STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GRAND TRAVERSE

JEANNE HARRISON,

Plaintiff,

v

File No. 09-27611-NH
HON. PHILIP E. RODGERS, JR.

MUNSON HEALTHCARE, INC., a Michigan corporation; SURGICAL ASSOCIATES OF TRAVERSE CITY, PLCC; and WILLIAM POTTHOFF, M.D.,

Defendants.
/

Thomas C. Miller (P17786)
Attorney for Plaintiff

Thomas R. Hall (P42350)
Attorney for Defendant Munson Healthcare

Brett J. Bean (P31152)
Attorney for Defendants Potthoff and Surgical Associates

DECISION AND ORDER
REGARDING MOTION FOR SANCTIONS

The trial was commenced in the above-captioned action on January 12, 2011. The cause of action was based upon a burn received by the Plaintiff outside the surgical field during a thyroidectomy. The cautery device known as a Bovie penetrated the drape, contacted the Plaintiff's arm and burned her. The burn was discovered and repaired at the conclusion of the surgery.

Plaintiff aggressively pursued the cause of this burn with pre-trial discovery. The Defendants claimed they did not know how the Bovie came to penetrate the drape and cause injury to the Plaintiff's left arm. Near the conclusion of the discovery period two individuals present in the surgical suite testified that they heard the alarm indicating the Bovie had been activated and saw that it was not in the Defendant Physician's hand. When the Defendant Physician stepped away from the Plaintiff, the Bovie was between his body and the Plaintiff's

left arm and was activated by pressure exerted by him leaning up against the Plaintiff. These witnesses did not recall how the Bovie came to be unholstered and located between the Defendant Physician and Plaintiff.

The parties agreed that the standard of care required the Bovie to be holstered when it was not in use. Given the absence of recollection as to how the Bovie came to penetrate the drape, the defense theory was based on habit and practice and probable mechanisms by which the Bovie may have been inadvertently unholstered during the surgical process without violating the standard of care.

On the third day of the trial, during the in-limine examination of the Defendant Hospital's Operating Room Manager, Barbara Peterson, it was first revealed that a contemporary incident report had been prepared. See, Exhibit A. The Court required that the report and any related documents be produced for an in-camera inspection. See, Exhibits A through D. Several points became immediately apparent upon inspecting the documents.

First and most importantly, the incident report reached a factual conclusion as to how the Bovie had come to penetrate the drape. Second, the Defendants claimed a peer review privilege and it was evident that the issues associated with peer review could not be resolved during the course of the jury trial.[1] Third, if the facts associated with the described incident were provided to the Plaintiff, the jury, and the Court, the Court would not allow expert testimony based on habit and practice regarding how the Bovie may have become unholstered which theories were inconsistent with the factual findings of the contemporaneous internal investigation.

The Court on its own motion declared a mistrial. A full-day evidentiary hearing was set to determine whether these documents were protected in whole or in part by the peer review statute; whether the facts contained within them were subject to production as opposed to the conclusions regarding standard of care issues, discipline or subsequent remedial measures; and whether a defense could be presented that was inconsistent with the contemporaneous investigation described by peer review documents and, if so, how that could be accomplished ethically.

The hearing was concluded on March 1, 2011 and substantial testimony was received. The issues were also fully briefed by the parties and the Court took the matter under advisement

[1] A key witness was unavailable due to a family emergency.

to review the proffered authority and documents.[2] The Court will now provide its conclusions of law on undisputed facts.

The Michigan Public Health Code provides rules for maintaining patient records and for confidentiality. MCL 333.20175. Most relevant to this discussion is the confidentiality provision commonly referred to as the peer review privilege, which is found in Section 8 and provides as follows:

> The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena. MCL 333.20175(8).

The Defendants take the position that even the factual information collected during the peer review process is absolutely protected from disclosure. Recognizing that peer review serves an important public purpose, it is still appropriate to inquire whether the Defendant Hospital can protect facts, as opposed to conclusions, from disclosure and, if so, whether it legally and ethically can take positions in litigation which are inconsistent with those facts. First, the Court must determine whether the incident report and related investigative documents were the product of "individuals or committees assigned a professional review function in a health facility." *Id.*

The manner by which a trial court determines whether documents are protected by the peer review privilege is described in a number of Michigan appellate decisions. The trial court is instructed to consider the hospital's by-laws, internal rules and regulations, and whether the committee overseeing the creation of the documents is involved in retrospective analysis for improvement or part of current patient care. *In re Lieberman*, 250 Mich App 381, 385; 646 NW2d 199 (2002); *Dorris v Detroit Osteopathic Hosp*, 460 Mich 26, 42; and *Monty v Warren Hosp Corp*, 422 Mich 138, 147; 336 NW2d 198 (1985).

At the evidentiary hearing, the Defendant Hospital's peer review procedures were described by various witnesses. Paul Shirilla, Vice President and General Counsel for the Defendant Hospital, testified regarding the peer review process, the quality committee and oversight by the Defendant Hospital's Board of Directors. Mr. Shirilla was not involved in the

[2] Relevant documents included the Defendant Hospital's Bylaws (Exhibit 1), its Risk Management Occurrence Reporting Policy (Exhibit 6), Confidentiality of Peer Review Records (Exhibit 8), the Incident Report (Exhibit A) and the related investigative and follow up materials (Exhibits B, C and D).

preparation or review of discovery responses in this case but did testify that an occurrence or incident report is part of the peer review process. However, he also acknowledged that incident reports and Risk Manager investigations are not discussed in the Defendant Hospital's policy on Confidentiality of Peer Review Records. (Exhibit 8.)

David McGreaham, M.D., is the Defendant Hospital's Director of Medicine. Dr. McGreaham also testified regarding peer review or quality assurance at the Defendant Hospital. He, too, opined that incident reports such as the one generated in this case are part of the peer review process. The Court agrees, but the inquiry cannot end here.

Dr. McGreaham acknowledged that the Hospital has an internal policy that precludes the incident report from inclusion in the medical chart, but the facts of the event are required to be charted. See, Exhibit 6. Interestingly, Dr. McGreaham testified that the Defendant Hospital has not developed forms to do so and, in his opinion, as little as possible should be disclosed to the patient in the medical record regarding the facts of an unusual event.

Exhibit 6 at page 2 states as follows:

> 4. Document the *facts of the event* in the patient's medical record using forms and documentation procedures as would be done for any other problem or deviation from normal or expected parameters.
>
> a. Include date, time, *facts of event*, and care rendered . . .

And, at page 3, the Exhibit 6 states:

> The medical record should contain only *facts of the event.* Never document that an occurrence report has been completed nor refer to such report in the patient's chart. (Emphasis supplied.)

The Defendant Hospital's Risk Manager, Bonnie Schreiber, also admitted there were no "forms and documentation procedures" to implement this Hospital policy. To her credit, Ms. Schreiber stated her belief that relevant facts should not be withheld from the patient.[3] Ms. Schreiber oversees the peer review process and is responsible for maintaining the occurrence or incident reports. It was Ms. Schreiber who drafted Exhibit 6 and who caused Barbara Peterson to conduct an investigation and it was Ms. Schreiber who accepted the findings of Ms. Peterson

[3] Ms. Schreiber's opinion was supported by Mary Murphy, Director of Surgical Services (Retired), who testified that she expected staff to write down the facts of an untoward event.

without comment or concern.[4] It was also Ms. Schreiber who was responsible for reviewing the Defendant Hospital's sworn discovery responses, including interrogatory answers, with counsel prior to their submission to the Plaintiff.

When the Hospital was asked to explain how the Bovie came to burn a hole in the drape, the Hospital's consistent response was "unknown" or "may not ever be known" and explanations were then based on habit and custom. See, e.g., Defendant Hospital's Answers to Plaintiff's Requests to Admit Dated December 14, 2009, Defendant Hospital's Answers to Plaintiff's Third Interrogatories Dated April 7, 2010. Two members of the surgical team recalled the Bovie alarm being activated, that it was not in the Defendant Physician's hand, and that as he stepped away from the patient it was discovered between him and the Patient's body.

No individual has a present memory of how the Bovie came to be on the drape, unholstered and in a position to burn the patient. Since the standard of care requires the Bovie to be holstered, it was critical in this case to know whether it was improperly placed on the drape out of its holster and not promptly reholstered by a member of the surgical team, or whether it became accidentally unholstered in a way that was within the standard of care.

On this point, the Defendant Hospital stated that the event was "sudden, accidental and unpreventable" . . . . and "more than likely resulted from an inadvertent dislodging of the Bovie from its holster." According to the Hospital, "As all Defendants have maintained throughout, what happened to this patient was entirely inadvertent, and could not reasonably have been detected and/or prevented before it occurred." See, Exhibits 17 and 20 to Plaintiff's Motion for Imposition of Sanctions.

The conclusion of the internal investigation was diametrically opposed to the Defendant Hospital's statements. In fact, the Bovie had not become accidentally unholstered: "Bovie was laid on the drape," and the "Bovie holder was on field for this case, however, Bovie was not placed in it." See, Exhibit A. These facts were not charted. Whether or not laying the Bovie on the drape was determined by the Defendant Hospital to be a standard of care violation, a cause for discipline or grounds for the implementation of subsequent remedial measures are not facts

[4] This action was consistent with the procedure described in the Risk Management Policy, Exhibit 6 at page 3. Mary Murphy, then Director of Surgical Services, testified that she too would have reviewed Ms. Peterson's findings and had them corrected if necessary.

sought by the Plaintiff nor would they be discoverable. Clearly, such internal conclusions drawn as part of the peer review process are protected from discovery for sound policy reasons.

In determining whether facts should be disclosed as opposed to deliberations, conclusions or subsequent remedial measures, the discussion in *Centennial Healthcare Mgt Corp v Michigan Dep't of Consumer & Industry Services*, 254 Mich App 275; 657 NW2d 746 (2002) is helpful. In discussing the scope of the peer review privilege, the *Centennial* court wrote as follows:

> Certainly, in the abstract, the peer review committee cannot properly review performance in a facility without hard facts at its disposal. However, *it is not the facts themselves that are at the heart of the peer review process. Rather, it is what is done with those facts that is essential to the internal review process*, i.e., a candid assessment of what those facts indicate, and the best way to improve the situation represented by those facts. Simply put, the logic of the principle of confidentiality in the peer review context does not require construing the limits of the privilege to cover any and all factual material that is assembled at that the direction of the peer review committee . . . *It is not the existence of the facts of an incident or accident that must be kept confidential in order for the committee to effectuate its purpose; it is how the committee discusses, deliberates, evaluates and judges those facts that the privilege is designed to protect. Id.* at pp 290, 291. (Emphasis supplied.)

The sound public policy reasons that support the nondisclosure of protected internal investigations, then, is not so broad as to allow the Defendant Hospital to ignore those facts and pretend they do not exist. Indeed, the Hospital's internal policy, fairly interpreted, requires that the facts of an untoward incident be charted.[5] Clearly, the standard of care conclusions,

---

[5] The argument against disclosing facts as opposed to conclusions is that medical staff will not be forthcoming in occurrence or peer review investigations. This argument is unprofessional and unpersuasive. The mission of medical staff and their careers is patient care, not covering up the occasional mistake. Footnote 11 in the *Centennial* opinion is instructive on this point. It reads as follows:

> We note that authority exists that rejects the premise that the function of a peer review committee would be impaired if such a privilege did not exist. See, e.g., *Syposs v United States*, 63 F Supp 2d 301, 306 (WD NY, 1999). Indeed, the Michigan Supreme Court appears to be heading away from the validity of this presumption. In *Bradley v Saranac Community Schools Bd of Ed,* 455 Mich 285, 299-300; 565 NW2d 650 (1997), the Court observed:
>
> > The plaintiffs assert that the integrity of the evaluation process will be compromised by the disclosure of their personnel records. They suggest that the evaluators will be less inclined to candidly evaluate their employees if the evaluations are to be made public. We draw the opposite conclusion. Making such documents publicly available seems more likely to foster candid, accurate, and conscientious evaluations than suppressing them because the person performing the evaluations will be aware that the documents being prepared may be disclosed to the public, thus subjecting the evaluator, as well as the employee being evaluated, to public scrutiny. *Id.* at p 289.

disciplinary action or subsequent remedial measures that may be flow from an untoward event need not and should not be charted. As the *Centennial* Court noted, "it is not the facts of an incident that must be kept confidential . . . it is how the committee discusses, deliberates, evaluates and judges those facts that the privilege is designed to protect." *Id.* at p 291.

The finding that the Bovie was laid on the drape and not placed in the holster is grossly inconsistent with an argument that the Bovie was properly holstered and then accidentally unholstered. This contemporaneous factual finding was recorded by Barbara Peterson, the only individual who conducted an investigation. No one else has any present memory as to how an unholstered Bovie came to be on the drape. Further, unlike the incident report in *Vergote v K-Mart Corp* (after remand), 158 Mich App 96, 109; 404 NW2d 711 (1987), the factual conclusion in the incident report is of dispositive significance and was not elicited from other sources during the trial. The report was not given to the jury and it would appear that it would be error to do so.

However, the facts recorded in the report as opposed to the conclusions drawn in the report should not have been kept from the jury in view of the holding in *Centennial* and the Defendant Hospital's own internal policy. See, Exhibit 6. Those facts should have been recorded in the medical chart. And, if the facts are not recorded and not given to the jury, the Defendants are precluded ethically from offering an explanation that is inconsistent with those facts.[6] This is true whether or not the incident report was requested.[7]

---

[6] MRPC 3.3 provides in relevant part as follows:

> (a) A lawyer shall not knowingly:
>
> (1) make a false statement of material fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;
>
> . . .
>
> (3) offer evidence that the lawyer knows to be false. If a lawyer has offered material evidence and comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal
>
> (d) In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts that are known to the lawyer and that will enable the tribunal to make an informed decision, whether or not the facts are adverse.
>
> (e) When false evidence is offered, a conflict may arise between the lawyer's duty to keep the client's revelations confidential and the duty of candor to the court. Upon ascertaining that material evidence is false, the lawyer should seek to persuade the client that the evidence should not be offered or, if it has been offered, that its false character should immediately be disclosed. If the persuasion is ineffective, the lawyer must take reasonable remedial measures. The advocate

The notes to the Michigan Rules of Professional Conduct 3.3 recognize that, "As officers of the court, lawyers have special duties to avoid conduct that undermines the integrity of the adjudicative process . . . the lawyer must not allow the tribunal to be mislead by false statements of law or fact or evidence that the lawyer knows to be false." The comments go on to note that "[t]here are circumstances where failure to make a disclosure is the equivalent of an affirmative misrepresentation . . . [and], (a)(3) requires that a lawyer refuse to offer evidence that the lawyer knows to be false, regardless of the client's wishes."

Even a casual inspection of MRPC 3.3 should prevent a lawyer from offering a defense to the court that is inconsistent with known but undisclosed facts. When the Defendant Hospital stated that it is unknown how the Bovie came to be on the drape in an unholstered position, it was not being candid. The incident report concluded that the Bovie was "laid on the drape." The incident report concluded that the "Bovie holster was on the field for this case, however, Bovie was not placed in it." Representations to the contrary, suggestions that it was accidentally unholstered or the failure to make a full factual disclosure are all affirmative misrepresentations and violations of the Michigan Rules of Professional Conduct. MRPC 3.3.

Given that the patient was unconscious during the relevant time period, the Plaintiff brought her complaint as a simple negligence action on a *res ipsa loquitur* theory. The Court dismissed the complaint on the Defendants' Motion for Summary Disposition because it found that standard of care testimony was required to determine whether the burn could have occurred in the absence of negligence. In fact, the alternative theory proposed by the Defendants could explain a burn occurring in the absence of negligence. Unfortunately for the Defendants, the alternative theory is not consistent with the facts recorded in the incident report.

Contrary to the Michigan Rules of Professional Conduct, the Defendant Hospital caused its attorney to move to dismiss the *res ipsa loquitur* theory with the argument that standard of care testimony was required. Yet, knowing the unholstered Bovie was laid on the drape, a standard of care violation should have been admitted. If counsel for the Defendants did not know this argument was false, the Defendant Hospital either did not disclose the incident report

---

should seek to withdraw if that will remedy the situation. If withdrawal from the representation is not permitted or will not remedy the effect of the false evidence, the lawyer must make such disclosure to the tribunal as is reasonably necessary to remedy the situation, even if doing so requires the lawyer to reveal information that otherwise would be protected by Rule 1.6.

[7] Bonnie Schreiber testified that the incident report was requested by Plaintiff's counsel on November 25, 2008.

to him or, contrary to MRPC 3.1, he failed "to inform [himself] about the facts of [his] client's case . . . . [so he could] make good-faith arguments in support of [the] client's position." Defendant Hospital's recent decision to admit liability is finally consistent with facts long known to Defendant Hospital. The fact that the unholstered Bovie was laid on the drape and was not inadvertently unholstered was known to the Defendant Hospital throughout this litigation and was known by its attorney at some point prior to the trial.[8]

This Court accepted the Defendants' argument and dismissed the *res ipsa loquitur* theory and ordered the case to be refiled as a medical negligence action with an affidavit of merit. Had the fact that the Bovie was laid on the drape been disclosed from the onset, this case would have been tried without delay based on admitted liability. Substantial time and energy was wasted in the effort to learn how the Bovie came to penetrate the drape and burn the Plaintiff's arm. Standard of care experts were retained and deposed. Facilitative mediation was conducted, a final settlement conference completed and the case was tried to a jury for three days.

If the Exhibit A incident report is a protected peer review document, and the Court finds that it is, the facts regarding causation had to be disclosed, liability admitted or a defense presented that was consistent with the internal investigation. Again, it is not as though the incident report is inconsistent with some other witnesses' present recollection of these same events.[9] The public policy supporting the investigation of untoward events and the retrospective review of causation for purposes of improving medical care is not furthered by failing to disclose those facts, covering up negligence and presenting an inappropriate defense. The Hospital's Risk Manager and defense counsel participated in a course of defense which, in this Court's opinion, is materially inconsistent with the findings of the contemporaneous investigation documented in the Exhibit A incident report and violated MRPC 3.3(a)(1), (3) and (e). Such a defense must be precluded as a matter of law. Their actions have prejudiced the Plaintiff in both delay and expense and Plaintiff has filed a Motion for Sanctions.

---

[8] The Defendant Physician was never consulted in the internal peer review investigation, had no memory of the incident, and the incident report was never shared with him until it was disclosed to the Court. His separate counsel did not appear until after the mistrial was declared.

[9] Every person who was in the surgical suite for any period of time has now testified to their memory or lack thereof under oath.

The Court has reviewed the Plaintiff's Motion for Sanctions, the Defendants' response and the Plaintiff's reply. The Court dispenses with further oral argument. MCR 2.119(E)(3). The operative court rule is MCR 2.114, which provides in relevant part:

> (C) Signature.
>
> > (1) *Requirement.* Every document of a party represented by an attorney shall be signed by at least one attorney of record . . .
>
> (D) Effect of Signature. The signature of an attorney or party, . . . constitutes a certification by the signer that . . .
>
> > (2) to the best of his or her knowledge, information and belief formed after reasonable inquiry, the document is well grounded in fact and is warranted by existing law or a good-faith argument for the extension, modification, or reversal of existing law; and
>
> (E) Sanctions for Violation. If a document is signed in violation of this rule, the court, on the motion of a party or on its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the document, including reasonable attorney fees. The court may not assess punitive damages.

Commencing with the Motion for Summary Disposition of the Plaintiff's original complaint, the Defendant Hospital initiated a course of defense that was based on the standard of care being a material factual issue. The Defendant Hospital persisted in this defense throughout this litigation when it was refiled as a medical negligence action insisting that there was no standard of care violation. At all relevant times, the Defendant Hospital knew that the unholstered Bovie had been laid on the drape and that whether it was laid there by the Physician or a member of the surgical team, the standard of care required a member of the surgical team to immediately reholster it. This was not done and the Plaintiff was burned. The standard of care was violated and the defense was inconsistent with the known undisputed facts.

The incident report was the product of the Defendant Hospital's Risk Management Policy. The investigation was conducted by the Operating Room Manager, reviewed by the Director of Surgical Services and the Defendant Hospital's Risk Manager. No corrections, additions or deletions were made. In the absence of contemporary witness memory, it is an irrefutable statement of how the Bovie came to injure the Plaintiff. The Hospital's defense was

never well grounded in fact, and the pleadings, discovery responses, motions and briefs filed in this case were signed in contravention of MCR 2.114(D)(2). Sanctions will be assessed.

The Defendants' objections to an award of sanctions are predicated on the argument that the incident report is protected by the peer review privilege and need not be disclosed. What the Defendant Hospital fails to appreciate is that the peer review privilege protects the Hospital's conclusions, discipline and subsequent remedial measures.[10] The Court has not found a case that would allow the Defendant Hospital to fail to disclose the causation facts and present a defense inconsistent with them.

The objection that the costs and fees sought by the Plaintiff are not authorized by statute is also incorrect. The relevant court rule is MCR 2.114 and its companion statute is MCL 600.2591. The appropriate sanction includes all reasonable expenses and reasonable attorney fees incurred as a result of the Defendant Hospital's discovery violations. MCL 600.2591(2) and MCR 2.114(E).

Plaintiff's Motion for Sanctions as amended seeks costs in the amount of $2,658.69 (Plaintiff's Exhibit 22), and fees at the rate of $200 an hour for 254 hours. (Plaintiff Exhibit 23.) The Defendants' objection to the costs are not that they were not incurred but that they are not authorized by statute. For reasons previously discussed, the Court rejects this argument. The costs were incurred and are reasonable.

The Defendants do not object to the $200 hourly rate sought by the Plaintiff's counsel. It is substantially less than the $400 per hour median rate for attorneys, such as Plaintiff's counsel, who specialize in plaintiff's medical malpractice work.[11] See, "Economics of Law Practice in Michigan." *Michigan Bar Journal*, February 2011, p 20. The rate of $200 per hour is identical with the median rate for attorneys practicing in Grand Traverse County, *Id.*, p 21 and in the 13th Circuit Court, *Id.*, p 23.

Finally, the Defendants do not dispute that the hours claimed by Plaintiff's counsel were actually incurred. Rather, the Defendant Hospital objects to the inclusion of hours for travel.

---

[10] It is a long-established maxim that privileges "ought to be strictly confined within the narrowest possible limits consistent with logic of its principle." *Centennial, Id.* at p 288, citing 8 Wigmore, Evidence (McNaughton rev), § 2291, p 554.

[11] Recognizing the factors articulated in *Crawley v Schick*, 48 Mich App 728, 737; 211 NW2d 217 (1973), Plaintiff's attorney is experienced, limits his practice to medical negligence cases and is a well-respected member of the Bar. He prepared his case, pursued discovery, diligently filed and responded to motions, took depositions, tried the case for three days and successfully prepared this Motion for Sanctions. His fees are reasonable.

Both counsel traveled to this Court from down state and both counsel maintain statewide law practices. The medical negligence field is highly complex and is a specialized form of practice where attorneys on both sides of the bar conduct statewide practices. The Court sees no reason in common sense or sound public policy to exclude those hours associated with travel from the attorney's fees unnecessarily and wrongfully incurred due to the Defendant Hospital's discovery abuses.

Finally, the Defendant Hospital objects to an award of $450 for Plaintiff's time and travel costs. (Plaintiff Exhibit 24.) Having burned her, failed to tell her why, taken her through facilitative mediation, a final settlement conference, a three-day trial and only now admitting liability, one cannot be shocked but only disappointed at this objection to modest travel costs and compensation for her wasted time.

For all the foregoing reasons, the Court will assess costs including Plaintiff's travel costs ($150) in the amount $2,808.69, attorney fees in the amount of $50,800 and $350 for Plaintiff's time for a total sanctions award of $53,958.69. These sanctions shall be paid jointly and severally by the Defendant Hospital and its attorneys to Plaintiff and her attorney not less than 28 days from the date signed below.

The Circuit Court Administration Office shall provide the parties with notice of the date for a new trial which shall proceed upon the Defendant Hospital's admitted liability.

This order does not resolve the last issue pending in this case and does not close the file.

IT IS SO ORDERED.

HONORABLE PHILIP E. RODGERS, JR.
Circuit Court Judge

Dated: 4/08/11