DEPARTMENT OF THE NAVY
NAVAL MEDICAL CENTER
620 JOHN PAUL JONES CIRCLE
PORTSMOUTH, VIRGINIA 23708-2197

IN REPLY REFER TO:

6320.35
0210A

DATE: 11/10/97

To: W DAVID LLOYD (ATTORNEY)
101 SOUTH ELM STREET
LOWER LEVEL
GREENSBORO NC 27401

RE: KIMBLE, RONNIE LEE
SPONSOR SSN #
HOSP REGISTER#

The blocks checked below relate to your request:

( ) Complete Copy of Records
( ) Copy of Narrative Summary
( ) Copy of Medical Board
( ) Operation Report
(X) X-Ray Reports/Notes
( ) Tissue Exam
( ) History and Physical Examination
( ) Prenatal
( ) Delivery Records
( ) Newborn Records
( ) Outpatient Records
( ) Patient hospitalized in the following year(s). Request should be forwarded to the **National Personnel Records Center, 9700 Page Blvd., St. Louis, MO 63132.**

YEAR	REG#	ACCESS#	LOC#/BOX#

( ) Computer indicates outpatient record located at:

(X) Outpatient records are not in file. Please check with the patient/parent regarding location of outpatient records
(X) Other: There are no inpatient records located at this medical facility.

R D Vaughan

R.D VAUGHAN, RRA
Head, Inpatient Medical Records
By direction of the Commander

W. DAVID LLOYD
ATTORNEY AND COUNSELLOR AT LAW
101 SOUTH ELM STREET
LOWER LEVEL
GREENSBORO, NORTH CAROLINA 27401
TELEPHONE (910) 691-0550

03 NOV 1997

DWI/TRAFFIC OFFENSES
FELONIES IN ALL COURTS
ACCIDENTS
PERSONAL INJURY

October 24, 1997

Commander: Naval Medical Center
620 John Paul Jones Cir.
Portsmouth, VA 27308
Attn: Records In-patient/Out-patient

Re: Records of Ronnie Lee Kimble USMC, SSAN
DOB 1-17-72

Dear Sir or Madam:

I represent the above on capital murder charges. We are slated to go to trial in January. I understand that Mr. Kimble while in the Marine Corps (he is no longer a marine) was treated at Portsmouth in your sleep clinic in January of 1996 and in 1995.

These records are very important for us and I would greatly appreciate any help you could give us. I have enclosed his signed release.

I am and remain

Sincerely yours,

W. David Lloyd

WDL/ld

Enclosure:

03 NOV 1997
X Rays

ms mail 8-4-95
cp left mess 8-4-95

SLEEP DISORDERS LABORATORY
NAVAL MEDICAL CENTER
PORTSMOUTH, VIRGINIA 23708-5100
(804) 398-7781

POLYSOMNOGRAPHY REPORT

Date: 31 July 95

Patient: KIMBLE, Ronnie
SSN: 20/
Date of Study: 21 Jun 95

Referring Physician: Dr. DeBeck
Clinic: NEUROLOGY-Camp Lejeune
Ref: A950248 & X950250

Chief Complaint: "Daytime drowsiness."

Reason for Referral: Rule out Narcolepsy, Myoclonus.

Pre-study Data: The 23 year old man describes a history of excessive daytime sleepiness which he feels is independent of total sleep time. PLM's are suggested from history. No secondary symptoms of Narcolepsy. He has no significant medical problems listed. Medications: Sudafed.

Height: 72 inches Weight: 168 pounds

Psychometrics: The Beck Depression Inventory was normal.

Polysomnography Data: Overnight polysomnography was performed with EEG, EOG, EMG, EKG, respiratory effort, respiratory airflow, and pulse oximetry leads attached in standard fashion.

a. Sleep Quality. The subject went to bed at 2200 and arose at 0630, sleeping for 474 minutes out of 511 minutes in bed for a sleep efficiency of 93%. Sleep architecture was normal. Subjective assessment of sleep quality was "better than usual."

b. The technician noted the following: No snoring, hypopnea or Myoclonus. Some body movement was seen during slow-wave sleep, suggesting night terrors or sleep-walking.

c. Respiratory Events. There were no abnormal respiratory events. There were no events associated with oxygen desaturations below 90%. No unusual cardiac events.

d. A trial on nasal CPAP was not done.

e. Periodic leg movements. There were no PLM'S noted.

f. Multiple Sleep Latency Test (MSLT). An MSLT was performed the morning after his polysomnogram. This was normal. Over 5 naps, the mean sleep latency was 12.4 minutes (normal is greater than 10 minutes) with one REM sleep onset (normal is one or less).

Patient: KIMBLE, Ronnie
SSN: 20/
Date of Study: 21 Jun 95
Ref: A950248 & X950250

Impression:

1. Normal overnight polysomnogram.

2. No evidence of Pathologic Sleepiness or multiple REM sleep onsets on his MSLT.

Recommend:

1. Review sleep hygiene (handout).

2. Try to increase allotted sleep time by 1-2 hours per night.

3. Follow up with Neurology at Camp Lejeune.

These findings were sent to the referring physician on 8/3/95

Andrew K. Vaaler, LCDR, MC, USNR

Sleep Hygiene Guidelines

Time in Bed
A person should stay in bed for as long as sleep is needed but no longer. Most patients with insomnia tend to stay in bed too long; the result is shallow and fragmented sleep with many awakenings. Some behavioral treatments (see page 20) severely curtail the time allowed in bed.[26]

Sleep-Wake Rhythm
Each day the internal oscillators that control the human circadian cycle must be synchronized with one another and "reset" to the rotation of the planet. For young persons, whose clocks are typically much slower than 24 hours, the most effective means of accomplishing these goals is to establish a regular wake-up time. In many elderly persons, with their often shorter than 24-hour clocks, a regular, somewhat delayed sleep-onset time is indicated to stretch the periodicity to 24 hours. The best way to maintain circadian cycling is to remain active and be exposed to bright light during the day, even after a night of poor sleep.[27]

Trying to Sleep
The more one tries to sleep, the less one is able to do so. Relaxation and sleep are promoted by quiet activities, such as reading, watching television, or listening to music. Investigators disagree about whether such activities should be done in bed or away from the bedroom. Whether a patient should engage in reading or TV-watching in bed depends on whether that individual finds the activity stimulating or soporific.

Exercise or a Hot Bath
Regular exercise in late afternoon or early evening seems to promote sleep,[28] but the effects may evolve slowly (over weeks). Intermittent strenuous exercise has little effect on sleep.[29] Exercise initially increases body temperature, but a rebound cooling 5 to 6 hours later seems to help sleep. Spending 20 minutes in a tub of hot water an hour or two before going to bed may have a similar effect.[30]

Napping
Individuals must determine for themselves whether a nap helps them. Some patients with insomnia "pay" for each daytime nap with more sleeplessness during the following night, whereas others are considerably refreshed by a daytime nap and seem to fall asleep more easily during the subsequent night.

Bedroom Environment
Both extreme heat and extreme cold can disturb sleep. In nearly all studies, a quiet environment is more soporific than a noisy one; in fact, even after subjects had seemingly habituated to an intermittent noise (eg, living near an airport), an EEG revealed partial arousal whenever the noise occurred.[31] When unavoidable, intermittent noises can be masked by background white noise, for example, from a fan or from an FM radio tuned between two stations. An illuminated bedroom clock can significantly contribute to anxiety when patients are unable to sleep.

Eating
A light bedtime snack, such as a glass of warm milk or cheese and crackers, can promote sleep.[32] Some researchers think digestive hormones have a sedative effect.[33] Others believe that the tryptophan in the snack might be involved.

Bolce Sleep Disorders Lab
Naval Medical Center
Building One
Portsmouth VA 23708

POLYSOMNOGRAPHY REPORT

Name: Ronnie Kimble, 20/. Date of Study: 22 JAN 97
Referring Provider: Dr Czander, NHCL Neurology

Type of Study: Full polysomnography, overnight, attended by a sleep technologist.

Beck Depression Inventory: Normal.

Sleep Architecture: Normal.

Subjective Impression of Sleep Quality: "Worse than usual."
Technologist's Notes: "Snoring noted."

Respiratory Events: There were 34 respiratory events, consisting of 7 hypopneas, 2 obstructive apneas, 15 central apneas, and 10 mixed apneas. The apnea + hypopnea index was 4 events per hour, while the apnea index was 3 events per hour. Number of oxygen desaturations < 90%: 1. Minimal SaO2: 89%. Most respiratory events occurred while the patient was supine, or on his stomach.

CPAP titration: Not performed.
Remarkable cardiac events: None.
Periodic limb movements (PLM's): None noted.
MSLT: Was performed, with a mean sleep latency of 10.4 min and no sleep-onset REM noted over 4 naps.

IMPRESSION: 1) Primary snoring, with no evidence of significant OSA, narcolepsy, or pathologic sleepiness.

RECOMMENDATION: 1) Consider "snore ball", dental device, and/or ENT consult to address snoring, if problematic. 2) Further management per Neurology Clinic.

A. S. Panettiere, M.D.
LCDR MC USN (FS)
Director, Sleep Lab

Patient Name: RONNIE KIMBLE
Test Date: 01/23/97

Staging Summary:

Recording start time :	21:40:23	Recording end time :	05:51:47
Analysis start time :	21:40:23	Analysis end time :	05:51:23
Total number of epochs :	982	Epoch size (sec) :	30
Total recording time (hr) :	8.2	Total sleep time (hr) :	7.7
Number of Awakenings :	16	Total wake time (hr) :	0.5
Sleep Efficiency (%):	94.4	Sleep Maintenance Effic(%):	97.8
Sleep onset latency (min) :	17.5	Stage REM latency (min) :	154.0

Oximetry Summary:

Total number of desaturations	47
Desaturation Index (/hr)	6
Basal O2 during sleep	95.9

Heart Rate Summary:

Basal heart rate during sleep (bpm)	61.9
Slowest heart rate (bpm)	45.5
Fastest heart rate (bpm)	128.6
Number of Bradycardic events	0
Number of Tachycardic events	0

Respiratory Summary:

	Total #	Min time	Max time	Mean	Total hrs
Apneas+Hypopneas	34	10	25	16	0.1
Apneas	27	10	25	16	0.1
Hypopneas	7	11	25	16	0.0

	REM	Non-REM	Sleep
Apneas	4	23	27
Hypopneas	4	3	7
Apneas+Hypopneas	8	26	34
% time in Apnea+Hypopnea	2	2	2
Apnea Index (/hr)	2	4	3
Apnea Arousal Index (/hr)	2	3	3

PLMs and Arousal Summary:

	Number of Movements	Index/hr
Sleep	14	1.8
Wake	0	0.0
Respiratory event related movements	3	

	Arousals	Possible Arousals
Number	234	0
Index (/hr)	30.3	0.0

MEDICAL RECORD / Joggled

CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Bossworth - Polysomnography	Camp Lejeune - Neurology	20 NOV 96

REASON FOR REQUEST (Complaints and findings)

28 yo male with excessive daytime sleepiness [illegible] w/ episodes of uncontrollable sleep [illegible] even while driving. Wife describes episodes of sleep apnea. He also has had hypnagogic hallucinations & cataplexy, sleep paralysis. Has had incomplete PSG/MSLT [illegible] 9/96 - [illegible]

PROVISIONAL DIAGNOSIS

R/O Narcolepsy, Obstructive Sleep Apnea

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
[signature] E.W. CZA[illegible] LT MC USNR 86-5097 NEUROLOGIST		☐ BEDSIDE ☐ ON CALL	☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ NO

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

11/26/96 left message at work for Patient to call.
1 auto accident - falling asleep

appt Wednesday Jan 22 @ 2100.

(Continue on reverse side)

SIGNATURE AND TITLE	DATE
Jot 910-451-4633	

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

KIMBLE, Ronnie
20/
17 Jan 72
AD/USMC/eCPL

W: 910 451-3240 5646
~~H: 910 677 2687~~ non-published
1-910-697-0076

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 6-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-[illegible]