Quantity	Product Sticker Product Name Lot and Serial Number Quantity
Product Sticker: 6.5mm Cannulated Screws Product Name: 208.437 (75mm) x1 Lot and Serial Number Quantity	Product Sticker Product Name Lot and Serial Number Quantity

POOR ORIGINAL

RECEIVED
JUN 10 2015

CCMSI ~ Las Vegas

100

UMC
UNIVERSITY MEDICAL CENTER

Surgical Services - Implant Log

Pat ACCT: 8928043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL
MRN: 0001906211 ADM: 03/07/15 44Y M

Date of Procedure: 3-7-15
Circulator Signature: Dhaliwal

Procedure: External fixator @ tibia-fib, external fixator @ femur open reduction internal fixation left fibula

Product Sticker: Synthes locs. small frag Product Name: 3.5 mm Cortex screw, self-tapping Lot and Serial Number: # 204.884, 14mm Quantity: x4	Product Sticker: Stryker ortho Cervical fixator Product Name: 5 x 150 mm Apex Pin Lot and Serial Number: # 5018-12-180 Quantity: x7
Product Sticker: Synthes locs. small frag Product Name: 3.5 mm Cortex screw, self-tap Lot and Serial Number: # 204.855, 66 mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locs. small frag Product Name: 3.5 mm Cortex screw, self-tap Lot and Serial Number: # 204.860 100 mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locs. small frag Product Name: 4.0 mm cancellous bone screw, full thread Lot and Serial Number: # 2010.010 110mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locs. small frag Product Name: One-third tubular locs. LCP plate 2 collar 117 mm Lot and Serial Number: # 241.401 10-hole Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Product Name: Lot and Serial Number: Quantity:	Product Sticker: Product Name: Lot and Serial Number: RECEIVED

JUN 10 2015

CCMSI ~ Las Vegas

101

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Deborah A Kuhls, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON:

ANESTHESIOLOGIST:

PREOPERATIVE DIAGNOSIS: Left open olecranon fracture, and mid shaft fracture of the left humerus.

POSTOPERATIVE DIAGNOSIS: Left open olecranon fracture, and mid shaft fracture of the left humerus.

PROCEDURE: Reduction of left humerus fracture, application of splint, and placement of moist gauze over left elbow laceration.

The above patient came in as a motorcycle crash, off-duty police officer, with a deformed left upper extremity and a laceration over his left elbow. Although he has an olecranon fracture by palpation the elbow joint appeared to be intact. We reduced his left humerus and placed him in an upper extremity splint. We placed moist gauze over the laceration over the olecranon.

The patient tolerated the procedure well. He was neurovascularly intact both before and after the procedure.

DAK/MedQ
DD: 03/07/2015 03:17:47
DT: 03/07/2015 07:36:40

DEBORAH A KUHLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 726631/546609268

DICTATED BY: DEBORAH A KUHLS, MD

OPERATIVE REPORT

102

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Alistair Jon Chapman, MD

ANESTHESIOLOGIST: Agata Vollers, MD

PREOPERATIVE DIAGNOSIS:
1. Left open knee dislocation.
2. Left open distal tibia and fibular pilon fracture.
3. Left columns acetabular fracture.
4. Left leg laceration equaling 40 centimeters.
5. Left humeral shaft fracture.

POSTOPERATIVE DIAGNOSIS:
1. Left open knee dislocation.
2. Left open distal tibia and fibular pilon fracture.
3. Left columns acetabular fracture.
4. Left leg laceration equaling 40 centimeters.
5. Left humeral shaft fracture.

TIME: 5:02

PROCEDURE:
1. Closed reduction, left knee.
2. External fixation application, femur to tibia.
3. Open reduction and internal fixation, left fibula.
4. Preliminary external fixation, open tibial pilon fracture.
5. Irrigation and debridement, left leg.
6. Primary closure, 40 centimeters.

ADDITIONAL PARTICIPATING SURGEON: Chris Goodwell, MS3.

ANESTHESIA: General.

TOURNIQUET: No tourniquet was used.

IMPLANT USED: Stryker Hoffman external fixator system with a Synthes 1/3 tubular plate on the fibula.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman involved in a motorcycle accident, sustaining mostly left leg injuries from his hip down to his ankle. Preoperative CT arteriogram shows a popliteal artery injury but with good runoff distally.

CONSENT: In consenting the patient, he understands that because of the vascular injury and the nature of his injuries there is a

possibility he may end up with an amputation in the future. We are doing preliminary stabilization of his injuries at this time.

DESCRIPTION OF PROCEDURE: The patient was placed in a supine position. After administration of general anesthesia, left lower extremity was prepped and draped in sterile fashion with 1-step Betadine. No tourniquet was used.

The knee was managed 1st. The knee was closed reduced using direct manipulation under C-arm guidance. Once good position of the knee was obtained, an anterior Hoffman fixator was placed from 2 pins in the femur and 2 pins in the tibia, this was connected by 2 bars while the knee was held in the reduced position. The fixator was adjusted, tightened, the pins were cut distally, and final images of the knee were taken.

Attention was focused down to the ankle where a significantly comminuted tibial pilon fracture was identified. In order to gain fixation, initially 2 pins were placed, 1 in the calcaneus, 1 in the tibia, spanning the fracture to hold preliminarily, after which a 12-hole 1/3 tubular plate was placed on the lateral surface with several screws across the mortise joint for additional fixation. Reduction, rotation and length of the fibula were maintained in order to provide stability to the distal ankle.

Once the fibula was fixed, an additional pin was placed in the tibia under C-arm guidance. The alignment and length and rotation were maintained. The 5-millimeter pins were connected to 2 carbon fiber bars, using the Quick Connects, these were tightened and excess pin length was carefully removed. C-arm images showed adequate reduction of the ankle with good position of the implants.

Pulse lavage irrigation was then used to irrigate thoroughly the open lacerations around the leg and knee, 6 liters of pulse lavage irrigation was used. It was noted on inspection that there was a complete disruption of the lateral joint retinaculum. The patellar tendon appeared to be intact.

A primary closure was then done using 0 Prolene with horizontal mattress sutures, approximating 40 centimeters in this complex laceration of the skin, which was in a stellate pattern.

Final images were taken, which showed good reduction with good position of the implants. The case at this point was turned over to Vascular Surgery for exploration and possible vascular bypass.

MM/MedQ
DD: 03/07/2015 05:08:52
DT: 03/07/2015 08:06:35

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 352153/646611833

104

DICTATED BY: MICHAEL MONROE, MD

OPERATIVE REPORT
Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/09/2015 03:53 PM EDT

105

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Quynh Peikes, M.D.

ASSISTANT SURGEON: Wesley Smith, CFT-CFA

PARTICIPATING SURGEON: Alistair Jon Chapman, MD

ANESTHESIOLOGIST: Agata Vollers, MD

PREOPERATIVE DIAGNOSIS: 1. Motorcycle accident.
2. Left lower extremity traumatic arterial injury with extensive degloving and orthopedic injuries.

POSTOPERATIVE DIAGNOSIS: 1. Motorcycle accident.
2. Left lower extremity traumatic arterial injury with extensive degloving and orthopedic injuries.

PRIMARY PROCEDURE:
1. Left popliteal artery repair with reversed saphenous vein interposition graft.
2. Open vein harvest from right lower extremity.

ANESTHESIA: General.

EBL: Less than 200 cubic centimeters.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: Patient is a 44-year-old off-duty policeman who was on his motorcycle when he was cut off by another vehicle. He sustained extensive injury to his left lower extremity, as well as pelvis and left arm. He was noted to have a dislocated left knee injury with extensive tib-fib fracture on the left lower extremity, as well as a left hip fracture. He was taken to the operating room emergently by Dr. Monroe for stabilization and currently has an ex-fix. I was notified by the trauma team that the patient also has absent palpable pulses to the left lower extremity, despite stabilization and I present now for evaluation for left lower extremity arterial injury.

FINDINGS: At the time of exploration, he had a complete transection of his popliteal artery right at the knee. There is also extensive injury and avulsion of one of the popliteal veins; the other one was intact. The nerve was seen and appeared to be somewhat bruised.

DESCRIPTION OF PROCEDURE: The patient was on the table in the operating room already, having undergone just recent external fixation by Dr. Monroe. The left and right lower extremities were then prepped and draped in a sterile manner. An incision was made medially on the

knee and extended down to below the knee, and dissection was carried out until the popliteal above the knee was identified. This was then controlled with vessel loop control. Further dissection to the below knee segment was carried out, and at this point, we found a short-segment of injury, about a 2 to 3 centimeter gap from an avulsed popliteal artery. The vein itself on one of the branches was also injured. At this point, once the artery was isolated and dissected out. The patient was then heparinized with 5000 units of heparin IV. After allowing for several minutes of circulation, the artery was clamped proximally and distally. The edges of the artery itself were debrided back to clean, viable tissue. At this point, we were left with a segment about 3 centimeters or so. Open vein harvest was carried out on the right lower extremity near the ankle, and there was a good vein segment from the saphenous vein there that was taken. Once done with open harvest, the artery was repaired with the saphenous vein graft in reverse as an interposition graft. This was done end-to-end on both proximal and distal ends using a running 6-0 Prolene suture. Once completed, the graft was flushed out there was a good triphasic Doppler signal down the posterior tibia. Hemostasis was obtained. The incision was then reapproximated with interrupted 0 Vicryl suture for muscle, fascia, and tendon. The subcutaneous tissue was closed with 2-0 Vicryl, and skin was closed with staples. The open harvest site on the right lower extremity was also closed in multiple layers with 2-0 and 3-0 Vicryl suture, and skin was closed with 3-0 Monocryl subcuticular stitch and sealed with Dermabond. Sterile dressing was applied. Patient tolerated the procedure. After the procedure, all needle and sponge counts were correct. The patient was left ventilated and moved back to the trauma ICU for further care by the Trauma Service.

QF/MedQ
DD: 03/08/2015 12:12:59
DT: 03/08/2015 13:50:00

QUYNH PEIKES, M.D.

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 728756/646700908

DICTATED BY: QUYNH PEIKES, M.D.

OPERATIVE REPORT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/09/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Jose Zeron, CST

ANESTHESIOLOGIST: Dr. Adangh

PREOPERATIVE DIAGNOSIS:
1. Left humeral shaft fracture.
2. Left olecranon fracture.

POSTOPERATIVE DIAGNOSIS:
1. Left humeral shaft fracture.
2. Left olecranon fracture.

Time: 2133 hours.

PROCEDURE PERFORMED:
1. Closed reduction, intramedullary rodding, left humeral shaft.
2. Open reduction and internal fixation left olecranon fracture.

ANESTHESIA: General.

TOURNIQUET TIME: None.

IMPLANT USED: Stryker humeral nail with a Stryker 6.5 millimeter screw.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman who presents following a motorcycle accident with left-sided injuries including the lower extremity and the upper extremity. He comes in for his upper extremity fixation. Informed consent is obtained from the family.

PROCEDURE: The patient was placed in a supine position. After administration of general anesthesia, the left upper extremity was prepped and draped in a sterile fashion with ChloraPrep. No tourniquet was used for the case.

A 2 centimeter incision was made proximally through which a guide pin was placed into the greater tuberosity. This was then overdrilled and a guidewire was passed across the fracture. The appropriate size nail length was selected and reaming was done to 1 millimeter over the nail size.

The nail was impacted into place, locked proximally, compressed and locked distally. It was noted at this time that some distraction was

108

still present at the fracture site. The proximal locking screw and guide ware removed prior to the distal lock which required replacement of the proximal jig.

Approximately 1 hour of surgical time was spent replacing the proximal jig, repositioning the C-arm and getting the proximal lock in the appropriate position. Final images showed good reduction of the fracture with good position of the implant.

The olecranon was then approached. There was an open laceration. This was extended. The olecranon fracture was identified and fixed with a point of reduction forceps. A 1.6 millimeter cannulated K-wire was placed down the olecranon shaft. This was overdrilled and the appropriate size 6.5 millimeter cannulated screw was inserted. Good position of the screw with good reduction of the olecranon was maintained.

Final images showed good position of all the implants. All incisions were irrigated and closed with 2-0 Vicryl and staples, and a sterile compressive dressing was placed on the patient, who was discharged back to the ICU in stable condition.

MM/MedQ
DD: 03/09/2015 21:36:56
DT: 03/10/2015 10:03:06

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 732550/646881781

DICTATED BY: MICHAEL MONROE, MD

OPERATIVE REPORT
Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/11/2015 02:40 PM PDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/08/2015

SURGEON: Gerald Mark Sylvain, MD

ASSISTANT SURGEON: Vilas Saldanha, M.D.

PARTICIPATING SURGEON:

ANESTHESIOLOGIST: Dr. Goffstein

PREOPERATIVE DIAGNOSIS: 1. Left T type acetabular fracture with fracture of both columns of the acetabulum.
2. Displaced left femoral head fracture.
3. Left trochanteric femur fracture.

POSTOPERATIVE DIAGNOSIS:

PROCEDURES PERFORMED:
1. Open reduction and internal fixation of left acetabular fracture.
2. Open reduction and internal fixation of left femoral head fracture.
3. Open reduction and internal fixation of left trochanteric fracture.

ANESTHESIA: General.

COMPLICATIONS: There were no complications.

PATIENT DISPOSITION: Stable to recovery.

INDICATIONS: The patient is a 44-year-old male with a history of severe injury with multiple trauma. The patient had a comminuted fracture dislocation of his femoral head and acetabulum along with a trochanteric femur fracture. The decision was made to proceed real emergently with operative repair and stabilization.

PROCEDURE IN DETAIL: The patient was taken to the operating room and underwent general anesthetic induction. He was then placed in the right lateral decubitus position, exposing the left hip on a pegboard. He was prepped and draped using the normal sterile technique. The patient did have distal external fixators which were sterilely covered.

An incision was made extending from his proximal femur up to the iliac crest. Tissue was dissected down to the fascia lata. This was spread longitudinally in line with the incision. The gluteus fibers were split in line with the fibers. There was a trochanteric fracture with attachment of the abductors. This was lifted anteriorly. The patient's femoral head was grossly dislocated with significant displacement of the fractures. The hip was externally rotated to

expose the joint. This was used to aid in reduction of the transverse portion of the fracture. The large femoral head fragment was obtained and reduced. This was held in place using pins from a Synthes 4.5 headless screw set and were placed across the fracture with excellent stability and security of the articular femoral head. Next, the head was reduced into the acetabulum. This was used to aid in templating the posterior column and wall portion of the T type fracture. The posterior column was reduced using 2 screws and a reduction clamp. This stabilized the posterior column in a reduced position which was also held manually. A 4-hole pelvic plate was then placed across the posterior column and secured using proximal and distal 3.5 cortical screws with excellent reduction. Next, the comminuted bone loss area was filled in with bone graft from a large cancellous portion of the fracture. The posterior wall was then reduced and an 8-hole pelvic plate was contoured to fit along the posterior column. This was secured with proximal and distal screws, 2 ilium screws and 2 screws into the ischium. Excellent buttressing of the posterior wall was obtained with good reduction seen under C-arm fluoroscopy. Two guidepins from the 6.5 cannulated screw were placed from the posterior column through the anterior column. Two 6.5 cannulated screws were then placed, further securing the anterior column in reduced position. C-arm fluoroscopy was used to check reduction as well as placement of hardware.

The wounds were irrigated. The capsule was then approximated using a #1 Vicryl suture. The trochanteric fracture was reduced and secured using 2 3.5 cortical screws with washers. The wound was then further irrigated. The fascia lata was closed using #1 Vicryl suture, subcutaneous tissues were closed using 2-0 Vicryl and skin was closed using staples. Antibiotic ointment was placed followed by a sterile dressing.

The patient tolerated the procedure well and was taken to recovery in stable condition.

GMS/MedQ
DD: 03/10/2015 16:28:28
DT: 03/10/2015 21:27:19

GERALD MARK SYLVAIN, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 360747/647016082

DICTATED BY: GERALD MARK SYLVAIN, MD

OPERATIVE REPORT

Electronically Authenticated by:
Gerald M Sylvain, MD On 03/19/2015 02:28 PM PDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/16/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Jose Zeron, CST

ANESTHESIOLOGIST: Dr. Hoon

PREOPERATIVE DIAGNOSIS:
1. Left lower extremity multitrauma.
2. Left tibia and fibular pilon fracture.
3. Left knee and tibia and fibular retained external fixators.

POSTOPERATIVE DIAGNOSIS:
1. Left lower extremity multitrauma.
2. Left tibia and fibular pilon fracture.
3. Left knee and tibia and fibular retained external fixators.
4. Left olecranon malunion.
5. Left olecranon retained hardware.

PROCEDURE:
1. Open reduction and internal fixation of left tibial pilon fracture.
2. External fixator removal from tibia and fibula.
3. Revision open reduction and internal fixation of left olecranon.
4. Hardware removal of left olecranon.

ANESTHESIA: General.

TOURNIQUET TIME: Less than 1 hour on the tibia, less than 1 hour on the upper extremity.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman who was in a motorcycle accident sustaining an injury to his left tibia, knee dislocation, acetabular fracture and upper extremity fractures. He comes in for a secondary procedure which is removal of the external fixator and fixation of the tibia. Previously, he had this humerus and olecranon fixed. In the preop he notes that he was rolling over and felt a pop in his left elbow, so we told him at that time that we would evaluate his olecranon while he was in surgery.

PROCEDURE IN DETAIL: The patient is placed in a supine position. After administration of general anesthesia, left lower extremity was prepped and draped in a sterile fashion with 1-step Betadine. The external fixator is removed from the knee and the tibia. The knee was then evaluated radiographically, stable concentric reduction was obtained in the knee. The distal tibia showed an area of comminution with significant bony and soft tissue involvement. A decision was

112

made to do a distal and a more proximal incision and to use a bridge plate technique for this tibial pilon fracture.

The incision was made distally along the course of the anterior tibial tendon, carried down sharply through skin and subcutaneous tissue. Care was taken to avoid neurovascular structures. Electrocautery was used to control bleeding. The fracture site was identified and the distal fragment was noted.

A 2nd incision was made proximally. Radiographs showed the position of the plate just proximal to the most distal fracture site. Both incisions extended approximately 8 centimeters.

A long Synthes anterior lateral plate was then placed on the ankle and a combination of locking and nonlocking screws were used to secure fixation. C-arm image was used in both AP and lateral planes in order to determine the position of the bone.

The final images showed good reduction of the tibia. Good reduction of the fibula with a significant comminution at the metadiaphysis with good alignment and articular congruity.

The incisions were then irrigated, closed with 0 Vicryl, 2-0 Vicryl and 3-0 nylon and a sterile compressive dressing was placed on the ankle as well as the knee, which was a long leg molded anterior-posterior splint.

At the end of the case the elbow was evaluated and displacement or malposition of the fracture was identified. The technique of a single 6.5-millimeter screw would not be adequate for this patient. Therefore it was converted to a tension band wire technique.

The incision was extended proximally and distally. The fracture site was opened, irrigated and fixed. It was held with a point of reduction forceps. Two 2-millimeter K-wires were then passed across the fracture and a 16-gauge wire was placed using a tension band technique under the K-wires. These wires were then bent and impacted into the bone. Final images showed good reduction with good position of the wires. The wires were cut short, bent, and left under the skin. The incisions were irrigated and closed with 2-0 nylon and a sterile compressive dressing was placed on the patient who was discharged to the recovery room in satisfactory condition. No complications.

MM/MedQ
DD: 03/16/2015 12:52:58
DT: 03/16/2015 16:24:33

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 375482/647700527

DICTATED BY: MICHAEL MONROE, MD

113

OPERATIVE REPORT

Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/20/2015 11:09 AM PDT

114

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911934

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6911934

XR CHEST 1 VIEW

HISTORY: Trauma

TECHNIQUE: Chest, 1 view.

COMPARISON: None.

FINDINGS:

The overlying trauma board limits assessment. Lungs are grossly clear. No pleural effusions. No pneumothorax. The heart size is normal. The mediastinal contour is normal. A minimally displaced left lateral fifth rib fracture is noted.

IMPRESSION:

1. Minimally displaced left fifth rib fracture.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911935

Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0103 - TR PELVIS 1 VIEW -- 6911935

XR PELVIS 1 VIEW

HISTORY: Pain, trauma

COMPARISON: None.

TECHNIQUE: Pelvis, one view.

FINDINGS:

Lower spine hardware fixation. Left pelvic fractures including of pubic rami and acetabulum with malalignment at left hip with proximal and medial migration of femur are noted with fracture at least of region of femoral head. There are lucencies in region of right acetabulum as well, correlate with physical exam to assess for fracture in that region.

IMPRESSION:

Fractures with malalignment on the left with presumed associated hematoma. Please see above comments.

110

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911938

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0018 - TR CT BRAIN W/O CONTRAST -- 6911938

CT BRAIN WITHOUT CONTRAST

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Thin section axial CT images were obtained from the vertex of the skull to the foramen magnum without contrast. All images were reviewed and interpreted.

CONTRAST: None.

FINDINGS:

Normal cerebral hemispheres. Normal cerebellum and brainstem. No hydrocephalus. Normal ventricles, sulci, and basilar cisterns. No intracranial hemorrhage. No intracranial edema. No mass effect. The visualized paranasal sinuses and mastoid air cells are clear. Normal calvarium and skull base. No hypodense or hyperdense intracranial lesions. No evidence of acute infarct, mass, hemorrhage.

IMPRESSION:

Unremarkable CT of the brain without contrast.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911939

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0012 - TR CT CERVICAL SPINE W/O CONTRAS -- 6911939

CT CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Trauma.

COMPARISON: None.

TECHNIQUE: Thin section axial CT images were obtained from the foramen magnum to the T1 vertebral body. Thin section sagittal and coronal reconstructed images were performed from the axial data set. All images were reviewed and interpreted.

CONTRAST: None.

FINDINGS:

There is reversed cervical lordosis. There is mild degenerative disk disease at C2-C3 through C6-C7.

There is congenital nonunion of the posterior C1 ring.

There is moderate to severe left C3-C4, mild right C4-C5 and mild right C5-C6 neural foraminal stenosis.

Cervical vertebrae have intact cortical margins, normal height and alignment.

IMPRESSION:

No cervical spine fracture or malalignment noted.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911940

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0163 - TR CT ABD AND PELVIS IV ONLY -- 6911940

CT OF THE ABDOMEN AND PELVIS WITH CONTRAST:

CLINICAL HISTORY: Trauma

COMPARISONS: None.

TECHNIQUE: Contiguous axially collimated images were obtained from the lung bases through the proximal femurs, after the uneventful intravenous administration of iodinated contrast. Postprocessing of the images was performed. Coronal reformatted images were prepared on a separate workstation and reviewed for anatomic correlation.

CONTRAST: Iodinated intravenous contrast

FINDINGS:

Lung bases: Unremarkable.
Liver: Normal.
Gallbladder: Normal.
Biliary tree: No ductal dilatation.
Pancreas: Normal.
Spleen: Normal.
Adrenal glands: Normal.
Kidneys: Normal, without urolithiasis or hydronephrosis.
Urinary bladder: Grossly unremarkable.
Pelvic structures: Unremarkable.
Bowel: To the extent evaluated with CT, the abdominal bowel is without evidence of obstruction, gross mass, or inflammatory change. There is no significant diverticulosis. There is no evidence of diverticulitis.
Lymph nodes: No pathologically enlarged lymph nodes identified.
Peritoneum: No intraperitoneal free air. No free intraperitoneal fluid.
Mesentery: Mild patchy mesenteric fat stranding is demonstrated within the proximal sigmoid mesentery best appreciated on images 77 and 74 series 210. No discrete mesenteric hematoma identified.
Retroperitoneum: The retroperitoneum is unremarkable.

Aorta: Normal in caliber.
Body wall: No body wall mass.
Osseous structures: There is a T-shaped transverse left acetabular fracture. The iliac fragment contains a large portion of the acetabular dome. The initial tuberosity fragment contains a small portion of the posterior/inferior acetabulum. The left superior pubic ramus fracture contains a small component of the anteroinferior acetabulum. There is isolation of a 3.4 x 1.2 cm fragment containing the posterosuperior acetabulum. This fragment is posteriorly and laterally displaced approximately 3 mm in relation to the acetabular dome fragment. The iliac fragment is laterally displaced 1.4 cm in relation to the superior pubic ramus fragment. The ischial tuberosity fragment is medially displaced 3.9 cm in relation to the iliac fragment. A minimally displaced fracture through the left inferior pubic ramus is evident. There is posterior left hip dislocation with a fracture through the head and proximal neck of the femur. This isolates a portion of the anterior femoral head which is displaced 3 cm distal and lateral to the donor site. The dislocated proximal femur is situated within the greater sciatic foramen. There is mild widening of the left sacroiliac joint. Refer to the CT chest for a discussion of rib fractures. There has been prior L5-S1 posterior spinal fusion with anterior interbody spacer placement.

IMPRESSION:

1. Transverse T shaped left acetabular fracture.
2. Posterior left hip dislocation.
3. Mild left sacroiliac diastasis.
4. Mild sigmoid mesenteric fat stranding may represent contusion. No discrete hematoma identified.

120

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911941

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0101 - TR CT CTA LOWER EXTREMITY -- 6911941

CTA BILATERAL LOWER EXTREMITIES WITHOUT & WITH CONTRAST

HISTORY: Left knee trauma

COMPARISON: None.

TECHNIQUE: Initially, thin section noncontrast images through portions of the extremity were obtained for the purposes of establishing proper bolus timing of contrast. Subsequently, thin section axial CT images were obtained through the area of clinical interest in the lower extremity after intravenous administration of nonionic iodinated contrast. To optimally assess the lower extremity vasculature, the original axial data was used to create 3D volume rendered, multi-planar reformatted and/or maximum intensity projection images in various planes. The axial and reformatted data were reviewed for this report.

CONTRAST: Iodinated intravenous contrast

FINDINGS:

Nonvascular findings:
Refer to the dedicated CT abdomen pelvis study for a discussion of the left pelvic fractures. There is moderate diastasis of the lateral femorotibial compartment within the left knee. A vertically oriented fracture line is demonstrated through the lateral aspect of the patella with mild lateral displacement of the lateral fracture fragment. Mild pneumarthrosis is present. It is also made of a moderately comminuted distal tibial shaft fracture.

Vascular findings:
There is complete traumatic occlusion of the left popliteal artery immediately distal to the origin of the superior geniculate branches. There is a 9.2 cm long segment of occlusion with reconstitution of flow demonstrated within the far distal aspect of the popliteal artery. Flow is demonstrated throughout the entirety of the left posterior tibial.

Traumatic injury of the distal anterior tibial artery is suspected at the site of the distal tibial fracture site without contrast opacification of the dorsalis pedis artery noted. No active arterial extravasation identified. No pseudoaneurysm demonstrated.
The right lower extremity arterial tree is within normal limits. No aneurysm identified.

IMPRESSION:

1. Traumatic occlusion of the left popliteal artery with reconstitution detailed above.
2. Left anterior tibial artery traumatic occlusion.

These findings were discussed with Dr. Van Wagonar by Jerrell Ingalls M.D. on 3/7/2015 2:36 AM PST.

120

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911943
Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0015 - TR CT CHEST WITH CONTRAST -- 6911943

CT CHEST WITH CONTRAST

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: After the uneventful intravenous administration of nonionic iodinated contrast, thin section axial CT images were obtained from the thoracic inlet through the lung bases and adrenal glands. Thin section coronal images were reconstructed from the axial data set. All images were reviewed and interpreted.

CONTRAST: Given FINDINGS:

There is bilateral lower lobe atelectasis. The lungs are clear otherwise. No definite pulmonary contusion noted. There is no pneumothorax, pleural effusion, pericardial effusion, lymphadenopathy or mediastinal hematoma. Thoracic aorta is normal.

Fracture noted in the left lateral fifth rib.

IMPRESSION:

Fracture noted in the left lateral fifth rib.

Bilateral lower lobe atelectasis noted.

Unremarkable exam otherwise. Normal thoracic aorta.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911945
Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0065 - TR HUMERUS (LEFT) -- 6911945

XR HUMERUS

HISTORY: Pain

COMPARISON: None.

TECHNIQUE: Left humerus, 2 views.

FINDINGS:

Comminuted fracture of mid humeral diaphysis with distraction, angulation and overriding is noted with soft tissue swelling. There is also fracture of proximal ulna/olecranon with commination with articular extension, suggest dedicated elbow radiography.

IMPRESSION:

Humeral diaphyseal fracture and fracture in region of elbow/ulna.

124

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911946
Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0140 - TR CT THORACIC SPINE RECONS -- 6911946

Thoracic spine CT.

Information: Trauma

Findings:

Reformatted thoracic spine CT images obtained.

The thoracic vertebrae have intact cortical margins, normal height and alignment.

There is multilevel mild degenerative disk disease.

At T4-T5, there is a left paracentral disk osteophyte complex indenting into the intrathecal sac.

Impressions:

No evidence of thoracic spine fracture or malalignment noted.

Thoracic spine CT.

Information: Trauma

Findings:

Reformatted thoracic spine CT images obtained.

The thoracic vertebrae have intact cortical margins, normal height and alignment.

There is multilevel mild degenerative disk disease.

At T4-T5, there is a left paracentral disk osteophyte complex indenting into the intrathecal sac.

DS

Impressions:

No evidence of thoracic spine fracture or malalignment noted.

120

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911947

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0141 - TR CT LUMBAR SPINE RECONS -- 6911947

Lumbar spine CT

Information: Trauma

Findings:

Reformatted lumbar spine CT images obtained.

There is anterior and posterior fusion at L5-S1 with diskectomy, intervertebral spacer placement and bilateral pedicle screws and stabilizing rods. No evidence of hardware failure noted.

Streak artifact compromised examination.

Within the limitation of study, no evidence of cortical disruption identified. Lumbar vertebrae have normal height and alignment.

There is mild degenerative disk disease at L2-L3, L3-L4 and L4-L5. There is grade 1 degenerative retrolisthesis of L2 over L3 by about 2 mm area

Impression:

No evidence of lumbar spine fracture.

Postoperative changes at L5-S1 noted.

IMPRESSION: \

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911952

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0141 - TR TIBIA FIBULA (LEFT) -- 6911952

XR TIBIA FIBULA 2 VIEWS

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left tibia and fibula, 2 views.

FINDINGS:

A moderately comminuted distal tibial shaft fracture is present without definite articular extension. Additionally, there is a mildly comminuted fractures through the distal tibial shaft approximately 2 cm proximal to the tibiotalar joint. The lateral malleolar fragment is anatomic with the tibial plafond fragment. There is redemonstration of proximal tibiofibular articulation widening. Note is made of intra-articular gas within the knee joint along with moderate widening of the lateral femorotibial compartment.

IMPRESSION:

1. Comminuted distal tibial shaft fracture.
2. Comminuted distal fibular shaft fracture.
3. Lateral femorotibial compartment diastasis.

128

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911953
Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0037 - TR FEMUR (LEFT) -- 6911953

XR FEMUR

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left femur, 2 views.

FINDINGS:

There is a left acetabular fracture, either transeverse or both column. The acetabular dome fragment is laterally displaced 2.7 cm in relation to the superior pubic ramus fracture fragment. Left hip dislocation is noted, either central or anterior. This could be evaluated at the time of CT. Additionally, an inferior left pubic ramus fracture is evident with 5 mm of inferior displacement of the ischial tuberosity fragment. There is a partially visualized lateral tibial plateau fracture. Widening of the proximal tibiofibular articulation is evident.

IMPRESSION:

1. Left acetabular fracture.
2. Left hip dislocation.
3. Widening of the proximal tibiofibular articulation compatible with traumatic subluxation/dislocation.

DA

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911954

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:32
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:32AM
PROCEDURE: TRD 0045 - TR FOOT LIMITED (LEFT) -- 6911954

XR FOOT

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left foot, 1 views.

FINDINGS:

Evaluation for fracture is limited by the lack of an orthogonal view. No grossly evident fracture or dislocation. Soft tissue swelling and gas is demonstrated about the medial hind foot.

IMPRESSION:

1. No definite fracture identified.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911979
Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 02:29
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 2:29AM
PROCEDURE: TRD 0052 - TR HAND LIMITED (LEFT) -- 6911979

XR HAND 2 VIEWS

HISTORY: Pain

TECHNIQUE: Left hand, 2 views.

FINDINGS:

On the frontal view, lucency projects over proximal portion of distal phalanx of first digit, without corresponding finding on other images, could be artifact, correlate with physical exam to exclude nondisplaced fracture. No acute fracture, malalignment, or destructive mass is identified. If concern for fracture remains, consider short follow-up radiography in 7-10 days.

IMPRESSION:

Lucency projecting over proximal portion of distal phalanx of first digit as described, otherwise no evidence of acute osseous abnormality.

13L

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911980
Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 02:29
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 2:29AM
PROCEDURE: TRD 0047 - TR FOREARM (LEFT) -- 6911980

XR FOREARM 2 VIEWS

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left forearm, 2 views.

FINDINGS:

There is a transversely oriented fracture through the proximal ulna at the olecranon process site. This extends to the trochlear notch. The olecranon process fragment is proximally displaced 7 mm. No additional fracture identified. An overlying fiberglass splint limits assessment of osseous detail. Circumferential elbow and forearm soft tissue swelling is evident.

IMPRESSION:

1. Mildly displaced proximal ulnar fracture.

(30)

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: TRCH:0201
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6912010

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 04:57
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 4:57AM
PROCEDURE: TRD 0141 - TR TIBIA FIBULA (LEFT) -- 6912010

INTRAOPERATIVE FLUOROSCOPY: 3/7/2015 4:57 AM PST

CLINICAL HISTORY: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 13 spot image(s) were submitted for interpretation. Interpretation is limited by the lack of the radiologist present during the procedure. Please refer to the operator's notes. Grossly, the images demonstrate gross anatomic alignment of the distal tibia status post lateral plate and screw fixation of the distal fibular fracture with syndesmotic screws as well as external fixation of the tibial shaft fracture.

Fluoroscopy time: 0.8 minutes.

IMPRESSION:

Intraoperative fluoroscopy.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KHASHMJI, HASANALI
Order Number: 6912114

Order Date: 03/07/2015

Interpreting Radiologist: COSTELLO, THOMAS
Dictated on: 03/07/2015 at 08:30
Signed and Finalized by: COSTELLO, THOMAS on 03/07/2015

Exam Charge Date: Mar 7 2015 8:30AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6912114

XR CHEST 1 VIEW

HISTORY: Intubation

TECHNIQUE: Chest, 1 view.

COMPARISON: Same day

FINDINGS:

Endotracheal tube is in good position above the carina. Right subclavian central line is in good position with its tip in the region of the superior vena cava near the right atrium. Nasogastric tube passes into the stomach.

There is poor expansion of both lungs. No major atelectasis. No consolidation. No pleural effusions. No pneumothorax. The heart size is normal. The pulmonary vascularity is normal. The mediastinal contour is normal. The hila are not enlarged. No acute bony abnormalities are present.

IMPRESSION:

Tubes and catheters are in good positions.
Poor expansion of both lungs.

Some abnormalities may not be detectable on portable exams.

12A

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2261

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KHASHWJI, HASANALI
Order Number: 6912162

Order Date: 03/07/2015

Interpreting Radiologist: HOYE, STEPHEN
Dictated on: 03/07/2015 at 10:21
Signed and Finalized by: HOYE, STEPHEN on 03/07/2015

Exam Charge Date: Mar 7 2015 10:21AM
PROCEDURE: TRD 0064 - TR HIP I VIEW (LEFT) -- 6912162

Left hip one view

Indication: Appropriate alignment post traction placement

Findings: Single limited frontal and lateral view the left hip submitted. There is a comminuted left acetabular fracture with fracture of the left inferior pubic ramus. The left hip appears dislocated although the direction cannot be definitively determined based on this image alone.

Impression: Comminuted appearing acetabular fracture with left inferior pubic ramus fracture. Left hip dislocation which is limitedly assessed on one view. Overall limited study related to patient body habitus with limited visualization of the femoral head.

Left hip one view

Indication: Appropriate alignment post traction placement

Findings: Single limited frontal and lateral view the left hip submitted. There is a comminuted left acetabular fracture with fracture of the left inferior pubic ramus. The left hip appears dislocated although the direction cannot be definitively determined based on this image alone.

Impression: Comminuted appearing acetabular fracture with left inferior pubic ramus fracture. Left hip dislocation which is limitedly assessed on one view. Overall limited study related to patient body habitus with limited visualization of the femoral head.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: SALDANHA, VILAS
Order Number: 6912534

Order Date: 03/07/2015

Interpreting Radiologist: SHIH, JIMMY
Dictated on: 03/07/2015 at 20:33
Signed and Finalized by: SHIH, JIMMY on 03/07/2015

Exam Charge Date: Mar 7 2015 8:33PM
PROCEDURE: TCT 0145 - TR CT PELVIS RECONS -- 6912534

CT PELVIS RECONSTRUCTION

INDICATION: Fracture.

COMPARISON: None.

TECHNIQUE: Contiguous reconstructed axial images of the pelvis obtained. Thin section sagittal and coronal images were reconstructed from the axial data set. Utilizing dedicated software and workstation, 3-D volume rendering images were created.

CONTRAST: None.

FINDINGS: 3-D volume rendering images demonstrate T-shaped comminuted left acetabular fracture with posterior hip dislocation. There is significant fracturing of the left femoral head which abuts the posterior aspect of the left acetabulum. Comminuted inferior left pubic ramus fracture noted. There is mild diastases left SI joint.

Please see CT abdomen and pelvis report for complete details.

IMPRESSION: 3-D volume rendering images created redemonstrating comminuted T-shaped left acetabular fracture with posterior left hip dislocation.

IMPRESSION: \

130

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 99290[illegible]3215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MCNICOLL, CHRISTOPHER
Order Number: 6912763
Order Date: 03/09/2015

Interpreting Radiologist: YEH, RICK
Dictated on: 03/09/2015 at 03:07
Signed and Finalized by: YEH, RICK on 03/09/2015

Exam Charge Date: Mar 9 2015 3:07AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6912763

XR PORTABLE AP CHEST

HISTORY: Intubation

COMPARISON: March 7, 2015

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Support devices are overall stable. Heart size is within normal limits. The lungs are better aerated than on the prior exam. There is likely mild volume overload and mild basilar atelectasis. The pleural spaces are clear.

IMPRESSION:

Improved aeration of the lungs compared to the prior exam. There is likely mild volume overload.

137

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: SYLVAIN, GERALD
Order Number: 6912842
Order Date: 03/08/2015

Interpreting Radiologist: SINGH, SUKHJINDER
Dictated on: 03/08/2015 at 12:05
Signed and Finalized by: SINGH, SUKHJINDER on 03/08/2015

Exam Charge Date: Mar 8 2015 12:05PM
PROCEDURE: SUG 0081 - OR HIP COMPLETE (LEFT) -- 6912842

HISTORY: Fluoroscopic guidance

Fluoroscopy time: 84 seconds.

TECHNIQUE: Fluoroscopy

FINDINGS: Fluoroscopy provided for procedure guidance. Multiple fluoroscopic spot images demonstrate ORIF of left hemipelvis and left femur. Radiologist was not in attendance. Please see operative report for further details.

HISTORY: Fluoroscopic guidance

Fluoroscopy time: 84 seconds.

TECHNIQUE: Fluoroscopy

FINDINGS: Fluoroscopy provided for procedure guidance. Multiple fluoroscopic spot images demonstrate ORIF of left hemipelvis and left femur. Radiologist was not in attendance. Please see operative report for further details.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6913764

Order Date: 03/09/2015

Interpreting Radiologist: SHIH, JIMMY
Dictated on: 03/09/2015 at 21:48
Signed and Finalized by: SHIH, JIMMY on 03/09/2015

Exam Charge Date: Mar 9 2015 9:48PM
PROCEDURE: SUG 0086 - OR HUMERUS (LEFT) -- 6913764

INTRAOPERATIVE FLUOROSCOPY

INDICATION: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 20 spot image(s) were submitted for interpretation. Interpretation is limited by the lack of the radiologist present during the procedure. Please correlate with operative report for complete details. Grossly, the images demonstrate ORIF of the left humerus and proximal ulna.

Fluoroscopy time: 5.3 minutes.

IMPRESSION: Intraoperative fluoroscopy.

IMPRESSION: \

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONICOLL, CHRISTOPHER
Order Number: 6913994
Order Date: 03/10/2015

Interpreting Radiologist: MECCA, MICHAEL
Dictated on: 03/10/2015 at 03:27
Signed and Finalized by: MECCA, MICHAEL on 03/10/2015

Exam Charge Date: Mar 10 2015 3:27AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6913994

XR PORTABLE AP CHEST

HISTORY: intubated

COMPARISON: 1 day prior

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Support devices in place unchanged. The lung volumes are low at exposure, mildly limiting interpretation. Within this limit, the lungs are clear apart from mild bibasilar atelectasis. No large pleural effusions. Heart and mediastinal contours within normal, pulmonary vasculature within normal limits.

IMPRESSION:

No acute findings. Stable examination.

140

PROBLEM LIST/MANAGEMENT: Multiple left-sided pelvic fractures with hip dislocation and femoral head fracture, left-sided comminuted tibia and fibular fracture with diastasis of the tibia-fibular joint near the knee. All of these fractures are open with significant loss of tissue and degloving injury to the anterior aspect of the knee. Dr. Monroe with Orthopedics was consulted, personally came and evaluated the patient, evaluated all films, and will be taking the patient to the operating room for washout with possible fixation of these fractures. The patient also sustained a left humerus fracture and olecranon fractures in conjunction with the laceration of the left elbow, likely represents an open fracture, which will also be taken by Dr. Monroe to the operating room for washout and possible fixation. Patient has a left rib fracture. He will be monitored for possible signs of pulmonary compromise; however, no major abnormalities on the CT scan were observed with exception of the rib fracture and a small amount of atelectasis. The patient also has a small amount of sigmoid fat stranding. We will perform serial abdominal evaluations to rule out the possibility of an occult bowel injury. Patient has an injury to the left popliteal artery at the level of the posterior knee dislocation. Dr. Quynh Feikes with Vascular Surgery was consulted. She is awaiting the results of Dr. Monroe's orthopedic procedure with fixation for further recommendations. We will follow up her recommendations. Dr. Monroe with Orthopedic Surgery was given a number to contact Dr. Quynh Feikes upon the completion of his procedure. Patient also has superficial abrasions to the right hand and right knee for which we will perform local wound care. Following the operation, the patient be sent to the ICU for aerial neurovascular checks.

Dr. Deborah Kuhls was present for this activation, directed all patient care and procedures.

ZDV/MedQ
DD: 03/07/2015 02:56:04
DT: 03/07/2015 04:07:09

ZACHARY D VANWAGONER, MD (RESIDENT)

DEBORAH A KUHLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 352100/646608958
PHYSICIAN: DEBORAH A KUHLS, MD
DICTATED BY: ZACHARY D VANWAGONER, MD (RESIDENT)

TRAUMA CENTER HISTORY AND PHYSICAL

30

UMC

Surgical Services - Implant Log

Patient: FIGUEROA DAVID MANUEL ACCT: 8928043216 DOB: 10/28/1970 MR# 0001906211 44Y M ADM: 03/07/15

Date of Procedure: 3/16/15

Circulator Signature: M Hmm

Procedure: ORIF Left Ankle

Synthes Plate 3.5mm

Product Sticker	Product Name	Lot and Serial Number	Quantity
241.453 17 holes 226mm			1
3.5mm locking screws 212.107 x 1 22mm			
212.113 x 3 18mm			
212.115 40mm x 1			
212.120 42mm x 2			
212.134 44mm x 1			
212.136 46mm x 1			

UMC UNIVERSITY MEDICAL CENTER

Surgical Services - Implant Log

ACCT: 8928043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MRN: 0001806211 ADM: 03/07/15

Date of Procedure: 3/8/15

Circulator Signature:

Procedure: Left
ORIF: Acetabular & Femoral Head Fractures
Synthes Implants.

Product Sticker	Product Sticker
3.5mm Pelvic Cortex Screws Product Name: 204.640 x 2 (40mm) 204.665 x 1 (65mm x 95mm) 804.665 x 1 Lot and Serial Number / Quantity	4.5mm Headless Compression Product Name: 02.226.740 x 2 Lot and Serial Number / Quantity
Product Sticker 3.5mm Cortex Screws Product Name: 204.820 x 3 (20mm) Lot and Serial Number / Quantity	Product Sticker 4.5mm Headless Compression Product Name: 02.226.746 x 1 Lot and Serial Number / Quantity
Product Sticker 3.5mm Low Profile Recon. Plates Product Name: 245.024 x 1 (52mm) Lot and Serial Number / Quantity	Product Sticker Product Name Lot and Serial Number / Quantity
Product Sticker 3.5 mm Low Profile Recon Plates Product Name: 245.036 x 1 (104mm) Lot and Serial Number / Quantity	Product Sticker Product Name Lot and Serial Number / Quantity
Product Sticker 6.5mm Cannulated Screws Product Name: 208.436 x 1 Lot and Serial Number / Quantity	Product Sticker Product Name Lot and Serial Number / Quantity
Product Sticker 6.5mm Cannulated Screws Product Name: 208.437 (75mm) x 1 Lot and Serial Number / Quantity	Product Sticker Product Name Lot and Serial Number / Quantity

34

UMC
UNIVERSITY MEDICAL CENTER

Surgical Services - Implant Log

Pat ACC#: 89280043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL
MRN: 0001906211 44Y M
ADM: 03/07/15

Date of Procedure: 3-7-15

Circulator Signature: Stephens

Procedure: External fixator @ tibia-fib, external fixator @ femur open reduction internal fixation left tibia

Product Sticker: Synthes locc. small frag Product Name: 3.5 mm Cortex screw, self-tapping Lot and Serial Number: # 204.824, 14mm Quantity: x4	Product Sticker: Stryker orthopedic external fixator Product Name: 5 x 150 mm Apex Pin Lot and Serial Number: # SD18-10-150 Quantity: x7
Product Sticker: Synthes locc. small frag Product Name: 3.5 mm Cortex screw, self-tap Lot and Serial Number: # 204.855, 65 mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locc. small frag Product Name: 3.5 mm Cortex screw, self-tap Lot and Serial Number: # 204.820 100 mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locc. small frag Product Name: 4.0 mm cancellous bone screw, full thread Lot and Serial Number: # 2016.010 110mm Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Synthes locc. small frag Product Name: one-third tubular locking plate 2 collar 117 mm 10-hole Lot and Serial Number: # 241.401 Quantity: x1	Product Sticker: Product Name: Lot and Serial Number: Quantity:
Product Sticker: Product Name: Lot and Serial Number: Quantity:	Product Sticker: Product Name: Lot and Serial Number: Quantity:

RECEIVED
JUN 10 2015
CCMSI Las Vegas

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Deborah A Kuhls, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON:

ANESTHESIOLOGIST:

PREOPERATIVE DIAGNOSIS: Left open olecranon fracture, and mid shaft fracture of the left humerus.

POSTOPERATIVE DIAGNOSIS: Left open olecranon fracture, and mid shaft fracture of the left humerus.

PROCEDURE: Reduction of left humerus fracture, application of splint, and placement of moist gauze over left elbow laceration.

The above patient came in as a motorcycle crash, off-duty police officer, with a deformed left upper extremity and a laceration over his left elbow. Although he has an olecranon fracture by palpation the elbow joint appeared to be intact. We reduced his left humerus and placed him in an upper extremity splint. We placed moist gauze over the laceration over the olecranon.

The patient tolerated the procedure well. He was neurovascularly intact both before and after the procedure.

DAK/MedQ
DD: 03/07/2015 03:17:47
DT: 03/07/2015 07:36:40

DEBORAH A KUHLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 726631/646609268

DICTATED BY: DEBORAH A KUHLS, MD

OPERATIVE REPORT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Alistair Jon Chapman, MD

ANESTHESIOLOGIST: Agata Vollers, MD

PREOPERATIVE DIAGNOSIS:
1. Left open knee dislocation.
2. Left open distal tibia and fibular pilon fracture.
3. Left columns acetabular fracture.
4. Left leg laceration equaling 40 centimeters.
5. Left humeral shaft fracture.

POSTOPERATIVE DIAGNOSIS:
1. Left open knee dislocation.
2. Left open distal tibia and fibular pilon fracture.
3. Left columns acetabular fracture.
4. Left leg laceration equaling 40 centimeters.
5. Left humeral shaft fracture.

TIME: 5:02

PROCEDURE:
1. Closed reduction, left knee.
2. External fixation application, femur to tibia.
3. Open reduction and internal fixation, left fibula.
4. Preliminary external fixation, open tibial pilon fracture.
5. Irrigation and debridement, left leg.
6. Primary closure, 40 centimeters.

ADDITIONAL PARTICIPATING SURGEON: Chris Goodwell, MS3.

ANESTHESIA: General.

TOURNIQUET: No tourniquet was used.

IMPLANT USED: Stryker Hoffman external fixator system with a Synthes 1/3 tubular plate on the fibula.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman involved in a motorcycle accident, sustaining mostly left leg injuries from his hip down to his ankle. Preoperative CT arteriogram shows a popliteal artery injury but with good runoff distally.

CONSENT: In consenting the patient, he understands that because of the vascular injury and the nature of his injuries there is a

possibility he may end up with an amputation in the future. We are doing preliminary stabilization of his injuries at this time.

DESCRIPTION OF PROCEDURE: The patient was placed in a supine position. After administration of general anesthesia, left lower extremity was prepped and draped in sterile fashion with 1-step Betadine. No tourniquet was used.

The knee was managed 1st. The knee was closed reduced using direct manipulation under C-arm guidance. Once good position of the knee was obtained, an anterior Hoffman fixator was placed from 2 pins in the femur and 2 pins in the tibia, this was connected by 2 bars while the knee was held in the reduced position. The fixator was adjusted, tightened, the pins were cut distally, and final images of the knee were taken.

Attention was focused down to the ankle where a significantly comminuted tibial pilon fracture was identified. In order to gain fixation, initially 2 pins were placed, 1 in the calcaneus, 1 in the tibia, spanning the fracture to hold preliminarily, after which a 12-hole 1/3 tubular plate was placed on the lateral surface with several screws across the mortise joint for additional fixation. Reduction, rotation and length of the fibula were maintained in order to provide stability to the distal ankle.

Once the fibula was fixed, an additional pin was placed in the tibia under C-arm guidance. The alignment and length and rotation were maintained. The 5-millimeter pins were connected to 2 carbon fiber bars, using the Quick Connects, these were tightened and excess pin length was carefully removed. C-arm images showed adequate reduction of the ankle with good position of the implants.

Pulse lavage irrigation was then used to irrigate thoroughly the open lacerations around the leg and knee, 6 liters of pulse lavage irrigation was used. It was noted on inspection that there was a complete disruption of the lateral joint retinaculum. The patellar tendon appeared to be intact.

A primary closure was then done using 0 Prolene with horizontal mattress sutures, approximating 40 centimeters in this complex laceration of the skin, which was in a stellate pattern.

Final images were taken, which showed good reduction with good position of the implants. The case at this point was turned over to Vascular Surgery for exploration and possible vascular bypass.

MM/MedQ
DD: 03/07/2015 05:08:52
DT: 03/07/2015 08:06:35

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 352153/6466611833

DICTATED BY: MICHAEL MONROE, MD

OPERATIVE REPORT

Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/09/2015 03:53 PM PDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

SURGEON: Quynh Peikes, M.D.

ASSISTANT SURGEON: Wesley Smith, CFT-CFA

PARTICIPATING SURGEON: Alistair Jon Chapman, MD

ANESTHESIOLOGIST: Agata Vollers, MD

PREOPERATIVE DIAGNOSIS: 1. Motorcycle accident.
2. Left lower extremity traumatic arterial injury with extensive degloving and orthopedic injuries.

POSTOPERATIVE DIAGNOSIS: 1. Motorcycle accident.
2. Left lower extremity traumatic arterial injury with extensive degloving and orthopedic injuries.

PRIMARY PROCEDURE:
1. Left popliteal artery repair with reversed saphenous vein interposition graft.
2. Open vein harvest from right lower extremity.

ANESTHESIA: General.

EBL: Less than 300 cubic centimeters.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: Patient is a 44-year-old off-duty policeman who was on his motorcycle when he was cut off by another vehicle. He sustained extensive injury to his left lower extremity, as well as pelvis and left arm. He was noted to have a dislocated left knee injury with extensive tib-fib fracture on the left lower extremity, as well as a left hip fracture. He was taken to the operating room emergently by Dr. Monroe for stabilization and currently has an ex-fix. I was notified by the trauma team that the patient also has absent palpable pulses to the left lower extremity, despite stabilization and I present now for evaluation for left lower extremity arterial injury.

FINDINGS: At the time of exploration, he had a complete transection of his popliteal artery right at the knee. There is also extensive injury and avulsion of one of the popliteal veins; the other one was intact. The nerve was seen and appeared to be somewhat bruised.

DESCRIPTION OF PROCEDURE: The patient was on the table in the operating room already, having undergone just recent external fixation by Dr. Monroe. The left and right lower extremities were then prepped and draped in a sterile manner. An incision was made medially on the

40

knee and extended down to below the knee, and dissection was carried out until the popliteal above the knee was identified. This was then controlled with vessel loop control. Further dissection to the below knee segment was carried out, and at this point, we found a short-segment of injury, about a 2 to 3 centimeter gap from an avulsed popliteal artery. The vein itself on one of the branches was also injured. At this point, once the artery was isolated and dissected out. The patient was then heparinized with 5000 units of heparin IV. After allowing for several minutes of circulation, the artery was clamped proximally and distally. The edges of the artery itself were debrided back to clean, viable tissue. At this point, we were left with a segment about 3 centimeters or so. Open vein harvest was carried out on the right lower extremity near the ankle, and there was a good vein segment from the saphenous vein there that was taken. Once done with open harvest, the artery was repaired with the saphenous vein graft in reverse as an interposition graft. This was done end-to-end on both proximal and distal ends using a running 6-0 Prolene suture. Once completed, the graft was flushed out there was a good triphasic Doppler signal down the posterior tibia. Hemostasis was obtained. The incision was then reapproximated with interrupted 0 Vicryl suture for muscle, fascia, and tendon. The subcutaneous tissue was closed with 2-0 Vicryl, and skin was closed with staples. The open harvest site on the right lower extremity was also closed in multiple layers with 2-0 and 3-0 Vicryl suture, and skin was closed with 3-0 Monocryl subcuticular stitch and sealed with Dermabond. Sterile dressing was applied. Patient tolerated the procedure. After the procedure, all needle and sponge counts were correct. The patient was left ventilated and moved back to the trauma ICU for further care by the Trauma Service.

QF/MedQ
DD: 03/08/2015 12:12:59
DT: 03/08/2015 13:50:00

QUYNH FEIKES, M.D.

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 728756/646700908

DICTATED BY: QUYNH FEIKES, M.D.

OPERATIVE REPORT

41

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/09/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Jose Zeron, CST

ANESTHESIOLOGIST: Dr. Adangh

PREOPERATIVE DIAGNOSIS:
1. Left humeral shaft fracture.
2. Left olecranon fracture.

POSTOPERATIVE DIAGNOSIS:
1. Left humeral shaft fracture.
2. Left olecranon fracture.

Time: 2133 hours.

PROCEDURE PERFORMED:
1. Closed reduction, intramedullary rodding, left humeral shaft.
2. Open reduction and internal fixation left olecranon fracture.

ANESTHESIA: General.

TOURNIQUET TIME: None.

IMPLANT USED: Stryker humeral nail with a Stryker 6.5 millimeter screw.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman who presents following a motorcycle accident with left-sided injuries including the lower extremity and the upper extremity. He comes in for his upper extremity fixation. Informed consent is obtained from the family.

PROCEDURE: The patient was placed in a supine position. After administration of general anesthesia, the left upper extremity was prepped and draped in a sterile fashion with ChloraPrep. No tourniquet was used for the case.

A 2 centimeter incision was made proximally through which a guide pin was placed into the greater tuberosity. This was then overdrilled and a guidewire was passed across the fracture. The appropriate size nail length was selected and reaming was done to 1 millimeter over the nail size.

The nail was impacted into place, locked proximally, compressed and locked distally. It was noted at this time that some distraction was

AD

still present at the fracture site. The proximal locking screw and guide were removed prior to the distal lock which required replacement of the proximal jig.

Approximately 1 hour of surgical time was spent replacing the proximal jig, repositioning the C-arm and getting the proximal lock in the appropriate position. Final images showed good reduction of the fracture with good position of the implant.

The olecranon was then approached. There was an open laceration. This was extended. The olecranon fracture was identified and fixed with a point of reduction forceps. A 1.6 millimeter cannulated K-wire was placed down the olecranon shaft. This was overdrilled and the appropriate size 6.5 millimeter cannulated screw was inserted. Good position of the screw with good reduction of the olecranon was maintained.

Final images showed good position of all the implants. All incisions were irrigated and closed with 2-0 Vicryl and staples, and a sterile compressive dressing was placed on the patient, who was discharged back to the ICU in stable condition.

MM/MedQ
DD: 03/09/2015 21:36:56
DT: 03/10/2015 10:03:06

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 732550/646881781

DICTATED BY: MICHAEL MONROE, MD

OPERATIVE REPORT
Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/11/2015 02:40 PM PDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/08/2015

SURGEON: Gerald Mark Sylvain, MD

ASSISTANT SURGEON: Vilas Saldanha, M.D.

PARTICIPATING SURGEON:

ANESTHESIOLOGIST: Dr. Goffstein

PREOPERATIVE DIAGNOSIS: 1. Left T type acetabular fracture with fracture of both columns of the acetabulum.
2. Displaced left femoral head fracture.
3. Left trochanteric femur fracture.

POSTOPERATIVE DIAGNOSIS:

PROCEDURES PERFORMED:
1. Open reduction and internal fixation of left acetabular fracture.
2. Open reduction and internal fixation of left femoral head fracture.
3. Open reduction and internal fixation of left trochanteric fracture.

ANESTHESIA: General.

COMPLICATIONS: There were no complications.

PATIENT DISPOSITION: Stable to recovery.

INDICATIONS: The patient is a 44-year-old male with a history of severe injury with multiple trauma. The patient had a comminuted fracture dislocation of his femoral head and acetabulum along with a trochanteric femur fracture. The decision was made to proceed real emergently with operative repair and stabilization.

PROCEDURE IN DETAIL: The patient was taken to the operating room and underwent general anesthetic induction. He was then placed in the right lateral decubitus position, exposing the left hip on a pegboard. He was prepped and draped using the normal sterile technique. The patient did have distal external fixators which were sterilely covered.

An incision was made extending from his proximal femur up to the iliac crest. Tissue was dissected down to the fascia lata. This was spread longitudinally in line with the incision. The gluteus fibers were split in line with the fibers. There was a trochanteric fracture with attachment of the abductors. This was lifted anteriorly. The patient's femoral head was grossly dislocated with significant displacement of the fractures. The hip was externally rotated to

44

expose the joint. This was used to aid in reduction of the transverse portion of the fracture. The large femoral head fragment was obtained and reduced. This was held in place using pins from a Synthes 4.5 headless screw set and were placed across the fracture with excellent stability and security of the articular femoral head. Next, the head was reduced into the acetabulum. This was used to aid in templating the posterior column and wall portion of the T type fracture. The posterior column was reduced using 2 screws and a reduction clamp. This stabilized the posterior column in a reduced position which was also held manually. A 4-hole pelvic plate was then placed across the posterior column and secured using proximal and distal 3.5 cortical screws with excellent reduction. Next, the comminuted bone loss area was filled in with bone graft from a large cancellous portion of the fracture. The posterior wall was then reduced and an 8-hole pelvic plate was contoured to fit along the posterior column. This was secured with proximal and distal screws, 2 ilium screws and 2 screws into the ischium. Excellent buttressing of the posterior wall was obtained with good reduction seen under C-arm fluoroscopy. Two guidepins from the 6.5 cannulated screw were placed from the posterior column through the anterior column. Two 6.5 cannulated screws were then placed, further securing the anterior column in reduced position. C-arm fluoroscopy was used to check reduction as well as placement of hardware.

The wounds were irrigated. The capsule was then approximated using a #1 Vicryl suture. The trochanteric fracture was reduced and secured using 2 3.5 cortical screws with washers. The wound was then further irrigated. The fascia lata was closed using #1 Vicryl suture, subcutaneous tissues were closed using 2-0 Vicryl and skin was closed using staples. Antibiotic ointment was placed followed by a sterile dressing.

The patient tolerated the procedure well and was taken to recovery in stable condition.

GMS/MedQ
ID: 03/10/2015 16:28:28
DT: 03/10/2015 21:27:19

GERALD MARK SYLVAIN, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 360747/647016082

DICTATED BY: GERALD MARK SYLVAIN, MD

OPERATIVE REPORT

Electronically Authenticated by:
Gerald M Sylvain, MD On 03/19/2015 02:28 PM EDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/16/2015

SURGEON: Michael Monroe, MD

ASSISTANT SURGEON:

PARTICIPATING SURGEON: Jose Zeron, CST

ANESTHESIOLOGIST: Dr. Hoon

PREOPERATIVE DIAGNOSIS:
1. Left lower extremity multitrauma.
2. Left tibia and fibular pilon fracture.
3. Left knee and tibia and fibular retained external fixators.

POSTOPERATIVE DIAGNOSIS:
1. Left lower extremity multitrauma.
2. Left tibia and fibular pilon fracture.
3. Left knee and tibia and fibular retained external fixators.
4. Left olecranon malunion.
5. Left olecranon retained hardware.

PROCEDURE:
1. Open reduction and internal fixation of left tibial pilon fracture.
2. External fixator removal from tibia and fibula.
3. Revision open reduction and internal fixation of left olecranon.
4. Hardware removal of left olecranon.

ANESTHESIA: General.

TOURNIQUET TIME: Less than 1 hour on the tibia, less than 1 hour on the upper extremity.

INDICATION FOR PROCEDURE: Mr. Figueroa is a 44-year-old gentleman who was in a motorcycle accident sustaining an injury to his left tibia, knee dislocation, acetabular fracture and upper extremity fractures. He comes in for a secondary procedure which is removal of the external fixator and fixation of the tibia. Previously, he had this humerus and olecranon fixed. In the preop he notes that he was rolling over and felt a pop in his left elbow, so we told him at that time that we would evaluate his olecranon while he was in surgery.

PROCEDURE IN DETAIL: The patient is placed in a supine position. After administration of general anesthesia, left lower extremity was prepped and draped in a sterile fashion with 1-step Betadine. The external fixator is removed from the knee and the tibia. The knee was then evaluated radiographically, stable concentric reduction was obtained in the knee. The distal tibia showed an area of comminution with significant bony and soft tissue involvement. A decision was

46

made to do a distal and a more proximal incision and to use a bridge plate technique for this tibial pilon fracture.

The incision was made distally along the course of the anterior tibial tendon, carried down sharply through skin and subcutaneous tissue. Care was taken to avoid neurovascular structures. Electrocautery was used to control bleeding. The fracture site was identified and the distal fragment was noted.

A 2nd incision was made proximally. Radiographs showed the position of the plate just proximal to the most distal fracture site. Both incisions extended approximately 8 centimeters.

A long Synthes anterior lateral plate was then placed on the ankle and a combination of locking and nonlocking screws were used to secure fixation. C-arm image was used in both AP and lateral planes in order to determine the position of the bone.

The final images showed good reduction of the tibia. Good reduction of the fibula with a significant comminution at the metadiaphysis with good alignment and articular congruity.

The incisions were then irrigated, closed with 0 Vicryl, 2-0 Vicryl and 3-0 nylon and a sterile compressive dressing was placed on the ankle as well as the knee, which was a long leg molded anterior-posterior splint.

At the end of the case the elbow was evaluated and displacement or malposition of the fracture was identified. The technique of a single 6.5-millimeter screw would not be adequate for this patient. Therefore it was converted to a tension band wire technique.

The incision was extended proximally and distally. The fracture site was opened, irrigated and fixed. It was held with a point of reduction forceps. Two 2-millimeter K-wires were then passed across the fracture and a 16-gauge wire was placed using a tension band technique under the K-wires. These wires were then bent and impacted into the bone. Final images showed good reduction with good position of the wires. The wires were cut short, bent, and left under the skin. The incisions were irrigated and closed with 2-0 nylon and a sterile compressive dressing was placed on the patient who was discharged to the recovery room in satisfactory condition. No complications.

MM/MedQ
DD: 03/16/2015 12:52:58
DT: 03/16/2015 16:24:33

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 375482/547700527

DICTATED BY: MICHAEL MONROE, MD

47

OPERATIVE REPORT

Electronically Authenticated and Edited by:
Michael Monroe, MD On 03/20/2015 11:09 AM PDT

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911934

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6911934

XR CHEST 1 VIEW

HISTORY: Trauma

TECHNIQUE: Chest, 1 view.

COMPARISON: None.

FINDINGS:

The overlying trauma board limits assessment. Lungs are grossly clear. No pleural effusions. No pneumothorax. The heart size is normal. The mediastinal contour is normal. A minimally displaced left lateral fifth rib fracture is noted.

IMPRESSION:

1. Minimally displaced left fifth rib fracture.

49

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911935
Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0103 - TR PELVIS 1 VIEW -- 6911935

XR PELVIS 1 VIEW

HISTORY: Pain, trauma

COMPARISON: None.

TECHNIQUE: Pelvis, one view.

FINDINGS:

Lower spine hardware fixation. Left pelvic fractures including of pubic rami and acetabulum with malalignment at left hip with proximal and medial migration of femur are noted with fracture at least of region of femoral head. There are lucencies in region of right acetabulum as well, correlate with physical exam to assess for fracture in that region.

IMPRESSION:

Fractures with malalignment on the left with presumed associated hematoma. Please see above comments.

50

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911938

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0018 - TR CT BRAIN W/O CONTRAST -- 6911938

CT BRAIN WITHOUT CONTRAST

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Thin section axial CT images were obtained from the vertex of the skull to the foramen magnum without contrast. All images were reviewed and interpreted.

CONTRAST: None.

FINDINGS:

Normal cerebral hemispheres. Normal cerebellum and brainstem. No hydrocephalus. Normal ventricles, sulci, and basilar cisterns. No intracranial hemorrhage. No intracranial edema. No mass effect. The visualized paranasal sinuses and mastoid air cells are clear. Normal calvarium and skull base. No hypodense or hyperdense intracranial lesions. No evidence of acute infarct, mass, hemorrhage.

IMPRESSION:

Unremarkable CT of the brain without contrast.

51

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911939

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0012 - TR CT CERVICAL SPINE W/O CONTRAS -- 6911939

CT CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Trauma.

COMPARISON: None.

TECHNIQUE: Thin section axial CT images were obtained from the foramen magnum to the T1 vertebral body. Thin section sagittal and coronal reconstructed images were performed from the axial data set. All images were reviewed and interpreted.

CONTRAST: None.

FINDINGS:

There is reversed cervical lordosis. There is mild degenerative disk disease at C2-C3 through C6-C7.

There is congenital nonunion of the posterior C1 ring.

There is moderate to severe left C3-C4, mild right C4-C5 and mild right C5-C6 neural foraminal stenosis.

Cervical vertebrae have intact cortical margins, normal height and alignment.

IMPRESSION:

No cervical spine fracture or malalignment noted.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911940
Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0163 - TR CT ABD AND PELVIS IV ONLY -- 6911940

CT OF THE ABDOMEN AND PELVIS WITH CONTRAST:

CLINICAL HISTORY: Trauma

COMPARISONS: None.

TECHNIQUE: Contiguous axially collimated images were obtained from the lung bases through the proximal femurs, after the uneventful intravenous administration of iodinated contrast. Postprocessing of the images was performed. Coronal reformatted images were prepared on a separate workstation and reviewed for anatomic correlation.

CONTRAST: Iodinated intravenous contrast

FINDINGS:

Lung bases: Unremarkable.
Liver: Normal.
Gallbladder: Normal.
Biliary tree: No ductal dilatation.
Pancreas: Normal.
Spleen: Normal.
Adrenal glands: Normal.
Kidneys: Normal, without urolithiasis or hydronephrosis.
Urinary bladder: Grossly unremarkable.
Pelvic structures: Unremarkable.
Bowel: To the extent evaluated with CT, the abdominal bowel is without evidence of obstruction, gross mass, or inflammatory change. There is no significant diverticulosis. There is no evidence of diverticulitis.
Lymph nodes: No pathologically enlarged lymph nodes identified.
Peritoneum: No intraperitoneal free air. No free intraperitoneal fluid.
Mesentery: Mild patchy mesenteric fat stranding is demonstrated within the proximal sigmoid mesentery best appreciated on images 77 and 74 series 210. No discrete mesenteric hematoma identified.
Retroperitoneum: The retroperitoneum is unremarkable.

Aorta: Normal in caliber.
Body wall: No body wall mass.
Osseous structures: There is a T-shaped transverse left acetabular fracture. The iliac fragment contains a large portion of the acetabular dome. The initial tuberosity fragment contains a small portion of the posterior/inferior acetabulum. The left superior pubic ramus fracture contains a small component of the anteroinferior acetabulum. There is isolation of a 3.4 x 1.2 cm fragment containing the posterosuperior acetabulum. This fragment is posteriorly and laterally displaced approximately 3 mm in relation to the acetabular dome fragment. The iliac fragment is laterally displaced 1.4 cm in relation to the superior pubic ramus fragment. The ischial tuberosity fragment is medially displaced 3.9 cm in relation to the iliac fragment. A minimally displaced fracture through the left inferior pubic ramus is evident. There is posterior left hip dislocation with a fracture through the head and proximal neck of the femur. This isolates a portion of the anterior femoral head which is displaced 3 cm distal and lateral to the donor site. The dislocated proximal femur is situated within the greater sciatic foramen. There is mild widening of the left sacroiliac joint. Refer to the CT chest for a discussion of rib fractures. There has been prior L5-S1 posterior spinal fusion with anterior interbody spacer placement.

IMPRESSION:

1. Transverse T shaped left acetabular fracture.
2. Posterior left hip dislocation.
3. Mild left sacroiliac diastasis.
4. Mild sigmoid mesenteric fat stranding may represent contusion. No discrete hematoma identified.

54

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911941

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0101 - TR CT CTA LOWER EXTREMITY -- 6911941

CTA BILATERAL LOWER EXTREMITIES WITHOUT & WITH CONTRAST

HISTORY: Left knee trauma

COMPARISON: None.

TECHNIQUE: Initially, thin section noncontrast images through portions of the extremity were obtained for the purposes of establishing proper bolus timing of contrast. Subsequently, thin section axial CT images were obtained through the area of clinical interest in the lower extremity after intravenous administration of nonionic iodinated contrast. To optimally assess the lower extremity vasculature, the original axial data was used to create 3D volume rendered, multi-planar reformatted and/or maximum intensity projection images in various planes. The axial and reformatted data were reviewed for this report.

CONTRAST: Iodinated intravenous contrast

FINDINGS:

Nonvascular findings:
Refer to the dedicated CT abdomen pelvis study for a discussion of the left pelvic fractures. There is moderate diastasis of the lateral femorotibial compartment within the left knee. A vertically oriented fracture line is demonstrated through the lateral aspect of the patella with mild lateral displacement of the lateral fracture fragment. Mild pneumarthrosis is present. It is also made of a moderately comminuted distal tibial shaft fracture.

Vascular findings:
There is complete traumatic occlusion of the left popliteal artery immediately distal to the origin of the superior geniculate branches. There is a 9.2 cm long segment of occlusion with reconstitution of flow demonstrated within the far distal aspect of the popliteal artery. Flow is demonstrated throughout the entirety of the left posterior tibial.

Traumatic injury of the distal anterior tibial artery is suspected at the site of the distal tibial fracture site without contrast opacification of the dorsalis pedis artery noted. No active arterial extravasation identified. No pseudoaneurysm demonstrated.
The right lower extremity arterial tree is within normal limits. No aneurysm identified.

IMPRESSION:

1. Traumatic occlusion of the left popliteal artery with reconstitution detailed above.
2. Left anterior tibial artery traumatic occlusion.

These findings were discussed with Dr. Van Wagonar by Jerrell Ingalls M.D. on 3/7/2015 2:36 AM PST.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911943
Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0015 - TR CT CHEST WITH CONTRAST -- 6911943

CT CHEST WITH CONTRAST

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: After the uneventful intravenous administration of nonionic iodinated contrast, thin section axial CT images were obtained from the thoracic inlet through the lung bases and adrenal glands. Thin section coronal images were reconstructed from the axial data set. All images were reviewed and interpreted.

CONTRAST: Given FINDINGS:

There is bilateral lower lobe atelectasis. The lungs are clear otherwise. No definite pulmonary contusion noted. There is no pneumothorax, pleural effusion, pericardial effusion, lymphadenopathy or mediastinal hematoma. Thoracic aorta is normal.

Fracture noted in the left lateral fifth rib.

IMPRESSION:

Fracture noted in the left lateral fifth rib.

Bilateral lower lobe atelectasis noted.

Unremarkable exam otherwise. Normal thoracic aorta.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911945

Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0065 - TR HUMERUS (LEFT) -- 6911945

XR HUMERUS

HISTORY: Pain

COMPARISON: None.

TECHNIQUE: Left humerus, 2 views.

FINDINGS:

Comminuted fracture of mid humeral diaphysis with distraction, angulation and overriding is noted with soft tissue swelling. There is also fracture of proximal ulna, olecranon with commimution with articular extension, suggest dedicated elbow radiography.

IMPRESSION:

Humeral diaphyseal fracture and fracture in region of elbow/ulna.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911946

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0140 - TR CT THORACIC SPINE RECONS -- 6911946

Thoracic spine CT.

Information: Trauma

Findings:

Reformatted thoracic spine CT images obtained.

The thoracic vertebrae have intact cortical margins, normal height and alignment.

There is multilevel mild degenerative disk disease.

At T4-T5, there is a left paracentral disk osteophyte complex indenting into the intrathecal sac.

Impressions:

No evidence of thoracic spine fracture or malalignment noted.

Thoracic spine CT.

Information: Trauma

Findings:

Reformatted thoracic spine CT images obtained.

The thoracic vertebrae have intact cortical margins, normal height and alignment.

There is multilevel mild degenerative disk disease.

At T4-T5, there is a left paracentral disk osteophyte complex indenting into the intrathecal sac.

Impressions:

No evidence of thoracic spine fracture or malalignment noted.

60

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: RUHLS, DEBORAH
Order Number: 6911947

Order Date: 03/07/2015

Interpreting Radiologist: CHIN, HUBERT
Dictated on: 03/07/2015 at 01:25
Signed and Finalized by: CHIN, HUBERT on 03/07/2015

Exam Charge Date: Mar 7 2015 1:25AM
PROCEDURE: TCT 0141 - TR CT LUMBAR SPINE RECONS -- 6911947

Lumbar spine CT

Information: Trauma

Findings:

Reformatted lumbar spine CT images obtained.

There is anterior and posterior fusion at L5-S1 with diskectomy, intervertebral spacer placement and bilateral pedicle screws and stabilizing rods. No evidence of hardware failure noted.

Streak artifact compromised examination.

Within the limitation of study, no evidence of cortical disruption identified. Lumbar vertebras have normal height and alignment.

There is mild degenerative disk disease at L2-L3, L3-L4 and L4-L5. There is grade 1 degenerative retrolisthesis of L2 over L3 by about 2 mm area

Impression:

No evidence of lumbar spine fracture.

Postoperative changes at L5-S1 noted.

IMPRESSION:

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUELS, DEBORAH
Order Number: 6911952
Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0141 - TR TIBIA FIBULA (LEFT) -- 6911952

XR TIBIA FIBULA 2 VIEWS

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left tibia and fibula, 2 views.

FINDINGS:

A moderately comminuted distal tibial shaft fracture is present without definite articular extension. Additionally, there is a mildly comminuted fractures through the distal tibial shaft approximately 2 cm proximal to the tibiotalar joint. The lateral malleolar fragment is anatomic with the tibial plafond fragment. There is redemonstration of proximal tibiofibular articulation widening. Note is made of intra-articular gas within the knee joint along with moderate widening of the lateral femorotibial compartment.

IMPRESSION:

1. Comminuted distal tibial shaft fracture.
2. Comminuted distal fibular shaft fracture.
3. Lateral femorotibial compartment diastasis.

62

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911953
Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:26
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:26AM
PROCEDURE: TRD 0037 - TR FEMUR (LEFT) -- 6911953

XR FEMUR

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left femur, 2 views.

FINDINGS:

There is a left acetabular fracture, either transverse or both column. The acetabular dome fragment is laterally displaced 2.7 cm in relation to the superior pubic ramus fracture fragment. Left hip dislocation is noted, either central or anterior. This could be evaluated at the time of CT. Additionally, an inferior left pubic ramus fracture is evident with 5 mm of inferior displacement of the ischial tuberosity fragment. There is a partially visualized lateral tibial plateau fracture. Widening of the proximal tibiofibular articulation is evident.

IMPRESSION:

1. Left acetabular fracture.
2. Left hip dislocation.
3. Widening of the proximal tibiofibular articulation compatible with traumatic subluxation/dislocation.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911954

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 01:32
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 1:32AM
PROCEDURE: TRD 0045 - TR FOOT LIMITED (LEFT) -- 6911954

XR FOOT

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left foot, 1 views.

FINDINGS:

Evaluation for fracture is limited by the lack of an orthogonal view. No grossly evident fracture or dislocation. Soft tissue swelling and gas is demonstrated about the medial hind foot.

IMPRESSION:

1. No definite fracture identified.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6911979

Order Date: 03/07/2015

Interpreting Radiologist: ASSEMI, SHAHROKH
Dictated on: 03/07/2015 at 02:29
Signed and Finalized by: ASSEMI, SHAHROKH on 03/07/2015

Exam Charge Date: Mar 7 2015 2:29AM
PROCEDURE: TRD 0052 - TR HAND LIMITED (LEFT) -- 6911979

XR HAND 2 VIEWS

HISTORY: Pain

TECHNIQUE: Left hand, 2 views.

FINDINGS:

On the frontal view, lucency projects over proximal portion of distal phalanx of first digit, without corresponding finding on other images, could be artifact, correlate with physical exam to exclude nondisplaced fracture. No acute fracture, malalignment, or destructive mass is identified. If concern for fracture remains, consider short follow-up radiography in 7-10 days.

IMPRESSION:

Lucency projecting over proximal portion of distal phalanx of first digit as described, otherwise no evidence of acute osseous abnormality.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD, LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KUHLS, DEBORAH
Order Number: 6511980

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 02:29
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 2:29AM
PROCEDURE: TRD 0047 - TR FOREARM (LEFT) -- 6911980

XR FOREARM 2 VIEWS

HISTORY: Trauma

COMPARISON: None.

TECHNIQUE: Left forearm, 2 views.

FINDINGS:

There is a transversely oriented fracture through the proximal ulna at the olecranon process site. This extends to the trochlear notch. The olecranon process fragment is proximally displaced 7 mm. No additional fracture identified. An overlying fiberglass splint limits assessment of osseous detail. Circumferential elbow and forearm soft tissue swelling is evident.

IMPRESSION:

1. Mildly displaced proximal ulnar fracture.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: TRCH:0201
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6912010

Order Date: 03/07/2015

Interpreting Radiologist: INGALLS, JERRELL
Dictated on: 03/07/2015 at 04:57
Signed and Finalized by: INGALLS, JERRELL on 03/07/2015

Exam Charge Date: Mar 7 2015 4:57AM
PROCEDURE: TRD 0141 - TR TIBIA FIBULA (LEFT) -- 6912010

INTRAOPERATIVE FLUOROSCOPY: 3/7/2015 4:57 AM PST

CLINICAL HISTORY: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 13 spot image(s) were submitted for interpretation. Interpretation is limited by the lack of the radiologist present during the procedure. Please refer to the operator's notes. Grossly, the images demonstrate gross anatomic alignment of the distal tibia status post lateral plate and screw fixation of the distal fibular fracture with syndesmotic screws as well as external fixation of the tibial shaft fracture.

Fluoroscopy time: 0.8 minutes.

IMPRESSION:

Intraoperative fluoroscopy.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KHASHMJI, HASANALI
Order Number: 6912114

Order Date: 03/07/2015

Interpreting Radiologist: COSTELLO, THOMAS
Dictated on: 03/07/2015 at 08:30
Signed and Finalized by: COSTELLO, THOMAS on 03/07/2015

Exam Charge Date: Mar 7 2015 8:30AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6912114

XR CHEST 1 VIEW

HISTORY: Intubation

TECHNIQUE: Chest, 1 view.

COMPARISON: Same day

FINDINGS:

Endotracheal tube is in good position above the carina. Right subclavian central line is in good position with its tip in the region of the superior vena cava near the right atrium. Nasogastric tube passes into the stomach.

There is poor expansion of both lungs. No major atelectasis. No consolidation. No pleural effusions. No pneumothorax. The heart size is normal. The pulmonary vascularity is normal. The mediastinal contour is normal. The hila are not enlarged. No acute bony abnormalities are present.

IMPRESSION:

Tubes and catheters are in good positions.
Poor expansion of both lungs.

Some abnormalities may not be detectable on portable exams.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: KHASHWJI, HASANALI
Order Number: 6912162

Order Date: 03/07/2015

Interpreting Radiologist: HOYE, STEPHEN
Dictated on: 03/07/2015 at 10:21
Signed and Finalized by: HOYE, STEPHEN on 03/07/2015

Exam Charge Date: Mar 7 2015 10:21AM
PROCEDURE: TRD 0064 - TR HIP I VIEW (LEFT) -- 6912162

Left hip one view

Indication: Appropriate alignment post traction placement

Findings: Single limited frontal and lateral view the left hip submitted. There is a comminuted left acetabular fracture with fracture of the left inferior pubic ramus. The left hip appears dislocated although the direction cannot be definitively determined based on this image alone.

Impression: Comminuted appearing acetabular fracture with left inferior pubic ramus fracture. Left hip dislocation which is limitedly assessed on one view. Overall limited study related to patient body habitus with limited visualization of the femoral head.

Left hip one view

Indication: Appropriate alignment post traction placement

Findings: Single limited frontal and lateral view the left hip submitted. There is a comminuted left acetabular fracture with fracture of the left inferior pubic ramus. The left hip appears dislocated although the direction cannot be definitively determined based on this image alone.

Impression: Comminuted appearing acetabular fracture with left inferior pubic ramus fracture. Left hip dislocation which is limitedly assessed on one view. Overall limited study related to patient body habitus with limited visualization of the femoral head.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: SALDANHA, VILAS
Order Number: 6912534

Order Date: 03/07/2015

Interpreting Radiologist: SHIH, JIMMY
Dictated on: 03/07/2015 at 20:33
Signed and Finalized by: SHIH, JIMMY on 03/07/2015

Exam Charge Date: Mar 7 2015 8:33PM
PROCEDURE: TCT 0145 - TR CT PELVIS RECONS -- 6912534

CT PELVIS RECONSTRUCTION

INDICATION: Fracture.

COMPARISON: None.

TECHNIQUE: Contiguous reconstructed axial images of the pelvis obtained. Thin section sagittal and coronal images were reconstructed from the axial data set. Utilizing dedicated software and workstation, 3-D volume rendering images were created.

CONTRAST: None.

FINDINGS: 3-D volume rendering images demonstrate T-shaped comminuted left acetabular fracture with posterior hip dislocation. There is significant fracturing of the left femoral head which abuts the posterior aspect of the left acetabulum. Comminuted inferior left pubic ramus fracture noted. There is mild diastases left SI joint.

Please see CT abdomen and pelvis report for complete details.

IMPRESSION: 3-D volume rendering images created redemonstrating comminuted T-shaped left acetabular fracture with posterior left hip dislocation.

IMPRESSION: \

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MCNICOLL, CHRISTOPHER
Order Number: 6912763

Order Date: 03/09/2015

Interpreting Radiologist: YEH, RICK
Dictated on: 03/09/2015 at 03:07
Signed and Finalized by: YEH, RICK on 03/09/2015

Exam Charge Date: Mar 9 2015 3:07AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6912763

XR PORTABLE AP CHEST

HISTORY: Intubation

COMPARISON: March 7, 2015

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Support devices are overall stable. Heart size is within normal limits. The lungs are better aerated than on the prior exam. There is likely mild volume overload and mild basilar atelectasis. The pleural spaces are clear.

IMPRESSION:

Improved aeration of the lungs compared to the prior exam. There is likely mild volume overload.

71

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: SYLVAIN, GERALD
Order Number: 6912842

Order Date: 03/08/2015

Interpreting Radiologist: SINGH, SUKHJINDER
Dictated on: 03/08/2015 at 12:05
Signed and Finalized by: SINGH, SUKHJINDER on 03/08/2015

Exam Charge Date: Mar 8 2015 12:05PM
PROCEDURE: SUG 0081 - OR HIP COMPLETE (LEFT) -- 6912842

HISTORY: Fluoroscopic guidance

Fluoroscopy time: 84 seconds.

TECHNIQUE: Fluoroscopy

FINDINGS: Fluoroscopy provided for procedure guidance. Multiple fluoroscopic spot images demonstrate ORIF of left hemipelvis and left femur. Radiologist was not in attendance. Please see operative report for further details.

HISTORY: Fluoroscopic guidance

Fluoroscopy time: 84 seconds.

TECHNIQUE: Fluoroscopy

FINDINGS: Fluoroscopy provided for procedure guidance. Multiple fluoroscopic spot images demonstrate ORIF of left hemipelvis and left femur. Radiologist was not in attendance. Please see operative report for further details.

72

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8010-1
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6913764

Order Date: 03/09/2015

Interpreting Radiologist: SHIH, JIMMY
Dictated on: 03/09/2015 at 21:48
Signed and Finalized by: SHIH, JIMMY on 03/09/2015

Exam Charge Date: Mar 9 2015 9:49PM
PROCEDURE: SUG 0086 - OR HUMERUS (LEFT) -- 6913764

INTRAOPERATIVE FLUOROSCOPY

INDICATION: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 20 spot image(s) were submitted for interpretation. Interpretation is limited by the lack of the radiologist present during the procedure. Please correlate with operative report for complete details. Grossly, the images demonstrate ORIF of the left humerus and proximal ulna.

Fluoroscopy time: 5.3 minutes.

IMPRESSION: Intraoperative fluoroscopy.

IMPRESSION: \

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONICOLL, CHRISTOPHER
Order Number: 6913994
Order Date: 03/10/2015

Interpreting Radiologist: MECCA, MICHAEL
Dictated on: 03/10/2015 at 03:27
Signed and Finalized by: MECCA, MICHAEL on 03/10/2015

Exam Charge Date: Mar 10 2015 3:27AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6913994

XR PORTABLE AP CHEST

HISTORY: intubated

COMPARISON: 1 day prior

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Support devices in place unchanged. The lung volumes are low at exposure, mildly limiting interpretation. Within this limit, the lungs are clear apart from mild bibasilar atelectasis. No large pleural effusions. Heart and mediastinal contours within normal, pulmonary vasculature within normal limits.

IMPRESSION:

No acute findings. Stable examination.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: 1T:8040-1
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MCNICOLL, CHRISTOPHER
Order Number: 6914224
Order Date: 03/11/2015

Interpreting Radiologist: HSU, FRANK
Dictated on: 03/11/2015 at 02:58
Signed and Finalized by: HSU, FRANK on 03/11/2015

Exam Charge Date: Mar 11 2015 2:58AM
PROCEDURE: TRD 0022 - TR CHEST PORTABLE -- 6914224

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 3/10/2015

TECHNIQUE: Portable chest, 1 view AP.

FINDINGS:

Cardiac and mediastinal silhouettes are unchanged from the previous examination. Endotracheal tube is at the level of the head of the clavicles . Nasogastric tube is visualized. Distal tip is not visualized on this study. . Right-sided central venous line catheter projects over the SVC. Diffuse ill-defined bilateral lung opacities are again noted without significant interval change.

IMPRESSION:

1. No significant interval change in the bilateral ill-defined lung opacities.

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: BCUN:1316-01
Encounter: 9929043215
Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MCNICOLL, CHRISTOPHER
Order Number: 6915572
Order Date: 03/13/2015

Interpreting Radiologist: MUIR, BENJAMIN
Dictated on: 03/13/2015 at 00:03
Signed and Finalized by: MUIR, BENJAMIN on 03/13/2015

Exam Charge Date: Mar 13 2015 12:03AM
PROCEDURE: RAD 0020 - CHEST PORTABLE -- 6915572

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 11/13/2015.

TECHNIQUE: Portable chest, 1 view AP.

IMPRESSION/FINDINGS:

Interval extubation and removal of enteric catheter compared to prior study. Right subclavian catheter, tip projects over SVC region.

Low lung volumes. Pulmonary vascular congestion. Improved aeration at left lung base compared to prior study.

XR PORTABLE AP CHEST

HISTORY: Intubated.

COMPARISON: 11/13/2015.

TECHNIQUE: Portable chest, 1 view AP.

IMPRESSION/FINDINGS:

Interval extubation and removal of enteric catheter compared to prior study. Right subclavian catheter, tip projects over SVC region.

Low lung volumes. Pulmonary vascular congestion. Improved aeration at left lung base compared to prior study.

76

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location:
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6918391

Order Date: 03/16/2015

Interpreting Radiologist: HYER, KEVIN
Dictated on: 03/26/2015 at 12:48
Signed and Finalized by: HYER, KEVIN on 03/27/2015

Exam Charge Date: Mar 16 2015 12:48PM
PROCEDURE: SOG 0010 - OR ANKLE LIMITED (LEFT) -- 6918391

History: Left ankle fracture.

Findings: 7 spot images of the left tibia and fibula obtained in the OR demonstrates intraoperative ORIF surgery. Fluoroscopy time was 56.1 seconds. Please refer to the surgical note.

IMPRESSION:

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
DEPARTMENT OF RADIOLOGY
1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Patient Name: FIGUEROA, DAVID
Sex: M
Location: BCUN:1316-01
Encounter: 9929043215

Date of Birth: 10/28/1970
MRN: 0001906211

Ordering Physician: MONROE, MICHAEL
Order Number: 6918392

Order Date: 03/16/2015

Interpreting Radiologist: TOPHAM, STEVEN
Dictated on: 03/16/2015 at 12:48
Signed and Finalized by: TOPHAM, STEVEN on 03/16/2015

Exam Charge Date: Mar 16 2015 12:48PM
PROCEDURE: SUG 0030 - OR ELBOW LIMITED (LEFT) -- 6918392

INTRAOPERATIVE FLUOROSCOPY: 3/16/2015 12:48 PM PDT

CLINICAL HISTORY: Intraoperative fluoroscopy.

COMPARISON: None.

FINDINGS: Intraoperative fluoroscopy was provided to the clinical service for purposes of procedural assistance. 5 spot image(s) were submitted.

Fluoroscopy time: 8.6 seconds.

IMPRESSION:

Intraoperative fluoroscopy.

78

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

ADMITTED: 03/07/2015

TRANSFERRED: 03/20/2015

ADMISSION DIAGNOSES:
1. Status post motorcycle crash.
2. Multiple left-sided pelvic fractures with hip dislocation and femoral head fractures.
3. Left-sided comminuted tibia and fibular fracture with diastasis of the tibia-fibular joint near the knee, open fractures.
4. Significant loss of tissue and degloving injury to the anterior aspect of the left knee.
5. Left humerus fracture and olecranon fracture in conjunction with laceration of the left elbow.
6. Left 5th rib fracture.
7. Focal sigmoid fat stranding on CT scan.
8. Injury to the left popliteal artery at the level of the posterior knee dislocation.

DIAGNOSES AT TIME OF TRANSFER:
1. Status post motorcycle crash.
2. Left pelvic fractures including acetabulum, femoral head, inferior pubic, status post ORIF.
3. Left posterior knee dislocation with popliteal artery injury, status post vascular artery repair.
4. Left comminuted tib-fib fracture with proximal tib-fib diastasis with anterior tibial artery injury, status post ORIF on March 8th.
5. Left 5th rib fracture, stable.
6. Left humerus and olecranon fracture, open, status post ORIF on March 9th and revision on March 18th.
7. Degloving injury of the left knee with open fracture, status post reduction.
8. Sigmoid fat stranding with benign abdominal exam. No evidence of bowel injury.
9. Paresthesias of the left lower extremity, likely secondary to severe injury, stable.

DIAGNOSTIC STUDIES:
1. A CTA of the lower extremity, march 7, 2015, showing traumatic occlusion of the left popliteal artery with reconstitution detailed above, left anterior tibial artery traumatic occlusion.
2. A CT of the abdomen and pelvis with IV contrast, on March 7, 2015, showing transverse T-shaped left acetabular fracture, posterior left hip dislocation, mild left sacral iliac diastasis, mild sigmoid mesenteric fat stranding, may represent contusion. No discrete hematoma identified.
3. A CT of the cervical spine, without contrast, March 7, 2015: No cervical spine fracture or malalignment noted, mild degenerative disc disease at C2-3 through C6-7, moderate-to-severe left C3-4,

79

mild right C4-5, and mild right C5-6 neural foraminal stenosis.

4. CT of the chest, with contrast, March 7, 2015: Fracture noted in the left lateral 5th rib. Bilateral lower lobe atelectasis noted.
5. CT of the brain, without contrast, March 7, 2015: Unremarkable CT of the brain without contrast.
6. CT of the thoracic spine, March 7, 2015: No evidence of thoracic spine fracture or malalignment noted.
7. CT of the lumbar spine, March 7, 2015: No evidence of lumbar spine fracture. Postoperative changes at L5-S1 noted.
8. Left humerus x-ray, March 7, 2015: Humeral diaphyseal fracture and fracture in region of the elbow and ulna.
9. Pelvis x-ray, March 7, 2015: Fractures with malalignment on the left, with presumed associated hematoma.
10. X-ray of the left tib-fib, March 7, 2015: Comminuted distal tibial shaft fracture, comminuted distal fibular shaft fracture, lateral femorotibial compartment diastasis.
11. Portable chest x-ray, March 7, 2015: Minimally displaced left 5th rib fracture.
12. Femur x-ray, March 7, 2015: Left acetabular fracture, left hip dislocation, winding of the proximal tibiofibular articulation compatible with traumatic subluxation/dislocation.
13. Left foot x-ray, March 7, 2015: No definite fracture identified.
14. Left forearm x-ray, March 7, 2015: Mildly displaced proximal ulnar fracture.
15. Left hand x-ray, March 7, 2015: No evidence of acute osseous abnormality. Lucency projecting over proximal portion of the distal phalanx of the 1st digit as described.
16. CT pelvis reconstruction, March 7, 2015: Comminuted T-shaped left acetabular fracture with posterior hip dislocation.

HOSPITAL PROCEDURES:

1. Open left knee dislocation with femoral head fracture, left tib fracture with multiple comminuted distal left tib-fib fractures, reduction and splinting of left lower extremity with a long leg splint, March 7, 2015.
2. Reduction of left humerus fracture, application of splint, and placement of moist gauze over left elbow laceration, March 7, 2015.
3. Closed reduction left knee, external fixation application femur to tibia, open reduction and internal fixation of left fibula, preliminary external fixation open tib pilon fracture, irrigation and debridement, left leg primary closure, March 7, 2015, per Dr. Monroe.
4. Left popliteal artery repair with reverse saphenous vein interposition graft, open vein harvest from right lower extremity, March 7, 2015, per Dr. Quynh Faikes.
5. Close reduction IM rodding left humeral shaft, open reduction and internal fixation left olecranon fracture, March 9, 2015, per Dr. Michel Monroe.
6. Open reduction and internal fixation of left acetabular fracture, open reduction, internal fixation of left femoral head fracture, open reduction, internal fixation of left trochanteric fracture, March 8, 2015, per Dr. Gerald Mark Sylvain.
7. Open reduction and internal fixation of left tibial pilon fracture, external fixator removal from tibia and fibula, revision open reduction, internal fixation of left olecranon, hardware removal of left olecranon, March 16, 2015, per Dr. Michael Monroe.

80

HOSPITAL COURSE: Mr. Figueroa is a very pleasant, 44-year-old gentleman who was involved in a motorcycle crash. He was brought to our facility as a full activation. Upon arrival to our facility. It was noted that he had an extensive injury to his left upper and left lower extremity. He reported that another vehicle turned left and into him while he was traveling approximately 35 miles per hour on his motorcycle. He was thrown from his bike approximately 30 yards. He was found lying in a prone position at the scene. He did have loss of consciousness. He complained of left foot pain and significant pain to his left lower extremity. He was evaluated by the trauma team and had the above diagnostics completed. The patient was severely injured and had risk of losing his left lower extremity. He had vascular repair and extensive orthopedic repair, per orthopedic surgery and vascular surgery. The patient was admitted into our intensive care unit initally. After he stabilized, the patient was transferred to our floor service where he has remained stable. He has had surgery to remove his external fixators while on the floor service. We have had difficulty managing his pain. Therefore, we consulted our pharmacy team to assist with pain management. At this point, the patient is stable. He has been immobilized by Physical Therapy and Occupational Therapy. At this point, the patient is not independent with mobility due to the fact that he is not able to use his left upper and left lower extremities at this time. He was deemed a candidate for rehabilitation on March 13th and is pending a rehab bed. At this time, he is tolerating a regular diet. His pain is controlled on oral pain medication. When a rehab bed is available, the patient will be transferred with explicit orders that patient is not to have any rehabilitation in his left upper and left lower extremity as he is still pending further reconstructive surgery.

DISPOSITION: Transfer to rehab when bed available.

CONDITION: Stable.

ACTIVITY LIMITATIONS: Nonweightbearing left upper extremity and left lower extremity..

HOSPITAL MEDICATIONS:
1. Tylenol 650 milligrams oral q.6 hours p.r.n.
2. Lovenox 40 milligrams subcutaneously before bed for DVT prophylaxis.
3. MiraLAX powder 17 grams by mouth daily. While on narcotics.
4. Zofran 4 milligrams IV q.4 hours p.r.n. nausea.
5. Robaxin 1000 milligrams by mouth q.i.d. for muscle spasms.
6. Oxycodone 15 milligram tablets q.4 hours p.r.n. breakthrough pain.
7. Hydroxyzine 25 milligrams q.6 hours p.r.n.
8. Oxycodone 12-hour release 20 milligrams by mouth 3 times a day, scheduled and 40 milligrams before bed.
9. Gabapentin 200 milligrams by mouth t.i.d.
10. Nexium 20 milligrams by mouth before breakfast.
11. Aspirin 81 milligrams by mouth daily.

DIET: Regular as tolerated.

FOLLOWUP:
1. Patient is to follow up with Dr. Monroe in 2 weeks.
2. Patient is to follow up with Dr. Quynh Peikes after discharge from rehab facility.
3. Patient is to follow up with trauma surgeon, Dr. Deborah Kuhls,

81

in 1-2 weeks after discharge from rehab facility.

4. Patient is to return to our emergency department if he has severe pain, fevers, chills, loss of sensation of his extremities or any concerns.

Transfer planning of this patient was discussed with attending rounding physician, Dr. Nichole Ingalls.

EC/MedQ
DD: 03/19/2015 10:00:57
DT: 03/19/2015 11:06:18

ESMERALDA CLARK, APN

NICHOLE INGALLS, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 759119/648132663
PHYSICIAN: NICHOLE INGALLS, MD
DICTATED BY: ESMERALDA CLARK, APN

TRANSFER SUMMARY

Edited by:
Esmeralda Clark, APN On 03/19/2015 02:13 PM PDT
Electronically Authenticated and Edited by:
Esmeralda Clark, APN On 03/20/2015 11:10 AM PDT
Electronically Authenticated by:
Nichole K Ingalls, MD On 03/24/2015 11:59 AM PDT

OneContent: Generated By UMC\kpark Generated On: 03/30/2015 16:14

UMC UNIVERSITY MEDICAL CENTER

1TRHRCD

ACCT: 9929043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MRN 0001998211 ADM: 03/07/15

TRAUMA TELEMETRY RECORD

MRU01283 (07/01/14) Page 1 of 1

0040

1. DOES PATIENT MEET TRAUMA FIELD TRIAGE CRITERIA? ☐ Yes ☐ No
2. CHOOSE ONE: ☐ Full ☐ Intermediate ☐ Burn Activation ☐ ED Eval
3. INTER-FACILITY TRANSFER? ☐ Yes ☒ No
4. BEDSIDE ACTIVATION? ☐ Yes ☐ No

DATE: 3/7/15 TIME: 041 ETA: 7
UNIT: 647

Arrived via:
☐ AMR ☐ M-W ☐ LVFR ☐ HFD ☐ CCFD
☐ NLVFD ☐ Mercy Air ☐ Guardian Air
☐ Other:

AGE: 44 SEX: ☐ Male ☐ Female

PRE-HOSPITAL CARE

☐ C Spine ☐ Back Board
☐ O2 via: @ L/min
☐ IV:
☐ Medication(s):
☐ Other:

VITAL SIGNS

BP: 1 P: 112 R: 18 O2Sat: 100% GCS: 15

MECHANISM OF INJURY

☐ MVC - Versus: / mph
☐ Ext Damage > 18 inches PCI & Location:
Apparatus: ☐ Restrained ☐ Unrestrained ☐ Air Bag deployed ☐ Car Seat
Victim Location: ☐ Driver ☐ Passenger → ☐ Front ☐ Back
Impact Type: ☐ Rear-ended ☐ Rollover ☐ T-Boned (driver side) ☐ Front End ☐ Head On ☐ T-Boned (passenger side)
☐ AUTO vs. PEDESTRIAN - mph → ☐ at least 20 mph
☐ MOTORCYCLE ☐ ATV ☐ BICYCLE ☐ WATERCRAFT
☐ Versus: @ mph ☐ Separation ☐ Helmet
☐ FALL - Distance: On to: 50YD
☐ PENETRATING INJURY - ☐ GSW ☐ Stab Wound ☐ Other:
☐ ASSAULTED - With / By:
☐ AMPUTATION: ☐ CRUSH:
☐ INHALATION INJURY: ☐ BURN: %
☐ OTHER: LOC + -

CHIEF COMPLAINT

☐ Head ☐ Abdominal ☐ Neck ☐ Back ☐ Chest ☒ Extremities Lt leg ☐ Anticoagulants

BURN ACTIVATION CRITERIA

☐ Patient 15 years of age or older - 2nd DEGREE BURNS OR GREATER WITH AT LEAST 20% TBSA

FULL ACTIVATION CRITERIA

PHYSIOLOGICAL CRITERIA (Attributable to Trauma)

☐ Glasgow Coma Score is 12 or less
☐ Confirmed Systolic BP is 90 mmHg or less at any time in adults and age specific for children
☐ Respiratory Rate is < 10 or > 29 breaths/minute with respiratory compromise, obstruction and/or intubation
☐ Children < 12 years old with uncertain physiologic condition

ANATOMIC CRITERIA

☐ Flail Chest
☐ Penetrating injury to head, neck, chest, abdomen or pelvis
☐ Traumatic paralysis
☐ Obvious skull or pelvic fracture (due to blunt trauma)
☐ Amputated, crushed, de-gloved or mangled extremity proximal to wrist or ankle

INTERMEDIATE CRITERIA

☐ Ejection of patient from motor vehicle
☐ Passenger compartment intrusion (12 inches on patient side OR 18 inches any other area within the passenger compartment)
☐ Pedestrian or cyclist hit by vehicle traveling greater than 20 mph
☐ Fall of greater than 20 feet
☐ Fall of > 3 times a child's height (age < 14 years)
☐ Rollover, patient unrestrained
☐ Motor vehicle crash with death of same vehicle occupant
☐ Motorcycle or personal watercraft crash greater than 20 mph
☐ Combination trauma with burns greater than 10% or inhalation injuries
☐ Prolonged extrication (20 minutes or longer)
☐ Penetrating injuries to the extremities, proximal to the knee or elbow

Additional Information:

ER Physician Name: Dr Berkley Physician / RN Signature:
☐ Conferred with Dr: regarding Activation Status

RECEIVED
JUN 10 2015

ORIGINAL: Chart COPY: Registrar

83

UMR Care Management
P.O. Box 8042
Wausau, WI 54402-8042

002952 001
002989

UMR
A UnitedHealthcare Company

March 13, 2015

002952

Umc Hospital
1800 West Charleston Blvd.
Las Vegas, NV 89106

Dear Umc Hospital,

Patient Name: David Figueroa
Admission/Start Date: 3/7/2015
Reference Number: 20150309-000393

We received a request to review inpatient services for you. This letter is notification regarding the review of clinical information necessary to determine if they are *medically necessary*, as defined in your plan document. Based on the information submitted, we have determined the following treatment is medically necessary.

3/7/2015 to 3/16/2015

The information in this letter does not guarantee payment or benefits.

Please note payment is based on the submitted claim, the actual health care services received, the medical guidelines and policies in place at the time of service and the member's plan of benefits when the services are received.

To confirm benefits, please call your customer service representative at the toll-free number listed on your member ID card.

If more treatment is necessary, another medical review will be required.

Sincerely,

Care Management
UMR

cc: David Figueroa
Deborah Kuhls

RECEIVED
JUN 10 2015
CCMSI ~ Las Vegas

OneContent: Generated By UMC\kpark Generated On: 03/30/2015 16:13

UMC

FACESHEET

ACCT: 9929043215 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MR# 0001906211 ADM: 03/07/15

MRU00139 Page 1 of 1 (06/12)

ACCT # 9929043215 MR# / EDN# 0001906211	PT TYPE TRA	SVC EMG	ADMIT DATE 03/07/15	ADMIT TIME 0051	ROOM/BED -

PATIENT NAME: FIGUEROA,DAVID MANUEL
DOB 10/28/1970 | AGE SEX 44Y M | M/S S | RACE 1 | REL

PATIENT INFORMATION
5207 SPARKLING VINE AVE
LAS VEGAS, NV 89131
HM: (347)682-6476
WK:
COUNTY: CLARK
COUNTRY: UNITED STATES
PLACE OF BIRTH:
EMPLOYMENT
LAS VEGAS METROPOLITAN P
400 S MARTIN LUTHER
LAS VEGAS NV 89106 (702)828-3475
OCCUP: POLICE OFFICER

GUARANTOR
FIGUEROA,DAVID MANUEL
5207 SPARKLING VINE AVE
LAS VEGAS NV 89131
DATE OF BIRTH: 10/28/1970
SS #: XXX-XX-9532
REL TO PT: SELF
HM: (347)682-6476
WK: (702)828-3475
EMPLOYMENT
LAS VEG
400 S MARTIN LUTHER KING
LAS VEGAS NV 89106
OCCUP: POLICE

SPOUSE/PARENT/OTHER
SS #: XXX-XX-
REL TO PT:
HM:
WK:
EMPLOYMENT
OCCUP:

RELATIVE/FRIEND
REL TO PT:
HOME #:
WORK PHONE #:

INSURANCE
LAS VEGAS METRO POLICE DE
C/O UMR
SALT LAKE CITY, UT 84130-0541
FIGUEROA,DAVID MANUEL
INS: FIGUEROA,DAVID MANUEL
REL: PATIENT IS INSURED
POL: 055729532
GRP: LV
DATE OF BIRTH: 10/28/70
BENEFIT/ELIG PH: (866)868-4295
NOTIFY PH:
AUTH #:

INSURANCE
MVA PENDING INFORMATION 0
INS: FIGUEROA,DAVID MANUE
REL: PATIENT IS INSURED
POL: 055729532
GRP:
DATE OF BIRTH: 10/28/70
BENEFIT/ELIG PH:
NOTIFY PH:
AUTH #:

INSURANCE
INS:
POL:
DATE OF BIRTH:
BENEFIT/ELIG PH:
GRP:

OCCUR/DATE	OCCUR/DATE	OCCUR/DATE	CONDITION CODE(S)
01 03/07/15			

ACCIDENT INFORMATION
DATE 03/07/15 TIME 0030 CODE A
ACC TYPE: UTO ACCIDENT
LOCATION: LONE MOUNTAIN
DESC:

REASONS FOR VISIT / COMMENTS
MCC

RECEIVED
JUN 10 2015
CCMSI ~ Las Vegas

PHYSICIANS
ADMITTING: 2284 KUHLS,DEBORAH A
ATTENDING: 2284 KUHLS,DEBORAH A
PCP:
CONSULT:

ADMISSION / REGISTRATION

ADM TYPE	POINT OF ORIGIN	FIN CLASS	DSCH DATE	DSCH TIME	REG ID
5	1	520116			TS

85

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

CONSULTANT: Daniel Lee, MD

REQUESTED BY:

DATE OF CONSULT:

REASON:

CHIEF COMPLAINT: Back pain status post trauma.

HISTORY OF PRESENT ILLNESS: This is a history of a 44-year-old status post motorcycle crash with a CTA left lower extremity, left popliteal artery dissection with reconstitution. Acetabular fracture, posterior hip dislocation. Mild left sacroiliac diastasis sigmoid. Mesenteric back stranding and left humerus diaphyseal fracture. Left 5th rib fracture. Left humerus olecranon fracture open. Degloving of left knee and left knee dislocation. His CT scan of the cervical, thoracic and lumbar was negative but he is having some back pain and I was called for consultation.

PAST MEDICAL HISTORY: Medical problems none.

PAST SURGICAL HISTORY: L5-S1 fusion.

SOCIAL HISTORY: Police officer. Negative for alcohol or tobacco.

MEDICATIONS: None.

ALLERGIES: NKDA.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS:

PHYSICAL EXAMINATION:
GENERAL: No apparent distress. Generally neural intact. Cannot turn him as he is in external fixators and splints, but no long tract signs. No hyperreflexia.

ASSESSMENT/PLAN: Status post motorcycle crash with back pain. Follow up in my clinic when he is out of the hospital. No surgical indications at this time from a spine standpoint, but further surgery from the standpoint of his upper and lower extremities from an orthopedic standpoint. Patient understands and wishes to proceed as does his wife.

cc: Nevada Orthopedic Spine Center

86

IN THE SUPREME COURT OF THE STATE OF NEVADA

CANNON COCHRAN MANAGEMENT SERVICES, INC. and LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Appellants,

vs.

DAVID FIGUEROA,

Respondent,

Supreme Court Case No.: 78926

District Court Case No.: A-18-779790-J

MOTION FOR STAY OF DISTRICT COURT'S ORDER

DANIEL L. SCHWARTZ, ESQ.
LEWIS BRISBOIS BISGAARD & SMITH LLP
2300 W. Sahara Avenue, Suite 300, Box 28
Las Vegas, Nevada 89102-4375
Attorneys for Appellants Cannon Cochran Management Services, Inc.and Las Vegas Metropolitan Police Department

JASON D. MILLS, ESQ.
JASON D. MILLS & ASSOCIATES, LTD.
2200 S. Rancho, Suite 140
Las Vegas, NV 89102
Attorney for Respondent David Figueroa

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page No(s).**

STATUTES

NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a), and must be disclosed:

1. The Appellant, CANNON COCHRAN MANAGEMENT SERVICES, INC., states that it does not have any parent corporation, or any publicly held corporation that owns 10% or more of its stock, nor any publicly held corporation that has a direct financial interest in the outcome of the litigation. NRAP 26.1(a)(2)(A-B).
2. The Appellant CANNON COCHRAN MANAGEMENT SERVICES, INC., states that there are no publicly held legal entities that it has issued shares to, nor any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding. NRAP 26.1(a)(2)(C-D).
3. The Appellant LAS VEGAS METROPOLITAN POLICE DEPARTMENT is a governmental party and is therefore exempt from the NRAP 26.1 disclosure.

The undersigned counsel of record for Appellants CANNON COCHRAN MANAGEMENT SERVICES, INC. and LAS VEGAS METROPOLITAN POLICE DEPARTMENT, has appeared in this matter before the District Court. DANIEL L. SCHWARTZ ESQ. is the primary attorney of record and has appeared for the same at the administrative proceedings before the Department of

Administration.

These representations are made in order that the judges of this court may evaluate possible disqualifications or recusal.

DATED this 11 day of June, 2019.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____
JOEL P. REEVES, ESQ.
Nevada Bar No. 013231
2300 W. Sahara Ave., Ste. 300, Box 28
Las Vegas, NV 89102
Attorneys for the Appellants

MOTION FOR STAY OF THE DISTRICT COURT'S ORDER

COMES NOW Appellants CANNON COCHRAN MANAGEMENT SERVICES, INC. and LAS VEGAS METROPOLITAN POLICE DEPARTMENT (hereinafter collectively referred to as "Appellants"), by and through their attorneys of record, DANIEL L. SCHWARTZ and JOEL P. REEVES, ESQ. of LEWIS BRISBOIS BISGAARD & SMITH, and hereby submits their Motion For Stay Of The District Court's Decision and Order. Appellants respectfully request that this Court stay the subject District Court's April 30, 2019 Order while this Court considers the pending appeal thereof.

This Motion is based upon NRAP 8, NRAP 27, the accompanying memorandum of points and authorities, the exhibits attached hereto, and any other record and briefing in this matter previously submitted to The Supreme Court of the State of Nevada.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

STATEMENT OF FACTS

This is a workers' compensation case. The Respondent has multiple prior industrial claims. In the instant matter, on March 7, 2015, according to the C-4 form, the Respondent was "driving" and was in an "MVA." (Exhibit p. 12.)

The Employer completed its C-3 form upon receiving the C-4 form. (Exhibit p. 13.)

An Injury Report was also completed on March 7, 2015. This report indicated the Respondent was not in the normal course of his work or duties as a police officer at the time of the incident. (Exhibit p. 14.)

The Respondent was notified on April 9, 2015 that his claim was being denied. (Exhibit pp. 15-16.)

The Respondent appealed the determination letter of April 9, 2015, regarding claim denial, to the Hearing Officer. (Exhibit p. 17.) This appeal was transferred directly to the Appeals Office. (Exhibit p. 18.)

This matter came on for hearing before the Appeals Officer on May 10, 2017. Respondent and Employer's Director of Risk Management, Jeff Roch (hereinafter "Mr. Roch"), gave testimony. (Exhibit pp. 151-226)

On July 25, 2018, the Appeals Officer for Appeal Number 1511793-MM issued the subject Decision and Order. The Appeals Officer noted that, on the day of the subject incident, Respondent had been released early from his shift. The Appeals Officer also noted that Respondent testified that his sergeant told him to leave early to get some "seat time" on Respondent's personal motorcycle and that Respondent was involved in the subject accident at 12:25 a.m. on his commute

home while he was still technically on the clock. The Appeals Officer also found that Respondent's co-worker, Tyler McMeans, was also released early.

The Appeals Officer made three salient determinations based the above referenced facts. The Appeals Officer concluded that Tyler McMeans had not been released early for Respondent to get some seat time. Further, the Appeals Officer also concluded that Respondent's commute home on the day in question was no different than any other day. Finally, the Appeals Officer concluded that there was no evidence that Respondent's sergeant explicitly required Respondent to "get some seat time" as a condition of his employment. Further, it should also be noted that the Appeals Officer included a discussion in the Decision as to how simply being on the clock does not render this claim compensable. Finally, there was an explicit line in the Decision noting that "[a]ny Finding of Fact more appropriately deemed a Conclusion of Law shall be so deemed, and vice versa." (Exhibit pp. 227-239)

On August 21, 2018, Respondent filed the subject Petition for Judicial Review.

On March 26, 2019, after the parties had presented to Department 18 for hearing, the judge called a bench conference, informed that he had not read the briefing, and the hearing was rescheduled for April 23, 2019.

On April 23, 2019, counsel for Appellant had a conflict and could not attend the hearing that had been reschedule after the bench conference and sent an e-mail to the law clerk for Department 18 and requested a continuance. The District Court chose to set this matter for an in chambers decision.

On April 30, 2019, the District Court issued an Order Reversing the Appeals Officer's Decision and Order. This Court determined that the Appeals Officer's Decision was affected by error of law and contained clearly erroneous facts. The Court found four errors. First, the Court determined that the Appeals Officer had omitted the fact that Respondent was still on the clock because it was not discussed in the Findings of Fact section. Second, the Court also determined that the Appeals Officer had omitted the fact that Respondent was given an "early out" to "get some additional practice riding a motorcycle, as he called it 'seat time.'"

Third, the Court concluded the Appeals Officer committed an error of fact in finding that Respondent Employer received no benefit from Respondent being on the road at the time of incident. The Court concluded that Respondent Employer did receive a benefit because Respondent was on the clock, could have been called back, was ordered to get some "seat time," and Respondent was still subject to Employer's rules and regulations. Therefore, the Employer did receive a benefit. Finally, the Court concluded that it was dispositive that Appellant "had his radio

and the general duty of law enforcement while traveling public thoroughfares under Tighe." (Exhibit pp. 240-245)

Appellants filed a Motion for Stay and Request for Reconsideration. The District Court denied both stating that it had not misapprehended the Appeals Officer's Order. (Exhibit pp. 246-247)

Appellants timely filed an appeal to this Honorable Court and hereby seek a stay of the District Court's Order.

II.

LEGAL ARGUMENT

A. Reasons Given By District Court For Its Action, As Required By NRAP 8(a)(2)(A)(ii)

N.R.A.P. 8(a)(2)(A) states the following:

> (A) The Motion [for Stay] shall:
>
> (i) show that moving first in the district court would be impracticable; or
>
> (ii) state that, a motion having been made, the district court denied the motion or failed to afford the relief requested and state any reasons given by the district court for its action.

Here, Appellants moved for a stay in the District Court before filing the instant Motion. The District Court denied the Motion for Stay explaining in the minutes that it had not misapprehended the Appeals Officer's Decision. The District Court continued to find that the Appeals Officer's failure to include in the Findings of Fact that Respondent was instructed to leave early and "get some seat

time" was a fatal flaw in the Appeals Officer's Decision. Further, the Court also stated that its conclusions were not based solely on the fact that Respondent was on the clock at the time of the incident. Rather, by virtue of the fact that Respondent was told to "get some seat time," the District Court concluded that its assessment of the facts was more accurate than the Appeals Officer's and that Respondent provided a benefit to his Employer by commuting home on his personal motorcycle. The District Court also considered the fact that Respondent made a personal decision to carry his radio home to be dispositive. Finally, the District Court concluded that although Respondent was on his commute home just as any other employee in the state would be doing, he was charged with "the general duty of law enforcement while traveling on public thorough fares under Tighe."

B. This Court Should Grant The Stay Because All Four Factors In NRAP 8(c) Weigh In Favor Of Granting Appellants' Stay Request

In deciding whether to issue a stay, the following four factors are considered: 1) whether the object of the appeal or writ petition will be defeated if the stay is denied; 2) whether appellant/Respondent will suffer irreparable or serious injury if the stay is denied; 3) whether respondent/real party in interest will suffer irreparable or serious injury if the stay is granted; and 4) whether appellant/Respondent is likely to prevail on the merits in the appeal or writ petition. N.R.A.P. 8(c); see also, Kress v. Corey, 65 Nev. 1, 189 P.2d 353 (1948). These four factors weigh in favor of granting Appellants' stay request. Appellants

addresses each factor in turn.

1. The Object Of Appellants' Petition Will Be Defeated If The Stay Is Denied

Here, the object of the instant Petition for Judicial Review is whether this claim is compensable. Absent a stay of the District Court's Decision, Appellants will be required to issue unrecoverable retro-active benefits for any lost time that Respondent sustained. Further, it must be noted that NRS 616C.138 was recently modified to allow insurers to recover amounts paid during the pendency of an appeal "from a health or casualty insurer" if the insurer is found to be entitled to the same. However, if there is no health or casualty insurer, these bills cannot be recovered. Here, just as in most cases, there is nothing to indicate whether Respondent has health or casualty insurance. Furthermore, as noted above, under no circumstances could Appellants recover any wage replacement benefits such as temporary partial disability or temporary total disability benefits. Nor could Appellants recover any permanent partial disability benefits or vocational rehabilitation benefits.

If Appellants are required to issue benefits, this appeal will essentially be rendered moot.

2. A Stay Is Necessary To Prevent Irreparable Or Serious Harm To Appellants

As noted above, without a stay, Appellants will be forced to issue

unrecoverable benefits. That is guaranteed to happen. However, if a stay is in place, the Appeals Officer's proper order would stand until this Court can issue a substantive ruling.

3. A Stay Would Not Cause Irreparable Or Serious Harm To Respondent

Here, there is no irreparable injury to Respondent. This is not a case involving something time sensitive such as emergency medical care. If, after this Honorable Court has decided this Petition and Respondent is ultimately deemed to be entitled to benefits, he will receive them. There would be no reduction or withholding of any benefits just because a stay was granted.

4. Appellants Will Prevail On The Merits Of This Petition

In the April 30, 2019 Order, the District Court found fault with the Appeals Officer's Order for not including reference in the Findings of Fact that Respondent was on the clock or the fact that Respondent was given an "early out" to "get some additional practice riding a motorcycle, as he called it 'seat time.'" However, both of these facts were discussed at length in the Conclusions of Law section of the Appeals Officer's Order and there was an explicit line in the Decision noting that "[a]ny Finding of Fact more appropriately deemed a Conclusion of Law shall be so deemed, and vice versa."

The District Court found that it was legal error to not contemplate the fact that Respondent was on the clock at the time of the incident. However, the Appeals

Officer absolutely considered this fact. Although it was not mentioned in the Findings of Fact section, the Appeals Officer noted in the Conclusions of Law that "the claimant was still on the clock at the time of the accident." Not only that, the Appeals Officer went into detail discussing the import of this fact to the case:

> 24. It must also be noted that the fact that this accident happened while claimant was still technically "on the clock" does not somehow render this claim compensable. Indeed, it is a mainstay of the Nevada workers' compensation law that a claimant must establish more than the fact that they are getting paid at the time of an injury to make out a compensable claim: "an injured employee is not entitled to receive workers' compensation 'unless the employee . . . establishes by a preponderance of the evidence that the employee's injury arose out of and in the course of his employment.'" Mitchell v. Clark Cty. Sch. Dist., 121 Nev. 179, 181, 111 P.3d 1104, 1105 (2005)(citing NRS 616C.150(1))
>
> 25. Just as with the claimant in Mitchell, the fact that claimant was "on the clock," by itself, does not render this claim compensable. Claimant must establish a workplace connection to his injury. Here, as established above, there is no work place connection. Claimant was on his personal motorcycle in civilian clothes while commuting home and happened to be involved in a traffic accident. Claimant's employment did not contribute to his accident in any way.

The Appeals Officer also quoted Rio Suite Hotel v. Gorsky, 113 Nev. 600, 939 P.2d 1043(1997) which held that the "Nevada Industrial Insurance Act is not a mechanism which makes Employers absolutely liable for injuries suffered by employees who are on the job." The Appeals Officer absolutely considered the fact

that Appellant was still on the clock at the time of this incident and included a detailed discussion of the same in the Decision.

As for the District Court's finding that the Appeals Officer "left out" the fact that Appellant testified that he was told to leave early and "get some seat time," the Appeals Officer addressed this fact at length. It was not "left out." And again, the subject Decision and Order explicitly noted that "[a]ny Finding of Fact more appropriately deemed a Conclusion of Law shall be so deemed, and vice versa."

As for the merits of the position that being on the clock should have rendered this claim compensable, the fact that Respondent or any other claimant in the state is on the clock and subject to an Employer's rules and regulations is simply not dispositive. As this Court has held numerous times over, it is the claimant's burden to prove more than just being on the clock when an injury occurs – the claimant must prove by a preponderance of evidence that the origin of the injury is related to some risk involved within the scope of employment. Gorsky; Mitchell; Rio All Suite Hotel and Casino v. Phillips, 126 Nev. _, 240 P.3d 2 (2010).

Furthermore, from a public policy standpoint, under the District Court's current ruling, if Respondent's accident had happened five (5) minutes later when Respondent was five (5) minutes further down the road with all other facts being the same, this claim would not be compensable. There is no further work

connection other than the passage of five (5) minutes. Appellants would submit that such an outcome is arbitrary on its face, especially considering this Court's opinion that being on the clock by itself is not enough for a compensable claim.

Next, the District Court concluded that it was error for the Appeals Officer to find that Employer "received no benefit from claimant being on the road." The District Court reasoned that Employer *did* receive a benefit because Respondent was on the clock, could have been called back, was ordered to get some "seat time," and Respondent was still subject to Employer's rules and regulations. However, save for the "seat time" which will be discussed more below, all of the reasons listed by this Court as "benefits" to the Employer are simply consequences of being on the clock which, as discussed above, is not enough reason by itself to render a claim compensable.

The District Court concluded that "there is no question the Appellant was on the clock at the time of the accident and, therefore, under the control of LVMPD unlike an off-duty officer returning home." Indeed, Appellants agree that the only difference between an off-duty police officer and Respondent is the fact that Appellant was on the clock. However, again, this Court has stated several times over that that is simply not enough to render a claim compensable.

Regarding the fact that Respondent testified that his sergeant ordered him to "get some seat time," the Appeals Officer weighed the facts and concluded that

there was no evidence to show that Respondent's job required him to ride his personal motor cycle as a condition of his employment. Indeed, it was Respondent's choice to have a personal motor cycle to commute to and from work and Respondent was not performing any training or any other police function while he was driving that personal motor cycle on the day in question. The Employer received as much benefit from Respondent commuting home on his personal motor cycle as it would have if Respondent were commuting home in a mini-van. That is to say that Employer received no benefit from Respondent commuting home in a vehicle of his choosing just as he would on any other day. It nothing else, this was a fact question for the Appeals Officer and there was substantial evidence to support the Appeals Officer conclusion.

Finally, the District Court concluded that it was error to affirm claim denial given that Respondent "had his radio and the general duty of law enforcement while traveling on public thoroughfares under Tighe." However, that is not the complete holding of Tighe[1]. Indeed, the Tighe Court held that injuries sustained by law enforcement officers on their commute "*may* be compensable" and that the "law enforcement exception is not sufficiently broad and all-inclusive to justify the conclusion that all law enforcement officers are *always* excluded from the general rule that injuries sustained while traveling to or from work do not arise out of and

[1] Tighe v. Las Vegas Metropolitan Police Dept., 110 Nev. 632, 877 P.2d. 1032 (1994)

in the course of employment." (Id.) This Court specifically concluded that Tighe satisfied the law enforcement exception because "Tighe was on call and driving a police vehicle equipped with a police radio, and he was prepared to respond to any public emergency he may have encountered."

Here, just as being injured on the clock is not enough by itself for a compensable claim, the fact that Respondent was a police officer on his commute home is not enough to render this or any other claim compensable. The law enforcement exception is fact sensitive and does not apply across the board to police officers on their commute home. Further, the fact that Respondent had his radio is not dispositive as he chose to bring the radio with him. In Tighe, the employer mandated that Tighe carry a radio to respond quickly given his "on call" status. Here, Respondent admitted that it was his choice to bring the radio and that he could have left the same at the station if he wanted to.

Respondent was not performing any police work at the time of the incident – we was commuting home just as any other police officer would. The only potential work connection that this claim has is that it occurred five (5) minutes before Respondent was technically off the clock. This Court has been clear that being on the clock is not enough, there must be a work connection. Other than being on the clock, the only other facts which the District Court found dispositive were Respondent's personal choices to drive a motor cycle and his personal choice to

bring his radio with him. There is no evidence that Employer instructed Respondent to purchase a motorcycle or even to undertake police duties while driving his personal motor cycle. Nor is there any evidence that Employer instructed Respondent to carry a radio with him.

The District Court's Order runs directly counter to several cases already decided by this Court and a stay is warranted until this Court can make a substantive ruling on the merits. Though the District Court may have ruled differently than the Appeals Officer did, the fact is that those conclusions of the agency which are "closely related to the agency's view of the facts, are entitled to deference, and will not be disturbed if they are supported by substantial evidence." Jones v. Rosner, 102 Nev. 215, 217, 719 P.2d 805, 806 (1986). There is substantial evidence to support each and every finding made by the Appeals Officer. Respondents therefore request that a stay until this matter can be decided on the merits.

III.

CONCLUSION

Based upon all of the above, it is the belief of Appellants, CANNON COCHRAN MANAGEMENT SERVICES, INC. and LAS VEGAS METROPOLITAN POLICE DEPARTMENT, that a stay of the District Court's

Order decision, dated April 30, 2019, is necessary to prevent irreparable harm to Appellants.

WHEREFORE, Appellants, CANNON COCHRAN MANAGEMENT SERVICES, INC. and LAS VEGAS METROPOLITAN POLICE DEPARTMENT, respectfully requests that this Court grant its Motion For Stay.

Dated this 4 day of June, 2019.

Respectfully submitted,
LEWIS, BRISBOIS, BISGAARD & SMITH, LLP

DANIEL L. SCHWARTZ, ESQ.
Nevada Bar No. 005125
JOEL P. REEVES, ESQ.
Nevada Bar No. 013231
LEWIS BRISBOIS BISGAARD & SMITH LLP
2300 W. Sahara Avenue, Suite 300, Box 28
Las Vegas, Nevada 89102-4375
Attorneys for Appellants

CERTIFICATE OF COMPLIANCE

1. I hereby certify that this motion complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

2. I further recognize that this Motion consists of fifteen (15) pages and therefore exceeds the page limits imposed by NRAP 27(d)(2). The undersigned respectfully requests that this Court permit the additional five (5) pages beyond the ten (10) pages authorized by NRAP 27(d)(2).

3. Finally, I hereby certify that I have read this motion, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Respectfully submitted,
LEWIS, BRISBOIS, BISGAARD & SMITH, LLP

DANIEL L. SCHWARTZ, ESQ(005125)
JOEL P. REEVES, ESQ.(013231)
LEWIS BRISBOIS BISGAARD & SMITH LLP
2300 W. Sahara Avenue, Suite 300, Box 28
Las Vegas, Nevada 89102-4375
Attorneys for Appellants

CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the 11th day of June, 2019, service of the attached **MOTION FOR STAY OF DISTRICT COURT'S ORDER** was made this date by depositing a true copy of the same for mailing, first class mail, and/or electronic service as follows:

Jason Mills, Esq.
JASON D. MILLS & ASSOCIATES, LTD.
2200 S. Rancho, Suite 140
Las Vegas, NV 89102

LVMPD-Health Detail
400 S. Martin Luther King Blvd.
Suite B
Las Vegas, NV 89106

CCMSI
P.O. Box 35350
Las Vegas, NV 89133

An employee of LEWIS, BRISBOIS, BISGAARD & SMITH, LLP

EXHIBIT

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
DAVID		FIGUEROA	10-28-70	☒M ☐F	

Home Address	Age	Height	Weight	Social Security Number
5209 SPARKLING VINE AVE	40	6'2	240	[redacted]

City	State	Zip	Telephone
LAS VEGAS	NV	89131	347-682-6476

Mailing Address	City	State	Zip	Primary Language Spoken
5209 SPARKLING VINE AVE	LAS VEGAS	NV	89131	ENGLISH

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
UMR		POLICE OFFICER

Employer's Name/Company Name	Telephone
LAS VEGAS METROPOLITAN POLICE DEPARTMENT	828-3111

Office Mail Address (Number and Street)

Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
3-15-11		3-15-11	3-15-11	SGT. J. RICHTER

Address or Location of Accident (if applicable)
LAS VEGAS BLVD @ I-95

What were you doing at the time of the accident? (If applicable)
SITTING IN DRIVER SEAT, STOPPED AT RED TRAFFIC SIGNAL.

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
STOPPED FOR RED TRAFFIC SIGNAL LOCATED AT NLB LV BLVD AND I-95. MY VEHICLE WAS REAR ENDED BY ANOTHER VEHICLE, WHICH WAS ALSO REAR ENDED.

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable) NHP OFFICERS, DRIVERS OF OTHER VEHICLES INVOLVED.

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
HEAD, NECK & BACK INJURIES	HEAD, NECK & BACK

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR HIV, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place: Las Vegas, NV
Name of Facility: The Neck and Back Clinics – Northwest Neck + Back Clinic

Date: 3/16/11, 3/15/11 wo
Hour:

Diagnosis and Description of Injury or Occupational Disease:
cervical sprain 847.0
lumbar sprain 846.0
Neuritis/Radiculitis 724.4

Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
☒ No ☐ Yes (if yes, please explain)

Treatment: physical therapy modalities

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☒ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

X-Ray Findings: cervical hypolordosis

If modified duty, specify any limitations/restrictions:
He may experience neck/back pain d/t work-duties and should take time off as needed.

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☒ Yes ☐ No

Is additional medical care by a physician indicated? ☒ Yes ☐ No

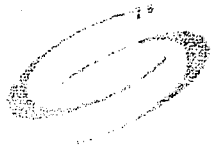
Do you know of any previous injury or disease contributing to this condition or occupational disease? ☒ Yes ☐ No (Explain if yes)
He was already being treated for a seperate collision that occured on 11/4/10. This incident made him worse

Date: 3/21/11
Print Doctor's Name: MATT OLMSTEAD DC
I certify that the employer's copy of this form was mailed to the employer on:

Address: 3430 N Buffalo Dr. ste 110
City: Las Vegas State: NV Zip: 89129
Provider's Tax I.D. Number:
Telephone: 702-255-5130
Doctor's Signature: Matt Olmstead DC
Degree: DC

INSURER'S USE ONLY

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev 10/07)



September 28, 2012

David Figueroa
5207 Sparkling Vine Ave
Las Vegas, NV 89131

RE:	Claimant	David Figueroa
	Claim Number	[illegible]687205
	Date of Injury	[illegible]
	Employer	LVMPD

Dear Mr. Figueroa:

As a result of your recent impairment evaluation, you have been granted a permanent partial disability award of eleven percent (11%) on a whole body basis. A copy of the report is enclosed. Your claim closed for a PPD effective as of the date of your evaluation.

This award entitles you to monthly payments of $[illegible].82 until age seventy (70), or a lump sum in the amount of $59,692.43, in accordance with Nevada Revised Statute 616C.490(6)(c).

Pursuant to NRS 616C.495(2), acceptance of payment for a permanent partial disability as a lump sum terminates all benefits for compensation and constitutes a final settlement of all factual and legal issues in the case. By so accepting you waive all rights regarding the claim, including the right to appeal from the closure of the case or the percentage of disability, except reopening rights according to the provisions of NRS 616C.390.

Please note, if a response is not received in this office within 30 days from the date of this letter, it will be necessary to initiate installment payments.

Attached are the necessary forms for you to sign and have witnessed. **Only you may sign these forms; no one else may sign for you.** Please read the documents carefully. Indicate your choice of payment on the Election of Method form, sign and return the election form and the reaffirmation form to this office as soon as possible. Upon receipt of the **original** signed documents, a check will be issued and mailed to you.

If you disagree with the above determination, you have the right to request a hearing regarding this matter. If this is your intention, please complete the attached Request for Hearing form and return it to

September 22, 2012

the Hearings Division at the address indicated on the form within 70 days from the date of this letter.
Thank you for your cooperation.
Sincerely,

Christina Cabrera
CWSI- Claims Representative

Encl: Request for Hearing (D-13a)
PPD Award Calculation (D-70)
Reopening Rights (D-13)

cc: Employer
GCRM
Claim File

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM—PROVIDE ALL INFORMATION REQUESTED

First Name: DAVID M.I. Last Name: FIGUEROA Birthdate: 10/28/70 Sex: ☒M ☐F Claim Number (Insurer's Use Only)

Home Address: 5304 SPARKLING VINE AVE Age: 40 Height: 6'3 Weight: 340 Social [redacted]

City: LAS VEGAS State: NV Zip: 89131 Telephone: 347-653-6476

Mailing Address: SAME City State Zip Primary Language Spoken: ENGLISH

INSURER: UMR THIRD-PARTY ADMINISTRATOR Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred: POLICE OFFICER

Employer's Name/Company Name: LVMPD Telephone

Office Mail Address (Number and Street): 400 CONVENTION CTR DR LV NV 89109

Date of Injury (if applicable): 9/21/11 Hours Injury (if applicable): am/1:30 pm Date Employer Notified: 9/21/11 Last Day of Work After Injury or Occupational Disease: 9/21/11 Supervisor to Whom Injury Reported: BRIAN MEYER

Address or Location of Accident (if applicable): MIRAGE/LV BLVD

What were you doing at the time of the accident? (if applicable): RIDING MOTORCYCLE - WORK RELATED SPECIAL EVENT

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary): ANOTHER MOTORCYCLE SIDESWIPED THE RIGHTSIDE OF MY MOTORCYCLE

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? Witnesses to the Accident (if applicable): KURT MCKENZIE

Nature of Injury or Occupational Disease: DIRECT IMPACT TO BOTH KNEE'S, BOTH ELBOWS (R) PALM Part(s) of Body Injured or Affected: BOTH ELBOW'S BOTH KNEES (R) PALM WITH GRAVEL

I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR ... [illegible] ... INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS ... SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date: 9/21/11 Place X Employee's Signature: [signature]

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place: Centennial Hospital Name of Facility

Date: 9/21/11 Diagnosis and Description of Injury or Occupational Disease: contusions

Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☒No ☐Yes (if yes, please explain)

Hour: 2050.

Treatment: N/A.

Have you advised the patient to remain off work five days or more? ☐Yes Indicate dates: from ___ to ___ ☒No If no, is the injured employee capable of: ☒full duty ☐modified duty

X-Ray Findings: N/A.

If modified duty, specify any limitations/restrictions:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐Yes ☐No

Is additional medical care by a physician indicated? ☐Yes ☐No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐Yes ☐No (Explain if yes)

Date: 9/21/11 Print Doctor's Name I certify that the employer's copy of this form was mailed to the employer on: INSURER'S USE ONLY

Address: 6900 N. Durango

City: Las Vegas State: NV Zip Provider's Tax I.D. Number Telephone: 629-1511

Doctor's Signature: [signature] Degree: MD

8001119534
FIGUEROA, DAVID
DOB: 10/28/1970 40 Y SX: M EMR
MRN: 7124088 ADM/REG DT: 09/21/2011
Centennial Hills Hospital

ORIGINAL - TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 - INSURER/TPA PAGE 3 - EMPLOYER

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
LAW ENFORCEMENT OPERATIONS	Corporation	886000028	

Office Mail Address	Location . If different from mailing address	Telephone
400 B S MARTIN LUTHER KING 435		702-828-3406

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
LAS VEGAS	NV	89106	LVMPD	CCMSI, Inc.

EMPLOYEE

First Name	MI	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
DAVID		FIGUEROA	[redacted]	10/28/1970	40	English

Home Address (Number and Street)	Sex	Marital Status
5207 SPARKLING VINE AVE	☑ Male ☐ Female	☑ Single ☐ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
LAS VEGAS	NV	89131	☑ Yes ☐ No	11/05/2006

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed
NV	POLICE OFFICERS AND DRIVERS	NORTH PATROL DIVISION

Telephone	Is the injured employee a corporate officer? . sole proprietor? partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
702-943-0636	☐ Yes ☑ No ☐ Yes ☑ No ☐ Yes ☑ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
09/21/2011	15:13	09/21/2011	B MEYER P#4324

Address or location of accident (Also provide city, county, state) (if applicable)	Accident on employer's premises? (if applicable)
3400 LV BLVD. LAS VEGAS CLARK NV	☐ Yes ☑ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
SCRATCH & BRUISE TO KNEES, ELBOWS & RT PALM

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary
WHILE RIDING POLICE MOTORCYCLE SB AN ACCIDENT OCCURRED WITH ANOTHER MOTORCYCLE OFFICER

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
MOTORCYCLE	UNK	☑ Yes ☐ No

Part of body injured or affected	If fatal, give date of death	Witness
MULTIPLE BODY PARTS - MULTIPLE BO		

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	
SPECIFIC INJURY - ALL OTHER INJURIES NOC		

	Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
	☑ Yes ☐ No	☑ Yes ☐ No

If validity of claim is doubted, state reason	Location of Initial Treatment
UNK	CENTENIAL HOSP

Treating physician/chiropractor name	Emergency Room	Hospitalized
	☐ Yes ☑ No	☐ Yes ☑ No

IMPORTANT	How many days per week does employee work?	From	To	Last day wages were earned
	4	1400	0000	9/21/11

Scheduled days off	S	M	T	W	T	F	S	Rotating
	☐	☐	☐	☑	☑	☑	☐	☐

Are you paying injured or disabled employee's wages during disability? ☑ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
11/05/2006			

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☑ Yes ☐ No		☐ Yes ☐ No ☑ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☑ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☑ BI-WKLY ☐ SEMI-MONTHLY	$ UNK per ☑ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
Sgt. Y [illegible]	9/30/11

Insurer Use Only

Claim is ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No	Class Code
		11D34B950842	

Claims Examiner's Signature	Date	Status Clerk	Date
		Dawn Angles	9-30-2011

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

OCCUPATIONAL INJURY/ILLNESS/EXPOSURE REPORT

1. Event #: 110921-2636

PART ONE STATEMENT OF INJURED EMPLOYEE

2. Name (Last name, First name)	3. P#:	4. Sex:	5. Date of Hire:	6. Date of Birth:	7. SS#: (Required)
Figueroa, David	9693	☑ Male ☐ Female	11/05/2006	10/28/1970	[redacted]

8. Home Mailing Address (#, Street, Bldg/Apt. #, City, State & Zip): 5207 Sparkling Vine Ave LVN 89131

9. Phone #(s)	10(a) Bureau of Assignment:	11. Classification:	12. Regular Work Hours:
Home:	Traffic	POII	1400-0000
Cell: 347-682-8476	10(b) Section or Detail of Assignment: TR32	13. Marital Status: ☑ Single ☐ Married	14. RDO's: WTF

15. Injury/Illness/Exposure:	16. Reported to Supervisor:	17. Left Shift:
Date: 09/21/2011 Time: 1513	Date: 09/21/2011 Time: 1513	Date: 09/21/2011 Time: 1730

NOTE: If you are claiming an occupational disease, indicate the date on which the employee first became aware of the connection between the condition and employment.

18. Address and location of occurrence: (Give sufficient Detail): 3400 LVBS

19. Was first aid provided? no

20. Action: ☐ Doctor's Care ☑ E.R. Card Only ☐ Hospitalized ☐ No Action Taken

21. Body part(s) affected/injured/exposed: rt knee, lt knee ,both elbows, rt palm

22. Nature of injury/exposure sustained: (scratch, cut, bruise, strain, exposure, etc.): scratch and bruise and soreness to all parts

23(a). What were you doing when the accident occurred? (Chasing a suspect, walking down stairs, driving, etc?): involved in an escort of vehicles southbound on LVBS

23(b). How did the injury/illness/exposure occur? (Explain in Detail): While riding police motorcycle southbound, an accident occurred with another motorcycle officer

24. Did the accident happen in the normal course of work? ☐ Yes ☑ No - Explain: Special event, police escort

25. Did you return to next scheduled shift after accident? ☑ Yes ☐ No - What date?

26. Lost Time: ☑ No ☐ Yes - Last day worked after injury: If yes, disability slip from physician available? ☐ Yes ☐ No

27. Have you had previous injury/exposure to body part(s) mentioned? (Explain): yes-knees only

28. How might this injury/illness/exposure have been prevented?: by checking for oncoming motor units a second time before continuing south

29. Specify what equipment, objects or substances were involved (include personal protective equipment used): helmet, gloves, boots, eye protection

30. Was anyone else involved? ☐ No ☑ Yes - List names of others involved: Durrett, Troyston

31. Witnesses to injury/illness/exposure: (Last name, First name, and P#): 1. unk 2. 3.

Employee's signature on this document acknowledges that they have received a copy of this document including a brief description of their Rights and Benefits under NRS 616 and 617 included with this document.

32. Employee's Signature: Date:

Note: If this is due to abnormal physical result, this form does not need to be signed by your chain or supervisor. Please fax directly to Health Detail at 828-1509 and Call Health detail at 828-3696.

PART TWO REPORT OF INVESTIGATION BY SUPERVISOR

33. Why did injury/illness/exposure occur?: Ofc. Figueroa was involved in a motor vehicle incident.

34. What unsafe condition or act caused or contributed to injury/illness/exposure?: Ofc. Figueroa and other officers were involved in a leap frog style escort

35. Corrective action taken or recommended to prevent recurrence: Officers to be more safety conscious, also have more officers assigned to this type of event so leap frogging won't be needed

36. Is there any reason to doubt the validity of the claim? ☑ No ☐ Yes - What reason?

37. If traffic accident, was the other party cited? ☑ No ☐ Yes - Attach copy of the traffic accident report

NOTE: If exposure, officer's report must be dictated and faxed to Health Detail at 828-1509.

38. Supervisor's Last Name, First Name and P# (Please Print):	Supervisor's Signature:	Date:
Meyer, Bryan 4324	[signature]	9-21-11

PART THREE BUREAU COMMANDER/DIVISION CHIEF'S REVIEW/COMMENTS

Bureau Commander's Signature	Date:	Deputy Chief's Signature	Date:

Comments:	Comments:

Note: Please fax directly to Health Detail at 828-1509 call Health Detail at 828-3696.

For assistance with worker's Compensation issues, you may contact the Office of the Governor, Consumer Health Assistance:
Toll Free (888)333-1537 Web Site: http://govcha.state.nv.us E-mail: cha@govcha.state.nv.us

LVMPD 29 (Rev. 9-10) INFOPATH 2007 "Employee should sign, date and retain a copy of this form. Original goes to employer. To file a claim for compensation, please see the next page. "Brief Description of Rights and Benefits", section titled "Claim for Compensation (Form C-4).

b

Charles E. Quaglieri, MD

3983 S McCarran Blvd, #584
Reno, NV 89502

Ph: 775-824-8100
Fax: 775-824-8111

March 5, 2013

Cannon Cochran Management Services
PO Box 35350
Las Vegas, NV 89133-5350

RE: DAVID FIGUEROA
CLAIM #: 11D34B950842
DOI: 09/21/11

Dear CCMSI,

This is an addendum to the PPD dictated in the case of David Figueroa on 01/10/13.

I received measurements of his joint spaces done with standing radiographs of the knees.

The right knee joint spaces were lateral 11 mm and medial 7 mm. The left knee joint spaces were lateral 12 mm and medial 7 mm. These x-rays were done on 02/06/13 and a copy is appended.

I reviewed his PPD. As far as the right knee is concerned, the claimant has had a right partial medial meniscectomy and resection of plica by Dr. Tingey on 03/20/12. There is no impairment due to joint space narrowing. The patient did have blunt trauma and does have patellofemoral pain and crepitus, which allows 2% impairment of the whole person. He is allowed 1% for the partial medial meniscectomy, as per the Diagnosis-Based Estimates in 17.2J. There is no impairment due to loss of range of motion. After combining the 2% for arthritis and the 1% for meniscectomy, there is a total of 3% impairment of the whole person due to the right knee.

The award for the right knee will require apportionment because he has had previous surgery and a PPD award for the right knee. I do not have those records.

As far as the left knee is concerned, he has had no surgery as a result of the industrial injury of 01/10/13. There is no award for joint space narrowing. There is no award for loss of range of motion. He does have crepitus and patellofemoral pain after blunt trauma, which allows 2% impairment of the whole person, as per Table 17-31. Again, there is no award for loss of range of motion.

The other body parts involved in this claim included the wrists.

There was 0% impairment of the upper extremity or the whole person due to the left wrist.

As far as the right wrist was concerned, there was 10% impairment due to loss of range of motion and 2% due to neuropathy, which combined for a total of 12% impairment of the upper extremity. This converts to 7% impairment of the whole person.

In summary, there is 7% impairment of the whole person due to the right wrist; 0% impairment of the whole person due to the left wrist; 3% impairment of the whole person due to the right knee; and 2% impairment of the whole person due to the left knee. These are combined for a total of 12% impairment of the whole person.

Again, apportionment is most likely necessary because this man has had previous awards for his knees. I will be glad to consider such when those records are supplied.

Respectfully,

CEQ

Charles E. Quaglieri, MD

CEQ/kc/128
Enc: X-rays of 02/06/13

CCMSI

April 22, 2013

Greenman, Goldberg, Raby & Martinez
Attn: Belinda Cox
601 S. 9th Street
Las Vegas, NV 89101

Re:		
	Claimant:	David Figueroa
	Claim No.:	11D34B950842
	D/of Injury:	9/21/11
	Employer:	Las Vegas Metropolitan Police Department

Dear Belinda:

Thank you again for forwarding Dr. Quaglieri's PPD addendum to our office. At this time, the initial PPD offer and abeyance of 2/1/13 still stands. We are in the process of investigating his prior claims and PPD's for ratings relating to his knees. We will be forwarding these to Dr. Quaglieri for consideration of apportionment as indicated in his addendum report. Upon receipt of his final report, we will render a final determination.

If you disagree with the above determination, you have the right to request a hearing regarding this matter. If this is your intent, please complete the enclosed Request for Hearing form and return it to the Department of Administration, Las Vegas office, within seventy (70) days from the date of this letter.

Respectfully,

Christina Cabrera
CCMSI Claims Representative

Encl: D-12
Cc LVMPD D. Figueroa

Reset Form | Print Form

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

Received copy of D2

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name: DAVID | M.I. | Last Name: FIGUEROA | Birthdate: 10/28/70 | Sex: M | Claim Number (Insurer's use only)
Home Address: 5207 SPARKLING VINE AVE | Age: 42 | Height: 6'2 | Weight: 0X | Social Security Number: [redacted]
City: LAS VEGAS | State: NV | Zip Code: 89131 | Telephone: 347-682-6476
Mailing Address: SAME | City | State | Zip Code | Primary Language Spoken
INSURER | THIRD-PARTY ADMINISTRATOR | Employer's Occupation (Job Title) when injury or occupational disease occurring
Employer's Name/Company Name: LVMPD | Telephone: 828-3111
Office Mail Address (Number and Street)
Date of Injury (if applicable): 3/15/11 | Hour of Injury: NOON | AM / PM | Date Employer Notified: 12/17/12 | Last Day of Work after Injury or Occupational Disease: 12/17/12 | Supervisor to whom injury reported: J. RICHTER
Address or location of Accident (if applicable): LV BLVD & 95
What were you doing at the time of the accident (if applicable)? STOPPED FOR RED TRAFFIC SIGNAL, REAR ENDED
How did the injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary.)
REAR ENDED, STOPPED AT RED TRAFFIC SIGNAL.
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?
Witnesses to the accident (if applicable): NHP
Nature of injury or occupational disease: HERNIATED DISC L4/L5 L5/S1 | Part(s) of body injured or affected: LOWER BACK

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASE ACTS. IF IS CLAIM IS ALLOWED, I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR OTHER PERSON, ANY HOSPITAL INCLUDING VETERANS ADMINISTRATION OR GOVERNMENT AGENCY, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE PERTINENT TO THIS INJURY OR DISEASE (EXCEPT INFORMATION RELATED TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION). A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Date: 12/17/12 | Place: UMC University Medical Center | Employee's Signature: [signature]

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place: UMC Trauma | Name of Facility: University Medical Center
Date | Hour
Diagnosis and description of injury or occupational disease: LOW BACK PAIN
Is there evidence that the injured employee was under the influence of alcohol and/or an other controlled substance at the time of the accident? ☒ No ☐ Yes
If yes, please explain
Treatment: PAIN MEDS, REST
Have you advised the employee to remain off work five days or more? ☐ Yes If yes, indicate dates: to
X-ray findings: (-)
☒ No If no, is the injured employee capable of ☐ Full Duty ☒ Light Duty
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☒ Yes ☐ No
If modified duty, list any limits or restrictions: NO HEAVY LIFTING 72 HRS
Is additional medical care by a physician indicated? ☐ Yes ☒ No
Do you know of any previous injury or disease contributing to this condition or occupational disease? If yes, explain: PATIENT HAS A HISTORY OF CHRONIC BACK PAIN & LUMBAR DISC DISEASE
Date | Print Doctor's Name: GUILLERMO
I certify that a copy of this form was mailed to the employer on:
1800 W. Charleston Blvd. | Tax Id 88-6000436
Address: Las Vegas Nevada 89102 | 702-383-2000
City | State | Zip | Telephone
Doctor's Signature | Degree: MD

ACCT: 00031390842 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL M 42 Y
MR# 001-906-211 ADM: 12/17/2012

ORIGINAL - TREATING PHYSICIAN OR CHIROPRACTOR | COPY 1 - INSURER/TPA | COPY 2 - EMPLOYER | COPY 3 - EMPLOYEE | FORM C-4 (REV10/07)

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

OCCUPATIONAL INJURY/ILLNESS/EXPOSURE REPORT

1. Event #: 121217-3367

PART ONE STATEMENT OF INJURED EMPLOYEE

2. Name: (Last name, First name)	3. P#:	4. Sex:	5. Date of Hire:	6. Date of Birth:	7. SS#: (Required)
Figueroa, David	9093	☑ Male ☐ Female	11/05/2006	10/28/1970	[redacted]

8. Home Mailing Address (#, Street, Bldg/Apt. #, City, State & Zip): 5207 Sparkling Vine LV,NV 89131

9. Phone #(s)	10(a) Bureau of Assignment:	11. Classification:	12. Regular Work Hours:
Home: 347-682-6478	Traffic	PO II Motor	1400-000
Cell: 9/8	10(b) Section or Detail of Assignment:	13. Marital Status: ☑ Single ☐ Married	14. RDO's:
	TR32		Wed,Thur,Fri

15. Injury/Illness/Exposure:	16. Reported to Supervisor:	17. Left Shift:
Date: 12/17/2012 Time: 1600	Date: 12/17/2012 Time: 1605	Date: 12/17/2012 Time: 1830

NOTE: If you are claiming an occupational disease, indicate the date on which the employee first became aware of the connection between the condition and employment.

18. Address and location of occurrence: (Give sufficient Detail): Bruce/Fremont LV.NV

19. Was first aid provided? no

20. Action: ☐ Doctor's Care ☑ E.R. Care Only ☐ Hospitalized ☐ No Action Taken

21. Body part(s) affected/injured/exposed: lower back

22. Nature of injury/exposure sustained: (scratch, cut, bruise, strain, exposure, etc.): Lower back pain from prior injury on 03/15/2011 that was diagnosed as ruptured disk on L4-L5 /L5-SM1.

23(a). What were you doing when the accident occurred? (Chasing a suspect, walking down stairs, driving, etc?): Picking up my dropped flashlight on roadway.

23(b). How did the injury/illness/exposure occur? (Explain in Detail): While bending over to retrieve flashlight I felt a pop in my lower back and then intense pain.

24. Did the accident happen in the normal course of work? ☑ Yes ☐ No - Explain

25. Did you return to next scheduled shift after accident? ☐ Yes ☑ No - What date? 12/22/2012

26. Lost Time: ☐ No ☑ Yes - Last day worked after injury: 12/17/2012 If yes, disability slip from physician available? ☑ Yes ☐ No

27. Have you had previous injury/exposure to body part(s) mentioned? (Explain): Prior diagnosed injury to lower back from traffic accident on 03/15/2011.

28. How might this injury/illness/exposure have been prevented? Back not giving out while bending over.

29. Specify what equipment, objects or substances were involved (Include personal protective equipment used): Department issued uniform, gun belt, and motor boots.

30. Was anyone else involved? ☑ No ☐ Yes - List names of others involved:

31. Witnesses to injury/illness/exposure: (Last name, First name, and P#) 1. 2. 3.

Employee's signature on this document acknowledges that they have received a copy of this document including a brief description of their Rights and Benefits under NRS 616 and 617 included with this document.

32. Employee's Signature: Date:

Note: If this is due to abnormal physical result, this form does not need to be signed by your chain or supervisor. Please fax directly to Health Detail at 828-1509 and Call Health detail at 828-3696.

PART TWO REPORT OF INVESTIGATION BY SUPERVISOR

33. Why did injury/illness/exposure occur? Officer's back giving out while bending over.

34. What unsafe condition or act caused or contributed to injury/illness/exposure? None

35. Corrective action taken or recommended to prevent recurrence: None

36. Is there any reason to doubt the validity of the claim? ☑ No ☐ Yes - What reason?

37. If traffic accident, was the other party cited? ☐ No ☐ Yes - Attach copy of the traffic accident report

NOTE: If exposure, officer's report must be dictated and faxed to Health Detail at 828-1509.

38. Supervisor's Last Name, First Name and P# (Please Print):	Supervisor's Signature:	Date:
J.Richter 5629	[signature]	12/17/2012

PART THREE BUREAU COMMANDER/DIVISION CHIEF'S REVIEW/COMMENTS

Bureau Commander's Signature	Date:	Deputy Chief's Signature	Date:
Comments:		Comments:	

Note: Please fax directly to Health Detail at 828-1509 call Health Detail at 828-3696.

For assistance with worker's Compensation issues, you may contact the Office of the Governor, Consumer Health Assistance:
Toll Free (888)333-1597 Web Site: http://govcha.state.nv.us E-mail: cha@govcha.state.nv.us

LVMPD 26 (Rev. 10/11) INFOPATH 2007 *Employee should sign, date and retain a copy of this form. Original goes to employer. To file a claim for compensation, please see the next page, "Brief Description of Rights and Benefits", section titled "Claim for Compensation (Form C-4).

11

150307-0108

Acct #

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT

FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
DAVID		FLOURNOY	10-28-70	☒ M ☐ F	

Home Address	Age	Height	Weight	Social Security Number
5207 SPARKLING VINE AVE	44	6'2"	210	

City	State	Zip	Telephone
LAS VEGAS	NV	89131	702-682-6476

Physical Address	City	State	Zip	Primary Language Spoken
SIA				ENGLISH

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
UMR		POLICE OFFICER

Employer's Name/Company Name	Telephone
LVMPD	702-828-3111

Office Mail Address (Number and Street)	City	State	Zip
400 S. MARTIN LUTHER KING BLVD	LV	NV	89106

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
03/07/2015	am pm	03/07/2015		R. JOHNSON

Address or Location of Accident (if applicable)
MARTIN LUTHER KING & RANCHO DR NORTH N. LAS VEGAS, NV

What were you doing at the time of the accident? (If applicable)
DRIVING

How did this injury/or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
MVA

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable)
TYLER MCMEANS

Nature of Injury or Occupational Disease

Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Date Place UMC Employee's Signature

DOCTOR'S REPORT (MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT)

Place UMC Trauma Name of Facility University Medical Center

Date 3/7/15 Diagnosis and Description of Injury or Occupational Disease HEAD INJURY, LACERATION, CONCUSSION

Hour 2:45 AM/PM Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☒ No ☐ Yes (If yes, please explain)

Treatment SUTURES + OBSERVATION OR TRANSFER

Have you advised this patient to remain off work/modified duty or return? ☒ Yes Indicate dates: from 3/7/15 to TO BE DETERMINED ☐ No If no, is the injured employee capable of: ☐ Full duty ☐ Modified duty

X-Ray Findings NEGATIVE FOR FRACTURE OR DISLOCATION

If modified duty, specify any limitations/restrictions: TO BE DETERMINED

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☒ Yes ☐ No

Is additional medical care by a physician indicated? ☒ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☒ No (Explain if yes)

Date 3/7/15 Print Doctor's Name BRIANA LEWIS

I certify that the employer's copy of this form was mailed to the employer on.

Address 1800 W CHARLESTON BLVD

City LV State NV Zip 89102 Provider's Tax I.D. Number [illegible] Telephone 702 383 2420

Doctor's Signature [signature] Degree MD

INSURER'S USE ONLY RECEIVED MAR 19 2015 CCMSI – LVMPD

ORIGINAL - TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev 07/08)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Las Vegas Metropolitan Police Department	Law Enforcement	886000028	UNK

Office Mail Address	Location (if different from mailing address)	Telephone
400B S MARTIN LUTHER KING 435	SAME	702-828-3406

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
LAS VEGAS	NV	89106	LVMPD	CCMSI, Inc.

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
DAVID		FIGUEROA	[redacted]	10/28/1970	44	English

Home Address (Number and Street)	Sex	Marital Status
5207 SPARKLING VINE AVE	☑ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
LAS VEGAS	NV	89131	☑ Yes ☐ No	11/05/2006

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
NV	POLICE OFFICERS AND DRIVERS	PATROL DIVISION

Telephone	Is the injured employee a corporate officer?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
702-943-0636	☐ Yes ☑ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of Injury (Hours, Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
03/07/2015	00:25	03/07/2015	R JOHNSON

Address or location of accident (Also provide city, county, state) (if applicable)
MARTIN LUTHER KING/CAMINO DE NORTE
LAS VEGAS CLARK NV

Accident on employer's premises? (if applicable) ☐ Yes ☑ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (If applicable)
RIDING A MOTORCYCLE

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary
ANOTHER MOTORIST MADE AN UNSAFE TURN STRIKING THE MOTORCYCLE AND RIDER. MULTIPLE FRACTURES AND DISLOCATIONS. LEFT ARM, ELBOW, RIBS, HIP, LEG, KNEE, ANKLE.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable) MOTORCYCLE ACCIDENT

Witness: *Witness* Name: T MCMEANS

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☑ No

Part of body injured or affected: MULTIPLE BODY PARTS - NOC

If fatal, give date of death:

Witness: *Witness* Name: NLVPD DR#1

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.): SPECIFIC INJURY - FRACTURE

Witness:

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☑ No

Will you have light duty work available if necessary? ☑ Yes ☐ No

If validity of claim is doubtful, state reason: UNK

Location of Initial Treatment: UMC

Treating physician/chiropractor name: DEBORA KELLER

Emergency Room ☑ Yes ☐ No

Hospitalized ☑ Yes ☐ No

IMPORTANT: How many days per week does employee work? 4

From 1430 To 0030

Last day wages were earned: 03/07/2015

Scheduled days off: S ☐ M ☐ T ☑ W ☑ T ☑ F ☐ S ☐ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☑ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
11/05/2006	UNK	UNK	UNK

Was the employee hired to work 40 hours per week? ☑ Yes ☐ No If not, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☑ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-6). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☑ FRI

Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☑ BI-WKLY ☐ SEMI-MONTHLY

On the date of injury or disability the employee's wage was: $ UNK per ☑ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title: Olga Clark

Date: 3-10-15

INSURER ONLY

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party

Deemed Wage:

Account No.: 15D34E729659

Class Code:

Claims Examiner's Signature:

Date:

Status Clerk:

Date: 3/10/15

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

13

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

OCCUPATIONAL INJURY/ILLNESS/EXPOSURE REPORT

1. Event #: 150307-0108

PART ONE - STATEMENT OF INJURED EMPLOYEE

2. Name: (Last name, First name)	3. P#:	4. Sex:	5. Date of Hire:	6. Date of Birth:	7. SS#: (Required)
Figueroa, David	9693	☑ Male ☐ Female	11/05/2006	10/28/1970	[redacted]

8. Home Mailing Address (#, Street, Bldg/Apt. #, City, State & Zip): 5207 Sparkling Vine Ave. Las Vegas, NV 89131

9. Phone #(s)	10(a) Bureau of Assignment:	11. Classification:	12. Regular Work Hours:
Home: 702-943-0536	Bolden Area Command	PO-II	1430-0030
Cell: 347-682-6476	10(b) Section or Detail of Assignment: BA-33	13. Marital Status: ☐ Single ☐ Married	14. RDO's: TWT

15. Injury/Illness/Exposure:	16. Reported to Supervisor:	17. Left Shift:
Date: 03/07/2015 Time: 0025	Date: 03/07/2015 Time: 0028	Date: 03/07/2015 Time: 0030

NOTE: If you are claiming an occupational disease, indicate the date on which the employee first became aware of the connection between the condition and employment.

18. Address and location of occurrence: (Give sufficient Detail): Camino El Norte & W. La Madre Way

19. Was first aid provided? Yes, NVLFD

20. Action: ☐ Doctor's Care ☐ E.R. Care Only ☑ Hospitalized ☐ No Action Taken

21. Body part(s) affected/injured/exposed: Left arm, elbow, ribs, hip, leg, knee, ankle

22. Nature of injury/exposure sustained: (scratch, cut, bruise, strain, exposure, etc.): Multiple fractures and dislocations

23(a). What were you doing when the accident occurred? (Chasing a suspect, walking down stairs, driving, etc?): Riding a motorcycle

23(b). How did the injury/illness/exposure occur? (Explain in Detail): Another motorist made an unsafe turn striking the motorcycle and rider

24. Did the accident happen in the normal course of work? ☐ Yes ☑ No - Explain: Riding motorcycle to become re-acclimated to motors

25. Did you return to next scheduled shift after accident? ☐ Yes ☑ No - What date?

26. Lost Time: ☐ No ☑ Yes - Last day worked after injury: 03/06/2015 If yes, disability slip from physician available? ☑ Yes ☐ No

27. Have you had previous injury/exposure to body part(s) mentioned? (Explain): No

28. How might this injury/illness/exposure have been prevented? Unknown. Other driver possibly DUI.

29. Specify what equipment, objects or substances were involved (include personal protective equipment used): Boots, pants, leather riding jacket, helmet

30. Was anyone else involved? ☐ No ☑ Yes - List names of others involved: Driver V-1. See NLVPD DR# 150307-0010

31. Witnesses to injury/illness/exposure: (Last name, First name, and P#)
1. McMeans, Tyler P# 13407 2. See NLVPD DR# 150307-0010 3.

Employee's signature on this document acknowledges that they have received a copy of this document including a brief description of their Rights and Benefits under NRS 616 and 617 included with this document.

32. Employee's Signature: unable to sign, hospitalized. Date: 03/07/2015

Note: If this is due to abnormal physical result, this form does not need to be signed by your chain or supervisor. Please fax directly to Health Detail at 828-1509 and Call Health detail at 828-3696.

PART TWO REPORT OF INVESTIGATION BY SUPERVISOR

33. Why did injury/illness/exposure occur? Figueroa, V-2, recently advised that he would be returning to Motors. He was becoming re-acclimated when struck by another motorist.

34. What unsafe condition or act caused or contributed to injury/illness/exposure? Driver of V-1 possibly DUI. The investigation is on-going.

35. Corrective action taken or recommended to prevent recurrence: No recommendations at this time.

36. Is there any reason to doubt the validity of the claim? ☑ No ☐ Yes - What reason?

37. If traffic accident, was the other party cited? ☑ No ☐ Yes - Attach copy of the traffic accident report

NOTE: If exposure, officer's report must be dictated and faxed to Health Detail at 828-1509.

38. Supervisor's Last Name, First Name and P# (Please Print):	Supervisor's Signature:	Date:
Johnson, Robert P# 4395	R[illegible] S/T 4395	03/07/2015

PART THREE BUREAU COMMANDER/DIVISION CHIEF'S REVIEW/COMMENTS

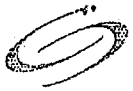
Bureau Commander's Signature	Date:	Deputy Chief's Signature	Date:

Comments:	Comments:

Note: Please fax directly to Health Detail at 828-1509 call Health Detail at 828-3696.

For assistance with worker's Compensation issues, you may contact the Office of the Governor, Consumer Health Assistance:
Toll Free (888)333-1507 Web Site: http://govcha.state.nv.us E-mail: cha@govcha.state.nv.us

LVMPD 28 (Rev. 10/11) INFOPATH 2007 *Employee should sign, date and retain a copy of this form. Original goes to employer. To file a claim for compensation, please see the next page, "Brief Description of Rights and Benefits", section titled "Claim for Compensation (Form C-4)



April 9, 2015

David Figueroa
5207 Sparkling Vine Ave
Las Vegas, NV 89131

RE:		
	Claim No:	15D34E72969
	Injury Date:	3/7/15
	Employer:	Las Vegas Metropolitan Police Department
	Type Injury/Body Part:	Left hip, left knee, left tibia, multiple fractures left lower extremity

Dear David Figueroa:

CCMSI is in receipt of your claim for the above-mentioned date of injury. After a careful and thorough review of your workers' compensation claim, it is the decision of the insurer to deny your claim. Your claim does not meet the requirements set forth in chapter 617 of the NRS, inclusive as an occupational disease. There is no evidence that shows causation for your injury to have arisen out of and in the course of your employment. You don't describe a specific accident or injury as defined & required by the Nevada Revised Statute.

NRS 616C.150: "An injured employee or his dependents are not entitled to receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, of NRS unless the employee or his dependents establish by a preponderance of the evidence that the employee's injury arose out of and in the course of his employment."

NRS 616A.265: "Injury" or "personal injury" means a sudden and tangible happening of a traumatic nature, producing an immediate or prompt result which is established by medical evidence, including injuries to prosthetic devices."

NRS 616A.030: "Accident" means an unexpected or unforeseen event happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury."

NRS 617.440 Requirements for occupational disease to be deemed to arise out of and in course of employment; applicability.

1. An occupational disease defined in this chapter shall be deemed to arise out of and in the course of the employment if: (a) There is a direct causal connection between the conditions under which the work is performed and the occupational disease; (b) It can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment; (c) It can be fairly traced to the employment as the proximate cause; and (d) It does not come from a hazard to which workers would have been equally exposed outside of the employment.

2. The disease must be incidental to the character of the business and not independent of the relation of the employer and employee.

3. The disease need not have been foreseen or expected, but after its contraction must appear to have had its origin in a risk connected with the employment, and to have flowed from that source as a natural consequence.

If you disagree with the above determination, you may request a hearing before a Hearing Officer by completing the enclosed Request for Hearing form within seventy (70) days after the date on which the notice was mailed, and sending it to the State of Nevada, Department of Administration, and Hearing Division.

If you have any questions, please call this office at (702) 477-7016.

Sincerely,

Christina Cabrera

Christina Cabrera
Claims Representative

cc: File/LVM PD/UMC/DIR/GGRM
Enc: D12 / Rights and Benefit

Nevada Department of Administration Hearings Division
2200 South Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

REQUEST FOR HEARING

CLAIMANT INFORMATION

Claimant:	David Figueroa
Address:	5207 Sparkling Vine Ave.
	Las Vegas, NV 89131
SSN:	
Telephone:	

EMPLOYER INFORMATION

Claim Number:	15D34E72969
Employer:	LVMPD
Address:	400 S. Martin Luther King Blvd., Building B
	Las Vegas, NV 89106
Telephone:	

PERSON REQUESTING APPEAL: (circle one) CLAIMANT EMPLOYER INSURER

I WISH TO APPEAL THE DETERMINATION DATED: 4/9/15

YOU MUST ATTACH A COPY OF THE DETERMINATION LETTER PER NRS 616C.315 2(a)(b)

BRIEFLY EXPLAIN REASON FOR APPEAL: Claimant disagrees with insurer's determination of letter dated 4/9/15, regarding denial of claim.

If you are represented by an attorney or other agent, please print the name and address below.

ATTORNEY/REPRESENTATIVE:

Name:	Thomas Askeroth, Esq.
Address:	601 S. Ninth St.
	Las Vegas, NV 89101
Telephone:	(702) 384-1616

INSURANCE COMPANY:

Name:	CCMSI
Address:	PO Box 35350
	Las Vegas, NV 89133
Telephone:	

Signature

April 22, 2015
Date

A COPY OF THE DETERMINATION LETTER MUST BE SUBMITTED:

NRS 616C.315 Request for hearing; forms for request to be provided by Insurer; appeals; expeditious and informal hearing required; direct submission to Appeals Officer.

2. Except as otherwise provided in NRS 616C.305, a person who is aggrieved by:

(a) A written determination of an Insurer; or

(b) The failure of an Insurer to respond within 30 days to a written request mailed to the Insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a Hearing Officer.

15D34E72969 - TH 17

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:	Hearing Number: 1510632-TH Claim Number: 15D34E72969
DAVID FIGUEROA 5207 SPARKLING VINE AVE LAS VEGAS, NV 89131	ABIGAIL BUCKLER LVMPD - HEALTH DETAIL 400 S MARTIN L KING BLVD STE B LAS VEGAS, NV 89106

_____/

ORDER TRANSFERRING HEARING TO APPEALS OFFICE

The Claimant's Request for Hearing was filed on April 22, 2015 and scheduled for May 18, 2015. The requesting party appealed the Insurer's determination dated April 9, 2015. The hearing was scheduled for May 18, 2015.

The parties have filed a stipulation to waive a hearing at the Hearing Officer level and to proceed directly to the Appeals Officer level.

> **NRS 616C.315(7)** provides that the parties to a contested claim may, if the Claimant is represented by counsel, agree to forego a hearing before a Hearing Officer and submit the contested claim directly to an Appeals Officer.

Therefore, good cause appearing, the Hearing Officer Proceeding shall be and is hereby transferred to the Appeals Officer for further proceedings.

IT IS SO ORDERED this 19th day of May, 2015.

Tracey Hagan
Hearing Officer

NOTICE: If any party objects to this transfer to the Appeals Office, an objection thereto must be filed with the Appeals Office at 2200 South Rancho Drive, Suite 220, Las Vegas, Nevada 89102, within 15 days of this order.

18

OneContent Generated By UMC\kpark Generated On: 03/30/2015 16:13

UMC

FACESHEET

ACCT: 9929043216 DOB: 10/28/1970
FIGUEROA
DAVID MANUEL 44Y M
MRN# 0001906211 ADM: 03/07/15

MRU00499 Page 1 of 1 (08/12)

ACCT # 9929043216 MRN# EDN# 0001906211	PT TYPE TRA	SVC EMG	ADMIT DATE 03/07/15	ADMIT TIME 0051	ROOM/BED -

PATIENT NAME:	DOB	AGE SEX	M/S	RACE	REL	SS #
FIGUEROA,DAVID MANUEL	10/28/1970	44Y M	S	1		[redacted]32

PATIENT INFORMATION
5207 SPARKLING VINE AVE
LAS VEGAS, NV 89131
HM: (347)682-6476
WK:

COUNTY: CLARK
COUNTRY: UNITED STATES
PLACE OF BIRTH:

EMPLOYMENT
LAS VEGAS METROPOLITAN P
400 S MARTIN LUTHER
LAS VEGAS NV 89106 (702)828-3475
OCCUP: POLICE OFFICER

GUARANTOR
FIGUEROA,DAVID MANUEL
5207 SPARKLING VINE AVE
LAS VEGAS NV 89131

DATE OF BIRTH: 10/28/1970
SS #: XXX-XX-9532
REL TO PT: SELF
HM:(347)682-6476
WK:(702)828-3475

EMPLOYMENT
LAS VEG
400 S MARTIN LUTHER KING
LAS VEGAS NV 89106
OCCUP: POLICE

SPOUSE/PARENT/OTHER

SS #:XXX-XX-
REL TO PT:
HM:
WK:

EMPLOYMENT
OCCUP:

RELATIVE/FRIEND

REL TO PT:

HOME #:
WORK PHONE #:

INSURANCE
LAS VEGAS METRO POLICE DE
C/O UMR
SALT LAKE CITY UT 84130-054
FIGUEROA,DAVID MANUEL

INS: FIGUEROA,DAVID MANUEL
REL: PATIENT IS INSURED
POL: 055729532
GRP: LV

DATE OF BIRTH: 10/28/70
BENEFIT/ELIG PH: (866)868-4295
NOTIFY PH:
AUTH #:

INSURANCE
MVA PENDING INFORMATION 0

INS: FIGUEROA,DAVID MANUE
REL: PATIENT IS INSURED
POL: 055729532
GRP:

DATE OF BIRTH: 10/28/70
BENEFIT/ELIG PH:
NOTIFY PH:
AUTH #:

INSURANCE

INS:
POL:

DATE OF BIRTH:
BENEFIT/ELIG PH:
GRP:

RECEIVED
JUN 10 2015

OCCUR/DATE	OCCUR/DATE	OCCUR/DATE	CONDITION CODE(S)
01 03/07/15			

CCMSI ~ Las Vegas

ACCIDENT INFORMATION
DATE 03/07/15 TIME 0030 CODE A
ACC TYPE: UTO ACCIDENT
LOCATION: LONE MOUNTAIN
DESC:

REASONS FOR VISIT / COMMENTS
MCC

PHYSICIANS
ADMITTING: 2284 KUHLS,DEBORAH A
ATTENDING: 2284 KUHLS,DEBORAH A
PCP:
CONSULT:

ADMISSION / REGISTRATION

ADM TYPE	POINT OF ORIGIN	FIN CLASS	DSCH DATE	DSCH TIME	REG ID
5	1	520116			TS

19

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

CONSULTANT: Daniel Lee, MD

REQUESTED BY:

DATE OF CONSULT:

REASON:

CHIEF COMPLAINT: Back pain status post trauma.

HISTORY OF PRESENT ILLNESS: This is a history of a 44-year-old status post motorcycle crash with a CTA left lower extremity, left popliteal artery dissection with reconstitution. Acetabular fracture, posterior hip dislocation. Mild left sacroiliac diastasis sigmoid. Mesenteric back stranding and left humerus diaphyseal fracture. Left 5th rib fracture. Left humerus olecranon fracture open. Degloving of left knee and left knee dislocation. His CT scan of the cervical, thoracic and lumbar was negative but he is having some back pain and I was called for consultation.

PAST MEDICAL HISTORY: Medical problems none.

PAST SURGICAL HISTORY: L5-S1 fusion.

SOCIAL HISTORY: Police officer. Negative for alcohol or tobacco.

MEDICATIONS: None.

ALLERGIES: NKDA.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS:

PHYSICAL EXAMINATION:
GENERAL: No apparent distress. Generally neural intact. Cannot turn him as he is in external fixators and splints, but no long tract signs. No hyperreflexia.

ASSESSMENT/PLAN: Status post motorcycle crash with back pain. Follow up in my clinic when he is out of the hospital. No surgical indications at this time from a spine standpoint, but further surgery from the standpoint of his upper and lower extremities from an orthopedic standpoint. Patient understands and wishes to proceed as does his wife.

cc: Nevada Orthopedic Spine Center

DL/MedQ
ID: 03/07/2015 21:41:39
DT: 03/08/2015 07:52:36

DANIEL LEE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MRN: 0001906211
ADM DATE: 03/07/2015
JOB#: 353563/646668155

DICTATED BY: DANIEL LEE, MD

CONSULTATION REPORT

Electronically Authenticated by:
Daniel Lee, MD On 03/08/2015 02:24 PM PDT

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

CONSULTANT: Michael Monroe, MD

REQUESTED BY: DEBORAH A KUHLS, MD

Date: 3/10/2015

REASON: Left pelvic fracture, left olecranon fracture, left humeral shaft fracture, left acetabular fracture with left hip dislocation, tibial shaft fracture with fibular shaft fracture.

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old male who presented after a motorcycle accident. He was wearing a helmet, traveling at 25-30 miles per hour when a car turned left in front of him and he struck him. He was thrown approximately 40 feet and found in a prone position with his legs apart. The patient denies any loss of consciousness during this event. He had immediate pain in his left upper and lower extremity.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: L5-S1 fusion.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: He denies any tobacco, alcohol, or illicit drug use.

FAMILY HISTORY: Not contributory to this issue.

REVIEW OF SYSTEMS:
A 12-point review of systems was obtained and was negative except for the above-mentioned complaints.

PHYSICAL EXAMINATION:
GENERAL: The patient is intubated when I see him.
HEAD: Pupils are equal and reactive to light. There is no facial trauma noted.
ENT: External appearance of ears and nose is normal. No exudates or erythema.
CARDIOVASCULAR: Pulses are brisk. Capillary refill is brisk in the bilateral upper and lower extremities.
LUNGS: Normal respirations without evidence of flail chest on the ventilator.
MUSCULOSKELETAL: There is a laceration over the knee with deformity and open distal tib-fib pilon fracture. The pelvis feels unstable on compression in AP and lateral plane on the left. There is gross deformity and angulation of the humeral shaft.

IMAGING: Radiographs of the left forearm reveal a transverse

olecranon fracture. Radiographs of the left foot reveal no fracture. Left femur reveals a left acetabular fracture, left hip dislocation. Left tibia and fibula show a comminuted distal tibia intra-articular fracture with distal fibular fracture. Also showing left knee dislocation. Bilateral acetabular fractures with pubic rami fractures. Left humerus shows a diaphyseal humeral fracture. CT of the pelvis reveals posterior left hip dislocation with mild sacroiliac diastasis on the left with left inferior pubic ramus fracture, ischial tuberosity fracture, iliac fracture, acetabular fracture. This appears to be a T-type left acetabular fracture.

IMPRESSION:
1. Left acetabular fracture.
2. Left hip posterior dislocation.
3. Left sacroiliac diastasis.
4. Left humeral shaft fracture.
5. Left transverse olecranon fracture, mildly displaced.
6. Open left pilon fracture.
7. Left knee dislocation.

TREATMENT AND PLAN: Our plan at this time is to perform closed reduction of the left knee dislocation, place an external fixator from the femur to the tibia for the dislocation, and then perform open reduction and internal fixation of the left fibula with preliminary external fixation of the open tibial pilon fracture. We plan to perform irrigation and debridement of all the open areas. For the left humerus, we would recommend humeral intramedullary nail, and for the olecranon, a large intramedullary screw. We will proceed with these procedures as medical clearance and OR schedule allows.

RJ/MedQ
DD: 03/10/2015 12:13:32
DT: 03/10/2015 16:39:22

ROSS JONES, MD

MICHAEL MONROE, MD

PATIENT: FIGUEROA, DAVID ACCOUNT#: 9929043215
MR#: 0001906211
ADM DATE: 03/07/2015
JOB#: 734267/646969650
PHYSICIAN: MICHAEL MONROE, MD
DICTATED BY: ROSS JONES, MD

CONSULTATION REPORT

Electronically Authenticated by:
Michael Monroe, MD On 03/11/2015 02:53 PM PDT
Electronically Authenticated and Edited by:
ROSS JONES, DO On 03/13/2015 05:53 PM PDT
Electronically Authenticated by:
Michael Monroe, MD On 03/20/2015 11:05 AM PDT

23

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9928043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Vital Signs/Data

Time	Staff	Temperature	Pulse	Respiration	Blood Pressure	Pulse Oximetry	Pain
03/07/2015 02:40	MP24	98.0 F	90 /min	22 /min	133/89 mm Hg.	98%	10/10

Allergies

NKA (03/07/2015 01:17)

Chief Complaint

MVA (MP24 03/07/2015 02:40)

Triage

Activation Level - Full. (MP24 03/07/2015 02:40)
2 - Emergent (MP24 02:40)
Domestic violence survey shows NEGATIVE risk for this patient. (MP24 02:40)
mcc (MP24 02:40)
Mentation - Patient is alert, oriented x3. Score = 0 (MP24 02:40)
Mobility - Patient is able to ambulate with no assistance. Score = 0 (MP24 02:40)
Elimination - Patient has independent elimination. Score = 0 (MP24 02:40)
No prior fall history. Score = 0. (MP24 02:40)
Patient is not at risk for falls. (MP24 02:40)
Patient has no thoughts of suicide. (MP24 02:40)
INFECTIOUS DISEASE/ CDC SCREENING: No risk factors for infectious disease. (MP24 02:40)
INFECTIOUS DISEASE/ CDC SCREENING: Pt has not been outside the US nor lives with anyone that has been outside the US in the last 6 months. (MP24 02:40)

Height/Weight

Hgt: 188 cm at 02:40 (MP24 03/07/2015 02:40)
Wgt: 109.1 kg at 02:40 (MP24 02:40)
BMI: 30.9 (MP24 02:40)
BSA: 2.39 sq. m (MP24 02:40)

Patient Problems

Multiple closed fractures of pelvis with disruption of pelvic circle (03/07/2015 03:02)

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Med Orders

albuterol soln for neb [VENTOLIN] 2.5 MG NEB RT Q4H PRN ROUTINE AEROSOL TX SVN Bronchodilator Protocol: Yes
Indications: dyspnea
albuterol soln for neb [VENTOLIN] 2.5 MG NEB RT QID ROUTINE AEROSOL TX SVN Bronchodilator Protocol: Yes

sodium chloride 0.9% 1000 ML IV 125 ml/hr CONTINUOUS ROUTINE

fentaNYL inj [SUBLIMAZE] 100 MCG IV Q1H PRN ROUTINE
Indications: Pain
midazolam inj [VERSED] 0.5 MG IV Q4H PRN ROUTINE
Indications: agitation
ondansetron inj [ZOFRAN] 4 MG IV Q6H PRN ROUTINE
Indications: nausea Comments: PO preferred, IV if NPO or unable to tolerate PO
famotidine inj [PEPCID] 20 MG IV BID ROUTINE

diphenhydrAMINE inj [BENADRYL] 25- 50 MG IV HS PRN ROUTINE
Indications: insomnia
acetaminophen [TYLENOL] 650 MG ORAL Q6H PRN ROUTINE
Indications: temp >/= 38.5 C
chlorhexidine 0.12% oral rinse [PERIDEX] 10 ML SWISH_SPIT QID ROUTINE

chlorhexidine 0.12% oral rinse [PERIDEX] 10 ML SWISH_SPIT PRN ROUTINE
Indications: oral care
potassium chloride [KLOR- CON] 40 MEQ ORAL PRN ROUTINE If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
KCl 40 mEq rider 40 MEQ IVPB 10 MEQ/HR PRN ROUTINE If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders Central Line
Indications: per Electrolyte Protocol (PROT #383)
potassium- sodium phosphate packet (8 mmol ptos) [PHOS- NAK] 2 PACKET ORAL PRN ROUTINE If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
KPhos inj 40 MMOL IVPB 7 MMOL/HR PRN ROUTINE Peripheral Line If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
magnesium sulfate 2 gm rider 2 GM IVPB 30 MIN PRN ROUTINE If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)
NaPhos inj 40 mmol IVPB 7 MMOL/HR PRN ROUTINE If serum creatinine is >/= 1.4 or UO < 0.5 ml/kg/hr x 3 hrs, DO NOT USE PROTOCOL; contact provider for new orders
Indications: per Electrolyte Protocol (PROT #383)

25

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

TR CT BRAIN W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CERVICAL SPINE W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT ABDOMEN AND PELVIS IV ONLY ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CTA LOWER EXTREMITY ONCE STAT Left
Entered By (MK23 RN 03/07/2015 01:06) Ordered By (01:06) Completed By (01:26)
TR CHEST PORTABLE ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 00:56) Ordered By (00:56) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR PELVIS 1 VIEW ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 00:56) Ordered By (00:56) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
CBC/AUTOMATED ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:12) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
BASIC METABOLIC PANEL ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:18) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
ABO RH TYPE ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Completed By (01:47) MD Sign (JDM1 MD 01:01)
ANTIBODY SCREEN - GEL TECHNIQUE ONCE LIFE THREATENING
Entered By (03/07/2015 01:01) Ordered By (JDM1 MD 01:01) Results Back (01:47) MD Sign (JDM1 MD 01:01) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
TR HUMERUS (LEFT) ONCE STAT trauma
Entered By (MK23 RN 03/07/2015 01:10) Ordered By (01:10) Completed By (01:26)
TYPE AND SCREEN ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Order Cancelled (02:21)
REQUEST THAWED PLASMA ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Completed By (01:38)
REQUEST RED BLOOD CELLS (BLOOD PRODUCT) ONCE STAT
Entered By (MK23 RN 03/07/2015 01:07) Ordered By (01:07) Completed By (01:38)
TR CT CHEST WITH CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:09) Ordered By (01:09) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT CERVICAL SPINE W/O CONTRAST ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:09) Ordered By (01:09) Order Cancelled (01:10) Comments: ...recon
TR CT THORACIC SPINE RECONSTRUCT ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Results Back (01:26) Notes: Portable X- ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR CT LUMBAR SPINE RECONSTRUCT ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Results Back (01:26) Notes: Portable X- ray at bedside. Returns from CT. Taken to CT. (CJE1 02:43)
TR CT ABDOMEN AND PELVIS IV ONLY ONCE STAT Pain - Trauma Related
Entered By (MK23 RN 03/07/2015 01:12) Ordered By (01:12) Order Cancelled (01:13) Comments: ...thin cuts
HEMATOLOGY SLIDE REVIEW ONCE LIFE THREATENING
Entered By (03/07/2015 01:16) Ordered By (01:16) MD Sign (01:16) Order Cancelled (01:33)
TIBIA + FIBULA (LEFT) ONCE ROUTINE mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:27)
FEMUR (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:27)
ANKLE LIMITED (LEFT) ONCE STAT mcc

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 8929043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non-Med Orders

Entered By (BD99 UNIT CLERK 03/07/2015 01:25) Ordered By (01:25) MD Sign (01:25) Order Cancelled (01:26)
TR ANKLE LIMITED (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:26) Ordered By (01:26) MD Sign (01:26) Order Cancelled (01:28)
TR FEMUR (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:27) Ordered By (01:27) Results Back (01:27) MD Sign (01:27) Notes: Portable X-ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR TIBIA + FIBULA (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:32)
TR ANKLE LIMITED (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:34)
TR FEMUR (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 01:28) Ordered By (01:28) MD Sign (01:28) Order Cancelled (01:34)
TR TIBIA + FIBULA (LEFT) ONCE ROUTINE mcc
Entered By (03/07/2015 01:27) Ordered By (01:27) Results Back (01:27) MD Sign (01:27) Notes: Portable X-ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR FOOT LIMITED (LEFT) ONCE STAT mcc
Entered By (03/07/2015 01:28) Ordered By (01:28) Results Back (01:32) MD Sign (01:28) Notes: Portable X-ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
ABO RH TYPE ONCE STAT
Entered By (03/07/2015 01:38) Ordered By (01:38) MD Sign (01:38) Order Cancelled (02:23)
ANTIBODY SCREEN - GEL TECHNIQUE ONCE STAT
Entered By (03/07/2015 01:38) Ordered By (01:38) MD Sign (01:38) Order Cancelled (02:24)
CROSSMATCH ELECTRONIC ONCE LIFE THREATENING
Entered By (03/07/2015 01:46) Ordered By (01:46) Completed By (CJE1 RN 02:43) MD Sign (01:46)
TR HAND LIMITED (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 02:24) Ordered By (02:24) Results Back (02:29) MD Sign (02:24) Notes: Portable X-ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
TR FOREARM (LEFT) ONCE STAT mcc
Entered By (BD99 UNIT CLERK 03/07/2015 02:24) Ordered By (02:24) Results Back (02:29) MD Sign (02:24) Notes: Portable X-ray at bedside. Taken to CT. Returns from CT. (CJE1 02:43)
PT + APTT ONCE STAT
Entered By (BD99 UNIT CLERK 03/07/2015 02:33) Ordered By (02:33) Results Back (02:42) MD Sign (02:33) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
HOLD CLOT FOR BLOOD BANK ONCE ROUTINE
Entered By (BD99 UNIT CLERK 03/07/2015 02:33) Ordered By (02:33) MD Sign (02:33) Notes: Blood Drawn - RN. Blood obtained from the right antecubital fossa. (CJE1 02:42)
Surgery Admit Order (basic requirements) ONCE ROUTINE Inpatient TICU Standard multiple extremity fractures with vascular injury KUHLS, DEBORAH A [CRITICAL CARE MED, SURGICAL CRIT CARE, GENERAL SURGERY, TRAUMA] (2294)
Entered By (03/07/2015 03:02) Ordered By (03:02)
Measure Height ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Measure Weight EVERY DAY ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Incentive Spirometry - NSG Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: X 10 Breaths
INCENTIVE SPIROMETER- RT to Instruct ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Admission Nasal MRSA Colonization Screen- ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Initiate Influenza Vaccine Assessment- CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: - Switch to influenza vaccine order if indicated
Initiate Pneumococcal Vaccine Assessment- CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: - Switch to pneumococcal vaccine order if indicated

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9929043215
Medical Rec. Number: 0001806211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

Intake & Output Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE Urine Output < 0.5 ml/kg/hr Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE HR<50 or >130 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE RR<10 or >30 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE SaO2 <90% Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE Temp >38.5C Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE SBP <80 or >180 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE DBP <60 or >110 Resident
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RD May Modify / Clarify Diet Orders CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Physician Consult CONTIN ROUTINE MONROE, MICHAEL TODD [ORTHOPAEDIC SURGERY, ORTHOPAEDIC SURGERY] (1017)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Intensivist is: CONTIN ROUTINE KUHLS, DEBORAH A [CRITICAL CARE MED, SURGICAL CRIT CARE, GENERAL SURGERY, TRAUMA] (2294)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Physician Consult CONTIN ROUTINE FEIKES, QUYNH N [GENERAL SURGERY, THORACIC SURGERY, THORACIC SURGERY] (20275)
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Activity CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Cervical Collar CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Neurovascular Checks Q1H ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: Site for NV checks: LLE
NPO MEALS
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Sequential Compression Device CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Nurse to Follow Protocol: CONTIN ROUTINE Print and follow PROT #383 (Electrolyte Protocol), place in chart
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RN to Order: CONTIN ROUTINE Repeat K level 2 hr after KCl, Phosphorous level 2 hr after KPhos/NaPhos/PhosNaK, Magnesium 2 hr after magnesium
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: per Electrolyte Protocol (PROT #383)
ABG LINE CONTIN ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Comments: Obtain ABG and call MD with results for sudden acute resp. distress
EKG 12 LEAD ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
Notify: CONTIN ROUTINE for any questionable arrhythmia (and obtain 12 lead EKG with rhythm strip) Admin Coordinator and House Officer
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
CBC/AUTOMATED IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
RENAL PANEL IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
MAGNESIUM LEVEL IN AM
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)

University Medical Center
1800 W. Charleston Blvd.
Las Vegas, NV 89102
702-383-2000

Final

Emergency Department Chart

Patient Name: FIGUEROA, DAVID M.	Account Number: 9928043215
Medical Rec. Number: 0001906211	Birthdate: 10/28/1970 Gender: M
Arrival Date: 03/07/2015 00:51	Primary MD:
Visit Date: 03/07/2015 00:54	Attending MD:

Non- Med Orders

NUTRITIONAL CONSULT ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
SOCIAL SERVICES CONSULT ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02)
CPK ONCE ROUTINE
Entered By (03/07/2015 03:02) Ordered By (03:02) MD Sign (03:02) Order Cancelled (03:10)
CPK ONCE LIFE THREATENING
Entered By (03/07/2015 03:11) Ordered By (03:11) MD Sign (03:11)

Disposition

NOT SEEN BY ER ATTENDING (see RN chart). (CJE1) 03/07/2015 03:12 Disposition status is Admit. Admitted to Operating Room. RN accompanied patient. MD accompanied patient. Monitor used during transport. Valuables inventoried and collected by UMC Public Safety. Patient physically left department and was removed from Tracking Board by CARLOS JUSTIN ESPARZA RN. (CJE1) 03/07/2015 02:59 Electronically signed by CARLOS JUSTIN ESPARZA RN. (CJE1) 03/07/2015 03:12

Discharge Summary

Chief Complaint: MVA.. Primary Diagnosis: NO DATA AVAILABLE.. Disposition Notes: NOT SEEN BY ER ATTENDING (see RN chart).. Discharge Prescriptions: NO DATA AVAILABLE. (03/07/2015 03:12)

Staff Legend

BD89	BRENDA DERLEIN UNIT CLERK
CJE1	CARLOS ESPARZA RN
MK23	MARTIN KOVACIK RN
MP24	MARITA PEREZ RN
RW4	ROBERT WILSON RN

29

UNIVERSITY MEDICAL CENTER
1800 West Charleston Boulevard
Las Vegas, Nevada 89102

DATE OF SERVICE: 03/07/2015

TIME: Approximately 12:50 a.m.

SENIOR RESIDENT: Zachary VanWagoner.

FELLOW: Dr. Alistair Chapman.

JUNIOR RESIDENT: Benjamin Fox.

This is a full activation.

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old male status post motorcycle collision. The patient had another vehicle turn left and into him while he was traveling approximately 35 miles an hour. Patient was thrown from his bike with approximately 30 yards of separation. He was found lying in prone position at the scene. Positive LOC. Negative loss of consciousness. The patient is complaining of no sensation in the left foot and also significant pain in the left lower extremity and left leg and left hip.

REVIEW OF SYSTEMS:
Ten-point review of systems is significant for loss of sensation in the left lower extremity and significant left arm, left hip, and leg pain.

PAST MEDICAL HISTORY: Patient denies.

PAST SURGICAL HISTORY: Significant for fusion of L5-S1 for a prolapsed disk.

MEDICATIONS: None.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Patient is a police officer. He denies any tobacco or alcohol or illicits.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

PRIMARY SURVEY: AIRWAY: Patent, phonating.
BREATHING: Clear to auscultation bilaterally. No wheezes, rhonchi, or rales.
CIRCULATION: Pulses: Radial 2+ bilaterally. Femoral 1+ on the left, 2+ on the right. Carotid 2+. Pedal pulses: Right 2+, _____ pulses on the left foot.
DISABILITY: Eye 4, verbal 5, motor 6. GCS of 15.
EXPOSURE: Patient has a very large degloving injury of the left knee with exposed proximal tibia and fibula and femur with obvious dislocation of the knee joint. The patient also has an obvious

30

deformity of the left humerus, laceration near the left elbow, and superficial abrasions over the right hand and knee.

SECONDARY SURVEY: VITAL SIGNS: Heart rate 90, blood pressure 135/92, respiration rate 22, temperature 96, O2 saturation 99%. IV access: Patient had a 16-gauge in the right hand and 16-gauge in the right AC.
HEENT: No step-offs or deformities. EOMI. PERRLA.
MAXILLOFACIAL: No step-offs or deformities.
NECK: C-collar is in place.
CHEST AND LUNGS: Clear to auscultation bilaterally.
CARDIOVASCULAR: Normal sinus rhythm. S1, S2. No murmurs, rubs, or gallops.
ABDOMEN: Soft, nondistended, nontender to palpation.
PELVIS: Significant pain on palpation of the left hip. Otherwise, appears stable.
BACK: T- and L-spines nontender to palpation. No step-offs or deformities.
RECTAL: Normal tone. No abnormality. No blood noted. Prostate in normal position.
EXTREMITIES: Decreased pulses in the left lower extremity with an exposed femur and knee and exposed proximal tib-fib. The left upper extremity also has a deformity with a laceration near the left elbow.
NEUROLOGIC: Mental status AAO x3. Cranial nerves 2-12 grossly intact. Bilateral motor is diminished in the left upper and left lower extremity secondary to pain and fractures. Sensation is diminished in the left foot at approximately the level of the left knee.

RADIOLOGY REPORTS: CT of the brain shows no abnormality. CT of the C-spine shows no abnormality. CT of the chest demonstrates a fracture of the left 5th rib, bilateral lower lobe atelectasis. CT of the abdomen and pelvis demonstrates a left acetabular fracture, posterior left hip dislocation, left SI diastasis, mild sigmoid mesenteric fat stranding. CT of the T-spine demonstrates no acute fracture. CT of the L-spine demonstrates no acute fracture. X-ray of the pelvis demonstrates multiple left pelvic fractures including pubic rami at 2 points, acetabular fractures, malalignment of the left hip with proximal migration of the femur and a femoral head fracture. X-ray of the left femur demonstrates the above-listed fractures. In addition, widening of the proximal tibial-fibular articulation compatible with a traumatic subluxation and dislocation. X-ray of the left tib-fib shows a left comminuted distal tib-fib fracture with the aforementioned diastasis of the tibiofibular articulation. X-ray of the left foot demonstrates no fracture. X-ray of the left humerus shows a diaphyseal fracture and fracture of the elbow and ulna. X-ray of the chest demonstrates minimally displaced left 5th rib fracture. CT of the left lower extremity shows injury to the left popliteal and anterior tibial arteries. There is 3-vessel reconstitution going into the leg; however, the anterior tibial ends abruptly at the level of the distal comminuted tibia and fibular fractures, and there is runoff of the posterior tibial vessel all the way to the foot.

LABORATORY DATA: WBC 10.0, HGB 15.7, hematocrit 47.9, platelets 214.

Sodium 138, potassium 3.8, chloride 108, CO2 19, BUN 22, creatinine 1.4, glucose 148.

CONSULTANTS: Dr. Monroe with Orthopedics and Dr. Quynh Pelkes with Vascular Surgery.