

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED

APPEAL FROM GEORGETOWN COUNTY
Court of Common Pleas

MAY 14 2020

SC Court of Appeals

Larry Hyman, Circuit Court Judge

Appellate Case No. 2019-001304

Phillippa Smalling, individually and as Next Friend for
Jahmerican M., a minor

Appellant,

v.

Lisa R. Maselli, M.D., both individually and
as agent/employee of Carolina OB-GYN,

Respondents.

**RECORD ON APPEAL
VOLUME 1 OF 2**

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Georgetown
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2016CP2200863

Phillippa Smalling et al
PLAINTIFF(S)

Lisa R Maselli et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (CHECK REASON): ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled);
☐ Other
- ☐ **ACTION STRICKEN** (CHECK REASON): ☐ Rule 40(j), SCRPC; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (CHECK APPLICABLE BOX):
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

Motion For New Trial Submitted By Attorney Graham; denied.
Motion To Alt And/or Amend By Attorney Graham; denied.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 06/27/2019 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.



Georgetown Common Pleas

Case Caption: Phillippa Smalling , plaintiff, et al VS Lisa R Maselli , defendant, et al
Case Number: 2016CP2200863
Type: Order/Electronic Form 4

So Ordered

s/ Larry B. Hyman 2152

Electronically signed on 2019-06-27 10:29:31 page 3 of 3

STATE OF SOUTH CAROLINA

) IN THE COURT OF COMMON PLEAS

COUNTY OF GEORGETOWN

) FOR THE FIFTEENTH CIRCUIT

)

Phillippa Smalling, Individually and as Next
Friend of Jahmerican M., a minor,

) C/A No. 2016-CP-22-00863

)

)

Plaintiff,

)

)

Versus

)

)

VERDICT FORMLisa R. Maselli, M.D., both individually and as
agent/employee of Carolina OB/GYN,

)

)

)

Defendant.

)

We, the jury, unanimously find as follows:

1. Did the Plaintiff prove by the preponderance of the evidence that the Defendants deviated from the standard of care?

_____ Yes or _____ No

If the answer to question 1 is "no," STOP and deliberate no further. If the answer to question 1 is "yes," continue to question 2.

2. Did the Plaintiff prove by the preponderance of the evidence that the Defendants' deviation from the standard of care was a proximate cause of the Plaintiff's injuries?

_____ Yes or _____ No

If the answer to question 2 is "no," STOP and deliberate no further. If the answer to question 2 is "yes," continue to question 3.

3. Did the Defendants prove by a preponderance of the evidence that the events of Jahmerican's delivery constitutes a genuine medical emergency?

X Yes or _____ No

Proceed to question 4.

4. Did the Defendants prove by a preponderance of the evidence that Jahmerican was not medically stable at the time of the events in question?

X Yes or _____ No

Proceed to question 5.

5. Did the Defendants prove by a preponderance of the evidence that there was an immediate threat of death or serious bodily injury to Jahmerican at the time of the events in question?

X Yes or _____ No

If the answers to questions 3, 4, and 5 are "yes," go to question 6. If the answer to either question 3, 4, or 5, is "no" do not answer question 6 and continue to question 7.

6. Did the Plaintiff prove by a preponderance of the evidence that the Defendants were grossly negligent?

_____ Yes or X No

If the answer to question 6 is yes, go to question 7. If the answer to question 6 is "no", STOP and deliberate no further.

7. What is the amount of damages sustained by the Plaintiff?

Economic Damages \$ _____

Noneconomic Damages \$ _____

TOTAL DAMAGES \$ _____

April 5, 2019

Yadd W. John
Jury Foreman

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF Georgetown
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2016CP2200863

Phillippa Smalling et al
PLAINTIFF(S)

Lisa R Maselli et al
DEFENDANT(S)

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (CHECK REASON): ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled);
☐ Other
- ☐ **ACTION STRICKEN** (CHECK REASON): ☐ Rule 40(j), SCRPC; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (CHECK APPLICABLE BOX):
☐ Affirmed; ☐ Reversed; ☐ Remanded;
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

Plaintiff's Motion for Summary Judgment. Motion Denied.

Plaintiff's Motion to Stay. Motion Denied.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

☐ See Page 2 for additional information.

For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 12/14/2018 .

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

E-Filing Note: The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.



Georgetown Common Pleas

Case Caption: Phillippa Smalling , plaintiff, et al VS Lisa R Maselli , defendant, et al
Case Number: 2016CP2200863
Type: Order/Electronic Form 4

IT IS SO ORDERED

s/ The Honorable William H. Seals Jr. #2157

Electronically signed on 2018-12-14 16:12:41 page 3 of 3

STATE OF SOUTH CAROLINA

COUNTY OF GEORGETOWN

Phillippa Smalling, Individually and as Next Friend of
American M., a Minor.

Plaintiff(s)

VS:

Lisa R. Maselli, M.D., both Individually and as
agent/employee of Carolina OB/GYN Properties, LLC
d/b/a Carolina OB/GYN; and Carolina OB/GYN
Properties, LLC d/b/a Carolina OB/GYN.

Defendant(s)

Submitted By: J. Layton Ruffin

Address: Graham Law Firm

P.O. Box 550

Florence, SC 29503

SC Bar #:

Telephone #:

Fax #:

Other:

E-mail:

72267

843.662.3281

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jluffin@grahamlawfirm.net

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

**If Action is Judgment/Settlement do not complete*

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
- ☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
- ☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

Contracts	Torts - Professional Malpractice	Torts - Personal Injury	Real Property
☐ Constructions (100)	☐ Dental Malpractice (200)	☐ Conversion (310)	☐ Claim & Delivery (400)
☐ Debt Collection (110)	☐ Legal Malpractice (210)	☐ Motor Vehicle Accident (320)	☐ Condemnation (410)
☐ General (130)	☒ Medical Malpractice (220)	☐ Premises Liability (330)	☐ Foreclosure (420)
☐ Breach of Contract (140)	Previous Notice of Intent Case #	☐ Products Liability (340)	☐ Mechanic's Lien (430)
☐ Fraud/Bad Faith (150)	<u>2016-NI-22-00003</u>	☐ Personal Injury (350)	☐ Partition (440)
☐ Failure to Deliver/ Warranty (160)	☐ Notice/ File Med Mal (230)	☐ Wrongful Death (360)	☐ Possession (450)
☐ Employment Discrim (170)	☐ Other (299)	☐ Assault/Battery (370)	☐ Building Code Violation (460)
☐ Employment (180)		☐ Slander/Libel (380)	☐ Other (499)
☐ Other (199)		☐ Other (399)	
Inmate Petitions	Administrative Law/Relief	Judgments/Settlements	Appeals
☐ PCR (500)	☐ Reinstate Drv. License (800)	☐ Death Settlement (700)	☐ Arbitration (900)
☐ Mandamus (520)	☐ Judicial Review (810)	☐ Foreign Judgment (710)	☐ Magistrate-Civil (910)
☐ Habeas Corpus (530)	☐ Relief (820)	☐ Magistrate's Judgment (720)	☐ Magistrate-Criminal (920)
☐ Other (599)	☐ Permanent Injunction (830)	☐ Minor Settlement (730)	☐ Municipal (930)
	☐ Forfeiture-Petition (840)	☐ Transcript Judgment (740)	☐ Probate Court (940)
	☐ Forfeiture-Consent Order (850)	☐ Lis Pendens (750)	☐ SCDOT (950)
	☐ Other (899)	☐ Transfer of Structured Settlement Payment Rights Application (760)	☐ Worker's Comp (960)
Special/Complex/Other		☐ Confession of Judgment (770)	☐ Zoning Board (970)
☐ Environmental (600)	☐ Pharmaceuticals (630)	☐ Petition for Workers Compensation Settlement Approval (780)	☐ Public Service Comm. (990)
☐ Automobile Arb. (610)	☐ Unfair Trade Practices (640)	☐ Other (799)	☐ Employment Security Comm (991)
☐ Medical (620)	☐ Out-of-State Depositions (650)		☐ Other (999)
☐ Other (699)	☐ Motion to Quash Subpoena in an Out-of-County Action (660)		
☐ Sexual Predator (510)	☐ Pre-Suit Discovery (670)		
☐ Permanent Restraining Order (680)			

Submitting Party Signature: _____

Date: October 5, 2016

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

Effective January 1, 2016, Alternative Dispute Resolution (ADR) is mandatory in all counties, pursuant to Supreme Court Order dated November 12, 2015.

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

Pursuant to the ADR Rules, you are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs.
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA,)
)
COUNTY OF GEORGETOWN)

IN THE COURT OF COMMON PLEAS

Phillippa Smalling, Individually, and as)
Next Friend of Jamerican M., a minor,)
Plaintiff,)

SUMMONS

vs.)

FILE NO. 2016-CP-22-00003

Lisa R. Maselli, M.D., both Individually and)
as agent/employee of Carolina OB/GYN)
Properties, LLC d/b/a Carolina OB/GYN;)
and Carolina OB/GYN Properties, LLC)
d/b/a Carolina OB/GYN,)
Defendant.)

FILED
GEORGETOWN COUNTY, SC
2016 OCT 12 AM 9:29
ALMA Y. WHITE
CLERK OF COURT

TO THE DEFENDANT ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to this complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the complaint, judgment by default will be rendered against you for the relief demanded in the complaint.

Florence, South Carolina



Plaintiff/Attorney for Plaintiff

Dated: October 5, 2016

Address: Graham Law Firm
P.O. Box 550
Florence, SC 29503

STATE OF SOUTH CAROLINA
COUNTY OF GEORGETOWN

IN THE COURT COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2016-CP-22- 009103

Phillippa Smalling, Individually, and as Next Friend of
Jamerican M., a minor,

Plaintiff,

vs.

Lisa R. Maselli, M.D., both individually and as
agent/employee of Carolina OB/GYN Properties, LLC
d/b/a Carolina OB/GYN; and
Carolina OB/GYN Properties, LLC d/b/a Carolina
OB/GYN,

Defendants,

TO: THE DEFENDANTS as set forth above:

COMPLAINT

ALMA Y. WHITE
CLERK OF COURT

2016 OCT 12 AM 9:29

FILED
GEORGETOWN COUNTY, S.C.

Please take notice that the Plaintiff, complaining of Defendants above named, would show unto the Court as follows:

1. Plaintiff **Phillippa Smalling** (hereinafter, "**Phillippa**") is a citizen and resident of Georgetown County, South Carolina, and brings this action as Next Friend of her minor son, **Jamerican M.** (hereinafter, "**Jamerican**");

2. Defendant **Lisa R. Maselli, M.D.** (hereinafter, "**Maselli**") is, upon information and belief, a citizen and resident of Georgetown County, South Carolina, who was, at all times relevant to this action, a physician duly licensed to practice medicine within the State of South Carolina.

3. Defendant **Maselli** held herself out to the public as having specialized knowledge, training and experience for the provision of obstetrical and gynecological care in compliance with the applicable standard of care.

4. Defendant **Maselli** owned, operated and/or maintained a professional medical office in Georgetown County, South Carolina, from which she offered obstetric and gynecologic care to the public, including the Plaintiff.

5. Upon information and belief, **Carolina OB/GYN Properties, LLC d/b/a Carolina OB/GYN** (hereinafter, "**Carolina**") is a corporation or other entity existing under the laws of South Carolina or another state and has its primary place of business in Georgetown, South Carolina.

6. Upon information and belief, Defendant **Maselli** was acting both individually, on her own behalf, and as an employee, agent and/or owner of the Defendant **Carolina**, within the course and scope of that employment and agency at all times relevant to this action.

7. At all times relevant to this action, the Defendant Carolina was a limited liability corporation organized and existing under the laws of South Carolina. The Defendant Carolina had its principal place of business in Georgetown County, South Carolina.

8. The Defendant Carolina held itself out to the public as having employees with specialized knowledge, training, and experience, as well as the equipment and facilities, for the provision of obstetrical and gynecological care in compliance with the applicable standard of care.

9. The Defendant Carolina is named as a Defendant herein because of its *respondeat superior* liability for torts of its agents, employees, and/or owners, including, but not limited to, Defendant Maselli.

10. Prior to his birth in 2013, Defendant Maselli admitted Phillippa to labor and delivery where she was responsible for managing the labor and the delivery of Jamerician at Georgetown Hospital located in Georgetown, South Carolina.

11. Phillippa Smalling, the mother of Jamerician M., discovered she was pregnant and, at approximately 16 weeks gestation, presented for prenatal care and attention to Defendant Maselli, at which time she established a patient-physician relationship with Phillippa, and Defendant Maselli assumed responsibility for providing Phillippa with prenatal, labor, and delivery obstetrical care, in compliance with the applicable standard of care.

12. Jamerician was a healthy infant prior to his birth in 2013, when his mother, Phillippa, was admitted to Georgetown Hospital by Defendant Maselli for labor and delivery.

13. At the time Phillippa was admitted to Georgetown Hospital, the Defendant Maselli was responsible for delivering professional obstetrical care to Phillippa and her then unborn baby, Jamerician, in compliance with the standard of care for an obstetrician.

14. The Defendant Maselli owed Phillippa, and her then unborn son, a duty of providing competent obstetrical labor and delivery care, consistent with generally accepted standards of obstetricians acting under the same or similar circumstances.

15. Defendant Carolinas, and its employee(s) and agent(s), owed Phillippa and her minor son a duty of providing obstetrical care, services, and attention consistent with generally accepted standards of care for obstetricians acting under similar situations.

16. The Defendants Maselli and Carolina breached their duties of care owed to Phillippa and her then unborn son, Jamerican.

17. The Defendants were negligent, reckless, willful, wanton, and/or otherwise wrongful in the care and attention to them, as a direct and proximate result of which Jamerican sustained severe, permanent, disfiguring, bodily injuries, limitations in function, losses and damages, including a brachial plexus nerve injury to his right shoulder, arm and hand.

18. Defendant Maselli was negligent, reckless, willful, wanton and/or otherwise wrongful in one or more, but not limited to, the following particulars:

- (a) Failing and refusing to acquire a safe level of professional knowledge, skill, training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to manage the birthing process of Jamerican; and/or
- (b) Choosing not to appreciate the heightened risk of shoulder dystocia in the delivery of Jamerican; and/or
- (c) Failing to timely recognize the signs and symptoms of shoulder dystocia; and/or in recognizing same, in failing to initiate and utilize appropriate maneuvers to alleviate the shoulder dystocia; and/or
- (d) Failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia; and/or
- (e) Failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Jamerican; and/or
- (f) Using improper and/or unsafe delivery technique(s); and/or
- (g) Using improper and excessive force, traction, and/or torsion; and/or
- (h) Directing and/or allowing the nurses to use fundal pressure in the presence of shoulder dystocia; and/or
- (i) Mismanagement of labor and the delivery of Jamerican; and/or
- (j) Mismanagement of shoulder dystocia; and/or
- (k) Failing to perform the delivery by caesarean section, and/or convert to a caesarean section; and/or
- (l) Failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health, including, but not limited to shoulder dystocia, an obstetrical emergency; and/or
- (m) Failing to timely and properly monitor, observe, record, and/or transcribe vital information about the patient's status and condition in the presence of an obstetrical emergency; and/or
- (n) Failing to appropriately inform and advise Phillippa of the risks and benefits, as well as to the alternatives, of treatment options, including but not limited to a vaginal delivery versus a surgical and/or cesarean section, thereby failing to obtain her informed consent; and/or
- (o) Such other failures as may be identified during discovery and the trial of this case.

19. Defendant Carolina, its predecessor(s) and/or successor(s), if any, and the shareholder(s), agent(s), and employee(s) thereof, were negligent, reckless, willful, wanton, and/or otherwise wrongful in one, or more, or all of, and including, but not limited to, the following particulars:

- (a) Failing and refusing to require its shareholder(s), employee(s), and agent(s) to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and recognition and management of shoulder dystocia in particular, before attempting to attend, manage or provide support for the birthing process of Jamerican; and/or
- (b) Failing to provide and/or require sufficient training to its obstetricians and labor and delivery staff about anticipation of a heightened risk of, and proper management of shoulder dystocia; and/or
- (c) Failing to require its obstetricians and labor and delivery staff to demonstrate current competency in the management of labor and delivery, including recognition and management of shoulder dystocia complications; and/or
- (d) Failing to appropriately monitor, supervise and/or train its employees in the recognition and management of shoulder dystocia; and/or
- (e) Failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to manage the birthing process of Jamerican; and/or
- (f) Failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia; and/or
- (g) Such other failures as may be identified during discovery and/or trial of this case.

20. As a direct and proximate result of the negligence and other wrongful conduct on the part of the Defendants Maselli and Carolina, Jamerican sustained certain permanent, severe injuries, disfigurement, limitation of function, and losses and damages, stated with particularity as follows:

- (a) Direct violent and traumatic injuries to various bodily members of Jamerican, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder, arm, and hand, commonly known as Erb's palsy;
- (b) Adverse effects on various other bodily parts, including disfigurement and functional limitations, such as gait, balance, and skeletal and muscular asymmetry;
- (c) Past, present, and future medical expenses;
- (d) Life care management expenses;
- (e) Permanent limitations, disfigurement, impairments, and disabilities;
- (f) Permanent disfigurement of his arm, shoulder, and/or hand;
- (g) Past, present, and future physical pain and suffering;
- (h) Past, present, and future mental, emotional, and psychological harm;
- (i) Adverse effect(s) on his future employability, earnings, and earning capacity;
- (j) Loss of enjoyment of life; and
- (k) Such further injuries, losses, and damages as may be revealed through discovery and trial of this case.

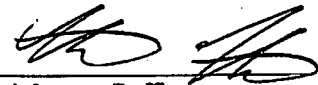
21. As the Parent of Jamerican, Phillippa asserts an individual claim for any past, present, and future pre-majority medical expenses of Jamerican that cannot be waived in favor of Jamerican, and which must be asserted and recovered by the parent. Such medical expenses have been incurred, and will continue to be incurred, as a direct and proximate result of the negligence and other wrongful conduct of the Defendants Maselli and Carolina.

21. Plaintiff previously complied with all statutory requirements for commencing this action and, after unsuccessful pre-suit mediation, the matter was declared at an impasse by the mediator. A copy of an Expert Affidavit of Steven Pliskow, MD, as required by §15-79-125 and §15-36-100(C)(1) *South Carolina Code of Laws* is attached hereto in support of the liability allegations made herein.

WHEREFORE, Plaintiff prays for judgment against Defendants Maselli and Carolina for an award of actual damages; for an additional award of punitive damages in an amount to be determined by the jury in accordance with the facts and circumstances presented at trial; for costs of her action; and for such other and further relief as this Court may deem just and proper.

GRAHAM LAW FIRM, P.A.

BY



J. Layton Ruffin
383 West Cheves Street (29501)
Post Office Box 550
Florence, S.C. 29503
803.662.3281 (Office)
1.800.859.7028 (Efax)
Email: jluffin@grahamlawfirm.net
Attorney for Plaintiff

Florence, South Carolina
October 5, 2016

A JURY TRIAL IS HEREBY REQUESTED.

GRAHAM LAW FIRM, P.A.

BY



J. Layton Ruffin
Email: jluffin@grahamlawfirm.net

STATE OF SOUTH CAROLINA
COUNTY OF GEORGETOWN

IN THE COURT OF COMMON PLEAS
C/A NO: 2016-CP-22- 008103

Phillippa Smalling, Individually and as
Next Friend of Jamerican M., a Minor;

Plaintiff,

v.

Lisa R. Maselli, M.D., both Individually and as
Agent/employee of Carolina OB/GYN
Properties, LLC d/b/a Carolina OB/GYN; and
Carolina OB/GYN Properties, LLC d/b/a
Carolina OB/GYN,

Defendants.

CONFIDENTIAL REFERENCE LIST

FILED
GEORGETOWN COUNTY, S.C.
2016 OCT 12 AM 9:30
ALMA Y. WHITE
CLERK OF COURT

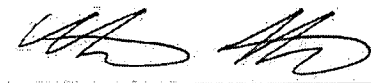
Where personal data identifiers are relevant to an issue in the case, below please find the reference list that identifies each item of redacted information and specifies an appropriate identifier that uniquely corresponds to each item listed.

Any reference in the case to a listed identifier will be construed to refer to the corresponding item of information.

This list is a **CONFIDENTIAL DOCUMENT WHICH IS NOT AVAILABLE TO THE PUBLIC**, and may be amended.

GRAHAM LAW FIRM, P.A.

By:



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Attorneys for Plaintiffs

Florence, SC
October 5, 2016

2016-NI-22-00003

STATE OF FLORIDA)
COUNTY OF PALM)

AFFIDAVIT

PERSONALLY APPEARED before me, STEVEN PLISKOW, M.D., FACOG, FACFE, who first being duly sworn, deposes, and says:

1. I am Steven Pliskow, M.D., FACOG, FACFE, of West Palm Beach, Florida. I make this Affidavit based on my professional background, knowledge, education, training, and experience, as well as my review of certain medical records and other materials relating to the birth of Jamerican M..., including; birth records and nursery records from:

1. Tidelands Next Step Rehabilitation Services (1-279)
2. Georgetown Pediatric Center (1-153)
3. Pawleys Pediatric & Adult Medicine (1-2)
4. Tidelands Georgetown Memorial Hospital (1-213)

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CLERK OF COURT

2. I am Board Certified through the American Board of Obstetrics and Gynecology, an independent, not-for-profit organization that certifies obstetricians and gynecologists in the United States, which administers written and/or oral examination for certification in the area of practice and specialty about which this opinion on the standard of care is offered. I am also Board Certified through the American Board of Forensic Medicine. Details of my qualifications and background are set forth in my *curriculum vitae* attached hereto as Exhibit 1.

3. I have actual professional knowledge and experience in the specialty and area of practice in which this opinion is given, as a result of my having been regularly engaged in the active practice in the area of specialty and practice for over 25 years immediately preceding this opinion. As part of my active clinical practice load, I routinely examine and treat patients in both

the office and hospital settings. Additionally, I have experience in the management of women in labor and delivery, including vaginal deliveries complicated by shoulder dystocia.

4. I am very familiar with the standards of care applicable to doctors, nurses and staff involved in managing labor and delivery, in general, and in particular with respect to the standards of care involved in the proper recognition, management, and resolution of obstetrical conditions, including a complication of vaginal delivery known as shoulder dystocia.

5. In this case, based on my review of the medical records noted above, I have concluded, and am competent to testify to, the following: Lisa R. Maselli, M.D., was acting on her own behalf, as well as on behalf of her group practice Carolina OB/GYN Properties, L.L.C, d/b/a Carolina OB/GYN in her capacity as a member of that group practice. Dr. Maselli committed at least one or more deviations from the generally accepted obstetrical standards of care during the delivery of Jamerican McCray, who was born on April 27, 2013. To a reasonable degree of medical certainty, Lisa R. Maselli, M.D. breached generally accepted standards of obstetrical practice in one or more of the following:

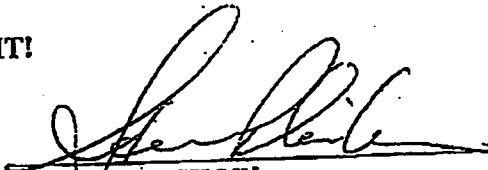
- (a) She failed to use the correct maneuvers for safe resolution of shoulder dystocia; and
- (b) She applied excessive lateral traction and/or torsion to the head, neck, and brachial plexus nerves of Jamerican McCray;

6. It is further my opinion, to a reasonable degree of medical certainty, that Jamerican McCray suffered severe and permanent injury to his brachial nerves as a direct and proximate result of these breaches of standard obstetrical practice.

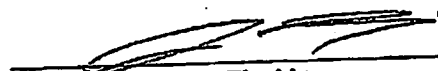
7. There may be other deviations from the generally accepted standards of care by Lisa R. Maselli, M.D. and/or other health care providers, which I may learn from additional

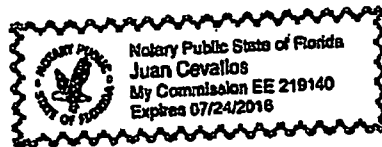
records, information, or depositions that may be provided to me in the future. Therefore, I reserve the right to change, modify, or supplement these opinions.

FURTHER AFFIANT SAYETH NAUGHT!


STEVEN PLISKOW

Sworn to before me this 31st day of March, 2016.


Notary Public for Florida
My Commission Expires: 7/24/2016



STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GEORGETOWN	)	FOR THE FIFTEENTH CIRCUIT
Phillippa Smalling, Individually and as	)	C/A No. 2016-CP-22-00863
Next Friend of Jamerican M., a minor,	)	
<i>Plaintiff,</i>	)	
	)	
Versus	)	ANSWER
	)	<i>(Jury Trial Requested)</i>
Lisa R. Maselli, M.D. and Carolina	)	
OB/GYN Properties, L.L.C. d/b/a	)	
Carolina OB/GYN,	)	
<i>Defendants.</i>	)	

Subject to and reserving all rights asserted pursuant to the Motion to Dismiss, or in the alternative for summary judgment, being filed contemporaneously with this Answer by named Defendant Carolina OB/GYN Properties, L.L.C.¹, Defendants Carolina OB/GYN and Lisa R. Maselli, M.D. (hereafter "these Defendants") hereby respond to the allegations in Plaintiffs' Complaint, subject to all affirmative defenses and motions, as follows:

1. Each and every allegation not specifically admitted herein is denied.
2. These Defendants lack sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of Plaintiffs' Complaint, and therefore deny the same.
3. These Defendants admit the allegations contained in Paragraph 2 of Plaintiffs' Complaint.
4. In response to the allegations contained in Paragraphs 3, 4, 5 and 6 of Plaintiffs' Complaint, these Defendants admit only that (1) Dr. Maselli is a licensed

¹ Carolina OB/GYN Properties, L.L.C. is contemporaneously filing a Motion to Dismiss Plaintiffs' Complaint, or in the alternative for summary judgment in favor of Carolina OB/GYN Properties, L.L.C. on the grounds that Carolina OB/GYN Properties, L.L.C. is not a proper party because it does not employ and has never employed Dr. Maselli. Rather, Dr. Maselli is a partner of Carolina OB/GYN.

physician who provides OBGYN treatment to patients in Georgetown County, South Carolina, including the Plaintiffs; (2) these Defendants maintain a medical office in Georgetown, South Carolina; and (3) Dr. Maselli is a partner of Carolina OB/GYN. These Defendants specifically deny that Carolina OB/GYN Properties, LLC (a) employs or ever employed Dr. Maselli and (b) is a proper party to this action. The remaining allegations contained in Paragraphs 3, 4, 5 and 6 of Plaintiffs' Complaint state conclusions of law to which no response is required.

5. The allegations contained in Paragraphs 7, 8 and 9 of Plaintiffs' Complaint state conclusions of law to which no response is required.

6. These Defendants admit the allegations contained in Paragraph 10 of Plaintiffs' Complaint.

7. In response to Paragraphs 11 and 12 of Plaintiffs' Complaint, these Defendants crave reference to Plaintiffs' medical records for a complete and accurate representation of Plaintiffs' medical conditions and treatment.

8. These Defendants admit the allegations contained in Paragraphs 13 and 14 of Plaintiffs' Complaint.

9. These Defendants deny, as written, the allegations contained in Paragraph 15 of Plaintiffs' Complaint. Further responding, Defendants Carolina OB/GYN and Lisa R. Maselli, M.D. owed Plaintiffs a duty of providing obstetrical care and services consistent with the standard of care, which they did at all times.

10. These Defendants deny the allegations contained in Paragraphs 16, 17, 18, including subparts (a) through (o), 19, including subparts (a) through (g), 20, including subparts (a) through (k), and 21 of Plaintiffs' Complaint.

11. The allegations contained in Paragraph 22² of Plaintiffs' Complaint states conclusions of law to which no response is required.

12. These Defendants deny the WHEREFORE clause after Paragraph 22³ of Plaintiffs' Complaint, those being the remaining allegations contained in Plaintiffs' Complaint.

13. These Defendants join in Plaintiff's request for a jury trial.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(No Deviation from the Standard of Care)

14. That the care and treatment administered by these Defendants conformed to and was in full compliance with the standard of care. All care and treatment administered by these Defendants were within acceptable medical standards and methods, and, at no time pertinent hereto, did these Defendants deviate from any medical standard while caring for or tending to Plaintiff. Consequently, Plaintiff is barred from recovery against these Defendants.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(Emergency Obstetrical Care)

15. Pursuant to S.C. Code Ann. § 15-32-230, these Defendants were not grossly negligent in the care provided in this case and, therefore, are not liable for any damages allegedly incurred by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THESE DEFENDANTS ALLEGE:
(No Proximate Cause)

² Improperly labeled "21."

³ Improperly labeled "21."

16. Even if these Defendants were negligent, as alleged in Plaintiffs' Complaint, which is specifically denied, the negligence of these Defendants was not the direct and proximate cause of any injury alleged by Plaintiffs and therefore these Defendants are not liable for any damages allegedly sustained by Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THESE DEFENDANTS ALLEGE:
(Limitation of Punitive Damages)

17. Any punitive damages awarded in this case would be subject to the limitations described in S.C. Code §15-32-530.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THESE DEFENDANTS ALLEGE:
(Punitive Damages Unconstitutional)

18. That any award or assessment of punitive damages as prayed for by Plaintiff would violate these Defendants' Constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution. More specifically, punitive damages (a) are unconstitutional; (b) violate the Due Process clauses of the South Carolina and United States Constitutions (both procedurally and substantively); (c) amount to an improper delegation of a State's police powers function to a private citizen; (d) are unconstitutionally vague; (e) amount to a denial of equal protection under the law; (f) are not rationally related to any legitimate governmental interest; (g) establish no consistent, recognizable or rational standard for submitting punitive damage issues to a jury or for appellate review; (h) constitute a violation of the Eighth Amendment to the United States Constitution; (i) would be, in effect and substance, a penal sanction without a corresponding adequate procedural and substantive criminal safeguard; (j) violate the prohibitions of the United States Constitution and the South Carolina Constitution on ex post facto laws; and (k) violate these Defendants' right

to equal protection under the law as guaranteed by the United States Constitution and the South Carolina Constitution. Furthermore, any award or assessment of punitive damages would violate federal and state due process unless Plaintiff is required to prove every element of the claim for punitive damages beyond a reasonable doubt. These Defendants also affirmatively plead all rights and defenses provided by BMW vs. Gore, 517 US 559 (1996) and State Farm Mutual Automobile Insurance Co. v. Campbell, 538 U.S. 408 (2003).

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THESE DEFENDANTS ALLEGE:
(Non-Economic Damage Awards)

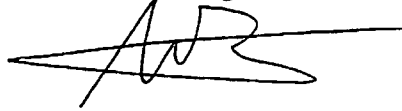
19. No award for non-economic damages shall exceed the statutory limits contained in the Non-economic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, *et. seq.* These Defendants are health care providers as defined by S.C. Code Ann. § 15-32-210 and pursuant to § 15-32-220 of the Non-economic Damage Awards Act of 2005, any potential recovery of non-economic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE.
THESE DEFENDANTS ALLEGE:
(Reservation and Non-Waiver)

20. These Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, and as is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered Plaintiffs' Complaint, and having asserted these affirmative defenses, these Defendants, Mary K. Neuffer, M.D. and Columbia Women's Healthcare, LLC, pray that Plaintiffs' Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter, and such other relief as the Court may deem just and proper.

HOOD LAW FIRM, LLC
172 Meeting Street
Post Office Box 1508
Charleston, SC 29402
Ph: (843) 577-4435 / Fax: (843) 722-1630
Email: Info@hoodlaw.com



James B. Hood (SC #70212)
A. Walker Barnes (SC #78485)

Attorneys for the Defendants
Lisa R. Maselli, M.D. and Carolina
OB/GYN

November 11, 2016
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the **ANSWER** was served on each party or counsel of record by ☐ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This _____ day of _____, 2016.

November 11, 2016

Ms. Alma Y. White
Georgetown County Clerk of Court
PO Box 479
Georgetown, SC 29442-0479

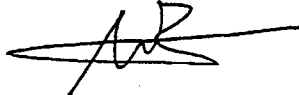
Re: Phillippa Smalling, Individually and as Next Friend of Jamerican M., a minor v. Lisa R. Maselli, M.D. and Carolina OB/GYN Properties, L.L.C. d/b/a Carolina OB/GYN
C/A No. 2016-CP-22-00863, Georgetown CP
HLF File No. 242.225

Dear Ms. White:

Enclosed for filing, please find the original and one (1) copy of Defendant Lisa R. Maselli, M.D. and Carolina OB/GYN Properties, L.L.C. d/b/a Carolina OB/GYN's Answer to the Plaintiffs' Complaint in the above-referenced matter. Please file the original and return a clocked-in copy of same in the enclosed self-addressed stamped envelope.

Kind regards,

Yours truly,



A. Walker Barnes

AWB/mpb

cc: J. Layton Ruffin, Esquire

STATE OF SOUTH CAROLINA

COUNTY OF GEORGETOWN

Phillippa Smalling, Individually and as Next Friend of
Jahmerican M., a Minor,

Plaintiff(s)

vs.

Lisa R. Maselli, M.D., both Individually and as
agent/employee of Carolina OB/GYN,

Defendant(s)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2016-CP - 22- 00863

Submitted By: J. Layton Ruffin

Address: Graham Law Firm

P.O. Box 550

Florence, SC 29503

SC Bar #:

Telephone #:

Fax #:

Other:

E-mail:

78267

843.662.3281

1.800.859.7028

jluffin@grahamlawfirm.net

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

Contracts ☐ Constructions (100) ☐ Debt Collection (110) ☐ General (130) ☐ Breach of Contract (140) ☐ Fraud/Bad Faith (150) ☐ Failure to Deliver/ Warranty (160) ☐ Employment Discrim (170) ☐ Employment (180) ☐ Other (199) _____	Torts - Professional Malpractice ☐ Dental Malpractice (200) ☐ Legal Malpractice (210) ☒ Medical Malpractice (220) Previous Notice of Intent Case # 20 ____ -NI- ____ - ☐ Notice/ File Med Mal (230) ☐ Other (299) _____	Torts - Personal Injury ☐ Conversion (310) ☐ Motor Vehicle Accident (320) ☐ Premises Liability (330) ☐ Products Liability (340) ☐ Personal Injury (350) ☐ Wrongful Death (360) ☐ Assault/Battery (370) ☐ Slander/Libel (380) ☐ Other (399) _____	Real Property ☐ Claim & Delivery (400) ☐ Condemnation (410) ☐ Foreclosure (420) ☐ Mechanic's Lien (430) ☐ Partition (440) ☐ Possession (450) ☐ Building Code Violation (460) ☐ Other (499) _____
Inmate Petitions ☐ PCR (500) ☐ Mandamus (520) ☐ Habeas Corpus (530) ☐ Other (599) _____	Administrative Law/Relief ☐ Reinstate Drv. License (800) ☐ Judicial Review (810) ☐ Relief (820) ☐ Permanent Injunction (830) ☐ Forfeiture-Petition (840) ☐ Forfeiture-Consent Order (850) ☐ Other (899) _____	Judgments/Settlements ☐ Death Settlement (700) ☐ Foreign Judgment (710) ☐ Magistrate's Judgment (720) ☐ Minor Settlement (730) ☐ Transcript Judgment (740) ☐ Lis Pendens (750) ☐ Transfer of Structured Settlement Payment Rights Application (760) ☐ Confession of Judgment (770) ☐ Petition for Workers Compensation Settlement Approval (780) ☐ Other (799) _____	Appeals ☐ Arbitration (900) ☐ Magistrate-Civil (910) ☐ Magistrate-Criminal (920) ☐ Municipal (930) ☐ Probate Court (940) ☐ SCDOT (950) ☐ Worker's Comp (960) ☐ Zoning Board (970) ☐ Public Service Comm. (990) ☐ Employment Security Comm (991) ☐ Other (999) _____
Special/Complex /Other ☐ Environmental (600) ☐ Automobile Arb. (610) ☐ Medical (620) ☐ Other (699) _____ ☐ Sexual Predator (510) ☐ Permanent Restraining Order (680)	☐ Pharmaceuticals (630) ☐ Unfair Trade Practices (640) ☐ Out-of State Depositions (650) ☐ Motion to Quash Subpoena in an Out-of-County Action (660) ☐ Pre-Suit Discovery (670)		

Submitting Party Signature: _____

Date: March 16, 2017

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

Effective January 1, 2016, Alternative Dispute Resolution (ADR) is mandatory in all counties, pursuant to Supreme Court Order dated November 12, 2015.

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

Pursuant to the ADR Rules, you are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs.
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

**Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA,)
)
COUNTY OF GEORGETOWN)
)
Phillippa Smalling, Individually, and as)
Next Friend of Jahmerican M., a minor,)
Plaintiff,)
)
vs.)
)
Lisa R. Maselli, M.D., both Individually and)
as agent/employee of Carolina OB/GYN ,)
)
Defendant.)

IN THE COURT OF COMMON PLEAS

SUMMONS

FILE NO. 2016-CP-22-00863

TO THE DEFENDANT ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to this complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof, exclusive of the day of such service, and if you fail to answer the complaint, judgment by default will be rendered against you for the relief demanded in the complaint.

Florence, South Carolina

Dated: March 16, 2017



Plaintiff/Attorney for Plaintiff

Address: Graham Law Firm
P.O. Box 550
Florence, SC 29503

SCCA 401 (5/02)

STATE OF SOUTH CAROLINA
COUNTY OF GEORGETOWN

IN THE COURT COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2016-CP-22-00863

Phillippa Smalling, Individually, and as Next Friend of
Jahmerican M., a minor,

Plaintiffs,

vs.

Lisa R. Maselli, M.D., both individually and as
agent/employee of Carolina OB/GYN,

Defendants,

**FIRST
AMENDED COMPLAINT**

TO: THE DEFENDANTS as set forth above:

Please take notice that the Plaintiffs, complaining of Defendants above named, would show unto the Court as follows:

1. Plaintiff Phillippa Smalling (hereinafter, "Phillippa") is a citizen and resident of Georgetown County, South Carolina, and brings this action in her individual capacity and as Next Friend of her minor son, Jahmerican M, (hereinafter, "Jahmerican").

2. Defendant Lisa R. Maselli, M.D. (hereinafter, "Maselli") is, upon information and belief, a citizen and resident of Georgetown County, South Carolina, who was, at all times relevant to this action, a physician duly licensed to practice medicine within the State of South Carolina.

3. Defendant Maselli held herself out to the public as having specialized knowledge, training and experience for the provision of obstetrical and gynecological care in compliance with the applicable standard of care.

4. Defendant Maselli owned, operated and/or maintained a professional medical office in Georgetown County, South Carolina, from which she offered obstetric and gynecologic care to the public, including the Plaintiff.

5. Upon information and belief, Carolina OB/GYN (hereinafter, "Carolina") is a corporation or other entity existing under the laws of South Carolina or another state and has its primary place of business in Georgetown, South Carolina.

6. Upon information and belief, Defendant Maselli was acting both individually, on her own behalf, and as an employee, agent and/or owner of the Defendant Carolina, within the course and scope of that employment and agency at all times relevant to this action.

7. At all times relevant to this action, the Defendant Carolina was a limited liability corporation organized and existing under the laws of South Carolina. The Defendant Carolina had its principal place of business in Georgetown County, South Carolina.

8. The Defendant Carolina held itself out to the public as having employees with specialized knowledge, training, and experience, as well as the equipment and facilities, for the provision of obstetrical and gynecological care in compliance with the applicable standard of care.

9. The Defendant Carolina is named as a Defendant herein because of its *respondeat superior* liability for torts of its agents, employees, and/or owners, including, but not limited to, Defendant Maselli.

10. Prior to his birth in 2013, Defendant Maselli admitted Phillippa to labor and delivery where she was responsible for managing the labor and the delivery of Jahmerican at Georgetown Hospital located in Georgetown, South Carolina.

11. Phillippa Smalling, the mother of Jahmerican M., discovered she was pregnant and, at approximately 16 weeks' gestation, presented for prenatal care and attention to Defendant Maselli, at which time she established a patient-physician relationship with Phillippa, and Defendant Maselli assumed responsibility for providing Phillippa with prenatal, labor, and delivery obstetrical care, in compliance with the applicable standard of care.

12. Jahmerican was a healthy infant prior to his birth in 2013, when his mother, Phillippa, was admitted to Georgetown Hospital by Defendant Maselli for labor and delivery.

13. At the time Philippa was admitted to Georgetown Hospital, the Defendant Maselli was responsible for delivering professional obstetrical care to Phillippa and her then unborn baby, Jahmerican, in compliance with the standard of care for an obstetrician.

14. The Defendant Maselli owed Phillippa, and her then unborn son, a duty of providing competent obstetrical labor and delivery care, consistent with generally accepted standards of obstetricians acting under the same or similar circumstances.

15. Defendant Carolinas, and its employee(s) and agent(s), owed Phillippa and her minor son a duty of providing obstetrical care, services, and attention consistent with generally accepted standards of care for obstetricians acting under similar situations.

16. The Defendants Maselli and Carolina breached their duties of care owed to Phillippa and her then unborn son, Jahmerican.

17. The Defendants were negligent, reckless, willful, wanton, and/or otherwise wrongful in the care and attention to them, as a direct and proximate result of which Jahmerican sustained severe, permanent, disfiguring, bodily injuries, limitations in function, losses and damages, including a brachial plexus nerve injury to his right shoulder, arm and hand.

18. Defendant Maselli was negligent, reckless, willful, wanton and/or otherwise wrongful in one or more, but not limited to, the following particulars:

- (a) Failing and refusing to acquire a safe level of professional knowledge, skill, training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to manage the birthing process of Jahmerican; and/or
- (b) Choosing not to appreciate the heightened risk of shoulder dystocia in the delivery of Jahmerican; and/or
- (c) Failing to timely recognize the signs and symptoms of shoulder dystocia; and/or in recognizing same, in failing to initiate and utilize appropriate maneuvers to alleviate the shoulder dystocia; and/or
- (d) Failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia; and/or
- (e) Failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Jahmerican; and/or
- (f) Using improper and/or unsafe delivery technique(s); and/or
- (g) Using improper and excessive force, traction, and/or torsion; and/or
- (h) Directing and/or allowing the nurses to use fundal pressure in the presence of shoulder dystocia; and/or
- (i) Mismanagement of labor and the delivery of Jahmerican; and/or
- (j) Mismanagement of shoulder dystocia; and/or
- (k) Failing to perform the delivery by caesarean section, and/or convert to a caesarean section; and/or
- (l) Failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health, including, but not limited to shoulder dystocia, an obstetrical emergency; and/or
- (m) Failing to timely and properly monitor, observe, record, and/or transcribe vital information about the patient's status and condition in the presence of an obstetrical emergency; and/or
- (n) Failing to appropriately inform and advise Phillippa of the risks and benefits, as well as to the alternatives, of treatment options, including but not limited to a vaginal delivery versus a surgical and/or cesarean section, thereby failing to obtain her informed consent; and/or
- (o) Such other failures as may be identified during discovery and the trial of this case.

19. Defendant Carolina, its predecessor(s) and/or successor(s), if any, and the shareholder(s), agent(s), and employee(s) thereof, were negligent, reckless, willful, wanton, and/or otherwise wrongful in one, or more, or all of, and including, but not limited to, the following particulars:

- (a) Failing and refusing to require its shareholder(s), employee(s), and agent(s) to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and recognition and management of shoulder dystocia in particular, before attempting to attend, manage or provide support for the birthing process of Jahmerican; and/or
- (b) Failing to provide and/or require sufficient training to its obstetricians and labor and delivery staff about anticipation of a heightened risk of, and proper management of shoulder dystocia; and/or
- (c) Failing to require its obstetricians and labor and delivery staff to demonstrate current competency in the management of labor and delivery, including recognition and management of shoulder dystocia complications; and/or
- (d) Failing to appropriately monitor, supervise and/or train its employees in the recognition and management of shoulder dystocia; and/or
- (e) Failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to manage the birthing process of Jahmerican; and/or
- (f) Failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia; and/or
- (g) Such other failures as may be identified during discovery and/or trial of this case.

20. As a direct and proximate result of the negligence and other wrongful conduct on the part of the Defendants Maselli and Carolina, Jahmerican sustained certain permanent, severe injuries, disfigurement, limitation of function, and losses and damages, stated with particularity as follows:

- (a) Direct violent and traumatic injuries to various bodily members of Jahmerican, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder, arm, and hand, commonly known as Erb's palsy;
- (b) Adverse effects on various other bodily parts, including disfigurement and functional limitations, such as gait, balance, and skeletal and muscular asymmetry;
- (c) Past, present, and future medical expenses;
- (d) Life care management expenses;
- (e) Permanent limitations, disfigurement, impairments, and disabilities;
- (f) Permanent disfigurement of his arm, shoulder, and/or hand;
- (g) Past, present, and future physical pain and suffering;
- (h) Past, present, and future mental, emotional, and psychological harm;
- (i) Adverse effect(s) on his future employability, earnings, and earning capacity;
- (j) Loss of enjoyment of life; and
- (k) Such further injuries, losses, and damages as may be revealed through discovery and trial of this case.

21. As the Parent of Jahmerican, Philippa asserts an individual claim for any past, present, and future pre-majority medical expenses of Jahmerican that cannot be waived in favor of Jahmerican, and which must be asserted and recovered by the parent. Such medical expenses have been incurred, and will continue to be incurred, as a direct and proximate result of the negligence and other wrongful conduct of the Defendants Maselli and Carolina.

21. Plaintiff previously complied with all statutory requirements for commencing this action and, after unsuccessful pre-suit mediation, the matter was declared at an impasse by the mediator. A copy of an Expert Affidavit of Steven Pliskow, MD, as required by §15-79-125 and §15-36-100(C)(1) *South Carolina Code of Laws* is attached hereto in support of the liability allegations made herein.

WHEREFORE, Plaintiff prays for judgment against Defendants Maselli and Carolina for an award of actual damages; for an additional award of punitive damages in an amount to be determined by the jury in accordance with the facts and circumstances presented at trial; for costs of her action; and for such other and further relief as this Court may deem just and proper.

GRAHAM LAW FIRM, P.A.

BY



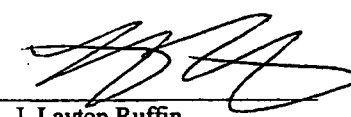
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Attorney for Plaintiffs

Florence, South Carolina
March 17, 2017

A JURY TRIAL IS HEREBY REQUESTED.

GRAHAM LAW FIRM, P.A.

BY



J. Layton Ruffin
Email: jlruffin@grahamlawfirm.net

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF GEORGETOWN	)	FOR THE FIFTEENTH CIRCUIT
Phillippa Smalling, Individually and as	)	C/A No. 2016-CP-22-00863
Next Friend of Jamerican M., a minor,	)	
<i>Plaintiff,</i>	)	
	)	
Versus	)	DEFENDANTS' ANSWER TO
	)	PLAINTIFFS' FIRST AMENDED
	)	COMPLAINT
Lisa R. Maselli, M.D., both individually	)	<i>(Jury Trial Requested)</i>
and as agent/employee of Carolina	)	
OB/GYN,	)	
<i>Defendants.</i>	)	

Defendants Lisa R. Maselli, M.D. and Carolina OB/GYN, by and through the undersigned counsel, hereby respond to the allegations in Plaintiffs' First Amended Complaint, subject to all affirmative defenses and motions, as follows:

1. Each and every allegation not specifically admitted herein is denied.
2. The Defendants lack sufficient information upon which to form a belief as to the allegations contained in Paragraph 1 of Plaintiffs' First Amended Complaint, and therefore deny the same.
3. The Defendants admit the allegations contained in Paragraph 2 of Plaintiffs' First Amended Complaint.
4. In response to the allegations contained in Paragraphs 3, 4, 5 and 6 of Plaintiffs' First Amended Complaint, the Defendants admit only that (1) Dr. Maselli is a licensed physician who provides OBGYN treatment to patients in Georgetown County, South Carolina, including the Plaintiffs; (2) the Defendants maintain a medical office in Georgetown, South Carolina; and (3) Dr. Maselli is a partner of Carolina OB/GYN. The remaining allegations contained in Paragraphs 3, 4, 5 and 6 of Plaintiffs' First Amended Complaint state conclusions of law, to which no response is required.
5. The allegations contained in Paragraphs 7, 8 and 9 of Plaintiffs' First Amended Complaint state conclusions of law, to which no response is required.

6. The Defendants admit the allegations contained in Paragraph 10 of Plaintiffs' First Amended Complaint.

7. In response to the allegations contained in Paragraphs 11 and 12 of Plaintiffs' First Amended Complaint, the Defendants crave reference to Plaintiffs' medical records for a complete and accurate representation of Plaintiffs' medical conditions and treatment.

8. In response to the allegations contained in Paragraphs 13, 14 and 15, the Defendants admit only that they owed Plaintiffs a duty of providing obstetrical care and services consistent with the standard of care, which they did at all times. The remaining allegations contained in Paragraphs 13, 14 and 15 of Plaintiffs' First Amended Complaint state conclusions of law, to which no response is required.

9. The Defendants deny the allegations contained in Paragraphs 16, 17, 18, including subparts (a) through (o), 19, including subparts (a) through (g), 20, including subparts (a) through (k), and 21 of Plaintiffs' First Amended Complaint.

10. The allegations contained in Paragraph 22¹ of Plaintiffs' First Amended Complaint states conclusions of law to which no response is required.

11. The Defendants deny the WHEREFORE clause after Paragraph 22² of Plaintiffs' First Amended Complaint, those being the remaining allegations contained in Plaintiffs' First Amended Complaint.

12. The Defendants join in Plaintiffs' request for a jury trial.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(No Deviation from the Standard of Care)

13. That the care and treatment administered by the Defendants conformed to and was in full compliance with the standard of care. All care and treatment administered by the Defendants were within acceptable medical standards and methods, and, at no time

¹ Improperly labeled "21."

² Improperly labeled "21."

pertinent hereto, did the Defendants deviate from any medical standard while caring for or tending to Plaintiffs. Consequently, Plaintiffs are barred from recovery against the Defendants.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(Emergency Obstetrical Care)

14. Pursuant to S.C. Code Ann. § 15-32-230, the Defendants were not grossly negligent in the care provided in this case and, therefore, are not liable for any damages allegedly incurred by the Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(No Proximate Cause)

15. Even if the Defendants were negligent, as alleged in Plaintiffs' First Amended Complaint, which is specifically denied, the negligence of the Defendants was not the direct and proximate cause of any injury alleged by Plaintiffs and therefore the Defendants are not liable for any damages allegedly sustained by Plaintiffs.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(Limitation of Punitive Damages)

16. Any punitive damages awarded in this case would be subject to the limitations described in S.C. Code §15-32-530.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(Punitive Damages Unconstitutional)

17. That any award or assessment of punitive damages as prayed for by Plaintiffs would violate the Defendants' Constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution. More specifically, punitive damages (a) are unconstitutional; (b) violate the Due Process clauses of the South Carolina and United States Constitutions (both procedurally and substantively); (c) amount to an improper delegation of a State's police

powers function to a private citizen; (d) are unconstitutionally vague; (e) amount to a denial of equal protection under the law; (f) are not rationally related to any legitimate governmental interest; (g) establish no consistent, recognizable or rational standard for submitting punitive damage issues to a jury or for appellate review; (h) constitute a violation of the Eighth Amendment to the United States Constitution; (i) would be, in effect and substance, a penal sanction without a corresponding adequate procedural and substantive criminal safeguard; (j) violate the prohibitions of the United States Constitution and the South Carolina Constitution on ex post facto laws; and (k) violate the Defendants' right to equal protection under the law as guaranteed by the United States Constitution and the South Carolina Constitution. Furthermore, any award or assessment of punitive damages would violate federal and state due process unless Plaintiff is required to prove every element of the claim for punitive damages beyond a reasonable doubt. The Defendants also affirmatively plead all rights and defenses provided by BMW vs. Gore, 517 US 559 (1996) and State Farm Mutual Automobile Insurance Co. v. Campbell, 538 U.S. 408 (2003) and subsequent Court decisions interpreting the assessment of punitive damages.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(Non-Economic Damage Awards)

18. No award for non-economic damages shall exceed the statutory limits contained in the Non-economic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, *et. seq.* The Defendants are health care providers as defined by S.C. Code Ann. § 15-32-210 and pursuant to § 15-32-220 of the Non-economic Damage Awards Act of 2005, any potential recovery of non-economic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE,
THE DEFENDANTS ALLEGE:
(Reservation and Non-Waiver)

19. The Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, and as is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered Plaintiffs' First Amended Complaint, and having asserted these affirmative defenses, the Defendants, Lisa R. Maselli, M.D. and Carolina OB/GYN, pray that Plaintiffs' First Amended Complaint be dismissed with prejudice and that they be awarded the costs and reasonable fees associated with this matter, and such other relief as the Court may deem just and proper.

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s/ A. Walker Barnes

James B. Hood (SC #70212)
A. Walker Barnes (SC #78485)

Attorneys for the Defendants
Lisa R. Maselli, M.D. and Carolina OB/GYN

April 17, 2017
Charleston, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS
COUNTY OF GEORGETOWN	)	2016-CP-22-00863
Phillippa Smalling,	)	
	)	
Plaintiff,	)	
	)	
Vs	)	Transcript of Record
	)	
Lisa R. Maselli, MD,	)	April 3 & 4, 2019
	)	
Defendant.	)	
	)	

B E F O R E:

The Honorable Larry Hyman and
The Honorable Bentley Price
Georgetown County Courthouse
Georgetown, South Carolina

A P P E A R A N C E S:

Edward Graham, Esquire
Attorney for Plaintiff

James Hood, Esquire
Attorney for Defendant

Sallie Beth Todd
Circuit Court Reporter

	<u>I N D E X</u>				
	<u>WITNESS</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>	<u>RECROSS</u>
1					
2					
3	DR. DANIEL ADLER				
4	By Mr. Graham	76		130	
5	By Mr. Hood		114		
6					
7	DR. STEPHEN PLISKOW				
8	By Mr. Graham	147		251, 263	
9	By Mr. Hood		208		261
10					
11	DR. CHARLES VANDERKOLK				
12	By Mr. Graham	265			
13	By Mr. Hood		278		
14					
15	ANTHONY MCCRAY				
16	By Mr. Graham	288		327	
17	By Mr. Radeck		316		
18					
19	DR. OLIVER WOOD, JR.				
20	By Mr. Graham	365			
21	By Mr. Radeck		380		
22					
23	PHILLIPA SMALLING MCCRAY				
24	By Mr. Graham	384			
25	By Mr. Radeck		420		

	<u>WITNESS</u>	<u>DIRECT</u>	<u>CROSS</u>	<u>REDIRECT</u>	<u>RECROSS</u>
1	DR. LISA MASELLI				
2					
3	By Mr. Hood	450		586	
4	By Mr. Graham		532		588
5					
6	DR. DAVID HASELTINE				
7	By Mr. Hood	589			
8	By Mr. Graham		595		
9					
10	DR. CHRISTOPHER ROBINSON				
11	By Mr. Hood	599		688	
12	By Mr. Graham		655		
13					
14	DR. MICHAEL DUCHOWNEY				
15	VIDEO DEPO	697			
16					
17	DR. SUNEET CHAUHAN				
18	By Mr. Radeck	710			
19	By Mr. Graham		756		
20					
21	-----				
22	Certificate of Court Reporter				888
23	-----				
24					
25					
		<u>EXHIBITS</u>			

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4	PL 4	MUSC Operative Note 2		X	101
5	PL 5	Fetal Monitoring Strips		X	157
6	PL 6	Labor Record		X	157
7	PL 7	MUSC Progress Note		X	103
8	PL 8	MRI Report		X	85
9	PL 11	Delivery Report		X	158
10	PL 12	Shoulder Dystocia Progress Note		X	159
11	PL 13	Handwritten Delivery Note		X	158
12	PL 15	Shriners Operative Note 1		X	101
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14	PL 23	Medical Billing Summary		X	287
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21	PL 32	CV of Dr. Vanderkolk		X	265
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4	DEF 3	Baby's Hospital Records	X		708
5	DEF 4	Labor & Delivery Progress Note		X	481
6	DEF 5	Typed Delivery Note		X	515
7	DEF 6	Handwritten Delivery Note		X	490
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10	DEF 10	Discharge Summary		X	523
11	DEF 11	Progress Note		X	695
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14	DEF 25	PPD1 Notes		X	521
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17	DEF 28	CV of Dr. Robinson		X	608
18	DEF 29	Progress Note 6/4/13		X	695
19	DEF 30	CV of Dr. Chauhan		X	711
20	DEF 31	Transcript of Dr. Duchowney	X		705
21	DEF 32	CV of Dr. Duchowney		X	708
22					
23					
24					
25					

1 Go ahead.

2 **MR. GRAHAM:** Thank you, Your Honor. I don't have
3 anything to submit in response.

4 **THE COURT:** All right. Very well. Thank you. Then
5 under the totality of the circumstances and the facts in this
6 case as they appear on the record, I find that the defense has
7 offered race neutral explanations for his strikes and there
8 has been no response by the plaintiff. Therefore, the jury is
9 seated. Thank you.

10 Would you bring the other jurors in first; okay?

11 **REPORTER'S NOTE:** (Remainder of jury panel enter
12 courtroom).

13 **THE COURT:** All right. Ladies and gentlemen, have we got
14 everybody in; I think so. We have selected our jury panel for
15 the case we'll be trying this week and you will not be needed
16 anymore this week and we thank you so much for coming here.
17 You know, one thing that I've learned over the last forty plus
18 years practicing law is this; there is nothing that moves
19 cases like the presence of a jury panel. Many times, folks
20 who are just unable to reach an accord or a satisfaction in a
21 case, are much more susceptible to settlement once they know
22 that their case is about to be tried. And there were many
23 cases that were scheduled for this week and those cases were
24 scheduled because you're here. So, please don't think that
25 you've wasted your time. You have moved many cases already

1 this week and you have provided a great service to the Court
2 by your being here. But, that said, you have completed your
3 obligation for jury service this week. You're not going to be
4 called back; we will not need you anymore. This case will
5 take the balance of the week and it is the last case that we
6 have on the docket for this week. So, thank you for your
7 service. We're glad to have our jurors in every week. It's
8 been a good week so far. Thank you for being here, but you
9 are excused.

10 **REPORTER'S NOTE:** (Jury venire released for week).

11 **THE COURT:** All right. Let's bring this jury panel back
12 in, please?

13 **BAILIFF:** Yes, sir.

14 **REPORTER'S NOTE:** (Jury Panel returns to courtroom 2:27
15 P.M.).

16 **THE COURT:** We've got our jurors in. All right. Ms.
17 McManus?

18 **JUROR 21:** Yes, sir.

19 **THE COURT:** If you would always occupy that seat. And,
20 Mr. Davis, always occupy that seat and Mr. Johnson, I always
21 want you in that seat because I am going to ask you to serve
22 as the foreperson of this jury. In that regard, you will be
23 the Court's liaison with the jury. If any problems arise, if
24 you have any questions, any issues, please, give a note to the
25 bailiff or the deputy, who may be sitting with you and they

1 will bring it directly to me and I will take care of that for
2 you. Also, it's your job to maintain order in the jury room
3 and to preside over the deliberations at the end of the case
4 and for that, I thank you in advance and I hope you will
5 accept this responsibility.

6 Now, I'm going to place you under oath and this is the
7 last time that we will do it, but you will be sworn by the
8 Clerk. Madam Clerk?

9 **CLERK:** Ladies and gentlemen, please stand and raise your
10 right hand.

11 **REPORTER'S NOTE:** (Jury sworn by the Clerk).

12 **CLERK:** Thank you. You may be seated.

13 **THE COURT:** And was there anyone who did not take that
14 oath?

15 And let the record reflect there was not. You will hear
16 me say that a lot, let the record reflect, and again, that's
17 just because Ms. Todd has to record everything that goes on in
18 the courtroom. Sometimes, there will be a non-verbal response
19 and I'm required to put on the record what that was. So,
20 that's what we're doing when we say that.

21 Before we begin this trial, I want to talk with you a few
22 minutes about what you might expect and what your duties are
23 going to be during the trial of the case. You know, it seems
24 that every time you turn on the news or any programs on T.V.,
25 you know, there's a trial going on or somebody is about to be

1 tried or there's something about a trial that's taking place
2 every time you turn around. And you know, it amazes me that
3 every one of those trials are just action packed, thrill a
4 minute events. I will tell you that in reality, that is not
5 necessarily the case and I would not expect it to be in this
6 case. Sometimes it is, but generally speaking, the search for
7 the truth and that's what this is about, the search for the
8 truth, is a slow, arduous, repetitive process that we -- we go
9 through. During that process, you will, at times, think that
10 you want to jump over the rail and grab one of these lawyers
11 by the neck and shake the living daylights of them because
12 you're going to hear them questions and you know where they're
13 going, but it seems like they'll ask ten questions to get to
14 one and you'll be thinking, well, there they are, they're just
15 wasting my time. They do that because they're good lawyers.
16 They do that because that's how they're supposed to present
17 evidence to you. We have, in this state and in all the Courts
18 of the state, rules of evidence and rules of procedure that
19 are tested by time; some of them are hundreds of years old.
20 And you know, when I practiced law and even now occasionally,
21 I will look at one of those rules and say, why in the world do
22 we have such a silly rule; what is that rule about; what do we
23 have to jump through those hoops; and then all of a sudden,
24 I'll be trying a case and that light bulb will come on and
25 I'll say hah, that's the reason that we have those rules. So,

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1 I would ask you to consider that these lawyers, when it
2 appears to you that they're wasting your time, that they're
3 not moving the case along, that they're doing it because
4 they're required to do it; they're doing it because that's
5 what the rules say.

6 Also, from time to time during the case, you might hear
7 one of them say something like, Your Honor, I object to this
8 or Your Honor, we need to take up a matter outside the jury.
9 Again, it's not because anybody is trying to keep anything
10 from you; it's because they're required to create a record.
11 If they feel that a piece of evidence has not been presented
12 properly or in the proper fashion, they're supposed to do
13 that. Good lawyers do that. And I might ask you to step out
14 of the courtroom when I rule on it and again, that's not
15 because we're trying to keep anything from you, it's because
16 of this. In this trial, the facts are what are disputed; what
17 happened, whether or not the case has been proven. Those are
18 the things that you must consider.

19 Determining the facts, where there's conflicts as to
20 those facts, is absolutely up to the jury. You know, if there
21 wasn't a difference of opinion as to what occurred, we
22 wouldn't need the jury. The jurors have to determine what the
23 facts are. You know, I'm not even allowed to have an opinion
24 and that's the reason I have to send you out, because
25 sometimes, ruling on how a piece of evidence might be

1 admitted, I might have to put on the record my opinion about a
2 piece of evidence and it would be so wrong for you to hear my
3 opinion, because my opinion doesn't make a hill of beans. It
4 doesn't make any difference in this case, because you, the
5 jury, are the sole judges of the facts. And that's really
6 important, because at the end of this case, you're going to be
7 asked to deliberate, that is return a verdict in this case and
8 that word, deliberation, it's sort of a term of art that we
9 use in the law. It involves sort of a three-part process.

10 First, the facts have to be determined. That's what you
11 do. And then you have to determine what the law is of this
12 case and that's going to be the easy part for you, because I'm
13 just going to give you the law. At the end of the trial, I'm
14 going to tell you the law that you must follow. You might not
15 agree with it, you might think it is something else, ought to
16 be something else; you're sworn to follow the law.

17 So, you take the law and the facts, the facts as you find
18 them, the law as I give it to you and that third process is
19 where you bring the facts and the law together. Imagine, if
20 you will, huge gears in a factory; you build one gear with the
21 facts; I build a gear with the law. That deliberation process
22 is where you bring them together and see how they fit. We'll
23 see whether or not the plaintiff has made its case.

24 You know, if this were a criminal case, the plaintiff
25 would have to prove its case beyond a reasonable doubt. That

1 is that they would have to remove all reasonable doubt that
2 you might have that the defendant committed the offense that
3 he's accused of. It's different in a civil case like we have
4 here, a common pleas case. In a common pleas case, the
5 defendant has to prove, I mean the plaintiff has to prove its
6 case by what we call a preponderance or greater weight of the
7 evidence; essentially, more likely than not. There's an
8 example that's been used in this state for a hundred years and
9 that is, if you would imagine a set of old balance beam
10 scales, you know, the one with the tray on each side, the one
11 that you see the blind lady holding, Lady Justice. Imagine
12 those scales at the beginning of the trial starting dead even
13 and you put all the plaintiff's evidence on one side and you
14 put all the defense's evidence on the other side and if those
15 scales stay still level, the plaintiff has not made her case
16 and she's not entitled to recover. If they tip slightly in
17 favor of the defense, again, has not proved their case. The
18 plaintiff though, only has to move that scale slightly to her
19 side and if she does that, she has met her burden of proof,
20 her standard of proof. She has made her case by a
21 preponderance of the evidence.

22 Now, you may sit there and think, well, you know, you
23 called out a list of people and you wanted to know if we knew
24 any of them and you wanted to make sure we didn't know any of
25 them and we're going to hear all this testimony, how are we

1 supposed to know who's telling the truth and who's not telling
2 the truth; how are we supposed to judge the credibility, the
3 believability of a witness or piece of evidence; how do we
4 know? Let me say this and this is why we select you as
5 jurors, strangers, you apply the same test for credibility,
6 believability, truth in this courtroom, that you were using
7 right out there on Cleland Street before you walked into this
8 courtroom. It's on different at all. You can -- you can
9 believe one witness over many, you can believe many over one,
10 you can believe everything a witness might say, you can
11 believe nothing a witness might say. You can consider things
12 like well, was this witness or did this witness happen to be
13 in a position to see or hear what that witness says that they
14 did. Does that witness have any interest in the outcome of
15 the case; does he have any bias or prejudice in the case? You
16 can even consider what we call a witnesses demeanor, how he
17 just appears on the witness stand, his intelligence, you can
18 consider all those things, common sense things that you use
19 every day in determining whether to believe someone or not
20 believe someone. That's how you as a jury make a
21 determination of what the facts are.

22 You know a trial is nothing more than an orderly
23 presentation of evidence to a jury, so a jury can make a
24 determination of fact. Everything we do, the things that the
25 lawyers do, the things that I do, the rules that we have are

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1 all geared to one thing, an orderly presentation of
2 information to you, so that you can make a determination of
3 the facts, so you can rule in this case.

4 In that regard, let me say this, you can only, only judge
5 this case from what you hear from the witness stand. That's a
6 real problem in this modern day and something that judges have
7 to be careful about, because it is so easy, especially a case
8 that may be go more than one day or two days or three days, to
9 go home and get on that genius phone, some people call it a
10 smart phone; it's a genius phone, it's got everything in it,
11 to look up the law, look up facts that you haven't heard. You
12 might even want to look up the lawyers Facebook's or mine. If
13 you look up mine, you're going to see four little
14 grandchildren running around; that's all you gone see. But
15 jurors do that sometime. That is highly improper. Don't do
16 it. Do not do it. You have to judge this case from what you
17 hear from this stand unaffected by any extraneous information
18 that you may have collected on your own. Do not do that.

19 I also would ask you not to pre-deliberate this case.
20 Pre-deliberate means that you, you start making a decision
21 about the case before you've heard both sides. Let me tell
22 you why, what really happens sometime, just from a commonsense
23 standpoint. You know, you may hear a witness here on the
24 witness stand and we are a small community, some of you may
25 know each other, others not, but it's so easy to walk back in

1 that jury room and say something like this; I don't believe a
2 word that rascal said or I believe everything that witness
3 says; it's done for me. Then, as the evidence develops, what
4 have you done; you have committed yourself and it's so hard
5 sometimes, it's just human nature, it's so hard for us to back
6 up on what we have said, especially, when we're with people
7 that we're not familiar with. So, wait, wait, listen to
8 everything before you commit yourself, before you discuss it.
9 I ask you not even to discuss the case when you go home. You
10 know, it's awfully hard to go home to your, your, your wife or
11 your significant other and they say what did you do today and
12 you say, well, I was on a trial; well, what's it about; I
13 really can't talk to you about that. It's awfully hard to get
14 away; you've got to have a real understanding wife in my
15 situation to do that, but just say, we'll talk about it when
16 we're done, because you know what; you start telling her or
17 him about the case and he or she might decide that they got an
18 opinion and they haven't heard anything about the case. So,
19 just don't do it. I'm required to ask you to do that and
20 you're required not to do that. So, please do not.

21 Now, let's talk a little bit about what you can expect as
22 far as the way this case is going to progress. I told you a
23 little bit about the case when we were doing jury selection.
24 And really, that's about all I know about the case, quite
25 honestly. But the attorneys have an opportunity at the

1 beginning of the trial to do what we call an opening remark.
2 Okay? And it'll start with Mr. Graham. Mr. Graham will tell
3 you about this case. He will give you much greater detail
4 than I have. He will tell you from his perspective, his
5 client's perspective, what he thinks he can show, what he
6 thinks he can prove and why he thinks his client should
7 recover in this case and that's proper. But, remember, it's
8 not evidence because why; it hasn't come from this witness
9 stand.

10 Then Mr. Hood or the defense has an opportunity to follow
11 and again, address you in making an open remark and tell you
12 about the case from their perspective and why they feel that
13 there is no basis for a recovery by the plaintiff. And that's
14 just as it should be, but again, he is going to discuss the
15 case from his client's perspective and what he says, again, is
16 not evidence because it hasn't come from this witness stand
17 yet. But it's proper for him to give you an overview, let
18 you know. The reason we do this, so you'll know where the
19 case is going.

20 Following that, Mr. Graham has to go forward first. He
21 represents the plaintiff. The plaintiff will call witnesses
22 and Mr. Graham will directly examine them. As when he
23 finishes with each witness, the defense has an opportunity to
24 cross examine and they may do it twice.

25 And so it will go until such time as Mr. Graham feels

1 that he has made his proof and then he will rest. Following
2 that, the defense has exactly the same opportunity; put up
3 witnesses, they'll be direct examination, cross examination
4 and so it will go until the defense rests.

5 Once they have rested, you will hear what we call closing
6 arguments or closing remarks, again, by both attorneys. They
7 will have an opportunity to sum up what you have heard by way
8 of evidence. Again, what they say is not evidence. They can
9 certainly talk about the evidence, but they can't add to it.
10 They can give their perspective on the evidence. They can
11 even talk to you about the law, but you've got to be guided by
12 the law as I give it to you and your determination of facts
13 has to be guided by what you heard from the witness stand.

14 Following that, I will instruct you on the law. It's
15 always been my practice, I don't know how many judges are
16 doing it; not many, but I prepare a transcript of the law so
17 there can be no question about it. You know, it's not fair
18 for us to -- for me to sit up here and talk to you for, you
19 know, 45 minutes about what the law is, very technical issues
20 under the law, and expect lay people to remember it all. So,
21 I type it up, I prepare it in a document, and I let you take
22 it in the jury room so that you can refer to it and so you
23 will have the law there. And then, you will return a verdict.

24 Now, that's the procedure that we will be following. I
25 ask you again, as I told you on yesterday, if you become

1 uncomfortable, if you need a break, if you need to refresh
2 yourself, do not hesitate to just raise your hand and let me
3 know. If you're uncomfortable, you can't be paying attention
4 and everything that is going on in this courtroom is
5 important. And the last thing I'm going to tell you is this,
6 is every one of those lawyers has the lawyer's disease; I had
7 it. I haven't had a lawyer appear before that doesn't have
8 lawyer's disease. Lawyer's disease is this, they will put up,
9 probably, I would suspect, I see some, charts, exhibits,
10 things that they want to use and I guess it's just the nature
11 of the way courtrooms are set up, they will have a tendency in
12 the excitement of presenting evidence to you, to stand in
13 front of you, some of you or move in front of the exhibit or
14 maybe turn their back and you can't hear them. Let me tell
15 you this, they will not be upset with you one bit if you raise
16 your hand and tell me you can't see; I can't see the exhibit,
17 or I can't hear the lawyer. They want you to do that. They
18 want you to see what they're talking about. It's important to
19 them. So, if one of them is stricken with the disease and
20 steps in front of you, please don't hesitate; you're not going
21 to upset the lawyer. He's going to thank you for doing it.
22 He didn't do it intentionally; it's just that in the moment,
23 moving around the courtroom; sometimes that happens. So,
24 please let us know if there's ever a moment that you -- or a
25 witness that you can't hear or you can't see, let us know.

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1 Okay?

2 Anything further, Mr. Hood?

3 **MR. HOOD:** No, Your Honor.

4 **THE COURT:** Anything further, Mr. Graham?

5 **MR. GRAHAM:** No, Your Honor.

6 **THE COURT:** All right. Very well, we're ready to go.

7 Mr. Graham, you may give your opening statement?

8 **MR. GRAHAM:** Thank you, Judge.

9 **THE COURT:** All right.

10 **MR. GRAHAM:** Good afternoon, everybody. You're probably

11 wondering why we're gathered together this week. The reason

12 we're here is because medical doctors have laws to follow just

13 like the rest of us. When a doctor is delivering a baby the

14 doctor uses finesse, not force. If a doctor uses force rather

15 than finesse and the baby is harmed because of that force,

16 then the doctor is responsible for all the harm that she

17 caused. Now, in this case you're going to be hearing all

18 types of medical jargon that -- I don't want to be

19 disrespectful to anyone who has medical training, but to most

20 of us we probably need to be warned about what's coming and

21 that's what I want to do for a moment. Just give you an idea

22 about the types of medical concepts and medical doctor talk

23 that you'll be hearing this week. First of all, you heard His

24 Honor talk about shoulder dystocia. Shoulder dystocia is a

25 situation in which, as the baby comes down through the birth

1 canal of the mother, instead of the top shoulder -- usually
2 the head comes out first and then the top shoulder comes out
3 second and then the whole body follows. In the situation
4 called shoulder dystocia that baby's top shoulder comes down
5 behind the mother's pubic bone. It's kind of like if you're
6 moving a couch through a door. If you have the couch angled
7 in the wrong direction you can't get through the door and you
8 have to change the direction to come through the door. So, in
9 this situation, doctors who deliver babies are trained early
10 in their career about how to recognize this situation, how to
11 deal with this situation safely and how to use special safety
12 maneuvers to get that baby's shoulder unstuck, rotated around
13 the birth -- the mother's pubic bone so it can come on out of
14 the birth canal. Now, why is this important? If that
15 shoulder being stuck behind the pubic bone, if that shoulder
16 is not gently unstuck then there can be a great stretch in
17 nerves -- certain nerves in the baby's neck. Now, the term
18 for those nerves is a whole cluster of nerves, kind of like
19 when I was in college all the different wires that I had
20 trouble untangling behind my stereo system. It's kind of like
21 that. As you will see here, the brachial plexus nerves start
22 out in these sections here. This shows C4, cervical, C for
23 cervical, through T2 or thoracics, the neck and the top of the
24 chest is what we're talking about. The main brachial plexus
25 nerves that you'll be hearing about from the experts is C5, 6,

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1 7, 8 and T1. Those make up the brachial plexus nerves. When
2 those nerves get stretched too far, like a rubber bank, they
3 can break. Sometimes they can actually get ripped out of the
4 spinal cord. These nerves come out of the spinal cord as you
5 can see here the spinal cord, these nerve roots can actually
6 get ripped out there or they might rupture and get torn in
7 this area. And you'll hear the doctors talk about different
8 types of injury and this is just a very simple discussion of
9 showing the different types of injuries. This top one is a
10 normal nerve, as you see it's intact. An avulsion, which I
11 talked about, is where the nerve root is actually ripped from
12 the spinal cord. A rupture is where -- it's more like a
13 rubber band popped, in the middle of a nerve it's cut in two,
14 it's ripped and torn. And sometimes when there's a rupture,
15 you know it's kind of like a scab when you cut your knee or
16 something. When the scab forms, unlike in your knee where
17 it's easy for the skin to grow back together, then you're
18 talking about the nerve that's some distance apart, sometimes
19 those nerves will try to grow back together and they just get
20 a mass, a wad of scar tissue that makes it even harder for the
21 nerve signal to go through that mass of scar tissue. It also
22 makes it harder for the surgeons to try to figure out how you
23 repair this nerve. Is there anyway we can cut the scab, the
24 scarring away from this nerve and away from this nerve and try
25 to take a nerve from the leg or somewhere else to reconnect

1 those nerves that have been pulled apart? You're going to
2 hear from the experts about that. I just want to give you
3 some idea of what's coming from the evidence. Now, we talked
4 about maneuvers early on. When the shoulder comes down behind
5 the birth canal it's diagnosed by the doctor using normal
6 gentle traction. That's how most babies come out through the
7 birth canal, are delivered with just the gentlest guidance or
8 gentle pulling force. You'll hear doctors talk about traction
9 but a pulling force, a gentle pulling force of the head that
10 will deliver the baby, get the shoulder down and deliver the
11 baby, no big deal. But, in the shoulder dystocia situation
12 the doctor is still supposed to use that gentle guidance, that
13 gentle traction. If the shoulder won't come with that degree
14 of pulling, then that means the shoulder is stuck behind the
15 bone. When that happens, there are some maneuvers nurses can
16 do to try to change the angles. They can push the mom's knees
17 up towards her shoulders and that gives a little more room
18 down in the birth canal that sometimes can help the baby come
19 out without any injury. And sometimes the nurses will do a
20 procedure called suprapubic pressure. Now, suprapubic is a
21 fancy word for pushing down just above the mother's pubic
22 bone. So, if you could imagine we've got here, we've got the
23 baby's head and the pelvis, there's the pelvic bone and the
24 baby's shoulder and the nurse with her hand here, is just
25 trying to reach down, and if she's doing this correctly, she

1 reaches down and tries to push that shoulder toward the chest
2 to make the baby's shoulders narrower so they can fit right.
3 Kind of like a soft couch where you bend it in or get a better
4 angle. Now, there's some internal maneuvers too. Nurses can
5 do those that I told you about. The other maneuvers have to
6 be done by the doctor reaching inside the birth canal. It
7 might sound odd, but they're trained to do this. It's a
8 simple matter of, if that shoulder is stuck then rotate it
9 that way, or even better, let's rotate it this way and get it
10 around the bone. Or they can deliver the bottom shoulder
11 first. You'll hear about all of this stuff. It's better to
12 hear it from the obstetrical experts. You'll hear from Doctor
13 Adler, he's going to be our first witness today. He's a
14 pediatric neurologist from New York. He'll tell you all about
15 nerves that you ever want to hear. Doctor Pliskow will come
16 tomorrow morning and he is an obstetrician from West Palm
17 Beach, Florida. He'll tell you about all of these maneuvers
18 and help you understand that when the nurses are doing their
19 maneuvers and the doctor is just doing gentle, gentle pulling
20 like she should, if the baby doesn't come out she's got a
21 choice to make. Does she do what she was trained to do? Let
22 go of the baby's head, reach inside, rotate the shoulders; or
23 does she pull harder or twist the head and the neck to try to
24 force that shoulder out? One of the issues that you will have
25 to decide in this case, one of the main issue you'll have to

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1 decide in this case is when that moment came and the nurses
2 were doing their part and the doctor was doing gentle
3 traction, was it wrong for her to increase the traction rather
4 than to stop that, reach inside, rotate the shoulders. You'll
5 hear from the experts in this case, the obstetrician who will
6 explain all of that to you. I'm not here to tell you how to
7 decide these issues, I'm just trying to help you understand.
8 This is the kind of thing you're going to be hearing about
9 this week. These are the kind of issues you're going to have
10 to decide as part of your jury service. Now, we've talked
11 about those issues. What I'd like to do now is tell you the
12 story of what happened in this case. April 27th, 2013 at
13 Georgetown Memorial Hospital, there was a woman who was ready
14 to deliver her baby. She was real ready to deliver her baby.
15 She realizes it's time. She heads to the hospital and her
16 water breaks. She winds up in the labor and delivery room.
17 There's a bed over here, her head's at that end, her feet were
18 down here. There's nurses in the room moving around. There's
19 the father in the room who starts off next to his wife and the
20 doctor comes in, Doctor Maselli. Doctor Maselli comes in and
21 gets at the foot of the bed between the mother's legs and the
22 mama pushes. The nurses tell mom to push, mom pushes. The
23 doctor is not happy with the slow process of delivery. The
24 doctor gives a drug called Pitocin, which makes the uterus
25 contract stronger and makes the contractions be more frequent.

1 It speeds up the passage of the baby through the birth canal.
2 Eventually the baby comes down through the birth canal, the
3 head comes out. The doctor, with gentle traction realizes
4 that this is not right, we've got a shoulder dystocia. The
5 doctor gets the nurses to push the mom's legs back toward her
6 shoulders. She decides to pull out some scissors off the
7 table and cut the vagina to create more room. It's called an
8 episiotomy, cuts that tissue to make it bigger. She tells the
9 nurses to do this other procedure, suprapubic pressure. There
10 was one nurse brought in a stool for one side of the bed, the
11 other nurse brought in a stool for the other side of the bed.
12 The nurses got on the bed and both of them started focusing on
13 the suprapubic pressure, four hands, four hands pushing down
14 toward the mother's birth canal. The doctor, again, using
15 gentle pressure, gentle traction, states that she's got a
16 situation here. She has choice now. She chooses not to do
17 any internal maneuver; she increases the pulling force. A
18 baby is born, active, crying, except his right arm is hanging
19 down like a limp dish rag. These nerves in his neck got torn,
20 ripped. You'll hear from Doctor Adler all the medical records
21 show what happened. The MRI shows what happened. Four
22 surgeries show what happened; two surgeries trying to repair
23 the nerves themselves, one surgery just to try to deal with
24 some of the problems with Botox to try to stop some muscles
25 from working so other muscles would balance better, and a

1 fourth surgery was to try to change the configuration of
2 muscles and tendons in his arm just so he could -- not so he
3 could have a perfect arm, but just so he could be able to do
4 his arm a little bit more this way and move his arm a little
5 bit more this way by learning how to bend his back, that sort
6 of thing. As a result of that, this child has suffered all
7 kinds of injuries. He's about to be six later this month.
8 You can imagine if you've got a permanent injury of your arm,
9 even with healing -- some healing, helped by the four
10 surgeries, you're still going to have major, major problems.
11 You know, something as simple as buckling and unbuckling a
12 belt. You know, how are you supposed to do that? Riding a
13 bicycle. Maybe, you know, he can use his left arm to pick his
14 right arm up to put on the steering wheel -- the handle on the
15 bicycle and start riding. But, unlike other children who fall
16 and can brace their fall, you know, he just --. There's so
17 many things and I'm just touching on a couple. You will hear
18 about all of the damages, lose of job options, earning
19 capacity, future medical care, all of the medical care in the
20 past. When shoulder dystocia occurs it's considered a medical
21 emergency in the sense that if that baby stays in there too
22 long and you don't do what you're supposed to do to get the
23 shoulder unstuck safely then eventually the bay's going to
24 have worse problems like run out of oxygen. But this is not
25 like somebody having a heart attach and -- this is a medical

1 emergency that these doctors were taught how to handle. One
2 of the main reasons we hire specialists is to take care of
3 special problems like emergencies. Taxi drivers deliver
4 babies, police officers, sheriff's deputies deliver babies
5 it's only when there's an emergency that you truly need a
6 specialist. Short cuts can save time, sometimes short cuts
7 can cause bad things to happen. Who are we suing and why? I
8 think it's pretty obvious we're suing Doctor Maselli. She
9 didn't use internal maneuvers. She pulled harder, she caused
10 nerve damage. Those are issues for you to decide. I'm not
11 telling you what happened, I wasn't there. This is your job.
12 I'm just trying to help you understand what's coming so you'll
13 understand what your job is. Let me just give you an idea of
14 -- before a lawyer bring a case like this on behalf of an
15 injured child there's a decision to be made about whether it's
16 worth it to face, you know, face the medical establishments
17 and all the money it takes to work with the medical
18 establishment and so I have to think about what are the
19 defendant's going to say. What are they going to say about my
20 case? I want to talk about those just a little bit. They're
21 going to say this is an emergency and you shouldn't judge a
22 doctor harshly when she's facing an emergency. She gets that
23 baby out in one minute of time. Everybody knows there's a lot
24 more time than that to be careful and use the training to get
25 the baby out safely as compared with taking that short cut.

1 There's no worry about insufficient oxygen, the baby's
2 evidence will show, you can hear it and decide. The evidence
3 for both sides will show that the baby was doing well when the
4 shoulder got stuck. One minute later when the baby came out,
5 the evidence will show you, the baby still doing super well.
6 You'll hear about Apgar scores. You'll hear about cord blood
7 gases, which are measurements on how the baby's doing. You'll
8 hear about all that stuff. Healthy in, healthy out. We've
9 got one minute in between. The baby was stable, and that will
10 be your job to think about and determine about whether that
11 baby was stable during that one minute. Now, there's
12 something in the delivery of babies called a nuchal cord. A
13 nuchal cord is simply where that umbilical cord can get all
14 wrapped around a baby. Nuchal is a word that basically means
15 neck. Sometimes the cord will wind up behind the baby's neck.
16 Sometimes it can get tied in a knot or a double knot a cause
17 all kinds of problems. It happens, you know, like 25-30
18 percent of the time we get a cord that's just loosely behind
19 the neck, just pull it over. That's all that happened in this
20 case, pull it over. I think we're going to hear some
21 testimony from the defense that that's a big deal. You have
22 to decide if it's a big deal. Also, this one really gets me.
23 You're going to hear the defense claim that this is not --
24 pulling too hard on the baby's head or twisting or bending is
25 not forceful manipulation of the baby's head, what this is is

1 the mama pushed too hard, the uterus squeezed too hard, they
2 jammed that shoulder up against that bone and they caused
3 these nerves to stretch beyond the breaking point. You're
4 going to hear that and it's up to you to decide if that makes
5 common sense. I want to talk briefly about the burden of
6 proof. I can't remember if any of you guys said you were on
7 criminal juries before but in the newspapers or novels or TV
8 shows we read about burden of proof in criminal trials being
9 beyond a reasonable doubt. In football terms we're talking
10 about getting them from one goal line to inches from the other
11 goal line. This is not that type of case. This is not about
12 putting somebody behind bars. This is not about taking away
13 somebody's medical license. This is not about anything like
14 that that requires that level of proof. In a case like this
15 the Judge will tell you, the burden of proof that we face is
16 preponderance of the evidence, a fancy word, one of those
17 lawyer talk, kind of like the medical jargon, lawyer jargon,
18 preponderance of the evidence. But I want to take a minute to
19 explain what that means. The scales of justice that His Honor
20 mentioned at start off balance, during the trial you'll hear
21 from us with, you know, powerful evidence that brings the
22 scales in our favor. There might be times when the scales
23 tilt the other way. You're going to hear evidence from both
24 sides. But, to pass that burden of proof, to meet that burden
25 of proof all we need is just a feather more. Just anything

1 more than a 50/50 tie. That's all the burden of proof is, is
2 it more likely that we're right or that we're wrong. That's
3 one of the issues that you guys are going to have to decide
4 and that burden of proof is going to be a very important part
5 of your job. Did we tilt the scales a feather's worth? I
6 don't think so, but all we've got to do is a feather's worth.
7 I talked a little bit about damages, I won't get into that in
8 detail. You're going to hear from a vocational expert
9 tomorrow. You're going to hear from an economist who's going
10 to be talking about the future medical expenses for the rest
11 of this child's life and his lost earning capacity for the
12 rest of his life. And then the economist will tell you his
13 future losses and because of the time value of money, he's
14 going to bring that down to present value. So, the figures
15 that you're going to hear from the economist is what it costs
16 today with money invested smartly to match the damages.
17 You'll hear all of that. I just want to give you some idea of
18 what's coming. You're going to hear from these parents,
19 Phillippa is from Jamaica, Anthony is from America. Their
20 child's name is Jahmerican. They love this country. They
21 love their child. They know how hard it is to come into this
22 courtroom going against the medical establishment, the best
23 defense lawyers in the state and beyond. They know, they know
24 what that involves but they're willing to stand tall. They
25 want to do what's right for their son. They want to do what's

1 right for this community. If we don't enforce community
2 safety rules ---

3 **MR. HOOD:** Objection, Your Honor.

4 **THE COURT:** Mr. Graham, you're going way beyond an
5 opening remark, please.

6 **MR. GRAHAM:** Thank you. I'll close quickly.

7 **THE COURT:** Thank you.

8 **MR. GRAHAM:** They don't want it to happen to anybody
9 else. This is the kind of case where we're going to come back
10 at the end and ask for a lot of money. We're going to be
11 asking for more than one million dollars. That might sound
12 like a lot right now but wait until you hear the evidence.
13 Thank you.

14 **THE COURT:** Mr. Hood, will you present?

15 **MR. HOOD:** Yes, sir. May it please the Court?

16 **THE COURT:** Yes.

17 **MR. HOOD:** One of the things that keep doctors, OBGYNs up
18 at night is things that they can't predict, things that they
19 can't prevent but they know they'll have to deal with. There
20 are certain things that happen and even in today's modern
21 world that remain unpredictable and unpreventable and you just
22 heard the reference to a medical emergency. Make no mistake,
23 the evidence in this case will show that on April 27th, 2013
24 during the delivery of this baby there was an unpredictable,
25 unpreventable obstetrical emergency. Why is it an emergency?

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1 Because the baby's head has been delivered and the rest of the
2 body hasn't. And in that moment not one person will come into
3 this courtroom and tell you they know how long this will last,
4 how to resolve it, what maneuvers if any will work, how many
5 times you'll have to do the maneuvers. No one can tell you
6 how the tolerance of the baby is going to withstand this. No
7 one's going to tell you when the buzzer goes off. The clock
8 is running, there is no clock, the buzzer will sound you just
9 don't know when. That is a medical emergency and that's why
10 obstetricians like Doctor Maselli spend so many years in
11 residency. They go through their training, they go to college
12 and then they go to medical school and if they decide they
13 want to become a doctor to deliver babies, then they have to
14 through a residency program. And that's where the science
15 meets the art. You have a trained physician who's certified,
16 board certified who takes a young doctor, teaches him or her
17 how to do their job. When it comes to delivering babies, many
18 of them are easy. Most of them are simple. Some of them are
19 not. The training is for those which are not. And you'll
20 hear Doctor Maselli explain to you what her training and
21 experience is, what her protocol is, what process she follows.
22 Because when one of these emergencies happens your training
23 kicks in, you follow your training, take every effort, try to
24 deliver the baby. And when do you deliver the baby? As
25 quickly and as safely as possible. Why? Because this

1 timebomb that we're talking about is not just shoulders and
2 forearms and clavicles that we're worried about. During the
3 time when the shoulders are in and the head is out, the baby's
4 oxygen supply is compromised. The baby is not breathing on
5 his own. The nuchal cord that he just talked about is
6 important because it's outside of the body through two
7 different points where that cord is around the neck and
8 squeezed by the mom. That nuchal cord is the oxygen supply.
9 And so, the reason that this is a medical emergency is because
10 this ticking clock leads up to one of potentially two
11 devastating outcomes, a brain injury or death. No mistake, in
12 this case that there is no evidence of a brain injury, thank
13 goodness. But, that's the ticking timebomb. That's the
14 unknown. And we'll hear plenty of testimony from physicians
15 about timing and things of that nature, about maybe it could
16 be four minutes, or it could be five minutes. But, in that
17 moment when you don't know when the solution is going to
18 present itself or if your maneuver is going to work. In that
19 moment do you count on four minutes. Is it not an emergency
20 because you're hoping that everything will be fine? Of course
21 not. Prudence dictates that you deliver the baby safely,
22 effectively and as quickly as possible to make sure you
23 minimize a risk of brain injury from getting not enough
24 oxygen. That's why it's a medical emergency and that's the
25 scene that was encountered on this day. I don't think that

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1 there will be any dispute in the case that this was
2 unpredictable and unpreventable, not something -- this isn't a
3 case where one side going to say the mom should have had a C-
4 Section and the other side says no. This case gets down to
5 the management of this obstetrical emergency. It gets down to
6 the management of this specific shoulder dystocia. The
7 shoulder is stuck, and you've got a geometry problem, you've
8 got a round whole and a square peg and it's not coming
9 through, so you've got to do some maneuvers. The OB's have
10 their own maneuvers, you've heard a few of them. If you flex
11 the legs back that helps with the alignment. They apply
12 pressure, there are internal maneuvers and you will hear
13 Doctor Maselli say that it was the legs flexed back followed
14 by the pressure with her there the whole time and her
15 delivering the baby that resolved the shoulder dystocia. And
16 what's remarkable about this is there was reference to flexing
17 the legs back. Well, I think you'll hear testimony that 70 to
18 90 percent of shoulder dystocia's are resolved just with that
19 one maneuver. Well, that's pretty good. You'll also hear
20 that all of the maneuvers, no matter what they are, internal
21 maneuvers have certain risks as well. It's just part of this
22 process. You're in a very precarious situation and the
23 doctors, Doctor Maselli, are doing exactly what they can to
24 try to minimize the chance of harm to the baby. That's what
25 happened here. Is there an injury? Yes, there is. No

1 dispute about that either. You're not going to hear from
2 anybody on the defendant's side saying oh there's no injury,
3 they're just making that up. There is and unfortunately it is
4 a permanent injury. But, if the existence of an injury was
5 all that needed to be shown there wouldn't be a need for
6 lawsuits, there wouldn't be a need for lawyers. The question
7 though, was Doctor Maselli negligent? This is what they call
8 a medical malpractice case and you've heard the Judge a few
9 moment ago talking about a medical malpractice case. Well, in
10 this case the plaintiff, who brought the claims, has three
11 things to prove. Each one of them they bear the burden of
12 proving those claims to your satisfaction by a preponderance
13 of the evidence. You've now heard that term a bunch. Well,
14 my challenge as you've already seen, is that the plaintiff
15 gets to go first. Most people generally think that first
16 impressions are important. I tend to agree. But
17 unfortunately defendant's don't get to make a first
18 impression. The plaintiff gets to go first, and they get to
19 describe the defendant in any way they choose and then the
20 defendant has to respond. So, we don't really get the first
21 impression opportunity. But, the reason for that tradeoff
22 where the plaintiff gets to go first is because they bear the
23 burden of proving their elements to you. And like I said, in
24 a malpractice case there are three elements. Standard of
25 care, you will hear testimony from expert physicians, you'll

1 hear testimony from Doctor Maselli herself talking about what
2 a prudent physician and OB, which is a delivery of babies
3 doctor, would do in the same or similar circumstances. You'll
4 hear evidence about the training, about the application of
5 gentle traction. And I want to mention one thing, you will
6 hear the term traction throughout this case. Traction, there
7 are various definitions, one of which I think you'll hear is a
8 pulling force that tends to elongate. Traction can be applied
9 in an axial or a lateral fashion. So, the direction of the
10 pull matters as well. What you'll hear is axial is in line
11 with the spine. So, lateral in the context of delivering a
12 baby, if this were the delivery bed axial would be in line
13 with the spine. Lateral would be down towards the floor.
14 It's a little counterintuitive because you think lateral would
15 be flat, but it all has to do with the angle as it relates to
16 the orientation of the baby. So, it's important, are we
17 talking about axial traction or are we talking about lateral
18 traction. Is traction a bad word? I submit to you that the
19 evidence will show to you that it's not. The physicians will
20 all testify that traction is used as a routine aspect of
21 vaginal deliveries. And I think that you'll hear that
22 sometimes deliveries require more traction than others. The
23 trick is a physician should not use and in this case, did not
24 use, excessive lateral traction to effect delivery. That's
25 where the case is. That's where the fight is in this case is

1 what's happening in that minute and you'll hear from Doctor
2 Maselli who will describe to you in great detail probably
3 twice because she do it when I ask her to testify and then Mr.
4 Graham will get to cross examine her. You'll hear about the
5 maneuvers, you'll hear about the delivery and you'll hear
6 about the quote, force that she's applying. And I put the
7 word force in quotes specifically. Now, my name is Jamie
8 Hood. John Radeck and I have the privilege of representing
9 Doctor Maselli. She's from West Virginia. She moved down
10 here, became board certified in 2000 and been living down here
11 delivering babies since. She's at Carolina OBGYN where she is
12 one of the partners over there. She splits her time between
13 being a mom, being a wife, being a business manager and being
14 an OB. What she was doing on this night that she was on call,
15 for a patient who was a patient of the practice, this was not
16 one of her patients. This was not a routine where the
17 plaintiff had been seeing Doctor Maselli prenatally, but she
18 was on call. You're going to have a chance to hear straight
19 from Doctor Maselli about what happened. And you're going to
20 see why she's here standing tall to defend herself and to tell
21 you the other side of the story. It is probably worth me
22 mentioning that there's two sides to every story. If you've
23 got kids, I've got three of them, then you know that there are
24 two sides to every story and with three kids sometimes there's
25 four sides. But, in this case the plaintiff tells their side.

1 They may call a witness and have a direct examination but then
2 I get to cross examine them, that's the other side. Plaintiff
3 will present their closing argument first, then I get to close
4 for the defense. The plaintiff presents all of their
5 witnesses and then we present ours. Why do I tell you this?
6 The reason is because as the Judge has instructed you, I would
7 suggest that justice requires that you keep an open mind until
8 you've had a chance to hear both sides of the story for
9 everyone's benefit. I told you there were three things they
10 have to prove. The first one was standard of care. The
11 second has to do with causation. Causation is a legal word
12 for there has to be a connection between some wrong that
13 someone allegedly did and the harm that was caused. It was
14 alluded to just a few minutes ago about a theory that mom's
15 pushing too hard. Well, that's not really what you'll hear
16 from our experts. What you'll hear is that there are two
17 schools of thought. One school of thought discusses that
18 these injuries, what we're talking about, shoulder injuries
19 during the birth process are in 99.9 percent of the time only
20 result in physicians. There's another school of thought that
21 recognizes that there are maternal forces, there are
22 expulsionary forces, there are the normal process of labor and
23 delivery that also participate in what's called a
24 constellation of factors and you will hear that. And the
25 evidence that we'll show about that is that there are babies

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1 who are delivered where there is no physician involvement at
2 all that have brachial plexus injuries. And you'll hear
3 experts talk about this, but this is the causation component
4 of the case. The question there is what was the underlying
5 cause of the baby's shoulder injury. So, that's the second
6 aspect of the case and the third has to do with damages. As a
7 defendant, when you're defending a case for your client and
8 you're saying to the jury, my doctor has complied with the
9 standard of care the whole time sometimes you wonder why you
10 even talk about damages then. Well, I've got a job to do and
11 I'm going to cross examine the witness, we're going to cover
12 it from top to bottom just like the plaintiff will present
13 their evidence. We'll challenge the evidence they present in
14 an appropriate way. But we're not suggesting that the child
15 here didn't suffer shoulder injury. That's clear. Those were
16 the three things that this case will sort of track over the
17 next few days. And then there's one other aspect, it has to do
18 with this emergency. In South Carolina there's a law which
19 you will hear about at the end of the case that deals with
20 obstetrical emergencies. If it's an obstetrical emergency
21 under certain criteria, then the plaintiff must show that the
22 doctor was grossly negligent. So, that's a statute that
23 applies for doctors and because I raised it, I have the burden
24 on that. That means I have to prove to your satisfaction that
25 this was an obstetrical emergency and I've got to prove that

1 there was imminent risk of harm or death. And I need to prove
2 to you that the baby was medically unstable and there'll be
3 lots of testimony on that. Those are the legal framework for
4 which this case is set up and is going to be presented. And
5 what you're going to hear is that when Doctor Maselli was on
6 call, the patient made slow progress, they did add to her
7 labor force a medicine called Pitocin. I don't think you'll
8 hear a single person critical of that in this case. No one's
9 going to say hey you shouldn't have done that here. It was a
10 slow labor process to get her to where she could start
11 pushing. So, as a routine measure that was utilized. She
12 becomes fully dilated ready to do her job, ready to do the
13 work. Now, Doctor Maselli's in, mom starts pushing, baby's
14 head is delivered. At that moment everything seems normal.
15 Head comes out, she sees the nuchal cord, the shoulders don't
16 follow. When the shoulders don't follow, the doctor knows now
17 we've got a problem. We've now encountered one of these
18 medical emergencies, these obstetrical emergencies. We have
19 to deal with this, we have a shoulder dystocia. Stops mom
20 from pushing, asks the nurse to get help, the nurse steps out
21 hollers for help, someone else comes in, another nurse. Now
22 you have two nurses and the doctor working in concert flexing
23 the legs back, telling mom to push. While that may work in 80
24 percent, 70 or 90 percent of the cases, it didn't work here.
25 You've got Doctor Maselli who's there, who cuts an episiotomy,

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1 and she'll describe what she did and why she did it, to help
2 provide more space. Mom's pushing, Doctor Maselli has her
3 hands with gentle routine normal guidance on the baby's head.
4 The baby is still not delivering. She instructs the nurses on
5 the application of the suprapubic pressure, they apply it.
6 What is happening is the should that's stuck behind the bone
7 is pushed in so that it'll slide underneath, and you'll hear
8 Doctor Maselli describe that she feels a give and she helps
9 with the implication of traction to deliver the baby at that
10 time. She didn't do internal maneuvers because they weren't
11 needed, she didn't do them because they weren't necessary.
12 She was able to effect delivery in this case through the use
13 of McRoberts and suprapubic pressure. And like every other
14 delivery she did provide traction. And what you'll see her
15 describing is that she said she used moderate controlled
16 traction and the medical records reflect that. There's a
17 form, whenever you preform one of these emergencies you've got
18 to fill out a shoulder dystocia form and the form says
19 describe the maneuvers that were preformed, the order in which
20 they were done, who all was there, how long it lasted, how
21 much traction you applied. The forms got three boxes: usual,
22 moderate controlled, other, and she checks moderate
23 controlled. And she'll testify to that and she'll explain
24 exactly what she meant, but make no mistake, what's happening
25 in this case is they are wordsmithing her words to suggest

1 something happened that it didn't. They're trying to take the
2 phrase moderate controlled, that means you used excessive
3 traction. That means you bent the head too far down towards
4 the floor and you caused this injury. That's not the case and
5 you'll hear that directly from Doctor Maselli. This is a
6 situation where people are cherry-picking the portions of
7 language that they choose to use to serve their ends as
8 opposed to looking at it in its entirety and that's why I ask
9 you to listen to the whole story. At the end of this case, if
10 we've done our job and we've presented you with all of the
11 evidence from both sides, then I hope it will be clear that
12 there is an opportunity for you to render a fair and just
13 verdict. A verdict that speaks the truth. And I'm going to
14 ask you at the end of this case to render a verdict in favor
15 of Doctor Maselli and her practice. Not because there wasn't
16 an injury, but because she acted reasonable and appropriately
17 in light of the circumstances that were present. And thank
18 goodness that she did. And while it is an awful tragedy that
19 this is a permanent shoulder injury, thank goodness that we're
20 not here talking about a brain injury or worse. I want to
21 thank you for your service. I know that y'all have better
22 places you'd rather be, but we couldn't resolve this case
23 without you. We will do our best to be efficient. We will
24 respect your time, but for the sake of the process on behalf
25 of Doctor Maselli this is a very significant moment for her,

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1 as it is for everyone involved because for years other people
2 have been putting words into her mouth and for the first time
3 someone independent will get to hear the story in its entirety
4 and make a decision and for that we're thankful. Thank you
5 very much.

6 **THE COURT:** All right. Would you take the jury into the
7 jury room and let's be back at 4. Okay? Can we do 15 and be
8 back at 4?

9 **BAILIFF:** Yes, sir.

10 **REPORTER'S NOTE:** (Jury retires to jury room 3:45 P.M.)

11 **(COURT IN RECESS)**

12 **THE COURT:** Keep your seats. Bring me the jury in.

13 **MR. GRAHAM:** Judge, may I ask you just one thing?

14 **THE COURT:** Yes.

15 **MR. GRAHAM:** When we're using these blowups, do you want
16 me to hold them so you can see them too or ---

17 **THE COURT:** No, just kind of back them up a little bit
18 and put them at an angle if you can. I'd like to see them,
19 but the Court Reporter and the jury sees them; show them to me
20 first, okay? Just let me get a glimpse of them.

21 **MR. GRAHAM:** Sure.

22 **BAILIFF:** Ready, Judge?

23 **THE COURT:** Yes, I've never seen a courtroom yet that was
24 designed so that everybody can see. I think it's an
25 impossibility.

1 **MR. GRAHAM:** And Jamie has seen all of these.

2 **THE COURT:** Okay.

3 **MR. GRAHAM:** These are four that we created.

4 **THE COURT:** Okay.

5 **MR. GRAHAM:** The rest of them that we wanted to use are
6 just enlargements.

7 **THE COURT:** Okay. All right. Okay. I know what you're
8 talking about. Just as you put it up, show me as you put it
9 up. Just give me a flash at it.

10 **REPORTER'S NOTE:** (Jury enters courtroom 4:04 P.M.)

11 **THE COURT:** All right. We have our jurors and the
12 alternates back in. Mr. Graham, please?

13 **MR. GRAHAM:** Yes, sir, Your Honor, we would call our
14 first witness, Dr. Dan Adler, who as luck would have it, just
15 stepped out for a second.

16 **THE COURT:** Okay. There's been a question about notes
17 and I ask that you not and that's pretty much the traditions
18 in this court and the reason it is because first of all, you
19 may be distracted PLISKOWwhile you're doing it, but secondly,
20 when you start your deliberation process, I don't want anybody
21 saying that I wrote it down. You have to go by what you see
22 and what you hear. Okay?

23 Come around, Dr. Adler, please. Let's swear him.

24 **CLERK:** Sir ---

25 **THE COURT:** You can do it from right there. Come around,

1 Doctor?

2 **DR. ADLER:** You want me to move over closer to you?

3 **CLERK:** Thank you.

4 **DR. DANIEL ADLER, HAVING BEEN**

5 **SWORN TESTIFIES AS FOLLOWS:**

6 **CLERK:** Please say and spell your full name for the
7 Court?

8 **DR. ADLER:** My name is Dr. Daniel Adler. Last name is
9 spelled A-D-L-E-R,

10 **CLERK:** You may be seated.

11 **DR. ADLER:** Thank you.

12 **DIRECT EXAMINATION OF DR. DANIEL ADLER BY MR. GRAHAM:**

13 **Q:** Good afternoon, Dr. Adler?

14 **A:** Good afternoon.

15 **Q:** Where did you fly from?

16 **A:** New York City.

17 **Q:** Introduce yourself to the jury, if you would, just tell
18 us a bit about your personal history; who you are, how you fit
19 into the world?

20 **A:** That's an interesting question actually. My name is Dr.
21 Dan Adler. I'm a Pediatric Neurologist. Neurologists are
22 doctors who take care of people who have problems of the
23 nervous system. Pediatric Neurologist are doctors who take
24 care of children who have problems with the nervous system.
25 Problems with the nervous system defined as problems with the

1 brain, problems with the spinal cord, problems with nerves,
2 the brachial plexus are collection of nerves. So, Pediatric
3 Neurologists see children who have problems with the brachial
4 plexus injuries and neurologists are also people -- also see
5 people who have problems with muscles.

6 I've been fully trained since 1980, was on a medical
7 school faculty one year full-time, two years part-time and
8 since 1983, I've been taking care of children with
9 neurological problems. During part of that time between 2001
10 and 2007, I did consulting work at a clinic, not different
11 than the brachial plexus clinic that's currently in operation
12 at MUSC, where doctors, primarily surgeons, because a lot of
13 the treatments are surgical. There were several surgical
14 remedies in this case that were performed to try and make this
15 boy better. But groups of doctors get together, examine
16 children with this type of injury and decide what their best
17 treatment course is.

18 **Q:** So, tell us about your professional training starting
19 with medical school and various ---

20 **A:** I attended the Albert Einstein College of Medicine. It's
21 a medical school in the City of New York. I graduated in
22 1975. I first trained as a pediatrician at a Children's
23 Hospital in the City of New York, which is now called the
24 Children's Hospital of New York. I trained then as a
25 Pediatric Neurologist back at Einstein and as I said, I was a

1 faculty member at Einstein actually for one year full-time and
2 two years part-time and I've been in the private practice of
3 Pediatric Neurologist since that time.

4 **Q:** Have you treated children with brachial plexus birth
5 injuries?

6 **A:** In my private office, yes and at the clinic as well.
7 Certainly, in the office, I can see two or three patients per
8 year perhaps on the average. I've been in private practice
9 for over thirty years and at the clinic, you know, we'd meet
10 and we'd see a dozen or two dozen at a time, three or four
11 times a year. So, I would say I treated or been involved in
12 the care and treatment of hundreds of children with brachial
13 plexus injuries.

14 **Q:** Have you had an opportunity to examine the child that
15 we're talking about in this case, Jahmerican McCray?

16 **A:** Yes, I've examined him on two occasions.

17 **Q:** And have you read the medical records and depositions in
18 the case?

19 **A:** Yes.

20 **Q:** Your Honor, we would proffer Dr. Adler as a Pediatric
21 Neurology expert?

22 **THE COURT:** Will you examine him?

23 **MR. HOOD:** Your Honor, just very briefly.

24 **VOIR DIRE OF DR. DANIEL ADLER BY MR. HOOD:**

25 **Q:** Dr. Adler, I understand you're not going to offer any

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1 OBGYN testimony; is that right?

2 **A:** Correct, I've not come to South Carolina to criticize
3 anybody, just to simply talk on Jahmerican McCray's behalf and
4 talk about his injury and how it occurred.

5 **Q:** You're not -- that second part about how the injury
6 occurred, you're not going to offer an opinion as to whether
7 Dr. Maselli deviated from the standard of care or anything
8 like that?

9 **A:** No, I mean I have an opinion about how she's involved in
10 the injury, but not that -- but I wouldn't suggest to the jury
11 that she did anything wrong in her -- in that role she played
12 in causing the injury.

13 **Q:** All right. Your Honor, at this point, based on that,
14 I'll reserve my questions.

15 **THE COURT:** All right. Ladies and gentlemen, let me tell
16 you about expert witnesses or make a few comments before the
17 doctor testifies. Generally speaking, in our courts, a person
18 may not give an opinion. A person may testify as to what he
19 or she sees, observes, things of that nature. There is an
20 exception when someone, because of the person's training or
21 experience in a particular art or science, is determined to be
22 an expert in this particular field or area. And in this case,
23 this doctor is offered as an expert in Pediatric Neurology; is
24 that correct, sir?

25 **MR. GRAHAM:** Yes, sir.

1 **THE COURT:** Okay. He may give an opinion based upon his
2 examination of the child. However, and he may give the
3 reasons for having that particular opinion. However, if you,
4 as a juror or a jury generally determine that the reasons
5 given for the opinion are unsound or if he does not have the
6 experience or training that satisfies you that his opinions or
7 reasoning is sound, you may give that testimony such weight as
8 -- or value as you determine would be appropriate. You may
9 accept or reject the evidence or testimony given by an expert.
10 You even may reject an expert's testimony if for no reason at
11 all, if it is not contradicted; let me put it that way. It's
12 entirely up to you determine whether or not a witnesses'
13 testimony, an expert witnesses' testimony is to be accepted by
14 you or what weight it is to be given.

15 All right, sir. Thank you. Mr. Graham?

16 **MR. GRAHAM:** Thank you, Your Honor.

17 **BY MR. GRAHAM:**

18 **Q:** Just to pin down the qualifications since I ran through
19 them real quickly. I'd like offer ---

20 **THE COURT:** The CV?

21 **Q:** --- the CV in that regard?

22 **THE COURT:** All right. Mr. Hood?

23 **MR. HOOD:** No objection.

24 **THE COURT:** All right. It's admitted. That would be
25 Plaintiff's 1?

1 **MR. GRAHAM:** It's already been pre-marked as Exhibit 30.

2 **THE COURT:** All right.

3 **PLAINTIFF'S EXHIBIT NUMBER 30**

4 **ADMITTED INTO EVIDENCE**

5 **THE COURT:** You may proceed.

6 **BY MR. GRAHAM:**

7 **Q:** Thank you, Your Honor.

8 **THE COURT:** And I find that he is qualified to give an
9 expert opinion in the field of Pediatric Neurology.

10 **BY MR. GRAHAM:**

11 **Q:** Doctor, at my request, have you evaluated the Pediatric
12 Neurology issues in this case so you could help us understand
13 it better?

14 **A:** Yes.

15 **Q:** Before I start asking questions, let me give you a word
16 of caution. I don't want you to tell us anything unless what
17 you're telling us are conclusions that you hold and you've
18 reached at least to a reasonable degree of medical certainty,
19 most probably; agreed?

20 **A:** Agreed.

21 **Q:** There's already been talk about Jahmerican's brachial
22 plexus nerve injuries, but I want to ask, with Your Honor's
23 permission, could the doctor step down?

24 **THE COURT:** Certainly.

25 **BY MR. GRAHAM:**

1 Q: And tell us what these nerves are?

2 THE COURT: Certainly, you may. And again, ladies and
3 gentlemen of the jury, if you can't see or hear, please let me
4 know.

5 BY MR. GRAHAM:

6 Q: Can everybody see this?

7 A: Are you asking me a question or am I just chatting away?

8 Q: If you would, Doctor, just -- can everybody see? Can you
9 just tell us, using this board ---

10 THE COURT: Would you identify the board just for the
11 record, please?

12 BY MR. GRAHAM:

13 Q: Yes, sir, Your Honor. The -- it has not yet been marked.

14 THE COURT: Okay. Well, will you mark it then at some
15 time, so the record will indicate what you're doing.

16 MR. GRAHAM: At the end of the court testimony today.

17 THE COURT: Okay.

18 BY MR. GRAHAM:

19 Q: Thank you, Your Honor. But the title is normal anatomy
20 of the right brachial plexus. Doctor, using this, could you
21 just explain to us what the brachial plexus nerves are and
22 what they do and where they're located?

23 A: Sure. So, the word, plexus, is just a medical term that
24 just -- that means that there's a group of nerves and they're
25 in the body in the same general location. In order to help

1 you understand where that plexus is, we'll throw a nerve in,
2 well, not a nerve, but a word in front of that. So, brachial
3 is a word that refers to the arm. So, when people talk about
4 the brachial plexus, they're talking about a collection of
5 nerves that come out of the neck, goes down to the side, this
6 is the collar bone, behind the collar bone into the arm pit.
7 These nerves exchange branches with each other; that's what a
8 plexus does. It's considered to be a network of wires and
9 you control movement and feeling in your arm through these
10 nerves. There are five and in medical illustrations, nerves
11 are always yellow. So, any of these structures where you see
12 something yellow, it's going to be a nerve; bones are
13 typically grayish color and if you are going to see a muscle
14 it's going to be red. So, the fifth, sixth, seventh and
15 eighth cervical nerves, they're referred that way because
16 that's the order in which they come out of the neck and then
17 there's one nerve that comes out of the chest, the first
18 thoracic nerve. They make up the brachial plexus. So, five
19 things move forward, become three things move forward and
20 become another four and then other nerves are formed. So,
21 this is the brachial plexus, this is the sternum, ribs. So,
22 this is the normal anatomy of the brachial plexus on the
23 right.

24 Q: Thank you, Doctor. We spoke briefly about the fact that
25 you did have an opportunity to examine Jahmerican. Where was

1 that done?

2 **A:** In my New York City office.

3 **Q:** What are these?

4 **A:** Those are copies of my two reports; one in 2016 and one
5 in 2018.

6 **Q:** Your Honor, at this time we would offer ---

7 **REPORTER'S NOTE:** (Bench conference with counsel).

8 **BY MR. GRAHAM:**

9 **Q:** Doctor, I am going to hand you a report dated March 5,
10 2016 with an Exhibit Number 27, which is for identification
11 only and I want to ask you some questions about that. In a
12 nutshell, what did you learn about Jahmerican when you saw him
13 that day?

14 **A:** In my examination in 2016 was consistent with the
15 examinations of doctors in South Carolina, that examined him,
16 he's had, or at least at that point, had had many, many
17 sessions of therapy in South Carolina. And so my exam was
18 consistent with the examination of others that he had
19 abnormalities in his right arm consistent with a brachial
20 plexus injury, consistent with what was written in the medical
21 records about him in terms of which nerves were injured and
22 the manner in which they were injured, meaning in this case,
23 an MRI, which is an imaging study using a magnet, allows you
24 to see under the skin and see neurological structures, among
25 other things. As well as, there was a direct visualization

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1 of the nerves, meaning doctors at MUSC attempted to repair the
2 damage to the nerves of the brachial plexus by doing surgery
3 and they got a chance to look at the nerves. So, my
4 examination was consistent with an injury to three of the five
5 nerves of the brachial plexus.

6 Q: Thank you. I hand you this document; what is this?

7 A: This is the -- this is the MRI report that talked about
8 the injuries that occurred.

9 Q: Okay. Thank you. Your Honor, we would offer the MRI
10 into evidence; it's pre-marked as Exhibit 8?

11 MR. HOOD: No objection as long as we have a clean copy
12 of it.

13 THE COURT: All right. Thank you. It's admitted.

14 PLAINTIFF'S EXHIBIT NUMBER 8

15 ADMITTED INTO EVIDENCE

16 BY MR. GRAHAM:

17 Q: To make is easier for everybody to see, could you do it;
18 is that an enlargement of the MRI that we just addressed?

19 A: Yes.

20 Q: Let me get this out of the way. All right. What about
21 the MRI that is important to you in understanding the issues?

22 A: The -- can I show one of these boards?

23 Q: Sure. Which one -- just pick anything you need.

24 A: Well, let me do this first. I'll give y'all a minor
25 anatomy lesson. So, those nerves don't sit in the neck by

1 themselves; they're wrapped up in muscles that are attached to
2 the neck and then drop down and attach to the collar bone and
3 to the upper ribs. So, if you -- if you want to stretch these
4 nerves, you need to stretch these muscles as well. So,
5 there's a resistance to movement that's created by the muscles
6 and there's a resistance to movement that -- or to stretch
7 that the nerves have by themselves. So, you need to overwhelm
8 the resistance of these muscles to cause the nerves to be
9 damaged.

10 Now, the first test that was done was an MRI. So, an
11 MRI, using a magnet, utilizes the fact that certain parts of
12 the body can be magnified differently than others, a computer
13 creates a picture, so you can see things. And these nerves,
14 which are I guess, you can still see them here, but certainly
15 here. When they're still connected to the spinal cord inside
16 the spine when you do an MRI, you don't see anything. When
17 the nerves are torn loose, which they are in this case, you
18 can see it here in this depiction that the fifth, sixth and
19 seventh cervical nerve have been torn, it leaves behind a
20 bubble of fluid and creates what radiologists call pseudo
21 meningocele. So, at two levels involving the fifth and sixth
22 cervical nerves, these radiologists are seeing what they're
23 calling pseudo meningocele, meaning there's seeing a bubble of
24 spinal fluid in a location where nerves should be and it's not
25 there anymore. When the surgery was done at MUSC, what they

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1 saw was essentially that the fifth and sixth cervical nerves
2 were essentially no longer in the space that they originate in
3 the spine and that -- and that the seventh cervical nerve was
4 still there, but it was in terrible condition. And in
5 addition, they saw a tremendous scar involving the, what's
6 called the upper trunk, which is this structure right here.
7 These two nerves come out, come forward and form another
8 structure called the upper trunk. So, there was a tearing,
9 essentially full tearing of two nerves out of the spine and --
10 and near complete tearing of a third nerve out of the spine,
11 which is called an avulsion. So, C-5, the fifth nerve to come
12 out of the neck, complete avulsion; C-6, complete avulsion; C-
13 7, the seventh cervical nerve, the third of five nerves of the
14 brachial plexus still connected, but basically, at least
15 clinically, according to the surgeons, basically not
16 functioning and then a large scar involving the upper trunk,
17 which is depicted in this diagram like that.

18 Q: Is there a name for that scar?

19 A: A neuroma.

20 Q: What is a neuroma?

21 A: Well, when all this tearing occurs, there's bleeding in
22 the area. The blood and abnormal nerves that are left behind,
23 form a dense scar that contains scar tissue and abnormal nerve
24 fibers.

25 Q: Thank you. I believe a moment ago, we were talking about

1 your report from March 2016 and then some of your comments got
2 us into that side issue. Could you go back and tell us what
3 was important about your examination of March 5th?

4 **A:** The function of the brachial plexus is easy to
5 understand; the higher nerves meaning the nerves with the
6 lower numbers, control the upper part of the arm. And as you
7 move down, you start controlling the lower part of the arm.
8 So, an injury to the fifth and sixth cervical nerves is going
9 to affect the shoulder. It's going to make it hard to bend
10 the elbow, turn your hand over. When the seventh cervical
11 nerve is injured, it makes it hard to lift your wrist or if
12 your hand is up, you can't lift your thumb and fingers into
13 the air. The lower nerves, which in this case, are normal,
14 allow you to close your hand and make a fist. So, my
15 examination in 2016 basically showed a pattern of injury
16 consistent with these findings at surgery at MUSC and these
17 findings on the MRI. So, what I saw, and all of that, by the
18 way, is described at MUSC by doctors and at the physical
19 therapy center that Jahmerican attended for the many sessions.

20 **Q:** Thank you. Excuse me, I'm going to -- the -- I'm going
21 to hand you again, Exhibit 27, so you'll have your report in
22 front of you. Using your report, could you just go through
23 and tell us what you found important that day?

24 **A:** Well, the first thing certainly was that there are a
25 whole host of abnormalities involving the right arm. If you

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1 have a brachial plexus injury, the arm doesn't grow normally,
2 so the right arm is shorter, because of the number of nerves
3 that were injured, it's also smaller. That's a typical
4 finding in a child who has a brachial plexus injury and it
5 involves three nerves like this, as well a neuroma. And then
6 with a pattern of abnormalities consistent with injuries to
7 those upper nerves, stiffness and tightness in the shoulder,
8 reduced movement in the shoulder, stiffness in the elbow,
9 abnormal movement in the elbow, difficulties with the hand.
10 That entire pattern of injury in 2016 consistent with -- with
11 the injuries that are seen here. So, and as I keep on saying,
12 consistent with all of the doctors have written about
13 Jahmerican McCray or at least certainly up to that examination
14 in March of 2016.

15 **Q:** Thank you. On the next to the last paragraph on page 1
16 of Exhibit 27, it talks about -- well, it says, after his
17 delivery, these medical records note that Jahmerican's right
18 arm was flaccid with some movement noted in his fingers. What
19 does that tell you?

20 **A:** Well, Jahmerican's birth was complicated. After he was
21 delivered, his right arm was essentially paralyzed and some
22 people say there was no movement of the hand and fingers;
23 other people say there was, but and certainly in the first
24 notes at MUSC, there's at least one note that suggests that
25 there was an injury to all of the nerves of the brachial

1 plexus on the right side.

2 **Q:** In that last paragraph, it says the right arm is held
3 with the shoulder to crest and internally rotated; what is
4 that?

5 **A:** The muscles in the arm are out of balance; some are
6 working, some are not, so that he doesn't hold his arm in a
7 normal position.

8 **Q:** Can you show us what that looks like?

9 **A:** I can, but I don't have a brachial plexus injury, but
10 basically the arm is down and rolled forward. It's really
11 hard to rotate it, but they don't hold their arm in a normal
12 posture because of the pattern of weakness.

13 **Q:** There's a reference to scapula winging, what is that?

14 **A:** The -- the shoulder blade, which is this structure, is
15 held up against the chest wall by various muscles and the
16 fifth and sixth cervical nerves control those muscles and if
17 they're damaged, then they're not going to be that -- the
18 shoulder is not going to be in the right location and certain
19 movements are going to cause it to move in an abnormal way and
20 doctors call that scapula winging.

21 **Q:** Now, this appointment was in March of 2016. So, almost
22 three years after his birth, 2 years and 11 months after his
23 birth, was -- was he able to -- in which ways could he move
24 his arm; was he able for example, to elevate the right wrist?

25 **A:** He was not.

1 Q: Was he able to extend his fingers and thumb completely?

2 A: He was not.

3 Q: Can you show us what that means to elevate the right
4 wrist and extend the fingers and thumb?

5 A: Elevated right wrist; so parallel to the floor, point
6 your fingers to the ceiling. Actually, extension and can do
7 the same thing with your thumb and you can see I'm just
8 elevating my thumb. So, all those movements; moving your
9 wrist up, straighten your fingers, elevating your fingers,
10 moving your thumb like this, is controlled by the seventh
11 cervical nerve, which in this case was essentially torn from
12 the spinal cord. So, any movement that the seventh cervical
13 nerve can create, this boy cannot perform normally and this
14 examination in 2016, is done after he's had not one, but two
15 attempts at nerve repair surgery at MUSC. So, with two
16 surgeries, this is his condition; he can't move his shoulder
17 properly and get it above 90 degrees or 100 degrees, he can't
18 bend his elbow completely, he can't extend his wrist, doesn't
19 move his fingers and thumb, but again, he can make a fist
20 because those nerves are not injured. So, that's the --
21 that's the pattern of injury that I saw in 2016 when I
22 examined him in my office.

23 Q: On page 3 of your report, there's a whole list of degrees
24 of movement or range of motion or something. Could you please
25 explain what a normal uninjured person can do and what the

1 difference is in terms of Jahmerican can do?

2 **A:** Well, every joint has a range of motion. For example, I
3 can bend my elbow forward 150 degrees, I can straighten my arm
4 to zero degrees, I can bring my shoulder or move my arm in 180
5 degrees, which is a shoulder movement. So, these are all
6 movements that you can measure. You can elevate your wrist to
7 75 degrees. So, these are all numbers that we know and -- and
8 in a young child, you just take the arm and you move it
9 yourself as opposed to asking the child to move it themselves.
10 Certainly, a two and a half year old is not going to be all
11 that cooperative. So, these passive movements are, at least
12 in the upper arm are abnormal; the right arm is 160 versus 180
13 in one for flexion; 45 versus 60, 135 versus 180; all the
14 movements in the upper arm passively, meaning they are
15 abnormal consistent with the injury that he has.

16 **Q:** Doctor, I don't want to belabor the point too long, but
17 your report goes on for several more pages, could you
18 highlight the most important parts of your report that we
19 haven't already gone over?

20 **A:** Yes. I think if you look at, again, if you look at my
21 report and you look at the records of other people in South
22 Carolina, the records of the Shriner's Children's Hospital,
23 where this boy had care, you see a consistent pattern of
24 injury. It's a lot of medicine to try and learn in 20
25 minutes, it probably took me several years to become -- but if

1 you look at the records, probably the easiest place to
2 understand this boy's level of disability is in the Shriner's
3 records. Since not every doctor uses the same language when
4 they describe something, sometimes we use rating systems or we
5 score things; we'll say, you know, we'll say something is 4-
6 plus, it's a method we use to indicate more than 2-plus. So,
7 what doctors who specialize in the care of brachial plexus
8 injuries do is they -- it's a scoring system called Mallet, M-
9 A-L-L-E-T. So, the maximum number in a Mallet score is 30.
10 That's a perfect score in the Mallet. In 2017, after two
11 nerve surgeries and additional treatment at MUSC, Jahmerican
12 McCray had a Mallet score of 15. So, if you think of it that
13 way, his arm was working at fifty percent of normal, despite
14 many therapy sessions and two surgical remedies involving the
15 nerve. That's probably the easiest way to understand the
16 level of function in his arm. So, 15 and should be 30, at
17 least fifty percent reduction in function based on these
18 injuries.

19 **Q:** I meant to hand you Exhibit 28, which is your November
20 2018 report. I'll take that. Could you highlight for us what
21 you saw in November of '18, apparently your first visit and
22 March '16?

23 **A:** Well, the examination was a little easier because now
24 it's 2018 and Jahmerican is a lot easier to evaluate and is a
25 lot more cooperative and he was able to create a lot of the

1 movements in 2018 that I couldn't get him to create in 2016.
2 For example, shoulder flexion should be 180 degrees from east
3 that he created a 90 degree movement; meaning it's 50 percent
4 reduced. You should be able to bring your arm behind your
5 back at least 60 degrees. He was not able to do that at all.
6 You should be able to get your arm away from your body 90
7 degrees and then bring it all the way up in the air; he
8 doesn't even get it 90 degrees, he gets only to 75 degrees.
9 The shoulder can be rotated; quarterbacks, pitchers get
10 rotator cuff injuries because they're muscles that rotate the
11 shoulder. So, you can rotate your arm away from your body,
12 that's called external rotation and you can rotate your arm in
13 towards your body, that's called internal rotation. So, he
14 was not able to externally rotate his arm at all and internal
15 rotation gets into his hip; you should be able to get your arm
16 behind your waist, behind your back and then up in between
17 your shoulder blades. He can't straighten his arm completely;
18 it should be zero, he gets to 20 degrees. So, he's short
19 there and should be able to produce a movement called
20 supination. This is a movement called supination. He should
21 be able to move it 180 degrees; he moves it 20. And pronation
22 is your arm is palm up, you should be able to turn it
23 completely over; he can only go halfway. He can't extend his
24 wrist more than 20 degrees; it should be 75 and going down
25 should be 75 and he only does it for 60 degrees because of

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1 tightness that he has in the wrist because of his brachial
2 plexus injury. And then he doesn't extend his fingers by
3 himself, but he can make a fist and move his thumb to make a
4 fist. And then the other difference between that examination
5 in 2016 is that the discrepancy in size and length of the
6 right arm versus the left arm, which was more obvious at that
7 point. He was bigger and when a chronic nerve injury takes
8 place, the affected arm just doesn't grow normally; it's not
9 the same -- it's certainly not the same length and may not be
10 the same size depending on how many nerves are injured. In
11 this case, where there are three nerves, it's not the same
12 size and it's not the same length. Those are all expected
13 abnormalities. Everything else was the same. His shoulder
14 blade didn't move properly, he didn't hold his arm in the
15 right place, everything that I saw in 2018 was 2016 and more.
16 I'll say it that way.

17 Q: Did you have a chance to see Jahmerican briefly before
18 you came to court today?

19 A: Yes, we said hello on the way in.

20 Q: Obviously, you didn't do a formal examination, but what
21 were your impressions compared to your last formal exam?

22 A: Well, he's had more treatment since then including
23 another surgical remedy. So, the exam is essentially the
24 same. The surgical remedy was designed to help him hold his
25 wrist up a little bit. He's got a big scar on the top of his

1 hand. He holds his wrist up better because he's had muscles
2 moved around to try to aide him in doing that.

3 Q: With all these surgeries, have those made anything normal
4 about his arm, shoulder, wrist?

5 A: No, he still can't get his arm above, you know above 90
6 degrees, he still can't bring his hand behind his back. The
7 general pattern is -- is the same.

8 Q: All right. Thank you. I want to ask you a few
9 questions about different characteristics of brachial plexus
10 nerve damage. First of all, are there different types of
11 injury?

12 A: Yes, I mean, in a case like this, which is a traumatic
13 injury, which is a stretching injury. We know it's a
14 stretching injury because we know the nerves have been pulled
15 out of his spinal column. So, we know it's a stretching force
16 that did that. So, it's just a question of where did the
17 injury occur? Did it occur at the spinal cord or did it occur
18 away from the spinal cord? So, a neuroma is caused by
19 something called a rupture where the nerve is torn into two
20 pieces. The wire from the refrigerator is cut into two
21 pieces, it's still connected to the socket; the refrigerator
22 still doesn't work. An avulsion is just to pull the plug out
23 of the wall; that's basically what it is. You think of the
24 wall as a spinal cord; you pull the plug out of the wall; you
25 pull the nerve out of the spinal cord. That's what an

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1 avulsion is. In this case, the nerve is still connected to
2 the spinal cord and it's just been torn in half.

3 Q: Okay. So, are there different locations of where those
4 injuries can be?

5 A: If by location you mean where, with respect to the spinal
6 cord, we just talked about that, at the spinal cord level ---

7 Q: Up and down the spine.

8 A: Well, I mean this is the typical pattern. Usually you
9 get -- there's almost, I would say in every case I've ever
10 seen, there's a neuroma of the upper trunk. Sometimes there
11 avulsions along with it; that's not that common, but it does
12 occur, and the seventh cervical nerve is virtually always
13 avulsed just by virtue of the way the brachial plexus is
14 constructed.

15 Q: I think doctors often use mild, moderate, severe; how
16 would you rate these injuries in terms of severity?

17 A: It's a catastrophic injury. The only -- the only thing
18 that -- the only good fortune that Jahmerican McCray has is
19 that he can close his hand, but since he can't keep his wrist
20 up, then his hand function is compromised. So, it's really a
21 catastrophic injury. He doesn't move his shoulder normally,
22 he doesn't bend his elbow normally, he can't bring his hand
23 behind his back; it's a catastrophic injury.

24 Q: How do you believe these injuries will affect Jahmerican
25 going forward?

1 **A:** Everything that he needs to do going forward, he's going
2 to have to accomplish with basically one arm and -- and
3 reduced hand function. I mean, he -- therapy and maybe
4 splinting could allow him to use his hand better, but he still
5 want have a normal arm in spite of more surgery, he's had
6 injections in muscles to allow him to have more therapy, but
7 he'll never have a normal arm. So, whatever he does, he's
8 going to have to figure out how to do with basically one arm.

9 **REPORTER'S NOTE:** (Bench conference with counsel).

10 **BY MR. GRAHAM:**

11 **Q:** Doctor, I hand you this document and I don't want you to
12 go into any details about the document. It's been marked for
13 identification only as Exhibit 25. Can you just state for the
14 record what this document is?

15 **A:** It's a Life Care Plan.

16 **THE COURT:** All right. For identification only.

17 **MR. GRAHAM:** Yes, sir.

18 **BY MR. GRAHAM:**

19 **Q:** What is a Life Care Plan; I don't want you to get into
20 any details about the document we just identified, but in
21 general, what is a Life Care Plan?

22 **MR. HOOD:** Your Honor, I think this is getting far afield
23 from Pediatric Neurology.

24 **THE COURT:** I will let him testify generally as to what a
25 Life Care Plan is. He's not giving an opinion.

1 **MR. HOOD:** Thank you, Your Honor.

2 **A:** A Life Care Plan is a document that outlines the care and
3 treatment that someone requires because of extraordinary
4 circumstances; an injury, an illness.

5 **BY MR. GRAHAM:**

6 **Q:** Does it basically project future treatment needs and how
7 much that costs and that sort of thing?

8 **MR. HOOD:** Your Honor, objection, leading.

9 **THE COURT:** It's leading, but I'll let him answer that
10 question.

11 **A:** So, it speaks to the type of care people need, what the
12 costs associated with that care are, defines how often
13 something should occur, meaning how many times a week or how
14 many times a month, how many years it should last, what types
15 of doctors or medicine someone might need to take, how many
16 pills you take a day, how much they costs, who are the doctors
17 that supervise that, all that is in a Life Care Plan.

18 **Q:** What type of future care do you believe Jahmerican needs,
19 just in general?

20 **A:** Therapy, being a doctor who treats children like
21 Jahmerican, additional therapy as he's growing is -- you know,
22 he's going to grow, his bones are going to elongate, his
23 muscles are going to get longer, the tendons and ligaments are
24 going to change, therapy while he's growing. What is general,
25 he's stopped growing by the age of 21, so the therapy as long

1 as they're growing. Boys like Jahmerican, often require other
2 surgery. The records talk about the possibility of surgeries
3 in the future; they don't say we will do surgery, but they
4 talk about it. So, children like Jahmerican need to see
5 specialists, the doctors at Shriner's Children's Hospital for
6 example, to try and determine whether more treatment is
7 required. And then, various accommodations in terms of
8 dressing, undressing, there's some types of devices that helps
9 him. I mean, he doesn't use both of his hands normally to
10 help him dress and undress. For example, I mentioned earlier
11 that he can't get his hand behind his back because of the
12 problem he has with his shoulder. You can't pick your pants
13 up and get them over your butt if you can't bring both of your
14 hands down to your back; it's hard to -- hard to button and
15 zipper if you can't get your hands together, you know, at your
16 waist. So, these are -- these children need therapy to help
17 them with that. They may need special devices to help them
18 button for example, if the boy can't bring his hand up. So,
19 it's difficult to manipulate your fingers effectively if you
20 can't do that. So, all those remedies for those types of
21 difficulties are potentially available with therapy and
22 appliances and various devices and all those things are
23 generally recommended and provided to children like Jahmerican
24 in the future.

25 Q: Dr. Adler, these are documents pre-marked Exhibit 3, 15,

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1 17 -- 3, 15, 16 -- at any rate, look through these and tell me
2 are these the surgical records that you referred to earlier at
3 MUSC and Shriner's?

4 **A:** Yes.

5 **Q:** Thank you.

6 **MR. GRAHAM:** Your Honor, we would offer these. However,
7 Mr. Hood and I have an agreement. There was some inadvertent
8 highlighting on one of them so we will fix that.

9 **THE COURT:** Mr. Hood?

10 **MR. HOOD:** Your Honor, no objection.

11 **THE COURT:** All right. Very well. They're admitted
12 subject to remedying the redaction or highlighting. Okay.

13 **PLAINTIFF'S EXHIBITS 3, 4, 15 AND 16**

14 **ADMITTED INTO EVIDENCE**

15 **BY MR. GRAHAM:**

16 **Q:** Do you still have this in front of you? That's fine, let
17 me get them back to you. Could you just go through and just
18 tell us, not in too much detail, but give us an idea of
19 exactly what happened with each of these surgeries?

20 **A:** Well, the first surgery was in September of 2013, not
21 quite five months after Jahmerican was born. And in that
22 surgery, they cleaned up the scars that they found of the
23 brachial plexus and they transferred nerves, one nerve to
24 another nerve in order to help Jahmerican move his shoulder
25 better. That was the first surgery.

1 The second surgery was basically the same type, where
2 they cleaned up scars and then connected another nerve to the
3 nerve that bends the elbow so that Jahmerican could move his
4 elbow. At that point, which was now in November, so
5 Jahmerican was now six and a half months of age, he wasn't
6 moving his elbow, so they transferred a normal nerve to an
7 abnormal nerve so that Jahmerican could bend his elbow. One
8 important point to make about these surgeries is that other
9 than the injuries to nerves that they witnessed and all the
10 scarring and the disconnection of nerves from the spinal
11 column, all the other nerves that they found were normal and
12 healthy appearing. That's an important point; it proves that
13 apart from the traumatic injury to nerves, Jahmerican McCray's
14 nerves are otherwise completely normal, that he wasn't a boy
15 with a nerve disease or a nerve problem, something that set
16 him apart that was going to cause him to have nerve damage
17 during a delivery.

18 **Q:** Thank you. Doctor, I hand you a document pre-marked
19 Exhibit 7. Is this a progress note by Dr. McGillicuddy at
20 MUSC dated -- dated July 22, 2013?

21 **A:** It is.

22 **MR. GRAHAM:** Your Honor, we'd offer this into evidence.

23 **THE COURT:** Mr. Hood?

24 **MR. HOOD:** No objection, Your Honor.

25 **THE COURT:** Without objection.

PLAINTIFF'S EXHIBIT NUMBER 7

ADMITTED INTO EVIDENCE

BY MR. GRAHAM:

Q: I need to hand it back to you, sir, and I'm going to call your attention to some of the lines on here from Dr. McGillicuddy at MUSC and ask you if you would just read those to the jury starting on in that first paragraph on line -- on line 4 to the right starting with his, please read that one sentence?

A: His and of course, is that what you're referring to?

Q: Yes..

A: His Apgar's were normal and no respiratory distress was noted.

Q: What does that statement by Dr. McGillicuddy tell you?

A: Well, just like the Mallet scoring system, Apgar scores are a scoring system as well. It's a very fast way of determining whether a newborn is healthy and whether the newborn needs the assistance of people in the delivery room. It's five different categories; the maximum score is 10. Jahmerican had -- and they are assigned at one minute and five minutes of life because some babies change very quickly. You want to know about those changes. So, at one minute, Jahmerican had an Apgar score of 8, which is obviously close to perfect and then at five minutes it was 9. So, those two scores indicate that he was healthy after his delivery than he

1 wasn't distressed or he was not having any difficulties
2 adjusting to the fact that he was now a baby outside his
3 mother's womb as opposed to in the body and that he'd not been
4 injured by the birth process itself. Having a normal Apgar
5 score is a good sign of that and he had no breathing problems.
6 **Q:** Is it within your field, your scope of expertise, to tell
7 us how long people can go without oxygen and stay well?
8 **A:** With -- with respect to the neurological system, which is
9 among -- since the brain is more easily injured than let's say
10 the kidney, for example, neurologists will typically offer
11 opinions as to how much, pardon me, how much brain injury may
12 have occurred as a result of a lack of oxygen since that
13 happens before any other organ is injured.
14 **Q:** Okay. And so, how many minutes would an adult be able to
15 go without oxygen, without becoming brain damaged?
16 **A:** If they were completely deprived of oxygen, if their
17 heart stops, someone has a heart attack and collapses to the
18 ground, if they're not effectively resuscitated within five
19 minutes, they're going to be brain damaged.
20 **Q:** And in terms of that timing, how do babies compare to
21 adults in terms of the effect of oxygen deprivation for short
22 periods of time?
23 **A:** Well, the unborn child is different than the adult.
24 Number one, they have special hemoglobin; the protein inside
25 their red blood cells that binds the oxygen, it's a lot more -

1 - it's a lot stronger than the hemoglobin, that protein that
2 you and I have. They have hemoglobin F; we have hemoglobin A.
3 Our hemoglobin is not efficient of holding on to oxygen than -
4 - than the hemoglobin that the fetus has. And another thing
5 is that the fetus lives in an environment where oxygen levels
6 are low. Our oxygen content is around 100 or at least it
7 should be around 100. Whereas, the oxygen content of the
8 fetus of an unborn child is 20. So, they tolerate low oxygen
9 levels much better than we do and have this special hemoglobin
10 that we don't have. So, if you did the same thing to an
11 unborn child, if you stopped its heart, they are not brain
12 damaged for at least ten to fifteen minutes. So, they
13 tolerate severe deprivation of oxygen for a long time, double
14 or triple the amount of time that an adult would tolerate it.
15 Q: And when you say ten to fifteen minutes, you're assuming
16 absolutely no oxygen?
17 A: Correct, if you -- I mean it is possible to eliminate all
18 oxygen to the -- to the unborn child.
19 Q: All right.
20 A: There are circumstances to where that occurs.
21 Q: In a shoulder dystocia, such as that in this case, with a
22 loose nuchal cord, is there a complete oxygen deprivation?
23 A: Well, in fairness, there's no way to measure that. You
24 have to understand how much compression of the -- of the
25 umbilical cord has taken place, but even if one assumes that

1 were to be so, then there really, the risk wouldn't really
2 begin for at least five minutes; meaning the risk that the
3 unborn child was going to be deprived of a significant amount
4 of oxygen wouldn't begin for five minutes or suffer injury
5 from the lack of oxygen, wouldn't begin for five minutes. An
6 injury, confirmed injury, wouldn't begin for at least another
7 -- at least another five to ten minutes at the minimum.

8 Q: So, is that how you get the numbers of the baby having at
9 least ten to fifteen minutes of no oxygen at all and no brain
10 damage, even if there's a complete absence of oxygen?

11 A: The risk of permanent brain damage doesn't occur until at
12 least ten minutes has passed when you have a situation where
13 there's a known complete and total removal of oxygen delivery
14 to the unborn child.

15 Q: What's the test for measuring oxygen in a baby after the
16 baby is born?

17 A: Well, you can do what's called a blood gas; you can
18 measure the amount of oxygen in the baby's blood, a measure of
19 the lack of oxygen is a measure of how much acid is in the
20 baby's blood. That's an indirect measure of the effect of the
21 lack of oxygen.

22 Q: That's called a cord gas?

23 A: The cord gas and you're specifically interested in a
24 value called the PH.

25 Q: Okay. Does that have to do with how much acid is there?

1 A: Yes, the amount of acid will tell you how long the oxygen
2 deprivation has occurred and was it significant.

3 Q: Was that test done in this case after Jahmerican was
4 born?

5 A: Jahmerican had a cord PH measure.

6 Q: Do you recall what that number was?

7 A: Yes, 7.31, which is normal.

8 Q: Given Apgar's of 8 and 9 and cord gas of 7.31, what does
9 that tell you about how Jahmerican was doing during that one
10 minute?

11 A: He was -- he was fine. He was not -- he didn't have low
12 oxygen levels, he wasn't -- he wasn't compromised in any way.
13 He was a healthy newborn at that point; well, he wasn't born
14 yet, so I'm not sure you would call him a newborn, but he was
15 a healthy fetus at that point up until the moment of his
16 birth.

17 Q: Tell us, Doctor, during that one minute shoulder dystocia
18 from the viewpoint of a Pediatric Neurologist, did Jahmerican
19 have any medial instability?

20 A: No, not according to facts in the medical records.
21 Normal Apgar scores, normal PH would indicate that he was
22 healthy at the time of his birth and was not damaged in any
23 way whatsoever.

24 Q: You talked about reading depositions before, does that
25 include the depositions of Dr. Maselli and two of the nurses?

1 **A:** And family members, yes.

2 **Q:** What caused this boy's nerve damage?

3 **A:** It's clear from the medical records that the nerves were
4 stretched or pulled beyond their point of tolerance and were
5 torn apart.

6 **Q:** When did that take place?

7 **A:** After the head of Jahmerican McCray was delivered and
8 during the time Dr. Maselli was moving the head. An amount of
9 force was created along the muscles and the nerves and caused
10 them to be physically injured in the manner I described in the
11 medical records.

12 **Q:** What type of manipulation with Dr. Maselli's hands and
13 arms would be required to cause that kind of damage?

14 **A:** The head ---

15 **MR. HOOD:** Objection, Your Honor, I think that's beyond
16 the scope.

17 **THE COURT:** I think this is beyond the scope of his
18 expertise unless you can establish a foundation.

19 **MR. GRAHAM:** Okay. Thank you.

20 **BY MR. GRAHAM:**

21 **Q:** Doctor, in the field of neurology, is one of the
22 important principals, the mechanism of injury?

23 **A:** Yes.

24 **Q:** All right. And does mechanism of injury have anything to
25 do with obstetrics?

1 **A:** I mean, I'm going to try to answer the question
2 specifically. The injury to the nerves here requires them to
3 be stretched in some manner. So, the question -- the question
4 is, how -- what movement of the head, which is going to cause
5 this injury, would be required to ---

6 **THE COURT:** I'm going to allow him to testify as to the
7 direction or way the head would be manipulated, but I'm not
8 going to allow him to testify as to any obstetrics or
9 practices. Okay?

10 **BY MR. GRAHAM:**

11 **Q:** Doctor, you hear no obstetric talk. Let's talk about the
12 mechanics involved in causing the kind of damage that you
13 talked about and which direction or directions would force
14 need to be applied to cause that kind of injury?

15 **A:** The head would have to move away from the injured nerves,
16 meaning the head would have to tilt to the left or to say it
17 another way, the left ear would have to get close to the left
18 shoulder.

19 **Q:** All right. And what about other modes of -- mechanical
20 modes of causing that injury; what affect would twisting of
21 the head have?

22 **A:** Twisting -- twisting of the head to the left, meaning the
23 chin moves to the left, will turn the neck and will also cause
24 stretching of the nerves on the right side of the brachial
25 plexus.

1 Q: And in terms of mechanics of injury, tell us about
2 direct, hard pulling?

3 THE COURT: You are ---

4 MR. HOOD: We're now quantifying traction or pulling or
5 whatever terms he's used and we're just bouncing back and
6 forth over the obstetrics.

7 MR. GRAHAM: I'll rephrase it.

8 THE COURT: Okay.

9 BY MR. GRAHAM:

10 Q: Doctor, if the baby's head is pulled straight out, can it
11 be damaged if the pulling force is hard enough?

12 A: If the head moves straight up, let's say or out, then the
13 force is along the spine and doesn't stretch the brachial
14 plexus.

15 Q: And if the head is twisted in the direction you described
16 and then pulled out, if that pulling force were hard enough,
17 can that cause this kind of damage to occur?

18 A: If the head is tilted and/or turned to the left, there
19 needed -- well, I'll say it this way. In order to produce the
20 injury that's present in this case, injury that was seen on
21 imaging, MRI, the imaging the doctors actually looked at under
22 a microscope when they were doing surgery on Jahmerican
23 McCray, the head must have moved either -- must have tilted to
24 the left or turned to the left and -- and those movements
25 created the amount of stretch on the nerves that caused those

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1 nerves to be torn in the manner that was described in the
2 medical records at MUSC.

3 **Q:** Thank you. Have you told us the complete basis of -- of
4 your conclusions about what caused this injury, is there any
5 other basis for it that we haven't discussed?

6 **A:** No, I told the jury my opinion based on all the facts
7 that are in the medical records, imaging studies, the direct
8 visualization of nerves by the doctors at MUSC and the fact
9 that not only were the injured nerves seen, but also that the
10 other nerves were completely normal and the records of other
11 doctors certainly don't describe other neurological problems.
12 So, the entirety of Jahmerican McCray's records indicate that
13 these nerves were stretched beyond their point of tolerance
14 because the head moved, and they were ripped and torn in the
15 manner described in the medical records.

16 **Q:** There has been some discussion about obstetrics and
17 Pediatric Neurology. Do you consider yourself an expert in
18 telling us whether Dr. Maselli was negligent when she did the
19 kind of head manipulation and applied the kind of force you're
20 talking about ---.

21 **MR. HOOD:** Objection to the question and to the scope and
22 ---

23 **THE COURT:** We've talked about this. His expertise is
24 limited to Pediatric Neurology.

25 **MR. GRAHAM:** Yes, sir. I'm just trying to follow-up and

1 pin that down.

2 **THE COURT:** Okay. All right. Well, let's make sure you
3 pin it down.

4 **BY MR. GRAHAM:**

5 **Q:** When you testified about the mechanics of injury as a
6 Pediatric Neurologist, are you telling us one way or another
7 about whether that was negligent for an obstetrician to do or
8 would you defer to an obstetrician?

9 **A:** I stated earlier in response to Mr. Hood's question and
10 to the jury that I'm not here to criticize Dr. Maselli in any
11 way. I'm simply indicating that this injury occurred as a
12 result of the head being moved and then she moved the head.
13 That's my only statement and I'm not criticizing her for
14 moving the head; I'm simply stating the injury occurred
15 because she moved the head. I'm speaking as an expert on
16 nerves; I'm not an obstetrician and I'm not an expert on
17 obstetrical care.

18 **Q:** Thank you. Now, is there any other way that makes any
19 sense of how Jahmerican's nerves could have been damaged other
20 than the mechanical mode of injury that you told us about?

21 **A:** No, I mean we -- well, what's required as an explanation
22 of how three nerves of the brachial plexus can be either
23 completely or partially torn from the spinal cord and how the
24 upper trunk for structure created by the fifth and sixth
25 cervical nerves can be ruptured. So, that which -- that

1 abnormality, which is a fact, not -- it's not a supposition,
2 it's not something that people are asking questions about;
3 it's something people actually saw, that phenomenon requires
4 an explanation. So, when a boy who has normal nerves seen by
5 other doctors at surgery and who had other diseases and there
6 was normal in every way at his birth, the only way that could
7 occur is that because those nerves were stretched and torn
8 apart and the only way that could occur in this case is that
9 after the head delivered, the head moved and stretched the
10 nerves.

11 Q: Dr. Adler, have all of the facts and opinions and
12 conclusions that you've given today been those that you hold
13 at least to a reasonable degree of medical certainty, most
14 probably?

15 A: Yes.

16 Q: By the way, are you paid for the work you do in a case
17 like this?

18 A: Yes, I cancelled my office hours today and my hourly rate
19 is \$500 an hour and you're compensating me at that rate.

20 Q: Is this -- is it customary for expert witnesses in trials
21 to charge for their time?

22 A: It's customary for people to charge for their time. I'm
23 charging for my time away from my practice in New York and New
24 Jersey to be here and testify on behalf of Jahmerican McCray.

25 Q: All right. I hate to admit this, I've been practicing

1 law over 40 years. How long have you been practicing
2 Pediatric Neurology?

3 A: I'm fully trained since 1980. So, a long time, 39 years.

4 Q: All right. And over my career, have I hired you in other
5 cases?

6 A: Yes, I've reviewed cases on behalf of you and your firm.

7 Q: And as many as a dozen or so over our career?

8 A: I would think. It's been -- we've known each other for a
9 few years.

10 Q: Over those 40 years, have you brought in a lot of gross
11 income from this type of activity before you take into account
12 business expenses, overhead and that sort of thing?

13 A: Well, I'm fortunate that I have a career that paid me
14 both for patient care and -- and to provide expert testimony.
15 So, yes, I've generated revenues, significant revenue from
16 both, but certainly expert work obviously pays me at the same
17 rate that I get paid in the office.

18 Q: Please answer any questions Mr. Hood has.

19 THE COURT: Mr. Hood.

20 CROSS EXAMINATION OF DR. DANIEL ADLER BY MR. HOOD:

21 Q: Those revenues you were talking about would be about four
22 million dollars?

23 A: Yes, over my career as an expert.

24 Q: And in your career as an expert, you had the opportunity
25 to testify on occasion as well, right?

1 A: I've testified at deposition and in court many times.

2 Q: You testified in depositions and in court in excess of
3 400 times?

4 A: Yes, I reviewed, at this point, in excess of 1600 cases
5 since 1992, testified certainly that 400 number I would think
6 is a minimum at this point.

7 Q: And we'll come back to some of those other questions, but
8 I wanted to get one thing straight, would it be fair to say,
9 based on your testimony that Dr. Adler would suggest to the
10 baby delivering world that you have 15 minutes before you have
11 to be concerned about a neurologic brain injury when you
12 encounter a shoulder dystocia?

13 A: I don't -- no, I don't think I said that. Well, you
14 don't get permanent brain damage for until at least 10 to 15
15 minutes has past. But I think I did say that by 5 minutes,
16 the amount of acid in the baby's blood is going to start to
17 increase and concern at that point. Speaking only as a -- I'm
18 not speaking as someone who delivers babies but talking about
19 could the fetus be compromised in a significant way. It would
20 be my opinion as a neurologist that at the 5 minute mark,
21 concern on behalf of those people involved in the delivery
22 needs to increase.

23 Q: Certainly, you are familiar with reported cases of anoxic
24 brain injury where there was a duration of less than 5
25 minutes?

1 **A:** I am familiar with that. The problem with those
2 published papers is that they're hard to completely evaluate.
3 There's -- there are collections of patients and the fact
4 pattern of everyone isn't exactly the same, so it's hard to
5 evaluate, but yes, some people have suggested that the injury
6 can occur in 5 minutes or less. I don't think it's correct,
7 but people have said that to be sure.

8 **Q:** And there are obviously individual characteristics that
9 some people may, or babies may respond differently than
10 others, true?

11 **A:** Yes, but usually you know that from the medical records.
12 But, generally, the unborn child tolerates low levels of
13 oxygen particularly well and 5 minutes is well within, for the
14 overall majority of newborns, an interval of time that they
15 will tolerate and not have permanent brain damage.

16 **Q:** Okay. So, I think -- I think maybe I get where we're
17 passing each other. You said that the medical records will
18 confirm; are you referring to the cord gases and the PH and
19 the Apgars and things like that?

20 **A:** Right and statements that might be present in the
21 mother's chart suggesting that the fetus was exposed to low
22 levels of oxygen before the actual time of birth, things like
23 that.

24 **Q:** Well, those things that you're talking about, that score
25 from 0 to 10, that babies get 1 minute and 5 minutes again,

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1 when you're in that moment where you don't have the baby

2 delivered, you don't have that information, do you?

3 **A:** No, I don't disagree with that. I'm not an obstetrician;

4 I can't speak to how obstetricians should behave when they

5 encounter a shoulder dystocia; that would be for others. I

6 would simply -- just speaking only about the baby. I would

7 say that from the baby's point of view, the point of view of a

8 fetus, who understands what low levels of oxygen is, because

9 how they developed over 9 months, you have a minimum of 5

10 minutes before you have to really become concerned that if

11 this goes on much longer, I'm going to get close to that 10

12 minute mark and then there's substantial risk.

13 **Q:** All right. We're -- we'll try to press and get you out

14 of here and off the stand today so, let me just sort of laser

15 in on my questions if you can laser in on the answers, we'll

16 get you out of here on your flight.

17 The Apgar score that you talked about on direct

18 examination, that's a piece of medical evidence that's created

19 after the baby is born, true?

20 **A:** True.

21 **Q:** That piece of evidence is not available to the physician

22 delivering the baby at that time because that has not been

23 measured yet, true?

24 **A:** True.

25 **Q:** The core gas, the other thing you talked about, the 7.31

1 determining whether there's acid in the blood, that piece of
2 medical evidence is not available to a delivering physician at
3 the time of delivery, true?

4 **A:** True.

5 **Q:** All right. Now, let's -- obviously you don't back -- you
6 don't deliver babies and you don't deal with shoulder dystocia
7 emergencies in your practice, right?

8 **A:** True.

9 **Q:** You're not called in to say, hey, we may have a problem,
10 we want you in the delivery room; that's just not something
11 that comes with neurology, you come in later?

12 **A:** True, I'm there afterwards.

13 **Q:** Okay. And you're not qualified to say whether shoulder
14 dystocia is predictable or preventable?

15 **A:** True, I'm not qualified.

16 **Q:** And you're not going to testify about how much force is
17 ever appropriate in a particular delivery, right?

18 **A:** True, that would be an obstetrical opinion.

19 **Q:** And in terms of force and things you were talking about
20 earlier, is it possible to -- to know how many foot pounds or
21 any other measurement of force a particular nerve in a
22 particular baby can tolerate?

23 **A:** You would know the average. You would know the answer in
24 a baby that you assumed to be healthy. You would know how
25 much force they could tolerate on that basis.

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1 Q: And for purposes of your practice, you don't concern
2 yourself with any amount of force applied by an obstetrician,
3 right?
4 A: Correct, I'm only talking about force that nerves are
5 exposed to; not force that obstetricians apply.
6 Q: And you're not testifying about how much force is applied
7 in the case of the mom's contraction forces either, true?
8 A: I would only say that the force was not -- would not be
9 sufficient to cause this injury; I would say that.
10 Q: But you're not going to testify about how much force is
11 applied, true?
12 A: By the mother?
13 Q: Right.
14 A: I would say the records don't permit you to give an
15 answer to that one way or the other.
16 Q: Yeah, it's not ascertainable?
17 A: Not in the records, yes, it can't be determined.
18 Q: Just like on the other side, when you got two different
19 concepts here; you've got a physician force, a maternal force
20 and there's no way to quantify either one of those?
21 A: Not from the medical records.
22 Q: Not just these medical records, but in just any delivery,
23 true?
24 A: True.
25 Q: Out of those 1600 cases, is it still true that you've

1 only testified 2 times on behalf of the defense?

2 **A:** In a brachial plexus case, yes.

3 **Q:** Okay. And one of those cases was a causation case and

4 another one was on the issue of damages?

5 **A:** Yes.

6 **Q:** And so that would be -- let's clarify that. Do you have

7 500 cases where you've testified in brachial plexus injuries?

8 **A:** I don't know if I've testified in that many, but -- but

9 apart from those 2 examples, all my other testimony is on

10 behalf of a child.

11 **Q:** Now, when you look at this particular testimony I jotted

12 down, it seemed to me that you were suggesting that the

13 outcome of a permanent injury is what we see here is proof in

14 your mind of what took place in this case?

15 **A:** Yes, based on my knowledge of nerves and -- and -- and

16 newborns or the head and neck anatomy of the fetus, yes.

17 **Q:** All right. And you were here during opening statements?

18 **A:** I was.

19 **Q:** And did you hear my opening statement where I eluded to

20 different schools of thought with respect to these mechanisms

21 of injury?

22 **A:** Yes.

23 **Q:** And you're aware that there are other equally trained

24 people, I don't know if they're equally trained or how peoples

25 training compare, but people who have the same position as

1 you, Pediatric Neurologist, who believe that maternal forces
2 can cause permanent brachial plexus injury?
3 **A:** I'm aware that there are people who say that.
4 **Q:** You don't agree with them, but you recognize that they're
5 out there?
6 **A:** Well, I'm only -- I only partially disagree. I agree
7 that it can when the fetus is abnormal in some way, but my
8 opinion is that in a normal fetus, only movement of the head
9 after birth can cause three nerves to be avulsed and another
10 nerve structure to be torn apart.
11 **Q:** Do you agree that a permanent brachial plexus injury can
12 occur even the absence of a shoulder dystocia?
13 **A:** Well, as a general proposition, yes.
14 **Q:** And you agree that it's been reported, and you've seen
15 the brachial plexus shoulder injuries or Erb's Palsies
16 occurring in spontaneous deliveries even where the doctor
17 never even touches the baby?
18 **A:** Well, in the one case that's been verified, the injury
19 was temporary and went away in 4 days.
20 **Q:** And you agree that permanent brachial plexus injury has
21 been documented to occur as a result of the force of impaction
22 of the pubic bone, dissent of the shoulders from internal
23 contractions only without the doctor having touched the baby?
24 **A:** Yes, in an abnormal fetus, yes.
25 **Q:** And, doctor, you agree that permanent brachial plexus

1 injuries have been documented to occur following caesarean
2 sections?

3 A: That's also true.

4 Q: And when we talked about spontaneous delivery, that means
5 where the actual physician's hands never touch the baby,
6 right?

7 A: I think that's an obstetrical definition.

8 Q: Okay.

9 A: I'll leave it with that answer.

10 Q: In this case, you did testify previously and give a
11 deposition, so we had a chance to peruse your opinions and one
12 of the things that you relied upon in -- was some literature
13 that was authored by Dr. Suneet Chauhan; is that true?

14 A: True.

15 Q: I want to shift gears. I want to talk about your report
16 for a minute. It sounds to me like you saw Jahmerican on two
17 different occasions; is that right?

18 A: Right, 2016 and '18.

19 Q: And they flew up, saw you and the arrangement and the
20 visit was scheduled and arranged by Mr. Graham's law firm?

21 A: True.

22 Q: You weren't like a treating doctor; you weren't there to
23 provide treatment; it was -- it was for part of this
24 litigation to assist in your testimony?

25 A: Correct, I'm not his treating doctor.

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1 Q: You didn't provide any treatment, true?

2 A: True.

3 Q: Any recommendations for treatment?

4 A: Correct.

5 Q: And you didn't provide any sort of road map of things

6 that should be pursued or considered or contemplated?

7 A: No, he's been getting great care in South Carolina.

8 Q: And it sounded like what you testified to earlier is that

9 what you saw was consistent with all the medical records from

10 Shriner's and MUSC, the folks here in South Carolina?

11 A: Correct.

12 Q: So, basically, you just agree with the medical records?

13 A: Well, my opinion is based on exam and the medical

14 records. So, yes, I -- I -- my exams are consistent with what

15 doctors in South Carolina have been saying about Jahmerican

16 from the beginning.

17 Q: And it sounded like at the first visit that you had with

18 him in 2016, he was a little bit limited because he was

19 younger and not cooperating with you?

20 A: Correct.

21 Q: And the later visit, he was a little bit older and he was

22 cooperative and that gave you a better to chance to testing

23 his range of motion and things like that?

24 A: Correct.

25 Q: In between those two visits, you weren't involved with

1 Jahmerican at all, were you?

2 A: Correct.

3 Q: I noted in whatever exhibit number it was, maybe 28, you

4 just referenced that he wasn't receiving treatments for

5 therapies; I think I saw that noted on the 2016 and 2018

6 visits; is that -- is that your recollection?

7 A: You're talking about my reports?

8 Q: Yes.

9 A: That's what I was told at that time.

10 Q: And as I understood your earlier testimony, were you

11 suggesting that therapies are needed through the age of 21 or

12 until he stopped growing?

13 A: To maximize recovery, yes.

14 Q: All right. And so was there any conversation about that;

15 did you -- did you say hey, guys, to maximize recovery, while

16 you're here, let me just give you a pointer, let me just give

17 you a unsolicited piece of practice advice, let's pursue these

18 therapies; it might be helpful?

19 A: I would say that I'm certain that I did not do it here

20 and I generally don't do it unless there's an obvious medical

21 problem in front of me at the office that I see.

22 Q: All right. So, when you saw him just recently, you

23 didn't identify or it wasn't reported to you, any other active

24 medical problems, right?

25 A: Correct, not apart from the brachial plexus injury.

1 Everything is -- he's fine otherwise.

2 Q: Okay. And Jahmerican was complaining of pain?

3 A: Correct.

4 Q: And to be clear, there was no brain injury during this
5 delivery, true?

6 A: Absolutely no brain injury.

7 Q: All right. And so, if there's testimony in any regard
8 that Jahmerican may have some cognitive or brain development
9 issues, that has nothing to do with this delivery, true?

10 A: Correct, I would say it's not related to the birth in any
11 way.

12 Q: All right. And then I think it is as of your last visit,
13 you indicated that there are no future procedures or surgeries
14 that were noted; is that fair?

15 A: Nothing is -- I think I noted that nothing was currently
16 being -- nothing was currently under consideration. That's
17 the way it said.

18 Q: You were talking about the mechanism of injury and some
19 of the documents and things like that that you had looked at.
20 Did you read the testimony of Dr. Pliskow?

21 A: Yes.

22 Q: Okay. Is another expert who's working with the
23 plaintiff; is that right?

24 A: Yes, he's an obstetrician.

25 Q: Okay. And were you aware that he had authored an

1 affidavit; did you see that?

2 **A:** I've seen his affidavit.

3 **Q:** Okay. And in that affidavit, he suggested that there was
4 potentially lateral traction; do you remember that?

5 **A:** Yes.

6 **Q:** And do you remember in his deposition the OB expert
7 retracted that and said that he would not opine that there was
8 lateral traction; do you recall that?

9 **MR. GRAHAM:** Objection, Your Honor. May we approach?

10 **REPORTER'S NOTE:** (Bench conference with counsel).

11 **BY MR. HOOD:**

12 **Q:** I don't know where we ended up on that back and forth,
13 but ---

14 **A:** You asked me if I could recall him saying that in his
15 deposition and I was going to say I did not.

16 **Q:** You didn't recall that; but you did take a look at his --
17 at his transcript, did you not?

18 **A:** I did.

19 **Q:** Okay. So, whether the OBGYN expert opines about the
20 angle of traction, whether it was axial or lateral, you don't
21 recall that one way or the other?

22 **A:** I don't. My -- my only opinion is that the head in some
23 form must have moved to the left either by tilting or turning
24 in order to injure the nerves of the right brachial plexus;
25 that's been my testimony. I didn't specify which of the

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1 movements that it was or whether it was both, for that matter;
2 it could have been both.

3 Q: All right. You discussed actual nerves in the diagram
4 just a few moments ago; did you not?

5 A: I did.

6 Q: And in this case, you didn't actually look at the images
7 themselves, you were just relying on the reports from the
8 surgeons?

9 A: True.

10 Q: And so, what we're looking at in these pictures, these
11 are obviously enhanced demonstrative aides, these don't fairly
12 and accurately depict what our nerves look like, true?

13 A: Correct, the nerves are always yellow in drawings; that's
14 what a typical demonstrative aide looks like.

15 Q: And they're not that large?

16 A: They are not.

17 Q: This is just a tool, it's not -- we should not think of
18 this as being a fair or accurate depiction of Jahmerican's
19 actual injury, true?

20 A: I don't believe his injury looks exactly like that; I
21 think it's a good way to understand the injury if you're not
22 in the healthcare business. In that sense, it's very useful.

23 Q: Okay. And I think we're maybe splitting hairs here.
24 Useful is one thing, but to be an accurate depiction of it is
25 another; do you see this as a useful device?

1 **A:** I see it as useful; it's not exactly what his nerves look
2 like.
3 **Q:** With respect to future surgeries, that's something you
4 would defer to a Pediatric Orthopedic Surgeon like the folks
5 at Shriner's?
6 **A:** Yes.
7 **Q:** You talked about -- well, you don't believe that the
8 brachial plexus injury will have any impact on Jahmerican's
9 life expectancy, true?
10 **A:** True, he'll live a full life with that brachial plexus
11 injury.
12 **Q:** And you agree that just because there's a bad outcome
13 doesn't mean that there was medical negligence; do you agree
14 with that statement?
15 **A:** I do.
16 **Q:** And also, in your deposition, did you share with us that
17 you were relying on that nerve and nerve injuries article?
18 **A:** That's a textbook, sir.
19 **Q:** Excuse me, what textbook is that from?
20 **A:** Nerve and Nerve Injuries by Sunderland.
21 **Q:** And that was a 1978 edition?
22 **A:** Yes.
23 **Q:** You haven't published a single article in a peer review
24 journal related to any of the issues involving this case,
25 true?

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1 **A:** True.

2 **Q:** You testified on direct exam just a few moments ago, the

3 only good thing is that he can close his hand?

4 **A:** I don't know if I said it exactly that way, I said that's

5 a positive, in terms of function; that he can make a fist so

6 he can hold something.

7 **Q:** Okay. And you recognize as a Pediatric Neurologist that

8 obstetrical emergencies, there can be situations where a child

9 is born with a brain injury?

10 **A:** I'm not sure what you mean by that question. Brain

11 injuries can occur during an obstetrical condition, I'll

12 answer it that way.

13 **Q:** Yeah, you treat babies, pediatrics, children, who have

14 sustained brain injuries during delivery, true?

15 **A:** Absolutely.

16 **Q:** That didn't happen here?

17 **A:** It did not, correct.

18 **Q:** So, that would be to add to the column of the good news

19 here?

20 **A:** Correct, the good news is that the delivery was completed

21 successfully without a brain injury.

22 **Q:** Just bear with me one minute. No further questions.

23 **THE COURT:** Mr. Graham, limited to cross examination.

24 Okay? We're not going to get too far afield if you'd like to

25 redirect. Okay?

1 **MR. GRAHAM:** Yes, sir.

2 **THE COURT:** Okay. All right.

3 **REDIRECT EXAMINATION OF DR. DANIEL ADLER BY MR. GRAHAM:**

4 **Q:** Doctor, the hour is late and I'm going to try to just
5 move through a few things very carefully and quickly here.

6 You were asked a question about the potential of some
7 babies having brain injury depending on the circumstances. Is
8 it ever necessary or was it -- do you believe it was necessary
9 in a case like Jahmerican's to cause nerve damage like you've
10 described in order to avoid brain damage in a one minute
11 shoulder dystocia?

12 **MR. HOOD:** Objection, Your Honor, he's asking an
13 obstetrical standard of care question.

14 **THE COURT:** Rephrase your question. I think you just did
15 ask an obstetric question but rephrase it.

16 **BY MR. GRAHAM:**

17 **Q:** All right. You remember Mr. Hood asked you a question
18 about some babies have a risk of brain damage if certain
19 things happen. This is a one minute shoulder dystocia, right?

20 **A:** Correct.

21 **Q:** All right. To avoid any risk at all of brain damage in
22 Jahmerican's case, was it necessary for his head to be
23 manipulated ---

24 **THE COURT:** I'm not going to allow that. That requires
25 an obstetric opinion and he's not been qualified in that

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1 field. Go on.

2 **BY MR. GRAHAM:**

3 **Q:** There was a question put to you about can the forces of
4 labor ever cause nerve damage. I couldn't quite hear you; was
5 your answer that if the baby's in bad enough shape, that can
6 happen?

7 **MR. HOOD:** Objection, Your Honor, leading. He just needs
8 to ---

9 **THE COURT:** I'm sorry.

10 **MR. HOOD:** Objection to leading.

11 **THE COURT:** Okay. Yes, he is. Rephrase your question.

12 **BY MR. GRAHAM:**

13 **Q:** Is there any possibility that a child of Jahmerican's
14 health status and Apgar scores and blood core gases could have
15 been injured by forces of labor the way that he was -- the way
16 that his nerve occurred?

17 **A:** My opinion is that an injury of the type that Jahmerican
18 McCray suffered, three avulsions, complete and incomplete, and
19 then a rupture of another nerve structure involved in the
20 brachial plexus; that severe an injury can never occur as a
21 result of the forces of labor; it can only occur after the
22 head delivers and then the head is moved in some form.

23 **Q:** Mr. Hood asked you all kinds of questions about all kinds
24 of subjects. Did any of his questions and your answers change
25 the testimony that you gave earlier today?

1 **A:** No.

2 **Q:** Thank you. Nothing further.

3 **THE COURT:** All right, Mr. Hood?

4 **MR. HOOD:** No further questions, Your Honor.

5 **THE COURT:** All right. Thank you. Ladies and gentlemen,

6 we're going to adjourn for the evening. I'm sorry we went

7 over a little bit, but we wanted to finish up this witness.

8 I'd ask you to be back in your jury room at 9:30 in the

9 morning and could you take them to their jury room and show

10 them how to get back in in the morning.

11 **BAILIFF:** Yes, sir.

12 **THE COURT:** All right.

13 **REPORTER'S NOTE:** (Jury excused for the evening 5:44 P.M.)

14 **THE COURT:** Thank you, Dr. Adler.

15 **DR. ADLER:** Thank you, sir.

16 **THE COURT:** Will there be any further need for this

17 doctor during the trial?

18 **MR. HOOD:** Not from the defense, Your Honor.

19 **THE COURT:** Then you're released from your subpoena.

20 **DR. ADLER:** Thank you.

21 **THE COURT:** All right. Gentlemen 9:30 in the morning

22 please. Thank you.

23 **MR. GRAHAM:** Thank you, Your Honor.

24 **MR. HOOD:** A quick procedural question; does that need to

25 go on the record?

1 **THE COURT:** Yes, sir.

2 **MR. HOOD:** What is Your Honor's preference, I mean like,
3 in my house, when a lady gets up from the table, the guys
4 stand up; it makes people uncomfortable and then all of a
5 sudden, guys stand up or they don't. I don't want us either
6 standing up or not standing up with the jury coming in or
7 leaving. I just want to know ---

8 **THE COURT:** I always did it because I stood when ladies
9 entered the room, period.

10 **MR. HOOD:** Me too.

11 **THE COURT:** And so, that's what I prefer.

12 **MR. HOOD:** Okay. Thank you, Judge.

13 **(COURT ADJOURNED)**

14 **THE COURT:** Okay. Are we ready?

15 **MR. GRAHAM:** Your Honor, is there a possibility we could
16 hear some of the motions in limine before the first witness
17 today?

18 **THE COURT:** Certainly. It depends on how much time, I
19 will give you some time, but, you know, I might cut you off
20 sooner or later because I have a jury that's sitting back
21 there.

22 **MR. GRAHAM:** I understand, Your Honor.

23 **THE COURT:** Okay.

24 **MR. GRAHAM:** Some of these we can save for later when we
25 have some down time.

1 **THE COURT:** Tell me what -- who are your witnesses that
2 you propose to call this morning?

3 **MR. GRAHAM:** The first one is Dr. Pliskow, our OB expert.

4 **THE COURT:** All right.

5 **MR. GRAHAM:** The second one is the father.

6 **THE COURT:** All right.

7 **MR. GRAHAM:** The third one is Dr. Vanderkolk, the
8 vocational expert and my best estimate is that that will get
9 us through the day.

10 **THE COURT:** Okay. All right. Whose motions do we have;
11 you said there are motions in limine?

12 **MR. GRAHAM:** Yes, sir, mine as well as -- I'm not sure
13 counsel wants to raise theirs or not. Some of these are just
14 very, I think they'll be admitted to. One of them just as to
15 the collateral sources. We got some medical records coming in
16 -- I mean a medical bill summary.

17 **THE COURT:** Well, that should be redacted.

18 **MR. GRAHAM:** That's why we got the summary.

19 **THE COURT:** Okay.

20 **MR. GRAHAM:** And we just want to make sure there's no
21 questions about that Medicaid collateral source.

22 **THE COURT:** Well, Mr. Hood?

23 **MR. HOOD:** I don't intend to violate the collateral source
24 rule. I mean, if we've got any motions dealing with this
25 specific witness list ---

1 **THE COURT:** Let's do them. Let's talk about the
2 witnesses that we propose to call today.

3 **MR. GRAHAM:** Well, that would go to the father. We'll
4 put them in through the father, who will be the second
5 witness.

6 **MR. HOOD:** Mr. Graham, I'm not going to inquire about how
7 much insurance paid or anything like that.

8 **THE COURT:** Okay.

9 **MR. GRAHAM:** Okay. Number 13, Your Honor, we haven't
10 agreed on it, it just has to do, there was some -- some
11 misdemeanor issues with the father back in 2006. There was
12 another charge within the last ten years that was originally
13 filed in General Sessions and the General Sessions Judge
14 bounced it to Magistrate's Court. The Magistrate Court just
15 has it pending. My understanding is that they will be nolle
16 prosed because it's a very ---

17 **MR. HOOD:** I don't intend to get into that.

18 **THE COURT:** He's not going to get into it.

19 **MR. GRAHAM:** We got into this a bit yesterday on Mr.
20 Hood's cross examination. Number 19 raises a question about
21 any testimony that the child's nerves were weaker than normal
22 because of biological variance from one to another. Their
23 only witness qualified to testify about that is Dr. Duchowney
24 whose trial deposition has already been taken. He says that's
25 not an issue in this case, so we just want to make sure it

1 doesn't sneak in.

2 **THE COURT:** Well, Mr. Hood?

3 **MR. HOOD:** I think I'm free to cross examine his experts,
4 in which I did yesterday and that issue was not previous
5 position of the nerves; it had to do with how babies respond
6 to different things and we were talking about a lack of oxygen
7 and whether you could make a determination that it was going
8 to be five minutes for all babies or some, you know, were
9 better suited than others and I think that's all fair points.

10 **THE COURT:** I believe so as well, but you're talking
11 about two different things; you're talking about oxygen
12 deprivation and you're talking about, I think you're talking
13 about the propensity of some children to be more prone to
14 injury, nerve injury than others; is that what you were
15 saying?

16 **MR. GRAHAM:** Yes, there is some literature out there and
17 it's not consistent, but there's some literature out there
18 that says if a baby is in poor health before the shoulder
19 dystocia starts, so that they're already oxygen deprived and
20 they're muscles have bad tone, that that makes them have more
21 susceptibility to getting injured.

22 **THE COURT:** Is there any evidence that this child was
23 anything other than a healthy child?

24 **MR. GRAHAM:** No, sir, which is the basis of my point.

25 **THE COURT:** Okay. Mr. Hood, I mean, do you have

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1 something to indicate otherwise?

2 **MR. HOOD:** I don't really know what he's talking about,
3 Judge. I mean ---

4 **THE COURT:** I'm not sure either, but, you know, I want to
5 follow him here.

6 **MR. HOOD:** --- so, yesterday he put up all of his
7 evidence from the neurology standpoint. My evidence from a
8 neurology standpoint is contained in a series of two
9 depositions that we're going to present to the Court and so I
10 think all these issues are sort of past us. I don't know that
11 there's going to be anyone else talking about nerves again
12 other than what's in the can and is already out.

13 **THE COURT:** Well, and then unless Mr. Graham brings it
14 up, I mean, unless he -- do you propose to offer another
15 witness on neurological issues?

16 **MR. GRAHAM:** No, sir.

17 **THE COURT:** Okay.

18 **MR. GRAHAM:** I just, out of an abundance of caution, I
19 just wanted to make sure that we didn't have any issues there.

20 **THE COURT:** Okay. All right.

21 **MR. GRAHAM:** That's it.

22 **THE COURT:** You seem to be in agreement, I'm not real
23 sure what we're talking about, but I -- am I correct that you
24 are telling me that there is some thought in the literature
25 somewhere that the propensity to be susceptible to this type

1 of -- of stress injury on a nerve is more prevalent in some
2 children than others and it has to do with muscle tone and
3 things of that nature; is that -- is that what you're saying?

4 **MR. GRAHAM:** What I'm trying to say, Your Honor, is that
5 there's literature out there that we don't believe is valid,
6 but it does exist out there.

7 **THE COURT:** Okay. All right.

8 **MR. GRAHAM:** And it says ---

9 **THE COURT:** All right.

10 **MR. GRAHAM:** --- that says if a baby is already floppy
11 and, you know, oxygen deprived and in horrible health before
12 the shoulder gets stuck, that that floppiness based on the
13 element triggered to make that nerve more susceptible ---

14 **THE COURT:** All right.

15 **MR. GRAHAM:** That has nothing to do with any issue in
16 this case.

17 **THE COURT:** Well, I don't know if it does or not. But if
18 there is expert opinion that could be produced and by now, you
19 should certainly know if you've taken Mr. Hood's expert's
20 deposition, I think you could explore it for what it's worth
21 and of course, you could challenge it?

22 **MR. GRAHAM:** Yes, sir. Well, here's my point, Your
23 Honor. Their only expert that I believe would be qualified to
24 address that topic has already given his trial deposition;
25 he's in South America. We've got it ---

1 **THE COURT:** So, you know exactly what's gone come of it?

2 **MR. GRAHAM:** Yes, and my point is, I don't want anybody
3 that is not qualified to sneak it in because some of the --
4 some of the obstetrical experts that have written literature,
5 really get into some neurological issues in their articles. I
6 just want to make sure they don't do that in their testimony.

7 **THE COURT:** Who would do that?

8 **MR. GRAHAM:** One of his experts ---

9 **THE COURT:** His are depositions, deposition experts,
10 right?

11 **MR. GRAHAM:** They're on the Pediatric Neurologist is in
12 the can for his trial deposition.

13 **THE COURT:** Okay.

14 **MR. GRAHAM:** They have -- they have two maternal fetal
15 experts, obstetricians with a subspecialty. Those, well one,
16 especially, Dr. Chauhan has written, he's a prolific author of
17 all kinds of articles. Some of those delve into some
18 neurological issues that we don't believe he's qualified to
19 talk about.

20 **THE COURT:** And you make that objection.

21 **MR. GRAHAM:** Well, we just wanted to do it ahead of time,
22 Your Honor.

23 **THE COURT:** Well, I don't know what he's going to say and
24 motions in limine are always difficult because the context in
25 which testimony may be offered or a -- or an exhibit or

1 evidence may be offered, determines whether or not there's
2 relevancy, it determines that -- what the probative value
3 would be and that goes to whether it should be excluded under
4 403. There's so many things that can, must be considered in
5 whether or not a piece of evidence or testimony should be
6 excluded. And, you know, I'm just going to have to defer a
7 ruling on that until I see how it's presented, if it's
8 presented. Okay?

9 **MR. GRAHAM:** I hear loud and clear. Thank you very much.

10 **THE COURT:** All right. Thank you.

11 **MR. HOOD:** Judge, just one issue, Mr. Graham shared with
12 me a -- what I think he's going to try to introduce as a
13 treatise with an expert. I typically wouldn't bring it up
14 ahead of time, but this is something that we don't have the
15 actual treatise, this is all that Mr. Graham has. I believe
16 it was published in 1998; it wasn't something the expert
17 reviewed or relied upon or produced during the course of his
18 deposition or produced in discovery. So, we would object to
19 using a treatise, a portion of a treatise, where the treatise,
20 in itself, is not available. We don't have any contacts. We
21 don't know anything other than what Mr. Graham showed us.

22 **THE COURT:** Well, of course the rule, the hearsay rule
23 would, as an exception for learned treatise.

24 **MR. HOOD:** Yes, sir.

25 **THE COURT:** First, it must be identified as a learned

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1 treatise; it must meet the standard. Then of course he can
2 ask the witness to testify or read from it. He can ask him
3 what his opinion may be on it. It seems to me that you're
4 saying I object because I haven't had an opportunity to look
5 at it.

6 **MR. HOOD:** Well, two things, number one, it should have
7 been produced and it wasn't. Number two is that under the
8 rule of completeness, he's handed him a blow-up; not a
9 treatise, but a portion, an excerpt, noone has the entire
10 treatise and ---

11 **THE COURT:** Who's going to authenticate that?

12 **MR. HOOD:** I have no -- I have no idea.

13 **MR. GRAHAM:** Judge, Dr. Pliskow.

14 **THE COURT:** I mean, he's going to say this is a quote
15 from a certain treatise?

16 **MR. GRAHAM:** Yes, sir. If Your Honor, please, we've got
17 the cover of the book; we have ---

18 **THE COURT:** You can't judge a book by its' cover, Mr.
19 Graham.

20 **MR. GRAHAM:** He's familiar as rain with what's behind me,
21 Your Honor. This is a blowup of language taken from this
22 paragraph on this page. Again, I was just going to read into
23 the --

24 **THE COURT:** Well, what -- what's -- what's the
25 periodical, what's the ---

1 **MR. GRAHAM:** It's ---

2 **THE COURT:** --- what do we have?

3 **MR. GRAHAM:** It's ACOG publication the American College
4 of Obstetricians and Gynecologists of which -- which is
5 published a lot of literature since '98 that is pretty much
6 the opposite of what this one says. We want to be able to
7 show that in '98, ACOG was saying one thing before their
8 witnesses ---

9 **THE COURT:** Well, let me ask you, what's the purpose in
10 your offering that, first of all; are you attempting to
11 introduce an opinion outside of the expertise of a particular
12 witness ---

13 **MR. GRAHAM:** No.

14 **THE COURT:** --- by his reference to some learned treatise
15 or are you offering that in support of his position or his
16 testimony in connection with his expert opinion; what -- what
17 -- why are we are offering it; what's the purpose of that?

18 **MR. GRAHAM:** First, of course, to identify it's reliable
19 ---

20 **THE COURT:** That's the foundation. That's the foundation
21 you must establish.

22 **MR. GRAHAM:** That's the foundation and then my proposal
23 was to just to read him either all or the relevant portion of
24 this page, ask him if he agrees with it and what affect does
25 it have on his opinion; if he says he supports it, it's

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1 consistent with it. It's one of the things that's part of
2 education that ---

3 **THE COURT:** Well, is he going to tell you then that he is
4 familiar with the document?

5 **MR. GRAHAM:** Absolutely.

6 **THE COURT:** Mr. Hood?

7 **MR. HOOD:** Part of the challenge here, Judge, I've been
8 online looking for it, is that this is an outdated no longer
9 used publication. It's not peer reviewed, it was published in
10 1998. An updated version of this same type of information
11 was, I think in 2013. So, they don't even make it available
12 for sale. So, I don't know what it says and I'm not sure how
13 a witness can authenticate an article from 1998 unless he
14 actually holds the article from 1998, unless he authored or
15 participated in it or had seen it in discovery.

16 **THE COURT:** Well, Mr. Graham, you must have the -- is it
17 a book, a periodical?

18 **MR. GRAHAM:** It's a book about the size of a large legal
19 pad.

20 **THE COURT:** Well, where is it, I mean, don't we have to -
21 --

22 **MR. GRAHAM:** I thought, Your Honor, I thought I had it in
23 my materials that I brought down here. I realize that I
24 mistakenly ---

25 **THE COURT:** Well, who's going to testify to that; who

1 will offer that testimony?

2 **MR. GRAHAM:** Dr. Pliskow.

3 **THE COURT:** And we're talking about him the last witness
4 this afternoon, right?

5 **MR. GRAHAM:** First.

6 **THE COURT:** First witness this morning. Okay. Well, I
7 think he can -- he can reference it, but he's going to be
8 subject to Mr. Hood's cross examination. Okay?

9 **MR. GRAHAM:** Yes, sir.

10 **THE COURT:** And there again, that's a qualified admission
11 of it. It's qualified when I hear his testimony, I hear the
12 circumstances surrounding the testimony, the foundation, I may
13 change my mind, but we'll just see. Okay?

14 **MR. GRAHAM:** Yes, sir. Just -- just by way of
15 background, briefly, Your Honor. Yesterday, Mr. Hood was
16 talking about two schools of thought. In 1998, there was one
17 school of thought. ACOG itself, which is who they relied on
18 in all of their publications that we're going to hear about
19 later in the trial, developed their school of thought after
20 the whole world unanimously agreed with this.

21 **THE COURT:** Okay. All right. Okay. I'm going to let
22 you ask him about it at this juncture. I may change my mind,
23 but as a preliminary matter, I'm not going to grant a motion
24 in limine at this time. Okay?

25 **MR. GRAHAM:** Thank you, Your Honor.

1 **THE COURT:** All right. Let's see, what else do we have
2 as far as that witness is concerned, Mr. Hood?

3 **MR. HOOD:** Nothing from me, Your Honor.

4 **THE COURT:** All right. Very well. Bring the jury -- oh,
5 you have something else?

6 **MR. GRAHAM:** No, Your Honor.

7 **THE COURT:** All right. Let's bring the jury in please.

8 **REPORTER'S NOTE:** (Jury enters courtroom 9:54 A.M.).

9 **THE COURT:** All right. I think we have all our jurors.
10 Please be seated, please. Ladies and gentlemen, it's good to
11 see you back this morning. I have a surprise for you. We
12 have a brand new Judge here with me. This is Judge Bentley
13 Price. He has been a practicing lawyer for a number of years
14 as a threshold that we all we have to practice before we're
15 eligible to even run for a judgeship. He was elected and he
16 sits down for his resident county is Charleston County. Like
17 all judges, he is required to do a shadowing period, where he
18 will sit, although he has a lot of trial experience, he will
19 sit with some other Judge. This week, he was in Greenville,
20 South Carolina and that court finished all of its work. So,
21 our Court Administration sent Judge Price down here to sit
22 with me. It's a special pleasure for me to have him because I
23 remember when he was born. He was -- he grew up in my church,
24 Trinity Methodist Church over in Conway and his parents were
25 great friends of mine. It's a wonderful thing to see him now

1 sitting on the bench and it's even better to have him sit with
2 me. Later in this trial, you may hear from him just on some
3 matters. Maybe even the charge in this case, I'm not sure.

4 Over here at this table are Ms. Julie Beeks, who is his
5 law clerk and my law clerk, Brad Jenkins. We sort of moved
6 them off to the side this morning. But, it's, as I said, a
7 pleasure not only to have you here, but to have Judge Price
8 with me and we're ready to go forward again and please
9 understand, I told you 9:30; I was on this bench at 9:30. We
10 just had some other things that had to be addressed involving
11 this trial and occasionally that will happen. We try not to
12 waste your time, but we will sometimes we have to do those
13 things.

14 Okay. Mr. Graham, are you ready to proceed?

15 **MR. GRAHAM:** Yes, sir, Your Honor. The witness was
16 standing out here while we were having that discussion. Dr.
17 Pliskow, please take the witness stand.

18 **THE COURT:** Come around, sir.

19 **MR. GRAHAM:** Dr. Steve Pliskow is our next witness.

20 **REPORTER'S NOTE:** (Dr. Steven Pliskow sworn by the
21 Clerk).

22 **DR. STEVEN PLISKOW, HAVING BEEN**
23 **DULY SWORN TESTIFIES AS FOLLOWS:**

24 **CLERK:** Okay. You may be seated.

25 **THE COURT:** Mr. Graham.

1 **CLERK:** Please state and spell your full name for the
2 Court?

3 **DR. PLISKOW:** My name is Steven, S-T-E-V-E-N, last name,
4 Pliskow, P-L-I-S-K-O-W.

5 **DIRECT EXAMINATION OF DR. STEVEN PLISKOW BY MR. GRAHAM:**

6 **Q:** Good morning, Dr. Pliskow?

7 **A:** Good morning, sir.

8 **Q:** Your Honor, we offer Dr. Pliskow's CV, Exhibit Number 31
9 with no objection.

10 **THE COURT:** Mr. Hood?

11 **MR. HOOD:** No objection.

12 **THE COURT:** All right. Without objection.

13 **PLAINTIFF'S EXHIBIT NUMBER 31**

14 **ADMITTED INTO EVIDENCE**

15 **BY MR. GRAHAM:**

16 **Q:** Doctor, just to get right into this, you are an
17 obstetrician practicing in West Palm Beach; is that correct?

18 **A:** That's correct.

19 **Q:** Okay. Tell us, please, introduce yourself to the jury in
20 terms of personal background and professional background?

21 **A:** Sure. My name is Steve Pliskow. I'm currently
22 practicing in a full service OBGYN practice in West Palm
23 Beach, Florida. I have two offices there. I deliver at two
24 hospitals. My practice itself is about fifty percent
25 gynecology, fifty percent obstetrics. I do all the current

1 surgeries that are available; NGYN as well as all the
2 obstetric routine procedures. I'm originally from New York.
3 I did my college and med school in upstate New York. I was
4 accepted out of high school to the six-year med program with
5 Rensselaer Polytechnic Institute and Albany Medical College.
6 I went to eight years of college and med school and six years
7 going every summer. Then from there, I went to the University
8 of Miami, where I did my OBGYN training. I was there for four
9 years and then subsequently came to West Palm Beach, where
10 I've been in practice since 1990 in the same practice.

11 **Q:** Thank you. Just going through your CV here, I see a
12 reference to Miami Rape Treatment Center staff physician;
13 could you tell us about that?

14 **A:** Sure. During the last two years that I was a resident
15 the University of Miami, I worked at the Rape Treatment Center
16 under Dorothy Hicks, who was one of the nation's experts in --
17 in rape treatment. I was a staff physician there doing intake
18 exams on victims, alleged victims and I had to testify at
19 trial in some of those cases and give depositions as to my
20 findings.

21 **Q:** Is that when your interest in courtroom procedures and
22 testimony became interesting to you?

23 **A:** Yes, I think that that was one of my main introductions
24 into the legal aspects of medicine and being in a courtroom.
25 Also, my brother was a defense, criminal defense attorney.

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1 So, I was exposed during my high school years, to the legal
2 process.

3 **Q:** During your residency training, what was your role among
4 your peers; I see on your resume it says chief resident, what
5 does that mean?

6 **A:** Yeah, so if you graduate through the first three years of
7 your residency program and we had ten residents in each year;
8 we had forty residents in our program, because our program did
9 approximately 16,000 deliveries a year during the time that I
10 was at Jackson Memorial. It's one of the busiest programs in
11 the country; I think it's ranked third as far as number of
12 deliveries. But, all of the residents, once they go through
13 the first year, the three years and get into the fourth year,
14 they become chief residents. So, that just means that you're
15 a fourth year resident getting ready to graduate. There are
16 two administrative chiefs; some of the programs have one, our
17 program had two because it was so large and those are the
18 chief residents that make the schedules for what rotations
19 people would be on and we'd bring information back from the
20 faculty back to the residents. I was not one of the
21 administrative chiefs.

22 **Q:** Thank you. What does it mean to be board certified?

23 **A:** So, I was always talking about these residency programs
24 that we go through. Once you finish med school, you choose
25 what specialty you want to go into and then there's a match

1 system, where you interview at different residency programs
2 and then they -- residency programs rank you where they want
3 to have you in their program and you rank them and then
4 there's a computer match that comes out around this time of
5 year every year. Then, once you're accepted into an
6 accredited residency program, depending on what the specialty
7 is, as how many years that residency training is. It's kind
8 of like on the job training and you're being watched very
9 closely to make sure that you're learning all of the aspects
10 of that field and have constant input with the attendings who
11 are there and correcting you and making sure that you're doing
12 things correctly before you graduate from that accredited
13 program.

14 At the end of that on the job training, there is a
15 written exam that you would take in most of the fields. OBGYN
16 is one of them. Once you finish that, you pass that test,
17 that written test, you become board eligible. And then the
18 board certification process requires for OBGYN's sitting for
19 your oral boards. We are questioned by a bunch of attendings
20 again from other parts of the country that all meet, usually
21 it's in Chicago, and at that point in time, if you pass that
22 second part of the board, the oral board, you become board
23 certified. And that's the highest, as a generalist OBGYN
24 really the highest level of certification that we can get.

25 Q: Thank you. So, when did you first become board

1 certified?

2 **A:** So, board eligible was 1990, after I finished my
3 residency program and then 1992 became board certified. You
4 have to go out into private practice and amass, or you can do
5 it at a hospital as well, but you need to amass a bunch of --
6 a certain number of cases; deliveries, cesarean sections, gyn
7 surgeries, before you would be eligible to sit for the board
8 and that was in 1992.

9 **Q:** Thank you, sir. Looking down your resume, I see -- I see
10 something here in 1998, there's something called the American
11 Board of Forensic Medicine. What on earth is that?

12 **A:** That's really -- it's not an accredited board as would be
13 OBGYN. It's not something that you do any residency training
14 for or even take a certification exam. There used to be an
15 exam with that program back twenty/thirty years ago, but
16 they've done away with it. It's basically an organization
17 where a group of likeminded individuals would share
18 information with regards to legal profession and it's not just
19 medicine, it could be also accounting, engineering, anything
20 that has to do with the interface between any of those
21 practices, any of those fields and the legal profession. They
22 do some, either monthly or quarterly, a magazine which I get,
23 which I read. They also co-sponsor some continuing education
24 courses, which I went to once, maybe ten or fifteen years ago.
25 And that's really all it is.

1 Q: Which hospitals have you had appointments in?

2 A: I've had appointments at five different hospitals in the
3 West Palm Beach, Palm Beach County area. Saint Mary's Good
4 Samaritan and what was Columbia Forty-Fifth Street and now it
5 is Jackson North. I know longer have privileges at those
6 hospitals because of geographic location. We've pretty much,
7 because of the size of Palm Beach County, now the number of
8 patients in our practice just are now concentrating on western
9 communities which is the Wellington, Wakodahatchee area and I
10 have two hospital privileges there, which is at Palm's West
11 Hospital, which is an HCA facility and Wellington Regional
12 Medical Center, which is a Universal Health Systems Hospital.

13 Q: What teaching activities, if any, have you had in the
14 field of obstetrics?

15 A: Well, right now currently, I am a clinical professor for
16 Palm Beach Graduate Medical Education Group. It's a group
17 that is responsible for training medical students in OBGYN
18 from different facilities. Right now, I am a clinical
19 associate professor of OBGYN at Kansas City University and
20 what that entails is the medical students, third year medical
21 students come from Kansas City University from Kansas City to
22 West Palm Beach to rotate with my practice on a monthly basis.
23 I get a new student every month and then train them in what is
24 OBGYN so that they can have information for their medical
25 school and be able to take their boards.

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1 Also, as part of Palm Beach Graduate Medical Education
2 Group, I teach OBGYN to first year residents in pediatrics and
3 family practice and emergency room medicine from the different
4 residency programs in those fields that are in our area in
5 Palm Beach County.

6 **Q:** At some point in your career, did you serve on hospital
7 committees or boards that would critique the actions of other
8 physicians that had had bad outcomes?

9 **A:** Yes. Currently I'm a vice-chair of the board of trustees
10 of Palm's West Hospital. Currently, in that position, it does
11 come up on occasion where a physician would be brought up to
12 the board of trustees to make a final decision on their
13 appointment or not, whether or not they need to be let go for
14 certain violations, whatever they may be; it could be medical,
15 it could be behavior. I have been on and I'm the chairman of
16 the OBGYN Department at that same hospital. I have been on
17 the credentials committee at that hospital and I've also
18 served on the peer review committee, where we review charts,
19 anything that falls out of the norm of practice for OBGYN at
20 my hospital.

21 **Q:** In doing so, were there times when you would exonerate
22 the physician for their involvement with regard to the care
23 that led to the bad outcome and other times when you do the
24 opposite?

25 **A:** Well, certainly. I mean, when we review a chart, we

1 review a chart in a non-bias way, looking at both -- well,
2 first of all, what you need to do anytime you review a chart
3 is put yourself in the physician's situation at the time. Try
4 not to use the retrospect to scope and knowing what the
5 outcome is, looking backward, you want to check when you're
6 looking at a certain page of a medical record, you want to be
7 looking at that page of the medical record like the physician
8 would be doing it at that time. That's the only way you can
9 really judge whether somebody is doing something appropriately
10 and following the standard of care. So, that's what I would
11 do and sure, there were times that we exonerated physicians
12 and there were times where we would send maybe a letter, a
13 reprimand that would be tracking whatever the problem was with
14 the physician and there are times where with tracking, the
15 problem had occurred so many times that we needed to take
16 further action.

17 Q: Are you a fellow and diplomat of the American College of
18 Obstetrics and Gynecology?

19 A: Yes, sir.

20 Q: Is that the primary group nationally for obstetricians
21 and gynecologists in this country that does various activities
22 on behalf of its members?

23 A: Yes, you'll hear it referred to as ACOG. The board
24 certification is ABOG and ACOG is that college of OBGYN that
25 we are members of, yes.

1 **Q:** All right. Your CV lists a bunch of other
2 organizations; I don't want to take the time to go through
3 those individual ones, but are you a member of the typical
4 organizations that you would expect from a practitioner such
5 as you in the West Palm area?

6 **A:** Sure, I'm a member of our local, state and national
7 organization, medical organizations.

8 **Q:** All right. Your Honor, I'm going to proffer Dr. Pliskow
9 as an expert in the field of obstetrics and gynecology?

10 **THE COURT:** Mr. Hood, would you like the opportunity to
11 cross examine him as to his qualifications?

12 **MR. HOOD:** Not at this time, Your Honor, thank you.

13 **THE COURT:** All right. Very well. Ladies and gentlemen,
14 this witness has been offered again as an expert in the field
15 of obstetrics and gynecology. As I talked to you yesterday, I
16 explained that certain people who by their education or
17 experience have become what we refer to as experts in a
18 particular field or science and those people, unlike a lay
19 person, are permitted to give an opinion in a trial.
20 Normally, a layperson who testifies, can testify as to what he
21 saw or smelled or heard, but is unable to give an opinion. An
22 expert is permitted to give an opinion. The Court is now
23 making a preliminary finding that this witness has met the
24 qualifications to give an opinion in the field of obstetrics
25 and gynecology.

1 Now, it is entirely up to you as to whether or not you
2 will accept his opinion. It's entirely up to you as what
3 weight you will give to his opinion. If you feel that his
4 education is not adequate or the reasons that he gives for an
5 opinion are not sound, you have the right to reject his
6 opinion or you can accept his opinion just as though you were
7 hearing from any other witness.

8 Now, Mr. Graham?

9 **MR. GRAHAM:** Thank you, Your Honor.

10 **BY MR. GRAHAM:**

11 **Q:** Doctor, I neglected to mention on your CV, there are a
12 number of articles and research that you authored, correct?

13 **A:** Yes, sir.

14 **Q:** And I'm not going to go into those in any detail.
15 Doctor, let me ask you, did you, at my request, review the
16 medical records and the depositions in this case to evaluate
17 the issues related to standards of care and violations of
18 standard of care and what caused the injury and that sort of
19 thing?

20 **A:** Yes, sir, I have.

21 **Q:** Let me ask you if you, with His Honor's permission. Your
22 Honor, may we have him step down and go through the important
23 medical documents?

24 **THE COURT:** Certainly.

25 **MR. GRAHAM:** May I approach, Your Honor?

1 **THE COURT:** Certainly.

2 **MR. GRAHAM:** Your Honor, we would move for admission of
3 certain medical documents and I believe it's with no
4 objection?

5 **THE COURT:** Well, identify them and let's see.

6 **MR. GRAHAM:** Yes, sir. Yes, sir, I was getting ready to.
7 Exhibit 5 are the fetal heart monitor strips starting at time
8 it looks 2:12 at least in the top block.

9 **THE COURT:** Okay. Mr. Hood?

10 **MR. HOOD:** No objection, Your Honor.

11 **PLAINTIFF'S EXHIBIT NUMBER 5**

12 **ADMITTED INTO EVIDENCE**

13 **MR. GRAHAM:** We have Exhibit 6, which is a typed labor
14 record. At the bottom it's stamped title and Georgetown
15 Memorial, mom, 21.

16 **THE COURT:** Mr. Hood?

17 **MR. HOOD:** No objection, Your Honor?

18 **THE COURT:** All right.

19 **PLAINTIFF'S EXHIBIT NUMBER 6**

20 **ADMITTED INTO EVIDENCE**

21 **MR. GRAHAM:** And the second page, 22. Next we have
22 Exhibit 2, which is a handwritten shoulder dystocia note dated
23 4/28/13.

24 **MR. HOOD:** No objection, Your Honor.

25 **THE COURT:** All right. Without objection, what was that

1 the number?

2 MR. GRAHAM: 2.

3 THE COURT: 2, okay.

4 PLAINTIFF'S EXHIBIT NUMBER 2

5 ADMITTED INTO EVIDENCE

6 MR. GRAHAM: And we have another written note, it's
7 called DEL note for delivery note dated 4/27/13, Exhibit 13.

8 THE COURT: Mr. Hood?

9 MR. HOOD: No objection.

10 THE COURT: All right.

11 PLAINTIFF'S EXHIBIT NUMBER 13

12 ADMITTED INTO EVIDENCE

13 MR. GRAHAM: Next, Your Honor, we have Exhibit 11, which
14 is a delivery report. It's stamped, Tidelands Georgetown
15 Memorial, mom, 204.

16 MR. HOOD: No objection, Your Honor.

17 THE COURT: All right. It's admitted without objection.

18 PLAINTIFF'S EXHIBIT NUMBER 11

19 ADMITTED INTO EVIDENCE

20 MR. GRAHAM: And I believe we already put in Number 12.
21 Your Honor, we would also offer it as Exhibit Number 12, a --
22 a document bate stamped, Tidelands Georgetown Memorial, mom,
23 27, entitled shoulder dystocia progress note.

24 THE COURT: Mr. Hood?

25 MR. HOOD: No objection, Your Honor.

1 **THE COURT:** It's admitted.

2 **MR. GRAHAM:** Thank you, Your Honor.

3 **PLAINTIFF'S EXHIBIT NUMBER 12**

4 **ADMITTED INTO EVIDENCE**

5 **BY MR. GRAHAM:**

6 **Q:** Doctor, before we get into, eventually I'd like you to
7 stand up and use the enlarged medical records, but before we
8 do that, let me ask you about this document, Exhibit Number 5;
9 what is that, sir?

10 **A:** That's a fetal monitoring tracing and tracing of the
11 uterine contractions.

12 **Q:** Okay. At the bottom of the -- if you could just hold it
13 up. At the -- so, we've got three strips on this page; is
14 that correct?

15 **A:** That's correct.

16 **Q:** And if we focus on one single strip, the bottom line
17 represents what?

18 **A:** Uterine contractions in millimeters of mercury.

19 **Q:** So, that's over my head. What are you talking about?

20 **A:** Basically, what that bottom line shows you is when a
21 contraction begins, how long it takes to occur, when the next
22 one will occur, how long it is between the contractions and it
23 gives you an estimate, and when we talk about millimeters of
24 mercury, we talk about the pressure inside the uterus of the
25 contraction, how strong the contraction is. Because this is

1 an external monitor, meaning on the outside. It has to
2 monitor through the abdominal wall and it's not as accurate as
3 if the pressure monitor is put inside the uterus and that
4 gives you a better numerical observation of how strong a
5 contraction is. So, strength cannot be determined accurately
6 on an external monitor.

7 Q: Let me stop you there. Of course, as we know, there was
8 an inner, IPCU or ---

9 A: IUPC, intrauterine pressure catheter.

10 Q: All right. We know that was used in this case. Do you
11 recall off the top of your head, when that was placed?

12 A: I wasn't there initially, but it was placed later on in
13 the labor.

14 Q: Okay. And once that was placed, the device that I can't
15 spell right, once that was placed, at that point, was there
16 any difference in terms of the accuracy measurement of the
17 strength of the contractions?

18 A: Yes, that would give you a more accurate reading of what
19 the strength of the contractions are.

20 Q: So, that's available to any health care provider in the
21 delivery room after the device was placed?

22 A: Yes.

23 Q: We talked about the bottom, now it looks like there are
24 two lines above that; what are those two?

25 A: The top lines are readings of heart rates and one is

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1 maternal, mom's heart rate; the other fetal, the baby's heart
2 rate.

3 Q: Okay. So, you know, it looks like some kind of shock
4 test to me, but what does it tell the obstetrician; what's --
5 what's the whole purpose of this?

6 A: The purpose of that is to monitor labor, monitor the
7 progress of labor, and monitor how the baby is responding to
8 the labor.

9 Q: So, the part -- are you telling us this is babies' way of
10 communicating how it liked that last contraction?

11 A: Yes, that's one way to put it, sure. You can basically
12 tell if a strip is, what we call reactive, meaning that with
13 fetal movement, the baby's heartrate is in a normal range.
14 The beats variability which tells how the baby is responding
15 from one heartbeat to the next, whether or not there is some
16 variability there. It tells you how the baby is responding to
17 a contraction; is the heartrate going down; is the heartrate
18 going up. Basically, it tells you how the oxygenation is for
19 the baby at that time; if it's good. If the strip is not
20 good, then the baby may still be okay, but it may not be okay.
21 It's not as accurate for that, but when it's good; it's good.

22 Q: Thank you. And going into this shoulder dystocia, did
23 you study these records to see about whether it's good or not
24 good? In other words ---

25 A: Yeah.

1 Q: Do these records tell you on a scale of well to hardly
2 sick, whether the baby was well or something else?

3 A: Yes.

4 Q: All right. And what was his fate?

5 A: The baby was fine. It was stable going into the shoulder
6 dystocia.

7 Q: Thank you. Now, we've got some enlargements of medical
8 records up here. You want me to pick one or is there some
9 that you'd like to start with?

10 A: Whatever you prefer?

11 Q: Let's just start with this one.

12 MR. HOOD: If you could call the exhibit number out, so -
13 --

14 MR. GRAHAM: Oh, sure. It's 11-A.

15 BY MR. GRAHAM:

16 Q: And let's see, all right. Tell us what this is and what
17 it means to you?

18 A: So, this is a typed delivery report for Ms. Smalling.
19 And basically, what it is discussing is the documentation of
20 the shoulder dystocia. It tells the time of the head
21 delivery, then the time of the body delivery. That's the very
22 first aspect of the form. And basically, what a shoulder
23 dystocia is, what this case is all about, is when during a
24 normal delivery, the head comes out and then the rest of the
25 baby comes out. With a shoulder dystocia, the head comes out

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1 and the baby gets stuck. The shoulders, which is the next
2 part to come out after the head, doesn't come out; it's stuck
3 by the boney structures of the pelvis. And in this particular
4 case, and in some cases, not all cases, it is the anterior,
5 shoulder to shoulder, that is more toward the ceiling that
6 gets stuck behind the pubic bone.

7 Q: Did you complete ---

8 A: No, I'm still over here.

9 Q: I'm sorry, just, yeah, just I don't want to interrupt
10 you. Just start at the top, go to the bottom, tell us what
11 you -- what kind of importance you place on that?

12 A: Okay. So, basically, what it says is that time of that
13 delivery was on 4/27, April 27, 2013 at 8 o'clock and 14
14 minutes, 8:14, 08:14. So, 8:14 in the morning. That's when
15 the head delivered and then the body delivered, the baby
16 completed delivery at 8:15. So, that tells us that the
17 dystocia, the amount of time between the delivery of the head
18 and the delivery of the body, head to body interval, as it's
19 called, is one minute. Then there is the next box, which says
20 initial traction and that is checked and it says gentle
21 attempt at traction assisted by maternal expulsive forces and
22 basically, what that means is while mom is pushing, she's
23 encouraged to push, there is an attempt to deliver the
24 shoulder with the head by gentle guidance of the head and
25 shoulder through the birth canal. And if that fails, that

1 basically makes the diagnosis of shoulder dystocia. The head
2 doesn't -- the body is not following after the head with the
3 normal mechanisms of labor, which would be mom pushing and
4 this gentle guidance of traction. And traction is the same as
5 force that's applied and when we say gentle, we are just using
6 the normal, we're assisting or guiding mom's normal pushing
7 and the baby's movement through the birth canal.

8 **Q:** Excuse me just a moment. I noticed when you were talking
9 about traction, you moved your hands toward you. Is traction
10 pulling as opposed to pushing?

11 **A:** Yes, traction is defined as a pulling force. However,
12 you never pull on a baby. Gentle traction is synonymous with
13 a guiding of the baby through the birth canal. There's no
14 actual pulling, where you would be pulling the head from the
15 shoulder or stretching the neck or anything like that.

16 **Q:** Thank you. Please continue.

17 **A:** Verified fundal pressure was not applied after the head
18 delivery. It says not applied. So, basically, what that
19 means, the uterus is enlarged all the way up to the mom's
20 sternum before the baby delivers and fundal pressure is an
21 application of force by an outside provider, usually a nurse,
22 to the top of the uterus, to the fundus of the uterus. That's
23 call fundal pressure and it's documented here by the nurses at
24 the time that fundal pressure was not applied. There is some
25 discrepancy in whether it was or wasn't, based on the

1 deposition testimonies in this case, but it is on this sheet,
2 documented as not applied.

3 Q: Is fundal pressure something that should or should not be
4 applied in a shoulder dystocia situation?

5 A: Yes, in a shoulder dystocia situation, fundal pressure
6 should not be applied, because what it does, is it basically
7 pushes the baby down. Remember, the -- in an anterior
8 shoulder dystocia, the front shoulder, the top shoulder is
9 stuck behind the pubic bone and if you're pushing down on the
10 baby, you will for lack of a better term, jam the shoulder
11 even further into the pubic bone making the delivery more
12 difficult to accomplish.

13 Q: Thank you. Please continue.

14 A: Next thing it says on the sheet is the arm under the
15 synthesis, which is the pubic bone we were talking about, at
16 the point the head was delivered and that says right. So,
17 that's telling us that the baby's right shoulder is the
18 shoulder that's stuck behind the pubic bone. That's all it's
19 telling us.

20 It says the primary care provider is Lisa Maselli, which
21 is the delivery attendant, the doctor who's doing the
22 delivery. The registered nurse in the room is Kathy
23 Cossentino. Motor reflex at delivery says asymmetric.
24 Basically, is a reflex that the baby will show at delivery
25 whether a baby moves its head one way or the other; it's

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1 saying it's asymmetric.

2 Other care providers in attendance is Dr. Hazeltine.

3 There's some other items in the note, a right arm x-ray that's

4 been done. And then it asks for any and all the maneuvers

5 that apply and the order in which they were used for the

6 shoulder dystocia. And there were four things written.

7 First, is McRoberts. McRoberts and that was the first thing

8 done in order and that was performed by both Nurse Cossentino

9 and Nurse Butterworth.

10 The McRoberts position is, is the flextion or actually

11 hyperflexion of the knees onto mom's chest to widen the

12 pelvis, move the pubic bone actually off of the shoulder to

13 attempt to widen the pelvis and make it easier for the baby to

14 deliver under the pubic bone.

15 Q: Excuse me just a second. Every once in a while you throw

16 out one of those big words; what do you mean by hyperflexion?

17 A: Right. So, what I'm showing is you flex the hip up

18 against the mom's chest. Okay. That's the McRoberts position.

19 Q: Please continue.

20 A: And then the second thing that's shown, the reason it's

21 listed twice is because two nurses were performing it, is

22 suprapubic pressure and that was the second maneuver that was

23 performed and that was again done by the Nurse Constantino and

24 Nurse Butterworth.

25 Q: Ordinarily, how many nurses are involved with that

1 maneuver of suprapubic pressure?
2 **A:** Usually two.
3 **Q:** And ---
4 **A:** The suprapubic pressure?
5 **Q:** Suprapubic.
6 **A:** I'm sorry. The McRoberts, usually two. Suprapubic
7 pressure can be brought on by one.
8 **Q:** And what's the most usual way of doing it with one nurse
9 or with a different number?
10 **A:** Well, normally you'll have -- you'll call for help as
11 soon as soon as the shoulder dystocia occurs. The nurses will
12 come into the room, usually the delivery nurse is there
13 already, plus another nurse then comes in and normally, there
14 will be two nurses there. Lifting the legs back while the
15 nurse who is facing the back of the baby, will be the one that
16 performs the suprapubic pressure.
17 **Q:** Why the back of the baby?
18 **A:** Because what you're trying to do with suprapubic
19 pressure, instead of as in this case, where the pressure was
20 directed down toward the vagina, it is really a turning of the
21 shoulder that's stuck, where you're trying to collapse the
22 shoulder and bring the baby's shoulder closer to its' chest
23 and then also rotate it and push it under the pubic bone. So,
24 it's really more of a lateral pressure than it is straight
25 down through the vagina. If you do straight down to the

1 vagina, you're going to be hitting into the pubic bone. What
2 used to be, thought to be the correct way to do it is actually
3 pushing to the floor and trying to push the shoulder under the
4 pubic bone and that can be correct in some instances, but the
5 real correct way to do it is to do that motion down toward the
6 floor at the same time collapsing the shoulder laterally from
7 back to front.

8 Q: We heard laterally in many contexts yesterday. Let me
9 make certain that I understand what you mean by lateral in
10 this context. Is -- I mean, you were saying something about
11 collapsing the shoulder?

12 A: Right.

13 Q: Can you help me understand that better?

14 A: Maybe with a picture, I can show you a little better.
15 May I use it?

16 Q: Sure. Let me know if that's the right one. First, let
17 me doublecheck. Mr. Hood just said without objection to this
18 next one.

19 THE COURT: Mr. Hood, without objection?

20 MR. HOOD: For demonstrative, yes.

21 THE COURT: Very well.

22 A: So, what you're seeing here is the baby's head presenting
23 to the outside world. Pubic bone here at the top and then the
24 baby is -- this is the anterior fontanel, the front part of
25 the head is facing towards me, the baby. So, again, the

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1 anterior shoulder facing up is going to be the right shoulder.
2 So, the person on the left side, which would be the person who
3 is facing the back of the baby, is going to be doing the
4 suprapubic pressure trying to rotate the shoulder and trying
5 to collapse it; it's actually not going to the lateral; it's
6 going to be toward the middle of the body, trying to push it
7 and down underneath the pubic bone. Yet, the main goal is to
8 get this trapped shoulder underneath the pubic bone.

9 Q: Thank you for that clarification. Let's go back to the
10 demonstrative 11A, were you finished with that?

11 A: I think so, yeah. We got to the bottom. The next is
12 just a stamp of the patient's keyplate at the bottom.

13 Q: Did you cover these two lines here?

14 A: Yes, so that's the suprapubic pressure and it says it was
15 performed by the two nurses.

16 Q: All right. And what about these two?

17 A: So, you have McRoberts are the top two; suprapubic
18 pressure are the bottom two.

19 Q: Thank you. Because you started talking about shoulder
20 dystocia, before we go on, I'd like to -- before we get to the
21 next medical record, I'd just like to get you to explain a
22 couple of more things about ---

23 MR. GRAHAM: Your Honor, this enlargement has not yet
24 been marked as a demonstrative, but it -- it --

25 BY MR. GRAHAM:

1 Q: Well, doctor, can you tell us what this shows?

2 A: So, basically shows a patient who's probably getting
3 ready to deliver and a delivery suite in a lithotomy position,
4 which is on the back, legs elevated, bent with the knees in
5 stirrups, which are these two flat instruments that are
6 holding the legs.

7 Q: Holding the bottom?

8 A: Correct, holding the back of the calves and there's
9 usually a resting area for the back of the leg as well, the
10 upper leg, and the delivery attendant in the middle between
11 the legs.

12 Q: All right. Earlier you were talking about flexing the
13 legs and hyperflexing the legs; here we see legs bent at the
14 knee and maybe bent down here as well. Is this McRoberts?

15 A: No, this is not McRoberts; this is like, I said,
16 lithotomy position and you do have some bend, flexion of the
17 hip here because the legs not flat; it's lifted somewhat and
18 held by the stirrup.

19 McRoberts, which is the hyperflexion of the leg onto the
20 chest, would be taking this knee and moving it up toward his
21 chest. Actually, both knees.

22 Q: You said we were done with Exhibit or demonstrative 11A,
23 but I just thought of one more question I wanted to ask you.
24 You talked about there being two nurses doing McRoberts and
25 two doing suprapubic. As I was just thinking about your

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1 testimony, to do McRoberts, you said it ordinarily takes two
2 nurses pushing the shoulder to, I mean the leg to the mother's
3 shoulder?

4 **A:** That's usually how it's done, yes.

5 **Q:** Alright, then you have the same two nurses doing
6 suprapubic?

7 **A:** That's correct.

8 **Q:** Which and correct me I'm wrong, but McRoberts that way;
9 do you do suprapubic that way too or do you do it this way?

10 **A:** They're opposite directions. So, normally what the nurse
11 who's doing the suprapubic pressure will do, is to continue to
12 hold the leg up in McRoberts and do the suprapubic pressure
13 with the right hand.

14 In this case, it's a little different because there were
15 two nurses doing the pressure on the uterus. So, it's
16 consistent with the testimony.

17 **Q:** So, if you had two nurses with their fists on each side
18 of the -- of the pregnant part down toward the pubic bone; one
19 nurse on this side with -- with her fists pushing down toward
20 the vagina and another one on this side with her two pushing
21 down toward the vagina, who's doing McRoberts?

22 **A:** Okay. So, McRoberts is the initial number one maneuver
23 that's done, and the nurses would do that. At that point in
24 time, when suprapubic, the second procedure is being done, if
25 the nurse is using both of her hands, because the patient

1 stays in McRoberts, it would have to be either another
2 assistant in the room or the mom would have to be asked to
3 hold her legs all the way up in McRoberts.
4 Q: Okay.
5 A: It's not an ideal way to do it.
6 Q: To go to true McRoberts, do you need nurses, one on each
7 leg, or mom trying to hold both legs?
8 A: True McRoberts would be best attained by two nurses doing
9 it that knew what they were doing.
10 Q: Could -- could two nurses, could the same two nurses do
11 McRoberts and two-fisted suprapubic at the same time?
12 A: The only way to do that would be one fist of each nurse
13 because they would have to hold the leg with one arm and push
14 with the fist with the other.
15 Q: But if they both had two fists on the momma's body down
16 here ---
17 A: Then there's nothing holding the legs; they only have two
18 hands each.
19 Q: Let's move on. This looks like it might be more than one
20 page here. Let's start with this page.. This is marked
21 demonstrative 6A. Tell us what this is and what is important
22 about it to you?
23 A: This is basically the labor and delivery note. It is a
24 dictated note, dictated by Dr. Maselli, discussing pretty much
25 every aspect of the delivery and the labor.

1 Q: Okay. And is there any part about that description that
2 is relevant to your opinions about whether she acted properly
3 or not with regard to this shoulder dystocia?

4 A: I don't see anything that would be pertinent on page one.
5 Page two really brings us into the shoulder dystocia.

6 Q: Thank you. What's important about that and this is baste
7 stamped, Tideland's Georgetown Memorial, mom, 22?

8 A: Some of the basic things that are important to the
9 shoulder dystocia include that it occurred from one minute of
10 time, that the procedures that were performed were McRoberts,
11 suprapubic pressure and an episiotomy. And really, that is
12 all that it is in this report. It's more informational than
13 anything else. Nothing that really tells anything with regard
14 to what was done wrong or right in those two procedures,
15 McRoberts and suprapubic are correct procedures to do, if done
16 correctly. Episiotomy is a reasonable thing to do. And then
17 it just says that the baby had decreased movement on the right
18 arm, and they performed an x-ray.

19 Q: That's it?

20 A: And the baby was moving his hand at the time. That's
21 really the only things that are important on that with regard
22 to the dystocia. That's the same copy of page 2. Two copies
23 it looks like.

24 Q: All right. Let's look at this next one. 12-A is the
25 demonstrative exhibit number. Tell us about this?

1 **A:** Okay. So, this is a shoulder dystocia progress note.
2 Date and time is April 27, 2013 at 8:30. So, this was written
3 approximately fifteen minutes after the delivery. The
4 estimated field weight on admission, which is the weight that
5 we think the baby's going to be when mom comes in in labor was
6 seven and a half pounds. It says pregnancy complications, yes
7 and what's marked is obesity here. That's one of the
8 pregnancy complications. Labor complications is checked yes
9 and is what is checked here is a protracted first stage. And
10 basically, what that means is in getting to ten centimeters,
11 mom took a longer time than normal.

12 **Q:** I got to stop you. Ten centimeters jumped out of
13 nowhere; what are you talking about?

14 **A:** Right. So, the cervix, which is the mouth of the womb,
15 has to be dilated open to allow the baby to come through and
16 to allow mom to start pushing. Ten centimeters is the time
17 that someone is completely dilated and that allows for the
18 baby's head to deliver through the cervix.

19 **Q:** Please continue.

20 **A:** So a protracted first stage, normally, a mom in the
21 active phase of labor, this is not her -- mom's first child,
22 but we usually use an average of a centimeter an hour of
23 dilation and this protracted active phase, a protracted first
24 stage means it just took longer than it would normally take.

25 **Q:** How much longer?

1 **A:** I'd have to look back at the exact hours, but it was
2 quite a bit longer. It was in the order of hours to get from
3 seven to ten, which was three centimeters of dilation that may
4 have take seven or eight hours. So, it was definitely
5 protracted; I agree with the statement there. That's just the
6 first part of that.

7 **Q:** So, tell me about this.

8 **A:** The delivery mode is spontaneous and what that means is
9 the head came out on its' own with mom's pushing. There were
10 no forceps or vacuums or anything used; there was not an
11 instrument for delivery.

12 Okay. The next one, which is probably most important
13 thing on the sheet, is that there was a level of traction
14 applied and that's checked as moderate/controlled. So, in a
15 contemporaneous document, meaning the document that was
16 written at the time of the delivery, which was fifteen minutes
17 after the delivery, Dr. Maselli wrote that she applied not
18 usual traction, which is the usual force that you would pull
19 on the baby for affecting delivery. Once the shoulder
20 dystocia is relieved, but she applied moderate traction, which
21 is greater than usual.

22 **Q:** Excuse me, you said moderate contractions?

23 **A:** Moderate traction. Moderate pulling, a moderate force on
24 the baby's head and as we learned from the deposition
25 testimony, that was after suprapubic pressure, actually, I'm

1 sorry, it was after the McRoberts failed and after the
2 suprapubic pressure failed, instead of going on to other
3 maneuvers that we would normally use, which was at delivery,
4 she decided to pull harder and that's what created an injury
5 on the baby. So, that's why it's important on this sheet,
6 with moderate controlled traction.
7 Q: All right. Let's look at this line on the left. Level
8 of traction applied, then there's a box that says usual.
9 A: Right.
10 Q: That box is blank.
11 A: Yes.
12 Q: Then it says another box, moderate/controlled; that one
13 is checked.
14 A: Yes.
15 Q: There's a third one with a box and then the word other.
16 A: Yes.
17 Q: That one is not checked, is it?
18 A: No.
19 Q: All right. If someone who had just delivered a baby
20 wanted to document that they used slightly more than normal
21 gentle traction, is there a place on here to say that?
22 A: Yes, you would check other and then there's a line here
23 to put other information in. The two boxes just gave the
24 usual, which would be what we'd normally use and then the
25 second which is moderate/controlled.

1 Q: Please continue.

2 A: The maneuvers that we used in this case were episiotomy
3 and what we call external maneuvers, meaning outside of mom,
4 which is McRoberts, moving the legs as we spoke and then
5 suprapubic pressure, pushing the shoulder under the pubic
6 bone. As we learned from the deposition testimony, neither of
7 those procedures affected freeing the shoulder; the shoulder
8 was still stuck. The only thing that freed the shoulder was
9 Dr. Maselli's moderate traction, actually pulling on the head
10 while mom pushed and while suprapubic pressure was being done
11 and it was also during a contraction at that time. So, there
12 were multiple forces at that time working on the baby. Some
13 of them making the dystocia worse and Dr. Maselli, instead of
14 going on to what we call in obstetrics, internal maneuvers,
15 which would be moving the baby's shoulder one way or the other
16 to put it in the part of the pelvis where there would be room
17 for it to deliver, she decided to just pull harder and that's
18 what tore the nerves in the neck of this baby and made the
19 baby have this permanent injury.

20 Q: Excuse me, may I butt in just a second?

21 A: Sure. Sure.

22 Q: All right. Does this help you explain what you're
23 talking about with internal maneuvers?

24 A: Yeah, this is one of the internal maneuvers you can do.
25 There are several in position preference, which one to go to

1 next. Some physicians will even use Rubin's maneuver instead
2 of suprapubic pressure. I happen to be one of them. It's not
3 wrong to do suprapubic pressure first, it's recommended to do
4 whatever you're most comfortable with. But some studies have
5 shown that Rubin's maneuver actually creates less pressure on
6 the brachial plexus than even McRoberts and suprapubic
7 pressure. So, I like this maneuver. And basically, what it
8 entails is actually, and Dr. Maselli was even there at this
9 time, because the nuchal cord, which is a cord around the
10 neck, when it's reduced, you actually put your fingers in
11 around the neck and you reduce the nuchal cord.

12 Q: What do you mean by reduce it?

13 A: You actually take the cord and you lift it over the head
14 so it's not around the neck anymore.

15 Q: How unusual is it to have a nuchal cord?

16 A: It's very common, probably fifteen, twenty percent of the
17 deliveries. It's not something that's unknown.

18 Q: Thank you. Please continue.

19 A: But the same two fingers can be placed just a little bit
20 further and you place it behind the baby's trapped shoulder
21 and what the idea behind Rubin's maneuver is, is to take that
22 shoulder and just rotate it, put some gentle pressure on the
23 posterior, the back of that shoulder, and just rotate it into
24 the oblique.

25 Q: Oblique?

1 **A:** I'm going to explain it. When you look at the pelvis, a
2 normal shaped pelvis, the largest diameter of the pelvis is in
3 the tiagnle or the oblique or off of the ninety degree angle.
4 So, if you would rotate the baby's shoulder into this axis,
5 there's much more room for the baby's shoulder to be delivered
6 out of the pelvis and that's an internal maneuver and those
7 are usually reserved for the times when the external maneuvers
8 don't work. And it wasn't done here; it was just skipped
9 altogether. The pulling was the next maneuver, which is
10 taught to us never to do.

11 **Q:** As I was listening to you, did I hear you say that this
12 picture with the baby facing that way, it would be the right
13 shoulder on top?

14 **A:** That's correct.

15 **Q:** And so, by having this person push from the back, it
16 would move that right shoulder toward the chest?

17 **A:** Correct. So, basically, it is the same physiology, the
18 same mechanics as the suprapubic pressure is trying to do from
19 the outside, this is trying to do from the inside.

20 **Q:** So, if you have suprapubic pressure being done the way
21 you said it should be done and if you have with the nurses on
22 the outside of the skin and if you have the doctor, inside the
23 birth control moving the right shoulder toward the chest, what
24 does that say in terms of efficiency and likelihood of
25 success?

1 **A:** That will likely work.

2 **Q:** Anything else on this?

3 **A:** No, the only thing I would add to that is that just a
4 reminder that that's not the way suprapubic pressure was done
5 in this case.

6 **Q:** Thank you. I believe when I interrupted you, we were
7 still on this page, 12-A or not?

8 **A:** Yes, we had gotten through the maneuvers. We were talking
9 next would be about the total duration of the shoulder
10 dystocia, which is the time of delivery of the head to the
11 delivery of the baby and that was one minute. As we said,
12 that's the amount of time the shoulder is stuck.

13 Cord gas is sent, that's yes. What that is, it is after
14 the delivery of the infant, you can take a segment of cord,
15 the nuchal cord, and draw blood out of it and send it to the
16 lab to see how the baby is doing with regard to the amount of
17 oxygen in its' blood, the acid base level, which tells whether
18 it's acidotic, which is when the organs start to become
19 involved with the lack of oxygen, which has the carbon
20 dioxide, which has the base excess, which is the difference
21 between the acid base and that was sent in this case and it
22 was normal. So, the baby, as we showed earlier in the fetal
23 monitoring strips, was stable and doing well going into the
24 shoulder dystocia. There's two things that show us that when
25 the baby comes out of the shoulder dystocia from an acid base

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1 and stability standpoint, the baby is still doing well and
2 that is cord gas is one hundred percent. The oxygen level was
3 good, the PH was good, and also the Apgar scores were good, 8
4 and 9. And what Apgar scores are, they measure the color of
5 the baby, the tone of the baby, the movement of the baby, the
6 breathing; whether it's spontaneous or not. So, the map score
7 you can get on that is a ten. This baby got eight at one
8 minute, which is excellent and a nine in five minutes, which
9 was also excellent. So, the baby was fine from an acid base
10 and oxygen standpoint at delivery. He was stable, but not
11 from the standpoint of the shoulder and the arm, because as we
12 see here, after delivery, the cord gas was normal, but the
13 right arm has -- so right arm with minimal movement and right
14 hand and fingers are moving?

15 **Q:** Thank you. I think I heard you say that right before the
16 one minute shoulder dystocia, the baby was well and stable
17 based on the cord gases, I mean based on those strips?

18 **A:** Based on the monitoring strips and then after the
19 delivery, the baby was stable based on the apgar score and the
20 core gases. And the good core gases at the end of delivery
21 and apgar scores, one would have extra evidence that the baby
22 would be stable going into it as well.

23 **Q:** All right. So, stable at the beginning, stable at the
24 end, and not only stable, but well and stable at the very
25 beginning, well and stable at the end?

1 A: Correct.

2 Q: What, if anything does that tell me about the one minute?

3 MR. HOOD: Objection, leading.

4 THE COURT: Mr. Graham, that is -- you're testifying.

5 Just ask the question. Okay?

6 BY MR. GRAHAM:

7 Q: All right. Let me rephrase that, Your Honor. Based on
8 what you've said about A and B, what was -- I mean do you have
9 an opinion to a reasonable degree of medical certainty, most
10 probably, as to what the baby's condition was in that one
11 minute?

12 A: That more likely than not, the baby was stable coming in
13 and stable coming out, would have been stable for at that one
14 minute period of time from a oxygen, acid based standpoint.

15 Q: Let me switch gears just briefly. I don't want to keep
16 having to ask you the long, legal jargon type questions, so
17 from now on, will you promise me that you want testify unless
18 the facts, opinions and conclusions you're testifying to, are
19 facts, opinions and conclusions that you hold to at least a
20 reasonable degree of medical certainty, most probably?

21 A: I have done that so far and will continue to do that
22 after.

23 Q: So, everything you've said so far, meets that standard?

24 A: Yes.

25 Q: And ---

1 **MR. HOOD:** I'm going to object to that, Your Honor. I
2 don't -- I mean, if I think that if he's offered an opinion,
3 there needs to be a basis or threshold so that the record is
4 clear about the appropriate standard has been satisfied.

5 **THE COURT:** All right. I will allow him to continue to
6 testify and -- I think he is adequately established that his
7 opinions are to a reasonable degree of medical certainty, most
8 probably? Thank you.

9 **BY MR. GRAHAM:**

10 **Q:** But, going forward, don't say anything unless it meets
11 that standard; agreed? Please continue.

12 **A:** Okay. And then it's the delivery note, the shoulder
13 dystocia progress note signed by Dr. Maselli.

14 **Q:** And now we would put up demonstrative marked 2A. Tell us
15 about this one?

16 **A:** So, this is a PPD number 1 note, which postpartum day
17 number 1, the day after delivery and this is 4/28/13, which is
18 the day after the delivery. The deliver was on 4/27. The
19 note reads shoulder dystocia underlined. The patient and
20 especially her husband, are appropriately concerned re,
21 regarding, the baby's movement. Mom grateful baby is alive in
22 quotations, states her nine-year old was nearly nine pounds
23 with no problem. Dad wants to know definitely if arm will be
24 all right. Prolonged discussion with both parents. Baby
25 needs to have close pediatric follow-up and possibly phys, P-

1 H-Y-S., physical therapy. Discussed c-section if another
2 baby. And then the note says AFED, A-F-E-D, which is afebrile
3 no fever, DSS vital signs stable. It says, I believe that's
4 AP at U-2, which I am not sure what that is. Breastfeeding
5 stable, probably discharge tomorrow, and then signed.
6 Q: Thank you. Next we have a demonstrative marked 13A.
7 Tell us about that?
8 A: So, this is 4/27/13, states 7:45 in the morning, 07:45.
9 It's a delivery note that says viable term male delivery SVD,
10 which is spontaneous vaginal delivery, with media lateral
11 episiotomy at 8:15. So, media lateral means the cut. If
12 we're looking at the vagina, is going this way, it's going to
13 be medium and it's going lateral; it's not straight up and
14 down toward the rectum.
15 The weight was eight pounds thirteen ounces. The apgars
16 were eight and nine. The nuchal cord times one was reduced;
17 we spoke about that cord around the neck. That was reduced.
18 Shoulder dystocia encountered for one minute period of time.
19 McRoberts, suprapubic pressure given, sent cord gas, cord
20 blood, placenta delivered by Maselli. Peds Hazeltine, EBL,
21 that's amount of blood loss 450 cc's. Core gas ph 7.31, as we
22 said, that was normal. Perform with 3.0 Vicryl, which is a
23 size and type of suture we use to suture the episiotomy. Baby
24 to nursery for observation, mom postpartum in stable
25 condition, dictation for details signed by Dr. Maselli. It

1 says a written delivery note and that the other one that we
2 went over was a dictated delivery note.

3 **Q:** Thank you. I think we're down to the last one. This is
4 not marked, but it's a date stamp Tideland's Georgetown Memorial,
5 mom, 29. Tell us about this?

6 **A:** This is a note 4/27/13 at 3:50 in the morning. It's a
7 labor note progress note. It says patient comfortable with
8 epidural. D cell to ninety lasting six minutes. It means
9 that the heart rate went down to 90 beats per minute for six
10 minutes. Oxygen placed; mom was given oxygen. Position
11 changed, meaning if mom was laying on her back, she was moved
12 to the left or moved to the right. Pitocin had been on for a
13 few minutes at four milliunits and it was turned off. Pitocin
14 is a medication that we give to make the contractions stronger
15 and mentally was saying that this portion of the labor was
16 slow. So, Pitocin was being used to make it quicker and to
17 speed up the delivery and the baby didn't tolerate the Pitocin
18 too well. So, the Pitocin was turned off as is appropriate.
19 This is the point 3:50 in the morning, when the IUPC catheter
20 that we talked about earlier was placed and an amnio infusion
21 was started. This particular baby, when membranes ruptured,
22 had already had a bowel movement inside. It was very light
23 and there was a faint amount of meconium, that's what we call
24 fetal stool is meconium, and that was in the amniotic cavity.
25 So, Dr. Maselli appropriately decided to do an amnio infusion;

1 that's where the intrauterine pressure catheter is placed in
2 the uterus and fluid is instilled into the uterus to clean out
3 the meconium fluid so that the baby doesn't swallow it or
4 aspirate it or get it into its lungs. So, that was done there
5 at this time. And then the heart rates came back to normal
6 baseline fetal heartrate of 150, which normal and it says now
7 with variables. And what a variable is, it's deceleration or
8 a drop in the heartrate that occurs variably with a
9 contraction. So, it doesn't occur necessarily with a
10 contraction, it can occur with a contraction, but variable,
11 when we talk about decelerations of the heart rate, the heart
12 rate deceleration is when the heart rate goes down. They meet
13 early, meaning they occur with the contraction. They can be
14 variable, meaning they occur with no relationship to the
15 contraction or they can be late, which occurs in the peak of
16 the contraction and the heart rate doesn't go back to normal
17 until after the contraction is over. Those are the most
18 dangerous. So, what we were seeing here was somebody was
19 saying was the patient was having variables and those are v-
20 shaped dips of the heartrate that occurred anytime related to
21 the contraction and they usually signify the cord being
22 squeezed, cord pressure. Remember the cord was around the
23 neck, so it makes sense to have some variable decelerations
24 and they -- what happens is the core gets squeezed, the baby's
25 heartrate goes down, the cord gets released, then the

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1 heartrate goes back to normal. So, normally, variables, as
2 long as they're not prolonged, or very severe, are things that
3 we see in normal labor and they're not dangerous to the baby.

4 It says here at the time of the cervix is still
5 unchanged. Now, we're trying to get the cervix to ten
6 centimeters so mom can push the baby out and it's saying that
7 it's seven centimeters at this time. Now, 90 percent effaced
8 is how thin the cervix is and you want it to get to a hundred
9 percent, so it's paper thin so it can dilate easier.

10 And then last notation, it says minus 2, minus 3. What
11 that's talking about, it's talking about the station and what
12 station is, is where the baby's head is in the pelvis. When
13 the baby's completely engaged into the pelvis, the top of the
14 head has reached the spine, the issue of spines which are
15 marked or is that they are in the middle of the pelvis. The
16 baby is said to be at zero station it goes minus 3, minus 2,
17 minus 1, zero, plus 1, plus 2, plus 3 out. So, that's a gauge
18 of how the baby is moving through the pelvis in labor. We
19 don't really worry too much that it's a minus 2, minus 3. At
20 seven centimeters, what we really look for in fetal descent is
21 how the baby descends after he gets to ten centimeters,
22 because that's the second stage of labor and we want to make
23 sure that the baby's at least moving through the pelvis at a
24 centimeter an hour and delivers before getting stuck at a
25 certain station and the baby's not getting through, which is

1 not the case here. The baby did not get stuck until after the
2 head came out. So, getting stuck in the second stage when the
3 head gets stuck in the pelvis, the baby would never get to a
4 shoulder dystocia station because baby's head still hasn't
5 come out. So, it was seven-ninety, minus two, minus three,
6 which is why the Pitocin was tried, to try to get mom to ten
7 centimeters.

8 So, then about an hour later, there's a note here that
9 says that Patient with some pressure, some honest feelings of
10 pressure to push, which is a good sigh. The fetal heart tones
11 are 150, still with my own variables, which are not really
12 concerning. So, this is now seven to eight centimeters, so
13 there's a little bit of progression there, but slow. And it
14 says we'll try to restart the Pitocin and implement position
15 changes. Still trying to position mom in different locations
16 because if, let's say the cord is on the right side of the
17 uterus and mom is laying on the right side, it can compress
18 the cord. So, we try to flip mom back and forth to different
19 sides to see if you can get rid of these variable
20 decelerations. You know, from after delivery, the cord was
21 around the neck; that was not going to be relieved. Mom
22 continued to have these mom variables until delivery. But as
23 you saw from the Apgar scores, the cord gas and the overall
24 good variability and reactivity on the fetal monitoring strip,
25 the baby was fine throughout that process, oxygen and acid

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1 base standpoint and that's it with this note.
2 Q: Okay. I want to follow-up one thing?
3 A: Sure.
4 Q: This one right here caused me some concern when I heard
5 you talk about it. Decel 90 lasting around six minutes.
6 A: Around 6 minutes, yes.
7 Q: All right. What relationship is there, if any, to the
8 epidural; it says she's comfortable with the epidural, what
9 relationship is there, if any, between giving the epidural and
10 having the drop in heartrate?
11 A: Well, sometimes giving an epidural will drop the mom's
12 blood pressure. That's why we try to hydrate them well
13 before, but it doesn't always, it sometimes happens if we can
14 give medication; we usually give ephedrine to increase the
15 blood pressure or anesthesia does and that will bring the
16 heartrate back to normal. I believe that what process from
17 this note, is it probably was related to the Pitocin the
18 oxytocin because it said that the Pitocin had been on for a
19 few minutes at 4 milliunits. So, it had to be turned off, but
20 it could have been from the epidural, it could have been from
21 the Pitocin. It concerned the doctor as well and that's why
22 she did amnio infusion and position change, stopped the
23 oxytocin, gave oxygen; these are all what we call intrauterine
24 resuscitation maneuvers that a physician will do to help the
25 baby out inside.

1 Q: What does it tell you, if anything, when heartrate drops
2 after Pitocin is started?

3 A: Well, basically, just stating at that moment in time, the
4 baby wasn't tolerating labor well; it could have been from the
5 nuchal cord, it could have been that the Pitocin, when it got
6 to the milliunits was too much for the baby and it created a
7 contraction to strong or hyper-stimulated the uterus, so it
8 needed to be turned off.

9 Q: During the drop in heartrate, they turned off the
10 Pitocin; did this baby suffer any type of injury or adverse
11 problem or any kind of negative reaction at all that is
12 significant from an obstetrical point of view?

13 A: No, not that we know of. There's no evidence of that
14 based on the fact that the strip, the fetal monitoring strip
15 came back to normal, the fact that the cord gases were great,
16 the fact that the apgar scores were good after delivery, the
17 baby had, to my knowledge, no hypoxic injury ever documented.

18 Q: We started off talking about this fetal heart monitor
19 strips, I didn't ask you about the squiggly lines; what do the
20 squiggly lines mean?

21 A: You have to show me. There's so many squiggly lines on a
22 monitoring strip.

23 Q: I'm sorry. All right. You told us the bottom is the
24 mom's contractions, I believe?

25 A: Correct.

1 Q: And the baby's heartrate is somewhere over here; it looks
2 like there are two lines.

3 A: Right. One is maternal and one is fetal. Usually
4 monitoring strip, they are colored one will be blue and one
5 will be red or one will be black and one will be red so you'll
6 know which is which. But, yes, what we look for, you're
7 talking about the squiggleness of the upper line?

8 Q: I'm talking about whichever one is the baby?

9 A: Right.

10 Q: I'm talking about the squiggleness of that one?

11 A: All right. So, basically, the squiggleness, we were
12 talking before about something called variability. There's
13 short term variability, which is from one beat to the next is
14 long term variability, which speaks about the variability of
15 the fetal heartbeat between like three and five minutes. And
16 basically, they both really mean the same thing, it's
17 basically how the baby's heart is reacting on a beat to beat
18 and if there is an oxygen deprivation, usually the heart will
19 stay as flat as possible. You want get this squiggleness, for
20 lack of a better term, of the line, which is a reassuring
21 finding meaning that the baby is most likely acid based and
22 oxygen stable.

23 Q: Okay. So, after the Pit was turned off, what was the
24 condition; what was the condition of the baby in terms of
25 medical stability?

1 **A:** So, this was 3:50. So, if we're looking here at notes at
2 3:50, wo, we're looking after 4 in the morning. The
3 variability of the fetal heart is normal, culpable moderate,
4 that's between 5 and 25 beats per minute and so it's fine. And
5 there's also some acceleration of the heart, which mean that
6 when the baby moves, the heartrate quickens; that means the
7 sympathetic and parasympathetic nervous systems are intact
8 which require oxygen to stay intact. So, it looks like after
9 that prolonged deceleration, we call it prolonged because it
10 was more than two minutes, but they became stable again.

11 **Q:** So, what does that tell us about whether or not the --
12 the six-minute heartbeat in the 90's have any -- anything
13 other than a six minute or so short-term issue?

14 **A:** Basically, it tells us that there were no long term
15 effects of that short term deceleration of the heartrate.

16 **Q:** Anything else on this?

17 **A:** No.

18 **Q:** Why don't you go ahead and take a seat?

19 **A:** Sure.

20 **REPORTER'S NOTE:** (Bench conference with counsel).

21 **THE COURT:** All right, ladies and gentlemen, let's take a
22 mid-morning break here. You've been at it about an hour and a
23 half and I promised you that's how long we would go. We're
24 almost through with preaching this morning, so I promise you
25 that will be as long as we -- I would keep you. So, let's go

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1 in and take a break. We'll be back in about ten minutes.

2 All right.

3 **REPORTER'S NOTE:** (Jury retires to jury room 11:30 A.M.)

4 **THE COURT:** All right. Let's take about a ten minute
5 break.

6 **(COURT IN RECESS)**

7 **THE COURT:** Everyone is back? Get my juror for me, all
8 right?

9 **MR. GRAHAM:** Your Honor, may I bring one thing to your
10 attention?

11 **THE COURT:** Yes.

12 **MR. GRAHAM:** Mr. Hood mentioned to me that he thought it
13 might be a good idea to bring this to the Courts and Your
14 Honor's attention before we get into the back and forth. What
15 it relates to, Your Honor, is a demonstrative video that will
16 help Dr. Pliskow illustrate what he means by the use of
17 traction and neck stretching. It's a live, I mean, it's the
18 video was taken live of an actual human delivery and it's --
19 it's substantially similar in many ways with regard to the
20 relevant parts. There is an instrumental delivery in the
21 other part of it, which we don't have, but everything else is
22 going to help the witness explain ---

23 **THE COURT:** Why is it necessary for the witness to use
24 that to explain the process; he seems to be doing very well so
25 far?

1 **MR. GRAHAM:** Well, you know ---

2 **THE COURT:** You have poster boards and all. Mr. Hood,
3 let me hear you on that?

4 **MR. HOOD:** Thank you, Your Honor. This is not a
5 animation. This is a real-life delivery from some physician
6 of whom we don't know who it is. We don't know who the
7 patient is, what the circumstances are surrounding the
8 delivery. It is very difficult to watch. It will be very
9 prejudicial and what I just heard is he just said it's
10 substantially similar to what we see here. There's no way on
11 God's green earth, that anyone can equate what transpired in
12 the delivery room in one instance is not recorded with some
13 other video and hasn't been produced until Sunday night before
14 trial or testified ---

15 **THE COURT:** I'm not going to allow that. I'm not going
16 to allow it. This witness is very articulate, very
17 knowledgeable, he's able to explain it. I don't think that
18 it's necessary and I'm not going to allow it. Thank you.
19 Okay?

20 Let's bring in our jury.

21 **REPORTER'S NOTE:** (Jury enters courtroom 11:47 A.M.).

22 **THE COURT:** All right. You may proceed.

23 **MR. GRAHAM:** Thank you, Your Honor.

24 **BY MR. GRAHAM:**

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1 Q: Dr. Pliskow, when did you deliver your first baby?
2 A: 1986.
3 Q: When did you last deliver a baby?
4 A: I'm sorry, I didn't hear the question?
5 Q: When is the last time you delivered a baby?
6 A: Friday. Last Friday.
7 Q: Over the years, how many babies have you delivered?
8 A: Approximately ten thousand.
9 Q: Of those ten thousand, how many were vaginal deliveries?
10 A: Probably six to seven thousand of those.
11 Q: So, we've got a chart here name, number of vaginal
12 deliveries, number of shoulder dystocias, number of permanent
13 brachial plexus injuries, and whether or not forces of labor
14 were present. I'm going to put your name here.
15 A: Okay.
16 Q: How many vaginal deliveries did you say you've done?
17 A: Ten thousand deliveries, assuming the c-section rate, I'd
18 say about sixty-five hundred to seven thousand.
19 Q: How many shoulder dystocias have you encountered during
20 that period of time, your best reasonable estimate?
21 A: Maybe forty to fifty.
22 Q: How many permanent brachial plexus birth injuries were
23 there to babies that you delivered?
24 A: Zero.
25 Q: And how many of those vaginal deliveries were forces of

1 labor present with the contraction and the mother's pushing?
2 **A:** All seven thousand. Well let's probably subtract maybe,
3 with mom pushing and forces of labor, all of them.
4 **Q:** Thank you. Do you know how shoulder dystocia is supposed
5 to be properly managed by obstetricians when -- when the
6 shoulder is stuck?
7 **A:** Yes.
8 **Q:** Please tell us. So, basically, once the, assuming an
9 anterior shoulder dystocia, the top shoulder is stuck behind
10 the pubic bone. Immediately, the patient is urged to stop
11 pushing. The physician takes his or her hands or midwife, his
12 or her hands off of the baby's head. The call bell is rang
13 and assistance or help is called for in the form of extra
14 nursing, anesthesia, if available, pediatrics and then the
15 first thing would be, would be to go into the external
16 maneuvers that we spoke to before, after setting a -- either a
17 timer or just looking at the clock and having a nurse keeping
18 track of how much time the shoulder dystocia is occurring for.
19 And those external maneuvers as we spoke about would be the
20 McRoberts position; placing mom in the hyperflexed legs up to
21 the abdomen, the suprapubic pressure and then moving on into
22 internal maneuvers, which would be the Rubin Maneuver, which I
23 showed you; it's a rotational maneuver. There is another type
24 of rotational maneuver using the posterior shoulder as opposed
25 to the anterior shoulder, called the Woods' screw maneuver.

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1 There is a third maneuver that's called a delivery of the
2 posterior arm. Some people prefer that, but it is a little
3 bit more risky to the posterior arm itself, because it can
4 result in a humoral fracture, a fracture of the one of the
5 arm. And that's where the delivery attendant reaches in,
6 brings the posterior arm across the baby's chest and delivers
7 it out of the vagina so that there would be now a posterior
8 arm out and that would create more room for the anterior
9 shoulder to move under the pubic bone. And if all of those
10 mechanisms fail, you can start back and go through the
11 rotational maneuvers again. Some people will move on to
12 something called a Gaskin maneuver, which is where the patient
13 is placed on all fours and that will sometimes, by gravity,
14 move the anterior shoulder off of the pubic bone by gravity
15 bringing it underneath. And then there are final rescue
16 maneuvers that may need to be done like pushing the baby up
17 and going for caesarean section, breaking the clavicle,
18 fracturing the pelvis, those are all last ditch effort
19 maneuvers that sometimes need to be used if maybe the baby is
20 severely stuck.

21 **Q:** All right. Apart from the sophisticated maneuvers or the
22 rescue maneuvers that you talked about, what are the basic
23 internal maneuvers that a doctor acting with knowledge inside
24 the standard of care, should be able to use and use properly?

25 **A:** So, the Rubin maneuver would be one, the Woods' screw

1 would be another and the delivery of the posterior arm would
2 be a third.

3 Q: If the internal maneuvers that you just mentioned or any,
4 if no internal maneuver has been attempted in a shoulder
5 dystocia delivery, when is it appropriate, under the standards
6 of care, to use more than gentle traction?

7 A: I can't think of an instance off the top of my head where
8 that would be the standard of care.

9 Q: Based on the medical records that you've reviewed, the
10 depositions that you've read, your knowledge, your training
11 and your experience, tell us, sir, what caused Jahmerican's
12 nerve damage?

13 A: Well, my opinion is, that the nerve damage, which are
14 avulsions, they are actual tearing of the nerves off of the
15 spinal column, occurred due to excessive traction, a greater
16 than normal traction, placed on those nerves by the delivery
17 attendant, who was Dr. Maselli.

18 Q: Now, let's talk about talk about standards -- well, you
19 told us about -- have you told us about the standards of care
20 under circumstances like these or similar to these in this
21 case?

22 A: Yes, so what I have said already is that in this
23 particular scenario where the external maneuvers of suprapubic
24 pressure, which was not performed correctly, and McRoberts
25 positioning did not relieve the shoulder dystocia; the next

1 thing standard of care would have been, well standard of care
2 would have been to perform the suprapubic pressure correctly
3 because correctly performed suprapubic pressure and McRoberts
4 positions, somewhere between fifty and seventy percent of
5 shoulder dystocias will be resolved. But then the next step
6 in standard of care, assuming fetal stability as we've already
7 told it was in this case, would be to move on to the internal
8 maneuvers of Rubin's maneuver, Woods' screw, posterior arm and
9 it doesn't really matter what order they're attempted; it's
10 really based on the comfort and experience of the physician
11 and which maneuvers they are most comfortable with, most
12 proficient in.

13 Q: All right. I've asked about the standard of care
14 applicable, but we didn't really get into a full definition.
15 I'm going to ask you to assume that the standard of care, His
16 Honor will tell us later what the exact words are, but
17 assuming the standard of care is that which a reasonably
18 prudent physician would do or would refrain from doing under
19 the same or similar circumstances or words to that affect.
20 Tell us if Dr. Maselli met those standards or not?

21 A: No, my opinion in this case is that Dr. Maselli did not
22 meet those standards and deviated from the standard of care by
23 not doing what a reasonably prudent physician would do under
24 like or similar circumstances, having the failed external
25 maneuvers and by using, going on to further traction and not

1 using the internal maneuvers to effectuate delivery.

2 **Q:** I just want to make sure you're clear with some semantics
3 or some -- some legal words of art. You talked about
4 violating the standard of care; what relationship is that to
5 negligence?

6 **MR. HOOD:** Objection, Your Honor.

7 **THE COURT:** That's a legal conclusion. Objection
8 sustained.

9 **MR. GRAHAM:** May I approach, Judge?

10 **THE COURT:** Certainly.

11 **BY MR. GRAHAM:**

12 **Q:** Doctor, I'm going to hand you the cover of a certain
13 document; what is this?

14 **A:** That is a photograph of the cover of PRECIS, which is an
15 obstetric manual; it says update in obstetrics and gynecology
16 put out and copyrighted 1998.

17 **Q:** By whom?

18 **A:** By the ACOG, American College of GYN.

19 **Q:** All right. Is any -- are you a member of ACOG, the
20 American College of Obstetrics or Obstetricians and
21 Gynecologists?

22 **A:** Yes.

23 **Q:** Have you read this book?

24 **A:** Yes, I mean a while ago, yes.

25 **Q:** Do you consider it to be generally reliable?

1 A: Yes.

2 Q: Do you consider it to be considered to be generally
3 reliable, not only in 1998, but also today?

4 A: Yes.

5 Q: I'm going to read you something and ask if you agree with
6 it? Brachial plexus ---

7 MR. HOOD: Your Honor, I would renew my objection under
8 901, but I'd also make under the rule of completeness.

9 THE COURT: All right. I'm going to allow it.

10 BY MR. GRAHAM:

11 Q: Brachial plexus injury occurs when excessive lateral
12 traction is applied to the fetal neck region during cephalic,
13 breach or caesarean birth. Injury to the other plexus and in
14 parentheses it says (C5 to C7) results in Erb's Palsy with a
15 limp arm, in parentheses (no moro reflex) and pronation of the
16 forearm. The grasp reflex is usually maintained. Most of
17 these lesions are mild and responsive to conservative
18 treatment over three months. Do you agree with those
19 statements?

20 A: Yes, I agree with every one of those sentences as you've
21 read them individually and together.

22 Q: All right. There were some words I wanted to ask you to
23 define. What does it mean cephalic?

24 A: Cephalic means the head is down, the head is coming
25 first, head down delivery.

1 Q: And then it refers to caesarean birth. Brachial plexus
2 injury occurs when excessive lateral traction is applied to
3 the fetal neck region during cephalic, breach or caesarean
4 birth. You do agree with the -- with that sentence,
5 specifically, with reference to caesarean birth?

6 A: Yes, I agree that lateral traction will -- really at any
7 time is inappropriate and can lead to stretching and injury of
8 the nerves.

9 Q: What does it mean to have a limp arm with no moro M-O-R-O
10 response?

11 A: It basically means that the nerves were injured, the
12 nerves of the brachial plexus.

13 Q: What -- what does it mean when -- it said most of these
14 lesions are mild and responsive to conservative treatment over
15 three months; can you tell me if an injury does not respond to
16 treatment in three months and it turns out to be a three nerve
17 injury with two nerve root avulsions and one partial avulsion,
18 which turns out to be permanent, what does that tell you about
19 the amount of lateral force or traction forces applied to that
20 baby's head in that?

21 A: That once the shoulder dystocia was encountered, because
22 there would not be enough stretch or force on the brachial
23 plexus to cause any bulging injury, assuming that there's no
24 other problem with the baby itself, assuming all other things
25 equal, there would not be enough stretch or force on the

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1 brachial plexus to cause an avulsion injury until the delivery
2 attendant actually placed external traction on those nerves.

3 Q: Do you remember the page from the medical record
4 Tideland's, well, it's marked for demonstrative purposes,
5 Exhibit 12A?

6 A: Yes.

7 Q: The one with the -- well, could you step down just a
8 moment?

9 A: Is that all right?

10 THE COURT: You may.

11 BY MR. GRAHAM:

12 Q: To create the type of permanent injury that Jahmerican
13 suffers from in this case, do you believe the appropriate way
14 to check this box would be usual, moderate/controlled or other
15 and if you checked other, what should be filled in there?

16 A: Can you just repeat the question? I missed the beginning
17 part of it.

18 Q: Sure. Based on everything you know about this case ---

19 A: Yes.

20 Q: The injury, what you read in the medical records and the
21 depositions about suprapubic pressure and McRoberts and -- and
22 no internal maneuvers ---

23 A: Yes.

24 Q: --- and greater than gentle traction, to produce an
25 injury of this magnitude and permanency ---

1 A: Yes.

2 Q: --- do you believe that a correct completion of this
3 report would describe the level of traction as usual,
4 moderate/controlled or other and if other, what should it say?

5 MR. HOOD: Objection, Your Honor. There's no basis ---

6 THE COURT: That's pure speculation, I'm not going to
7 allow that. Thank you, Mr. Graham. Go ahead.

8 BY MR. GRAHAM

9 Q: Take your seat.

10 A: Okay. Thank you.

11 Q: Without reference to that page of the medical records,
12 sir, let me ask you, do you have an opinion to a reasonable
13 degree of medical certainty, most probably, as to the degree
14 of traction force that was applied to the head and neck of
15 Jahmerican McCray in this delivery?

16 MR. HOOD: Objection, Your Honor, same foundational
17 basis.

18 THE COURT: I think the foundation has been laid. I'll
19 allow him to answer that question. Because an opinion is the
20 amount of force.

21 BY MR. GRAHAM:

22 A: Yes, I do have an opinion and it would not be usual
23 because this type of avulsion type injury will not occur with
24 usual traction.

25 MR. HOOD: He's now trying to answer using the form that

1 you just sustained. So, I would object to it.

2 **THE COURT:** I'm going to allow the answer. Okay.

3 **MR. HOOD:** Thank you, Your Honor.

4 **BY MR. GRAHAM:**

5 **Q:** I think that moderate could cause an injury like this,
6 but more likely it was greater than moderate. The term we
7 normally use is excessive. It was more than what was needed
8 to affect this delivery. It was pulling against an
9 obstruction. At the time that the obstruction was being made
10 worse by suprapubic pressure being performed incorrectly
11 during a maternal contraction, during mom pushing. All of the
12 scenarios that would make the obstruction worse and Dr.
13 Maselli did no maneuvers to free the shoulder except pull on
14 the shoulder, pull on the neck and that's what created this --
15 this injury. So, certainly greater than normal. Moderate
16 would be a term. Excessive might be another term because it
17 was more than what was needed. So, any of those terms more
18 likely because of the extent of the injury and involving a
19 third nerve root that it was even potentially more than
20 moderate.

21 **Q:** Doctor, can forces of labor without excessive traction
22 cause this type, this magnitude of permanent nerve damage?

23 **A:** That would be next to -- assuming that there's no
24 inherent problem with the nerves or some sort of underlying
25 defect of the baby, no. Under normal circumstances, this is

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1 called caused by excessive external forces.

2 Q: Well, let me ask you this, is there any evidence anywhere
3 in the medical records or the depositions or the operative
4 notes to suggest that there's any inherent abnormality or
5 weakness in these nerves?

6 A: No, there's absolutely no evidence of that with regard to
7 the medical record as far as any defect or abnormality in mom,
8 in the uterus or the child itself. The child had seen
9 neurologists and surgeons and OT and PT, which is the
10 therapists and there was never any mention made of any
11 congenital defect in the child.

12 Q: Given the facts and circumstances of this case and this
13 child's medical makeup, anatomy and characteristics of all
14 kinds, is there any way the forces of labor could have caused
15 this kind of permanent nerve damage?

16 A: I do not believe so, no.

17 Q: Just a few follow-ups. You talked earlier about
18 suprapubic not being done correctly and McRoberts not being
19 done correctly. Do you blame the nurses for that or someone
20 else?

21 MR. HOOD: Objection, Your Honor. Can we approach?

22 THE COURT: Yes, please.

23 REPORTER'S NOTE: (Bench conference with counsel).

24 BY MR. GRAHAM:

25 Q: Doctor, based on your -- all the work you've done in

1 evaluating this case, records, depositions, and especially the
2 deposition of Dr. Maselli. Who directed the nurses to perform
3 suprapubic pressure and the McRoberts positioning the way that
4 they did?

5 **MR. HOOD:** Objection, Your Honor ---

6 **THE COURT:** I'm going to allow the question.

7 **MR. HOOD:** --- foundation.

8 **BY MR. GRAHAM:**

9 **A:** Dr. Maselli ordered both of those external maneuvers for
10 the nurses to do it and if the nurses were doing it
11 improperly, Dr. Maselli would have seen that right in front of
12 her face and told them to stop doing that the way they were
13 doing it, similar to if fundal pressure was being performed,
14 that would be Dr. Maselli's responsibility to tell them not to
15 do that either because fundal pressure is a deviation of
16 standard of care.

17 **Q:** Can there be any possible cause of brachial plexus nerve
18 damage in a child other than a child with Jahmerican's
19 injuries other than excessive traction?

20 **A:** Not that I know of because these are avulsions and
21 avulsions are a tearing of the nerve off of the spinal cord
22 and the only thing that would cause that type of tearing
23 injury would be traction.

24 **Q:** Thank you, doctor, please answer any questions Mr. Hood
25 may have.

1 **THE COURT:** Mr. Hood?

2 **CROSS EXAMINATION OF DR. STEVEN PLISKOW BY MR. HOOD:**

3 **Q:** Let's start at the back and move our way to the front.

4 The nurses in this case are employed by the hospital, right?

5 **A:** That's my understanding.

6 **Q:** You read their depositions, you know that to be a fact,
7 true?

8 **A:** Yes.

9 **Q:** You also know from their depositions, they were
10 represented by their own lawyer, right?

11 **A:** Yes.

12 **Q:** The nurses in this case have not been identified as
13 having deviated from the standard of care and causing harm in
14 your testimony, true?

15 **A:** Correct, I did not testify that they caused harm. I said
16 in my deposition testimony as I said here today, that the
17 suprapubic pressure was performed incorrectly and that that
18 made it more difficult for the shoulder dystocia to be
19 resolved.

20 **Q:** The performance or the application of suprapubic pressure
21 was done by the nurses, true?

22 **A:** True.

23 **Q:** You're involved in hundreds of these cases, right, I mean
24 you've reviewed ---

25 **A:** I'm sorry?

1 Q: You've reviewed hundreds of medical legal cases in your
2 career?
3 A: I thought you meant shoulder dystocia cases.
4 Q: Have you reviewed hundreds of medical legal cases in your
5 career?
6 A: Yes.
7 Q: And have you reviewed dozens of shoulder dystocia cases?
8 A: Yes.
9 Q: And have you seen cases where the hospital is also a
10 defendant in the case?
11 A: Sure.
12 Q: And with those the nurses are being accused or alleged of
13 improperly applying suprapubic pressure, true?
14 A: I've seen that, yes.
15 Q: And you've offered testimony about that in some of those
16 cases as well, correct?
17 A: Sure.
18 Q: And you've offered testimony in cases where the nurses,
19 who are applying McRoberts position, moving the legs, have
20 been alleged to have done that improperly?
21 A: Yes.
22 Q: And you've offered expert testimony in cases like that to
23 opine that those nurses deviated from the standard of care
24 applicable to nurses in the delivery room, true?
25 A: Sure.

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1 Q: You didn't do that in this case?
2 A: Sure, I did.
3 Q: You did?
4 A: I opined that the suprapubic pressure was probably being
5 done incorrectly.
6 Q: Okay.
7 A: And that was from how the nurses would normally manage a
8 suprapubic -- giving suprapubic pressure, because they didn't
9 have direct memory of this particular delivery. So, that's
10 the information that I gave.
11 Q: So, let's make sure the jury understands the full
12 picture. When this case started years ago, you signed an
13 affidavit, right?
14 A: Yes.
15 Q: That's sworn testimony written out that the lawyer helped
16 you write, and you signed it approving the contents of it?
17 A: Yes.
18 Q: And after ---
19 A: That was before any depositions or testimony is taken ---
20 Q: Sure.
21 A: --- or anything like that.
22 Q: And what you had done is you had reviewed the labor and
23 delivery records and the other records that were available to
24 you at that time and you offered what opinions you held at
25 that point in time?

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1 A: Yes.

2 Q: At that point in time, you did not offer any opinions
3 that the hospital or their employees, the nurses, deviated
4 from any standard of care, true?

5 A: I wouldn't have known that because I -- there were no
6 depositions taken at that time.

7 Q: Understood, but my question is, is in your affidavit, in
8 your sworn testimony, you did not allege that the nurses, who
9 are employed by the hospital, deviated from the standard of
10 care?

11 A: Yeah, I would have no way of knowing that and no way to
12 allege that.

13 Q: Subsequently, you reviewed the depositions of the parties
14 in the case, true?

15 A: Yes.

16 Q: And you reviewed the depositions of the two nurses, Nurse
17 Butterworth and Cossentino as well, true?

18 A: Yes.

19 Q: Neither one of those nurses had a specific memory of this
20 actual delivery, true?

21 A: You are correct.

22 Q: And that's a normal set of circumstances that you see in
23 reviewing medical legal cases?

24 A: I've seen that before, yes.

25 Q: And these L&D nurses are delivering babies all day on

1 their shifts day after day three days a week?

2 **A:** Assisting in delivery, yes.

3 **Q:** So, it doesn't come as a surprise when they might not

4 have a specific memory of the way in which a particular

5 delivery went forward?

6 **A:** Not at all.

7 **Q:** And these nurses, when you saw their testimony, didn't

8 have any specific recollection?

9 **A:** Correct.

10 **Q:** But they were asked questions for hours about how they

11 would typically, customarily do suprapubic pressure?

12 **A:** That's correct.

13 **Q:** They didn't testify how suprapubic pressure was done in

14 this particular case, true?

15 **A:** They did not.

16 **Q:** Dr. Maselli testified about how suprapubic pressure was

17 done in this case, true?

18 **A:** She did.

19 **Q:** She did testify also about how McRoberts was done in this

20 case?

21 **A:** Correct.

22 **Q:** And based on her testimony, she describes that it was

23 done in an appropriate manner, true?

24 **A:** Inappropriate?

25 **Q:** In an appropriate manner?

1 **A:** The McRoberts, yes, but the suprapubic, no, because she
2 stated in her deposition, if I'm correct, that the suprapubic
3 pressure is where the pressure is also same as the nurses, the
4 pushing goes toward the vagina, which is incorrect.

5 **Q:** I thought you said earlier that suprapubic pressure used
6 to be applied towards the vagina; now it's applied straight
7 down?

8 **A:** Then you must have misheard because that's not what I
9 said.

10 **Q:** All right.

11 **A:** What I said was and I'll repeat it again, is that when
12 suprapubic pressure is applied toward the vagina, it worsens
13 the impaction of the shoulder against the pubic bone. It is
14 normally either applied in the olden, I call it the olden days
15 because I'm still practicing, but it's where the pushing is
16 going toward the floor or in a downward motion, not toward the
17 vagina and now it is a downward and lateral motion, actual
18 medial motion where the shoulder is collapsed inward.

19 **Q:** In your opinion, did the application of suprapubic
20 pressure cause the brachial plexus injury?

21 **A:** In my opinion, it did not cause, as a direct cause, the
22 injury to Jahmerican, no.

23 **Q:** You talked about an article or a blowup of an article,
24 I'd like to ask you about that. So, this article, it's
25 PRECIS, 1998?

1 A: Yes.

2 Q: Twenty years old?

3 A: Yes.

4 Q: Out of date?

5 A: There has been more information since that time.

6 Q: Not just more information, this one is no longer

7 available, true?

8 A: I have not tried to get it since I read it back at that

9 time.

10 Q: The last time you read it was 1998?

11 A: Or soon thereafter, correct.

12 Q: You haven't read it in nearly twenty years?

13 A: Probably pretty close to that.

14 Q: And probably pretty close to the last time you've heard

15 about it was this morning when Mr. Graham asked you about it

16 before you came into testify, right?

17 A: I couldn't tell you exactly when the last time I heard

18 about it was.

19 Q: Well, you talked to him this morning about this article,

20 did you not, before you testified?

21 A: I believe so, yes.

22 Q: Yeah, and he told you he was going to ask you some

23 questions about this article?

24 A: Yes.

25 Q: Before that, you hadn't reviewed it?

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1 A: No, I had not reviewed it.
2 Q: And he didn't show you the article, did he?
3 A: No.
4 Q: He didn't even hand you the whole thing?
5 A: Just the excerpt you're seeing right there.
6 Q: He just read to you something that you think might have
7 come from that article?
8 A: True.
9 Q: Do you even know if it came from the article?
10 A: Without actually seeing the article and comparing it, I
11 could not tell you. I was asked if I agreed with those
12 statements and those statements I did agree with.
13 Q: All right. Do you know who wrote the article?
14 A: Usually, those articles are written by multiple
15 physicians together, but I could not tell you the authors of
16 the article, no.
17 Q: Do you know the title of the article?
18 A: No.
19 Q: Do you know if it was ever peer reviewed?
20 A: If it's put out by ACOG, it was probably peer reviewed,
21 yes.
22 Q: Are you sure about that?
23 A: I am not sure about that. I said probably, I do not know
24 for a fact.
25 Q: Are you going to offer -- I mean you can't say one way or

1 another whether this, whatever it is, was peer reviewed, true?

2 A: That is true.

3 Q: So, you don't know the author, you don't know if it's
4 peer reviewed, you know that it's outdated, you don't know
5 whether it's even currently available, you haven't seen a copy
6 in twenty years, yet, you think it's reasonably reliable?

7 A: Yes.

8 Q: And you think it's reasonably reliable because it's
9 published by ACOG?

10 A: Yes.

11 Q: And ACOG is the organization of which you are a member?

12 A: Yes.

13 Q: The American College of Obstetrics and Gynecologists?

14 A: Correct.

15 Q: That is the shining star for your feelings, true?

16 A: That is the organization that governs what we do and
17 provides our oversight.

18 Q: And not just oversight, but they actually administer --
19 their board administers the board examination to be board
20 certified?

21 A: That's correct.

22 Q: So, with all of the doctors coming in and talking about
23 board certifications, if you're an OBGYN and you go through
24 the medical school, you go through the residency and you want
25 to go out in private practice, you really going to need to be

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1 board certified, right?

2 **A:** Sure, that would be the most desirable.

3 **Q:** It would be hard to get privileges to hospitals, for

4 example, if you're not board certified?

5 **A:** Sometimes you can't.

6 **Q:** And it's the board that is vetting the quality of the

7 physicians to make sure that their knowledge basis is

8 efficient and they're comfortable endorsing them with their

9 approval, true?

10 **A:** That's true.

11 **Q:** And they do that through a written examination as well as

12 an oral examination?

13 **A:** Correct, that's to be originally certified; that's

14 correct.

15 **Q:** And then they have a re-certification program that takes

16 place every what, six years now?

17 **A:** Every six years there's a test unless you choose to do

18 annual recertification.

19 **Q:** Right, which is twenty-five hours of CME and written

20 tests and answer questions and things like that?

21 **A:** Yes, sir.

22 **Q:** And this organization, ACOG, they actually test you, like

23 you just said, annually about articles, true?

24 **A:** Correct.

25 **Q:** They want to make sure you're up to date with the most

1 current medical literature, true?
2 **A:** Exactly.
3 **Q:** Because things are changing, medicine is changing?
4 **A:** Correct.
5 **Q:** Science is changing, medicine and science together are
6 changing?
7 **A:** Right.
8 **Q:** True?
9 **A:** True.
10 **Q:** You're familiar with the concept of knowledge doubling;
11 do you know what that is? 1900, it took a hundred years for
12 the collective knowledge of the world to double; it took one
13 hundred years. In 1945, it took twenty-five years, right?
14 And today it takes thirteen months; are you familiar with
15 that?
16 **A:** I would not argue with that.
17 **Q:** The rate of knowledge growth is exponential today, true?
18 **A:** True.
19 **Q:** Before today, you looked at some more ACOG publications,
20 right?
21 **A:** Sure.
22 **Q:** I mean, I saw them when I pulled up; I just pulled up
23 next to you in the car and saw your rental car running and I
24 said, I bet that's Dr. Pliskow right there and you were
25 reading this book?

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1 **A:** I wasn't reading it, I was putting it into my bag though.
2 I had read it before.

3 **Q:** Yeah. This book is called Neonatal Brachial Plexus
4 Palsy, right?

5 **A:** Yes.

6 **Q:** And this is a publication that was put out by your
7 college, the American College, to address issues associated
8 with neonatal brachial plexus palsy, true?

9 **A:** Yes, to give an overview of the subject, yes.

10 **Q:** Okay. It is a comprehensive evaluation of the known
11 literature, current thinking, as of the date of this
12 publication in one document; that was the idea, right?

13 **A:** Yes, that's what the thought process behind putting out
14 that article would be.

15 **Q:** This was published in what year?

16 **A:** I mean, mine is 2014.

17 **Q:** In 2014, some sixteen years after this, whatever it is,
18 was published, does not endorse the same sentences that you
19 just agreed to, correct?

20 **A:** I mean, I would have to go sentence by sentence, but I
21 would not disagree with that.

22 **Q:** In 1998, twenty years ago, the information at that time
23 was what you were relying on and said is reliable in that
24 article, fair?

25 **A:** What I said was that I agreed with the statements that

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1 were made that were read to me today.

2 **Q:** And you said it was reliable because it came from ACOG?

3 **A:** Yes.

4 **Q:** So, I trust then that this too is reliable because it too
5 came from ACOG?

6 **A:** I have opined that that is reasonable and reliable. I
7 may not agree with every single thing in there, every line,
8 but I think it's a reliable resource, yes.

9 **Q:** All right. We'll come back to this, but you've also
10 described it as illogical, have you not? Let me, I want to
11 make sure that I quote you correctly.

12 **A:** Sure.

13 **Q:** It makes no logical sense, certain portions of it; is
14 that fair?

15 **A:** Certain portions, I would agree with that.

16 **Q:** Okay. This -- this text that we're talking about from
17 2014 put out by your college, that makes no logical sense in
18 some aspects; it's endorsed by the American Academy of
19 Pediatrics, true?

20 **A:** True.

21 **Q:** It's endorsed ---

22 **MR. GRAHAM:** Objection, Your Honor. May we approach?

23 **THE COURT:** Yes, sir.

24 **REPORTER'S NOTE:** (Bench conference with counsel).

25 **BY MR. HOOD:**

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- 1 Q: Your article, not your article, the Neonatal Brachial
2 Plexus Palsy taskforce from ACOG Publications, it was endorsed
3 by the American Academy of Pediatrics, true?
- 4 A: True.
- 5 Q: It was endorsed by the American Academy of Physical
6 Medicine and Rehabilitation, true?
- 7 A: True.
- 8 Q: It's endorsed by the American Gynecological and
9 Obstetrical Society, true?
- 10 A: Yes.
- 11 Q: It's endorsed by the Child Neurology Society, true?
12 True.
- 13 Q: Society for Maternal Fetal Medicine endorsed this as
14 well, true?
- 15 A: Yes.
- 16 Q: In countries like Japan, Australia and Canada have also,
17 their obstetrical groups have endorsed this as well, correct?
- 18 A: Correct.
- 19 Q: This publication describes, does it not, a different
20 mechanism of birth injury than those lines that were read to
21 you from 1998, true?
- 22 A: It entertains different ideas, but in general, they are
23 somewhat the same, but they do entertain different ideas and
24 plausible theories of injury, yes.
- 25 Q: Let me ask you for the executive summary of this, if you

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1 agree with this statement. What is known at this time, within
2 reasonable medical certainty, is that NBPP, Neonatal Brachial
3 Plexus Palsy, shoulder, just like we're talking about?
4 **A:** Yes.
5 **Q:** Occurs infrequently and can be caused by maternal forces
6 or clinician applied forces or a combination of both; do you
7 agree with that statement?
8 **A:** Yes.
9 **Q:** Thank you.
10 **A:** Yes.
11 **Q:** It goes on to say, finally, in the presence of shoulder
12 dystocia, all intervention by way of ancillary maneuvers, no
13 matter how expertly performed, will necessarily increase the
14 strain on the brachial plexus, true; do you agree with that
15 statement?
16 **A:** I'm sorry, could you repeat it again?
17 **Q:** I will.
18 **A:** Thank you.
19 **Q:** Finally, in the presence of shoulder dystocia, all
20 intervention by way of ancillary maneuvers, no matter how
21 expertly performed, will necessarily increase strain on the
22 brachial plexus.
23 **A:** Yeah, I agree with that, sure.
24 **Q:** Some of the attachments that accompany this, we had a
25 number of exhibits or appendices that follow this, one of

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1 which is ACOG Practice Bulletin Number 40.

2 **A:** Yes, sir.

3 **Q:** You're familiar with that as well?

4 **A:** I am.

5 **Q:** And just so the jury understands, ACOG, the same group,
6 publishes practice bulletins to help provide guidance for
7 physicians who practice obstetrics?

8 **A:** They do.

9 **Q:** And you would generally agree with the statement that a
10 physician applying and complying with the ACOG practice
11 guidelines is in compliance with the standard of care, true?

12 **A:** I don't think that the ACOG practice bulletin really is
13 meant to or defines standard of care. It is usually a -- a
14 general statement on the topic that's being spoken about, but
15 the standard of care really goes to what's going in an
16 individual like or similar circumstance. I think a better way
17 to maybe say it would be that it sets up really some
18 guidelines to follow for a given condition and how it may or
19 may not be resolved or taken care of.

20 **Q:** Number 40, practice bulletin number 40, the sentence is
21 clear, the brachial plexus injury can occur regardless of the
22 procedure or procedures used to disimpact the shoulders; do
23 you agree with that statement?

24 **A:** Sure, I mean, yes, I mean there are multiple, multiple
25 causes of brachial plexus injury, not necessarily just

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1 physician traction. Of course, I agree with that.

2 Q: Now, let me back up for a moment. I want to move through
3 a couple of topics that you spent a significant amount
4 testifying to already this morning and see if these are areas
5 in which we agree or we disagree and if we agree on something,
6 we'll just keep moving?

7 A: Okay.

8 Q: Fetal monitoring strips, based on your review of all of
9 the evidence in this case, are you aware of anyone who has
10 suggested that the fetal monitoring strips demonstrate any
11 fetal problems?

12 A: I'm not aware of anyone, no.

13 Q: In fact, when it comes to whether the baby is doing well
14 in the beginning and well after, is that even in dispute in
15 this case?

16 A: No, I was just answering the questions that were asked to
17 me.

18 Q: Understood. You just got to hit the pitches that come at
19 you. But in this case, you haven't seen any testimony from
20 defense experts or Dr. Maselli to suggest that there's a
21 problem with the monitoring strips or the squiggleness of
22 them, right?

23 A: Nor, did I opine on that in my deposition.

24 Q: True. You spent a long time talking about it today, so I
25 want to make sure the jury understands that the strips and the

1 condition of the baby is not at issue in this case before the
2 shoulder dystocia, true?
3 A: When you say at issue; you mean it's not being -- nobody
4 is ---
5 Q: It's not contested.
6 A: Yeah, nobody is contesting that.
7 Q: Well, let's move on.
8 A: Okay.
9 Q: Fundal pressure, you're not here to imply that fundal
10 pressure was offered, true?
11 A: Was what?
12 Q: You're not here to offer an opinion that fundal pressure
13 was used, true?
14 A: Yeah, I will not offer that opinion. As I said in my
15 deposition, that's something that is at odds in the testimony.
16 Q: And like Mr. Graham said, if you're not going to say it
17 to a reasonable degree of medical certainty, just tell me no,
18 you're not going to testify to it and we'll move on, okay?
19 A: Yeah, I'm not going to say that to a reasonable degree of
20 medical certainty.
21 Q: The Apgar scores, '8 and 9, those are good, right?
22 A: Yes, sir.
23 Q: Nobody said otherwise, true?
24 A: True.
25 Q: Core gases 7.31, those are good, right?

1 **A:** True.

2 **Q:** Nobody said otherwise?

3 **A:** Not that I saw anywhere.

4 **Q:** All right. So, you got -- you went through a form too,
5 it was the shoulder dystocia checklist or procedure list and
6 you explained to the -- to the jury what -- how this process
7 gets filled out. One thing I didn't hear though, is -- is a
8 description of when physicians intentionally use what's
9 described as excessive traction?

10 **A:** Right, that can be something that happens, yes.

11 **Q:** And that would be a circumstance where the baby is stuck,
12 you've done your maneuvers, it's not working, you've gone
13 through the rotations, internal and external, the clock has
14 run out and you have really very limited options here and you
15 may choose to pull as hard as you can?

16 **A:** Yeah, I was never asked about that.

17 **Q:** I know, that's why I'm asking you now. In that
18 situation, it would be appropriate to check the box, other,
19 and indicate exactly what you had done, true?

20 **A:** Sure, anytime that you have done anything out of
21 something that's a box that you can check, you could check
22 other and then expound upon that, sure.

23 **Q:** So, we're talking about forces, the amount of traction
24 that was applied by Dr. Maselli, you have no way to quantify,
25 true?

1 **A:** That is true.

2 **Q:** You have no way to quantify the amount of force or
3 pressure applied internally by the mother either, true?

4 **A:** True.

5 **Q:** Your testimony earlier, mentioned traction, but you never
6 described the angle of the traction?

7 **A:** I did not.

8 **Q:** And you're not going to offer an opinion here today of
9 what angle the traction was applied, true?

10 **A:** I'm unable to tell what angle the traction was applied.
11 This type of injury, looking at it, usually occurs with ---

12 **Q:** Let me just ask you -- no, you don't know.

13 **THE COURT:** Mr. Hood, please. Let him answer the
14 question fully if he was trying to explain. Okay?

15 **MR. HOOD:** Well, I just don't want him to offer an
16 opinion that he said he's not going to offer.

17 **THE COURT:** Why don't we do this. Restate your question
18 ---

19 **MR. HOOD:** Sure.

20 **THE COURT:** Okay.

21 **BY MR. HOOD:**

22 **Q:** In this case, you're not going to offer an opinion as to
23 the angle of the traction applied here?

24 **A:** As I said in my deposition, I do not know the angle of
25 traction that was applied here.

1 Q: Okay. In your affidavit, and we can get it if we need
2 to, but you had originally opined that there was excessive
3 traction and/or torsion, which would be twisting of the neck?
4 A: It was and/or torque I believe, which is again, the same
5 thing, twisting of the neck.
6 Q: Sure and I think that -- that in the course of your
7 testimony, you acknowledge that there was no evidence of that
8 and if you were to revise it, you would just say there was
9 excessive traction?
10 A: Excessive lateral traction is what my affidavit says and
11 I said that the only thing I would take out of that would be
12 the torque, that's correct.
13 Q: Okay. And with respect to traction, let me pull up your
14 testimony real quick.
15 A: Sure.
16 Q: So, let me restate the question and ask you verbatim.
17 You don't have any criticism of the angle of traction because
18 you don't know what the angle was, true?
19 A: That is true.
20 Q: Some other things I want to make sure we agree on. No
21 concerns with the prenatal care in this particular situation?
22 A: I do not see any concerns with the prenatal care.
23 Q: We talked about Pitocin for a long time; no concerns
24 about the use of Pitocin or the discontinuation of the use of
25 Pitocin?

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- 1 A: No, it looked like it was used appropriately.
- 2 Q: Okay. And when there were some low heartrates, then the
- 3 nurse or the doctor learned either directly or from the nurse,
- 4 of the change in the heartrate, right?
- 5 A: Yes..
- 6 Q: And the doctor responded immediately stopping the
- 7 Pitocin?
- 8 A: Correct.
- 9 Q: The doctor is Dr. Maselli?
- 10 A: That's correct.
- 11 Q: You had no criticisms or concerns about the management of
- 12 labor up until the point of the shoulder dystocia that you've
- 13 already talked about, true?
- 14 A: Correct.
- 15 Q: You have no criticisms after the reduction of the
- 16 shoulder dystocia and the baby was delivered, true?
- 17 A: That is true.
- 18 Q: No criticisms exist in a one-minute time frame?
- 19 A: A hundred percent..
- 20 Q: Ms. Smalling had a -- Ms. Smalling had a (inaudible)
- 21 pelvis, yes?
- 22 A: Yes.
- 23 Q: There's no reason for a c-section in this case?
- 24 A: Correct.
- 25 Q: McRoberts was performed, true?

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- 1 A: True.
- 2 Q: Suprapubic pressure was applied, true?
- 3 A: Correct, suprapubic?
- 4 Q: Pressure, I'm sorry?
- 5 A: No, suprapubic pressure was applied, but I don't believe
- 6 it was applied correctly.
- 7 Q: I understand, that's your testimony and that's your
- 8 opinion.
- 9 A: That's right.
- 10 Q: But in this case, the nurses checked off that they did
- 11 suprapubic pressure, true?
- 12 A: True.
- 13 Q: And that was sufficient in their mind and consistent with
- 14 their training, true?
- 15 A: True.
- 16 Q: So, they did what the hospital taught them to do, yes?
- 17 A: I don't know where they learned how to do the suprapubic
- 18 pressure; whether it was the hospital taught them or I'm not
- 19 sure. I can't opine on that.
- 20 Q: You were -- made a flip chart up earlier about rate of
- 21 incidents and births; congratulations, by the way.
- 22 A: On?
- 23 Q: Never having a permanent brachial plexus injury.
- 24 A: Thank you.
- 25 Q: Do you guarantee your patience they want have one?

1 **A:** No, of course not.

2 **Q:** Thank you. You actually are familiar enough with this
3 subject matter, brachial plexus injuries, in litigation to
4 have a compilation of literature that you typically use to
5 support your opinions, right?

6 **A:** Yes.

7 **Q:** Let me see if I have -- oh, I'm actually looking at it;
8 it's under my stuff, sorry. The podium is not big enough for
9 my mess. All right. So, when one of these cases of shoulder
10 dystocia case comes in, I mean it's, you sort of have things
11 that you look for; labor and delivery records, you know, you
12 want to look at some of the prenatal I records?

13 **A:** Right..

14 **Q:** Some of these cases, they actually start way before you
15 get to the hospital, right, prenatal?

16 **A:** Oh, sure.. Sure.

17 **Q:** Because we talk and you agree that a brachial plexus
18 shoulder dystocia is unpredictable and unpreventable?

19 **A:** Yes, sir.

20 **Q:** And as I understand your testimony, in this case, it was
21 unpredictable and unpreventable?

22 **A:** That's correct.

23 **Q:** Now, there are certain instances, certain cases, that you
24 reviewed, where there have been red flags that maybe increase
25 a likelihood that a particular patient may experience it or

1 not?

2 **A:** Sure.

3 **Q:** None of that applies here?

4 **A:** Red flags that it may occur, I mean, as was checked in
5 the box in the medical record, obesity is a risk factor, but
6 whether a patient who has a larger BMI is going to have a
7 shoulder dystocia or not; it's not a given, no, it's not.

8 **Q:** Sure. All right. And so, when you looked at the
9 records, prenatal records, you didn't see anything that jumped
10 out and said hey, I think this doctor should have ordered a c-
11 section before the patient ever came to the hospital?

12 **A:** No, I did not opine that and I did not see that and
13 thought the prenatal care was fine.

14 **Q:** Thank you. Some of the cases you deal with have those
15 circumstances in them.

16 **A:** Oh, for sure.

17 **Q:** And some of them deal with monitoring strips like you
18 talked about earlier, where maybe the baby is not tolerating
19 labor very well, right?

20 **A:** Yes.

21 **Q:** And you've got to be worried about not tolerating labor
22 means the baby could be suffering a brain injury and in some
23 of those cases, you opined that the doctor should perform a c-
24 section or affect delivery sooner, right?

25 **A:** Yes.

1 Q: But that's not an issue in this case?

2 A: It is not.

3 Q: No brain injury in this case?

4 A: No, not that I saw or know.

5 Q: Okay. What are the risks associated with shoulder
6 dystocia for harm to the baby?

7 A: I'm sorry, say it again?

8 Q: What risks are associated with shoulder dystocia for the
9 baby?

10 A: Well, I mean you certainly have local injury, so a
11 fractured clavicle, fractured humerus, injury to the nerves,
12 anoxic injuries from lack of oxygen from prolonged shoulder
13 dystocia and potentially death.

14 Q: All right. Now, I started this by talking about your
15 exhibits and I got your exhibits from your deposition in a
16 notebook. Do you remember your deposition exhibits and your
17 deposition?

18 A: I don't recall what was put as exhibits, but if you have
19 them, you have them.

20 Q: Yeah, let me -- let me just ask you, I mean, we marked at
21 that time, all of the customary materials that you used to
22 support your opinions in cases like this, true?

23 A: Okay.

24 Q: And you stand by those as being authoritative, right?

25 A: No, I don't stand by anything being authoritative.

1 Reliable, reasonably reliable, yes.

2 Q: All right.

3 A: I don't think I've ever called anything authoritative.

4 Q: So, one article that I'd like to specifically ask you

5 about is titled Optimizing Shoulder Dystocia Management ---

6 A: Okay.

7 Q: --- To Prevent Birth Injury.

8 A: Okay.

9 Q: That was edited or authored by Edith Gurewitsch; are you

10 familiar with that?

11 A: Yes.

12 Q: Do you find that to be a reasonably reliable article?

13 A: All the articles that I had are reasonable reliable. I

14 don't necessarily pull an article because it only says

15 everything that I need it to say. There are different

16 opinions on things and they may be in the article and I -- if

17 I have that article there, I felt it was reasonably reliable.

18 Q: Okay. So, the answer is yes?

19 A: Yes.

20 Q: Tell me if you agree with this from Dr. Gurewitsch's

21 article. The incidences of shoulder dystocia and associated

22 brachial plexus injury have not changed over time and are even

23 rising; agree or disagree?

24 A: It is true that they have not changed significantly over

25 time. I'd have to look at the time period in which she's

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1 actually talking about and the population with regard to the
2 rising. I've seen some things that have said where it was
3 slightly decreasing. So, I think the overall thought process
4 in the OBGYN community is that it has not changed
5 significantly over time.

6 **Q:** I just want to say ironically, this has occurred despite
7 more frequent recognition of shoulder dystocia, more
8 widespread in even prophylactic use of shoulder dystocia
9 maneuvers, liberal use of caesarean section and near
10 elimination of mid-pelvic operational delivers; do you agree
11 with that?

12 **A:** Yes.

13 **Q:** Furthermore, injuries once thought exclusively to be the
14 result of excessive, external applied traction, have been
15 proven to occur spontaneously; do you agree with that?

16 **A:** Repeat it again?

17 **Q:** Furthermore, injuries once thought exclusively to be the
18 result of excessive, externally applied traction, have been
19 proved to occur spontaneously; do you agree with that?

20 **A:** I guess anything is possible, yes, I mean, you have to
21 know, you're asking about a given sentence in a given article,
22 you'd have to know more specifically what they're talking
23 about. But anything in that is possible, yeah.

24 **Q:** I'm just reading you the introduction from the article
25 that's reasonably reliable that's part of your materials that

1 you support -- you believe support your opinions?

2 **A:** Okay. And that article is probably twenty or thirty
3 pages. So, you're reading me one line. So, I mean, I can
4 read you a hundred lines from that article that I would say
5 are reasonably reliable. So, as a whole, yes, I think the
6 article is reasonably reliable.

7 **MR. GRAHAM:** Excuse me, Your Honor. Could we ask that
8 Mr. Hood provide the witness with a copy of that article?

9 **THE COURT:** He hasn't asked for it.

10 **BY MR. HOOD:**

11 **A:** Yes, so far I haven't needed it, but I will ask if I need
12 it, yeah.

13 **THE COURT:** The witness will ask if he needs it.

14 **BY MR. HOOD:**

15 **Q:** And you've been examined many times in trial, correct?

16 **A:** Ten times; if that is many to you, then yeah.

17 **Q:** You're familiar with this process, I'm asking about your
18 articles?

19 **A:** I can't recall that the articles have been asked in
20 trial, more than once or twice, but, yeah, you're allowed to
21 ask what you want to ask.

22 **Q:** Sure. So, my point is if at any time, you need to repeat
23 it or you'd like to see it, we can open your transcript and
24 you can look at the exhibits. Okay? I just wanted you to
25 know that's available.

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1 **A:** Okay. That would be great. Sure.

2 **Q:** So, the next sentence in the introduction says the
3 prevailing interpretation of this phenomenon is a brachial
4 plexus injury is not linked inexorably to shoulder dystocia
5 and is unrelated to clinician intervention; do you agree with
6 that sentence?

7 **A:** Sure. Of course, there are times that brachial plexus
8 injury can occur from a precipitous delivery, where nobody
9 touches the baby at all, and it just delivers precipitously
10 with a shoulder dystocia. That's not what we're talking about
11 in this case, but, yes, I mean, I would agree with that
12 sentence.

13 **Q:** Do you agree that brachial plexus injuries occur in the
14 absence of shoulder dystocia have reported too?

15 **A:** Yes, absolutely. That's what I was just talking about
16 and also it occurs in the posterior shoulder where there's no
17 dystocia of the interior shoulder. When the posterior
18 shoulder gets hooked up on the sacral promontory, it occurs
19 even before the head is delivered. So, there would be no way
20 for you to know that and that's not what occurred in this
21 case.

22 **Q:** Do you agree that shoulder dystocia is an obstetrical
23 emergency?

24 **A:** I think that it's an emergent condition and something
25 that needs to be taken care promptly and expeditiously and it

1 can rise into a genuine emergency, but when it starts out, I
2 haven't opined that it is a genuine emergency at the time that
3 the shoulder dystocia occurs, because as in this case, a
4 shoulder dystocia is, most of the time, will resolve within
5 the first minute and it doesn't arise to a medical emergency
6 where life and limb of the baby or the mom is endangered.

7 Q: Going back to the emergency point, I'm still on the same
8 article that is your materials. Do you agree with this
9 statement, it's axiomatic that every (inaudible) will
10 eventually or inevitably face the shoulder dystocia emergency
11 that is more difficult than others?

12 A: Yes.

13 Q: And on this point, about emergency, while I'm talking
14 about it, another article from your materials is titled
15 Improving Neonatal Outcome Through Practical Shoulder Dystocia
16 Training; are you familiar with that?

17 A: Author?

18 Q: Authored by, the lead author is Draycott?

19 A: Oh, sure, yeah.

20 Q: All right. And do you find that to be a reasonably
21 reliable source of information?

22 A: Yeah, Draycott's article is to the fact that ---

23 Q: I just asked if you think it's reliable and I'm going to
24 ask you about a specific portion in that article?

25 A: Okay. Yes, it's reasonably reliable.

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1 Q: Okay. And I just have to make sure you agree with that
2 before I can read it; that's the reason I keep asking if it's
3 reliable. Shoulder dystocia is an unpredictable, acute, life
4 threatening emergency and therefore, it is difficult to train
5 staff during the actual event; do you agree with that
6 statement?

7 A: Yes, overall, I agree with his statement.

8 Q: Another article that was called The Effects of Shoulder
9 Dystocia Training on the Incidence of Brachial Plexus Injury
10 authored by Inglis from your materials; are you familiar with
11 that?

12 A: Yes.

13 Q: Is it reliable?

14 A: It is.

15 Q: On the issue of emergency, do you agree with this
16 statement; despite numerous efforts to ascertain which
17 maneuvers most effectively resolve shoulder dystocia
18 emergencies, controversy remains about which one are the most
19 effective and safe approaches for managing these cases?

20 A: I agree with that.

21 Q: And when I see this article, I count seven different
22 times where they discuss shoulder dystocia emergencies?

23 A: Yes, as a whole, the condition is an emergent condition.
24 It can arise to emergency. So, when ACOG and other authors
25 speak about the shoulder dystocia, that shoulder dystocia is

1 an emergency, they're talking about the whole condition; not
2 talking about from the time it occurs until the time it ends,
3 they're not talking about when it becomes a genuine emergency,
4 they're talking about the condition itself and I agree the
5 condition itself can be considered an emergency because at
6 some point, in that condition, life and limb can be at risk.
7 Q: And you don't know like whether McRoberts or suprapubic
8 pressure or Rubin's or anything else is going to actually
9 work, true?
10 A: That's true.
11 Q: And you don't know how long it's going to take?
12 A: You don't.
13 Q: And so, the information you're talking about with the
14 cord gases and the Apgars, all that information comes to you
15 after the fact, right?
16 A: Right, you only have the fetal monitoring strips before,
17 but you have the cord gas and Apgar's are after.
18 Q: So, you're in a tunnel for a little period of time, you
19 just don't know how long that time period is?
20 A: That's right.
21 Q: And what we see in some of the more recent publications,
22 like this one from ACOG talks about fetal tolerance to perhaps
23 different insults?
24 A: Absolutely.
25 Q: And they spend some time discussing in here how different

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1 people or different babies respond differently to different
2 circumstances?

3 A: That's correct.

4 Q: And that's just part of the normal human variation that
5 we all have, God given?

6 A: Yeah, there's variation from child to child, but then
7 again, there is children that may be acidotic, they have low
8 PH's and they have more easier injury because the muscles are
9 lax and they don't have the protective mechanisms for those
10 nerves. So, that is true.

11 Q: And you agree that unresolved shoulder dystocia can lead
12 to grave bodily harm to the mother?

13 A: Yeah.

14 Q: Or the child?

15 A: Yeah, I already said that.

16 Q: There's no evidence to suggest that Dr. Maselli did not
17 stay calm during this medical emergency, is there?

18 A: That is a bone of contention, because I believe she
19 opined that she did, but I believe the other observers in the
20 room did not feel she was calm. So, again, I have no opinion
21 on that.

22 Q: All right. When the McRoberts and suprapubic pressure
23 were being applied, there was no way to know whether those
24 maneuvers would actually deliver the shoulder, right?

25 A: Correct.

1 Q: And as I understood your testimony earlier, it sounded to
2 me like you think that there were four maneuvers; there was
3 McRoberts, episiotomy, suprapubic pressure and then a fourth
4 maneuver, which was just excessive traction?

5 A: Oh, I see what you mean, yes, that's correct.

6 Q: That's not -- nowhere is it charted that there were four
7 maneuvers, is it?

8 A: No, the -- well, so you're talking about the nursing of
9 the tight shoulder dystocia form and if you break out what
10 you're talking about, I can talk about it. So, if we look --
11 if we look at the maneuvers that are -- it says any and all
12 maneuvers that apply and the order in which they were used,
13 they only list two.

14 Q: That's right.

15 A: So, they list McRoberts and they list suprapubic
16 pressure. The episiotomy is not necessarily a maneuver and it
17 is, you know, certainly something that we use that is helpful.

18 Q: Sure.

19 A: But it's not a maneuver; it's not things being moved that
20 -- in that particular procedure, and then if you look at the
21 other forms, so there's no episiotomy there and then the
22 traction is not made mention in the nurse's note; it's made
23 mention in Dr. Maselli's notes.

24 Q: We'll get to it. So, the nurses complete this typed up
25 form, this Exhibit 11 that we were just looking at; that's

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1 what the nurses completed?

2 **A:** Yes, sir.

3 **Q:** And the nurses know what they did because they did it?

4 **A:** I would assume so.

5 **Q:** Dr. Maselli completes this form, which is Exhibit Number

6 12?

7 **A:** Because she knows what she did because she did it.

8 **Q:** Right. And she indicates, here it lists episiotomy as a

9 maneuver on this form, okay?

10 **A:** Yes.

11 **Q:** And she checked the box for episiotomy and McRoberts and

12 suprapubic pressure and she places the order in which they

13 were done as well?

14 **A:** Correct.

15 **Q:** All right. There's no fourth maneuver checked, other

16 traction down there, right?

17 **A:** No, of course not. That came from her deposition

18 testimony.

19 **Q:** And there's no discussion anywhere in the chart that

20 after the suprapubic pressure had been applied, that Dr.

21 Maselli tried now a different approach, which was, let's just

22 pull harder; you didn't see that in any of the notes, did you?

23 **A:** No, that's not in the medical record; that's in her

24 deposition testimony.

25 **Q:** And we'll hear from her I'm sure during the course of the

1 week. You had testified in this case that the episiotomy, I
2 just want to close the loop on that, that was fine; you have
3 no criticisms of that, true?

4 A: Not at all, yes, true.

5 Q: All right. So, I want to talk about the traction and I'm
6 going to back up and talk about your qualifications and then
7 I'm going to stop so we can go have some lunch. Okay?

8 A: Okay.

9 Q: In this case, you've testified about what you believe to
10 be excessive traction, fair?

11 A: Yes.

12 Q: And you testified under oath previously that to me, it's
13 more than what's usual or more than what's needed for that
14 given situation, true?

15 A: Yeah, I -- I wouldn't doubt that I said that. I agree
16 with that.

17 Q: That's a fair Pliskow working definition of excessive?

18 A: Right. Like I said in my deposition, I have a different
19 definition of excessive than Dr. Maselli does. That's why our
20 -- we weren't really talking the same language in the
21 deposition testimony.

22 Q: So, it's -- and that's not uncommon where one physician
23 describes one thing using more slightly in a different way
24 than others; it's maybe the same concept, just different
25 words, right?

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1 A: Sure, that's not uncommon.

2 Q: And that's why you wanted to clarify your version, how

3 the terms you're using are defined by you?

4 A: Right. I wanted to make sure it was understood that to

5 me, moderate traction is excessive because it's more than

6 what's needed.

7 Q: And what you said under oath is in terms not of moderate

8 traction, I don't believe, it was having to do with the

9 concept of excessive traction?

10 A: You talking in this case or another case?

11 Q: Yeah, in this case.

12 A: Okay.

13 Q: To me, it's more than what's usual or more than what's

14 needed for that given situation?

15 A: Yeah, that's my definition.

16 Q: Of excessive?

17 A: Correct. In excess of what's needed, excessive.

18 Q: And you acknowledge that both you and Dr. Maselli have

19 different variations in your definitions, true?

20 A: Yes, she does not believe that what she did was

21 excessive.

22 Q: Now, she described as you're familiar with, as applying

23 slightly more than gentle guidance?

24 A: She stated that in her deposition, that is correct. She

25 put moderate on the Checklist Form.

1 Q: Okay. And you read her deposition, right?
2 A: I did, yes.
3 Q: It was long?
4 A: It wasn't that long.
5 Q: Well, it was six hours long.
6 A: Oh, it didn't read that on paper.
7 Q: Yeah, well she was asked a lot of questions about what
8 those terms meant and what she was describing, fair?
9 A: Yes.
10 Q: And that's a fair way to try to figure out what a doctor
11 was thinking when they wrote something?
12 A: Of course.
13 Q: And when she was asked what does moderate control mean,
14 she says, it means slightly more than gentle guidance?
15 A: Right.
16 Q: Now, I asked you earlier a little bit about your
17 experience testifying in some of the materials that you have,
18 you've worked with Mr. Graham in about fifteen cases; is that
19 right?
20 A: I would say overall, yes, that's true.
21 Q: How many cases do you currently have for him?
22 A: I mean, I don't know exactly, I'd say less than five.
23 Q: And of the fifteen or so cases, probably twelve of those
24 are brachial plexus injury cases?
25 A: Yeah, there was only a few that were cerebral palsy birth

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1 injury cases.

2 Q: Okay. And you've actually seen testimony or seen medical
3 records sort of like this where usual or gentle traction is
4 checked, true?

5 A: Yes.

6 Q: And you opined that it was still excessive?

7 A: That's possible, I don't know. You'd have to show me
8 what you're talking about.

9 Q: Okay. As you sit here today, you're not familiar with
10 any cases for Mr. Graham or with my law firm, where the doctor
11 described using gentle traction and you said it was excessive?

12 A: It's possible. I may have to see, you know, all the
13 parts of that case; the deposition testimony, everything else
14 that you're talking about one aspect of a medical record. I
15 mean, something in the deposition could have changed that; I
16 don't know as I sit here. It's possible.

17 Q: You testify for plaintiffs over ninety percent of the
18 time?

19 A: You mean cases are sent to me by plaintiff attorneys
20 ninety percent of the time. More than half of the cases that
21 are sent to me by plaintiff attorneys, I don't find any
22 negligence in. So, I wouldn't say that I testify for
23 plaintiffs ninety percent of the time. I don't agree with
24 that.

25 Q: Let me be clear then. Big picture, in your entire

1 medical legal experience can you approximate a percentage of
2 cases, medical malpractice cases, in which you testified on
3 behalf of plaintiff or the defense?
4 A: Okay. So, we're talking about testimony.
5 Q: Right.
6 A: Which is deposition and trial and then ninety percent is
7 correct with that question as asked.
8 Q: Thank you. So, ninety percent of your testimony is on
9 behalf of plaintiffs?
10 A: That's correct.
11 Q: And in cases like this involving shoulder injuries,
12 you've never testified for a defendant or doctor, true?
13 A: Testified, no. I've offered opinions for the doctor, but
14 I've never been to a deposition or a trial where I've done so;
15 that's correct.
16 Q: You're charging seven thousand dollars a day to be here?
17 A: That's correct.
18 Q: And that's your going rate?
19 A: Is that the going rate?
20 Q: Going rate for a day?
21 A: Yes.
22 Q: And you still advertise your services online?
23 A: I have my website. So, yes, I would assume that that's
24 advertising and I'm also listed on expertpages.com, which is a
25 referral service. So, yes, I would say that's advertising

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1 too.

2 Q: And the reality is that when you advertise on
3 expertpages.com and pay that organization to advertise your
4 services, most of those people who use that service are
5 plaintiffs' lawyers like Mr. Graham?

6 A: That's true, because, you know, the defense experts can
7 go to the university and just get their experts. It's much
8 easier for defense attorneys to get their experts. So, yeah,
9 I would assume that that's true, that plaintiff attorneys
10 would look at that more than defense attorneys.

11 Q: And you've testified about ten or twelve different states
12 including Florida and North Carolina, you've been to South
13 Carolina before, New Hampshire, Texas, Pennsylvania, Georgia,
14 Maryland, Arkansas, Michigan, New York, Oklahoma, Puerto Rico
15 and even the country of Canada?

16 A: I would -- I've never been to testify in Canada, but I
17 have testified on a case in Canada, yes.

18 Q: And you're averaging about \$150,000 a year in testifying
19 as an expert witness, true?

20 A: If that's what the number was last year; I don't know,
21 when you say averaging, I don't know what you mean by
22 averaging over what period of time, but yes, that was last
23 year's number.

24 Q: All right. And so, you've been doing medical consulting
25 work since what year?

1 A: 1998, I think would be the when I really started doing
2 it. Like I said earlier, 1990 with the Rape Treatment Center,
3 I did a few cases, but really started doing it with regards to
4 product liability and medical malpractice, that would be after
5 1998, 1997, 1998.

6 Q: All right. And just doing the math there, I mean that's
7 a multiple seven-figure revenue generated from your consulting
8 work, true, twenty years? I mean if it was just \$100,000 a
9 year, it would be \$200,000.

10 A: I wouldn't say multiple, but yes, I would say seven
11 figures is possible.

12 Q: Bear with me one minute please.

13 A: Take your time.

14 Q: All right. Let's see that document -- you're not aware
15 of any publication that defines moderate traction as excessive
16 traction, true?

17 A: No, I couldn't give you one off the top of my head, no.

18 Q: Thank you.

19 THE COURT: All right, ladies and gentlemen, we're going
20 to break for lunch now. It's about 1:15. I'd ask you to be
21 back at 2:30 please. Take them to their jury room.

22 REPORTER'S NOTE: (Jury retires to jury room 1:18 P.M.)

23 THE COURT: All right. We'll be at ease until 2:30.

24 (COURT IN RECESS)

25 THE COURT: Please, just keep your seats. All right.

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1 Thank you very much. All right. You want to get my jury;
2 bring them in. Thank you.

3 **REPORTER'S NOTE:** (Jury enters courtroom 2:38 P.M.).

4 **THE COURT:** Redirect limited to new matters on cross.

5 **MR. GRAHAM:** Yes, sir.

6 **THE COURT:** Mr. Graham, you may.

7 **MR. GRAHAM:** Thank you, Your Honor.

8 **REDIRECT EXAMINATION OF DR. STEVEN PLISKOW BY MR. GRAHAM:**

9 **Q:** Good afternoon.

10 **A:** Good afternoon, sir.

11 **Q:** Doctor, I just want to go through a few of the matters
12 that Mr. Hood asked you questions about. There was a question
13 about whether you -- whether you thought all ACOG publications
14 were reliable. Do you believe that all parts of all ACOG
15 publications are reliable?

16 **A:** No, sir, I can't, without looking at a particular
17 document, say whether it's reliable or not. And certainly, I
18 would never say that all parts of every document are reliable.
19 As we discussed earlier, medicine is changing and evolving,
20 and things would change and evolve in those documents as well.

21 **Q:** There was some reference to your prior testimony that
22 some aspect of a publication was illogical. Even in the ACOG
23 publications that you find to be reliable in some ways, tell
24 us whether or not there were other ways where you thought it
25 was illogical?

1 **A:** Sure. I mean, one of the examples that I can give that
2 just comes quickly to mind in the ACOG on the shoulder
3 dystocia issue, is that they make several remarks, I believe
4 it's number 2 in the bibliography, the article number 2. They
5 make several references in the compendium to that article, but
6 they missed the most important point of that article, which is
7 that before the operator or before the delivery attendant
8 touches the head of the baby, that there is not enough stretch
9 in the brachial plexus that occurs, whether it's in shoulder
10 dystocia delivery or not to injure the brachial plexus, to
11 stretch the nerves far enough that they would undergo an
12 avulsion like this, that it would take about a fifty percent
13 stretch for that to occur. So, that was, you know, just one
14 of the things that I don't know if they left it out
15 intentionally or they just didn't make mention of it, but they
16 talk about one aspect of an article, but they don't talk about
17 all the aspects of every article. So, over all, I think it's
18 a very good publication. It's a good summary of the issue,
19 but it -- it's not exhaustive, it's not complete.

20 **Q:** Moving on, there was a reference to some organizations
21 endorsing the ACOG position paper that came out in 2014?

22 **A:** Yes, sir.

23 **Q:** Do you have any knowledge of which executive or expert
24 witness from ACOG approached those organizations?

25 **A:** I was not involved in any of that, so I don't know how

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1 those endorsements were arrived at; whether it was by money or
2 how it occurred; I don't know.

3 **Q:** You -- can you tell us which executive or expert witness
4 on behalf of the endorsing organizations were reached out to
5 by ACOG?

6 **A:** I would have no idea.

7 **Q:** Can you tell us whether or not there was a quid pro quo
8 between ACOG and those endorsing organizations?

9 **MR. HOOD:** Your Honor, I object to the leading and he's
10 already established he doesn't acknowledge this. It's
11 argumentative.

12 **THE COURT:** Okay. All right, sir. Please, I'm going to
13 let give you some leniency with this.

14 **BY MR. GRAHAM:**

15 **Q:** I realize you said you didn't know who for ACOG
16 approached who for an endorsement, but now I'm asking you, do
17 you know whether there was a quid pro quo between those two
18 and if so, what it was?

19 **A:** Again, I have no knowledge of any of that, no.

20 **Q:** Do you know whether some of those organizations were
21 endorsements on part of the ACOG position paper and finding
22 other parts illogical?

23 **A:** No, I don't know that, but I would assume that the
24 Pediatric Societies ---

25 **MR. HOOD:** Objection, Your Honor.

1 **THE COURT:** Please limit your remarks or your answers to
2 that which you know. Okay?

3 **DR. PLISKOW:** Yes, Your Honor.

4 **BY MR. GRAHAM:**

5 **Q:** No substitute.

6 **A:** Yes. Yes, I don't know.

7 **Q:** Mr. Hood was asking you all kinds of questions about did
8 you agree with this, did you agree with that, about whether
9 forces of labor could cause injury, whether other things could
10 cause injury without a doctor pulling too hard. My question
11 for you, sir, is in any of those questions, did Mr. Hood ask
12 you about permanent injuries or did he ask you about all
13 injuries, including temporary injuries?

14 **A:** I don't believe the term permanent was used at all this
15 morning.

16 **Q:** If he added the word permanent to that question, do you
17 agree that permanent injuries can be caused by forces of labor
18 alone; would have that have effect on your answer and if so,
19 how?

20 **A:** Without any other intervening aspects, meaning normal
21 baby, normal mom, no other things that can cause it, then, no,
22 the actual forces of labor, contractions and delivery will not
23 cause an avulsion or tearing of the nerve injury without
24 external forces. Otherwise, I mean the forces of labor occur
25 on every single delivery that there is. I mean, there's

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1 contractions and there's baby moving through the pelvis. It
2 would occur way higher frequency than it does just by evidence
3 based medicine.

4 Q: Mr. Hood asked you if there is some degree of stretch of
5 nerves involved with every maneuver, every internal maneuver
6 and I believe your answer was yeah, there is stretch involved.
7 I'm going to ask you, is there any stretch involved that would
8 be injurious to the baby?

9 A: The idea of the external/internal maneuvers is to reduce
10 the stretch and the strain on those nerves to prevent the
11 injury.

12 Q: I hold in front of you a rubber band.

13 A: Yes, sir.

14 Q: Is a rubber band somewhat comparable to a nerve tissue in
15 terms of stretch and how it responds?

16 A: Yes, it can be.

17 Q: All right. Can there be stretch without injury?

18 A: Absolutely.

19 Q: If there is stretch involved with internal maneuvers,
20 would that involve injury?

21 A: No, it should not involve injury. Fetal nerves are more
22 resistant to injury than adult nerves and it takes a lot of
23 stretch to permanently injure or avulse a fetal nerve, to my
24 knowledge.

25 Q: Earlier you said you used Rubin's as your first

1 technique; why is that?

2 **A:** No, normally I would use -- I would use, I'm sorry,
3 McRoberts and then I'd usually go to Rubin's, but it depends.
4 Every single patient is different, and it depends on what is
5 presenting to me. Sometimes you wouldn't be able to get a
6 hand in to do Rubin's and maybe suprapubic is -- is better in
7 that scenario or maybe the delivery of the posterior arm may
8 be better in that scenario, so my preference, my go to
9 normally of the internal maneuvers is Rubin's. First of all,
10 it's easy to perform and usually successful and studies have
11 shown that it reduces the stretch to the brachial plexus even
12 more than McRoberts or suprapubic, which would be the external
13 maneuvers. So, I like it.

14 **Q:** Talking about your answer to Mr. Hood about some of the
15 ACOG stuff is illogical, when -- when there is an assertion by
16 ACOG or anyone else that a baby can be born with brachial
17 plexus injury without there being any degree of traction, can
18 you tell us about all the other possible causes that wouldn't
19 involve traction?

20 **A:** Sure, so the precipitous delivery we spoke about earlier,
21 the baby just moving rapidly through the pelvis; a posterior
22 injury can occur without fetal traction. As a matter of fact,
23 a posterior shoulder getting hooked up on the sacral
24 promontory occurs even before the head delivers; so, that's
25 another incidence. Another instance would be very low, very

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1 low PH where that would affect the muscle tone, so that the
2 the baby would be more apt to be injured. There are things
3 like maternal fibroids, large tumors in the uterus that can
4 produce compression on a nerve in utero. Sometimes the baby
5 could be malpositioned in utero; it's just stuck in a position
6 where the nerve is being compressed. There's something called
7 a cervical rib where there is a rib that actually compresses
8 or lays on those nerves. So, they're, I'm sure there are
9 nerves, osteomyelitis, which is an infection of the bone and
10 overlying brachial plexus can cause injury to the brachial
11 plexus. So, there's a ton of things that can cause brachial
12 plexus injury without a physician putting traction, which I
13 would add, none of which existed in this case.

14 **Q:** Even if any of those existed in this case, would they be
15 able to cause the magnitude and permanency of the damage that
16 this child suffered?

17 **A:** No, not at all, not to my knowledge, my medical
18 knowledge.

19 **Q:** There was a question put to you about the rate of
20 brachial plexus injuries in this country either staying the
21 same or going up?

22 **A:** Yes.

23 **Q:** Does that apply to all hospitals?

24 **A:** Again, that comment was related to a particular paragraph
25 in a particular article. It would depend on the hospital. It

1 would depend on what the training of the physicians are.
2 There are some articles and studies that show, one in
3 particular, I'm thinking that with 562 shoulder dystocias,
4 they had no brachial plexus injuries after training the
5 physicians not to put traction. So, I mean, overall, because
6 of all the things that I spoke about just before that caused
7 brachial plexus injuries, I have no doubt that overall maybe
8 it's pretty constant, maybe a little bit up; maybe a little
9 bit down over time, over the years. But when we speak about
10 this type of an injury, there's nothing else that causes this.

11 Q: All right. There were questions put to you about the '98
12 language from the ACOG publication being obsolete, outdated,
13 all that stuff. In those hospitals which follow the teaching
14 of avoiding traction, is the rate of injuries going up for
15 them?

16 MR. HOOD: Objection, Your Honor, foundation.

17 THE COURT: Please establish a foundation for that
18 question.

19 BY MR. GRAHAM:

20 Q: Doctor, are you familiar with the studies of the rates of
21 injury, brachial plexus injury at hospitals that train their
22 doctors not to use traction and those other hospitals that
23 train their doctors that it's the uterus that is the culprit?

24 A: Sure. So, for instance, the one that I was just speaking
25 about, the Crofts study that speaks about training the

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1 physicians and of the delivery attendants not to put traction
2 and then the numbers went down to zero after 560 plus shoulder
3 dystocias. Opposing counsel had spoken about Draycott and
4 Inglis studies he mentioned this morning, mentioned about
5 emergency. But the real importance about those studies where
6 they were showing that with the reduction of the traction on
7 the brachial plexus, that the number of injuries to the
8 brachial plexus went way down.

9 Q: I believe you have already testified that the Croft
10 articles you referred to is generally reliable; is that
11 correct?

12 A: Yes, it's in that list of articles that I had given --
13 that I had said was generally reliable.

14 Q: All right. I want to read a sentence or two from that
15 article ---

16 A: Sure.

17 Q: --- and ask if you agree or disagree?

18 A: Okay.

19 MR. HOOD: If you could use the name and that title
20 please?

21 MR. GRAHAM: It's -- if it helps it's Exhibit 8 of the
22 deposition that you were referring to earlier, but it's
23 Prevention of Brachial Plexus Injury, 12 Years of Shoulder
24 Dystocia Training: an Interrupted Time-Series Study.

25 MR. HOOD: Thank you.

1 **BY MR. GRAHAM:**

2 **Q:** Now, back to where I was. We suggest that usefully be
3 standardized, expression of publication of permanent brachial
4 plexus injury rate as -- tell me if you agree or disagree with
5 this?

6 **A:** Okay.

7 **Q:** That none of 17,039 babies in the last cohort -- that
8 none of the 17,039 babies in the last cohort suffered
9 permanent brachial plexus injury challenges, challenges that
10 come and get commonly held to you that permanent injury is
11 largely unavoidable. Permanent brachial plexus injuries must
12 no longer be viewed as inevitable complication of shoulder
13 dystocia.

14 **A:** Yes, I agree with that with regard to, you know, training
15 the physician or delivery attendant not to put traction on the
16 brachial plexus, lowers those numbers extensively and then
17 that article completely eliminated them.

18 **Q:** Mr. Hood asked you if shoulder dystocia was predictable
19 and preventable. My question, sir, is is permanent brachial
20 plexus nerve damage preventable?

21 **A:** Yes, if it's related to a stretch injury or an avulsion,
22 the answer is yes. If it's related to some of those other
23 causes that I gave, the answer is possibly no.

24 **Q:** What about Jahmerican, could his injury could have been
25 prevented and if so, how?

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1 **A:** A hundred percent. So, if Dr. Maselli had reverted to
2 internal maneuvers prior to resorting to increased traction,
3 whether it's axial or lateral, the increase of strength of the
4 -- of the traction is what created this injury. So, it was a
5 hundred percent preventable, yes. And following the standard
6 of care would have prevented it.

7 **Q:** Does anything that Mr. Hood asked you about change any of
8 your opinions and conclusions that you've testified to?

9 **A:** No, not at all.

10 **Q:** Thank you.

11 **A:** Thank you.

12 **THE COURT:** Mr. Hood?

13 **MR. HOOD:** Very limited to the article.

14 **RE CROSS EXAMINATION OF DR. STEVEN PLISKOW BY MR. HOOD:**

15 **Q:** You were just talking about the Croft article?

16 **A:** Crofts?

17 **Q:** That's the one you were just talking about?

18 **A:** Yes, sir.

19 **Q:** That was in The United Kingdom?

20 **A:** It is.

21 **Q:** It was studying things from the 90's?

22 **A:** Yes.

23 **Q:** And when they started over there in the 90's, do you
24 remember what percent of delivering doctors were using
25 McRoberts?

1 A: I couldn't tell you the exact percent without seeing the
2 article.

3 Q: Would it shock you to learn that less than thirty percent
4 actually ever used McRoberts?

5 A: No, it wouldn't shock me because there is no -- there's
6 not a deviation standard of care what maneuvers you do first.
7 There's no set order for them and if you just do Rubin's all
8 the time and that happens to work or suprapubic, you wouldn't
9 need to use McRoberts. It's whatever they are trained to use
10 there and what they're comfortable with.

11 Q: Well, let's just make sure we understand the data set
12 that you're relying on for the opinion and then I'll sit down?

13 A: Sure.

14 Q: Before the training you talked about, which is back from
15 '96 to '99, about the time that article was written, you
16 talked about internal rotational maneuvers only were utilized
17 seven percent of the time; posterior arm, seven percent of the
18 time; suprapubic pressure only twenty-seven percent of the
19 time and McRoberts twenty-nine percent of the time. In a
20 shoulder dystocia, those are all the maneuvers that you've
21 gone through, true; those are the things you described as the
22 standard maneuvers availed to an OBGYN, right?

23 A: Sure.

24 Q: In England and the United Kingdom, back in the 90's, less
25 than one-third of the OB's were actually using those which had

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1 been utilized here in the United States since the 70's and
2 80's?

3 **A:** Less than one-third were using each individual, but you
4 have to add them together.

5 **Q:** It's not additive; have you read the study?

6 **A:** Yes, absolutely.

7 **Q:** Okay. Then that's your opinion and is that opinion as
8 reliable as all the other opinions you've offered here today?

9 **A:** I don't understand the question.

10 **Q:** You just told me that it's additive, all this data that
11 you're relying on, you said absolutely. And my question to
12 you simply is are you as confident about that opinion as every
13 other opinion you've offered here today?

14 **A:** No.

15 **Q:** You still don't guarantee that your children that you're
16 delivering will be delivered without a permanent brachial
17 plexus injury; you don't guarantee that?

18 **A:** No, of course not.

19 **Q:** Thank you.

20 **THE COURT:** All right. You may step down. Thank you,
21 sir.

22 **DR. PLISKOW:** Sure.

23 **MR. GRAHAM:** May I ask him just one?

24 **THE COURT:** One, yeah. Okay.

25 **RECROSS EXAMINATION OF DR. STEVEN PLISKOW BY MR. GRAHAM:**

1 Q: Why can you not make the guarantee?

2 A: That a child want be born with a brachial plexus injury?

3 Q: Yes?

4 A: Because they're, as I said previously, there are many
5 different things that cause brachial plexus injuries and I
6 can't guarantee that somebody want have an abnormal nerve or
7 an infection in their clavicle or something along those lines.
8 So, I mean, there's no way to guarantee something like that.
9 It would be absurd thing to do.

10 THE COURT: Mr. Hood?

11 MR. HOOD: Nothing.

12 THE COURT: All right. Thank you.

13 DR. PLISKOW: Okay. Thank you.

14 THE COURT: Mr. Graham, witness?

15 MR. GRAHAM: Thank you, Your Honor. Our next witness is
16 Dr. Charles Vanderkolk, please come forward.

17 REPORTER'S NOTE: (Witness sworn by the clerk).

18 DR. CHARLES VANDERKOLK, HAVING
19 BEEN SWORN TESTIFIES AS FOLLOWS:

20 CLERK: You may be seated.

21 MR. GRAHAM: Your Honor, we would offer at this time,
22 pre-marked exhibits for the plaintiff, 29 and 32. 29 is a
23 vocational evaluation dated December 28th, 2017 and Exhibit 32
24 is Dr. Vanderkolk's CV.

25 THE COURT: Mr. Hood?

1 **MR. HOOD:** Your Honor, I would object to 29; it's his
2 report, it's hearsay. There would be no objection to his CV.

3 **MR. GRAHAM:** 29 for identification only.

4 **THE COURT:** All right. Thank you.

5 **PLAINTIFF'S EXHIBIT NUMBER 32**

6 **ADMITTED INTO EVIDENCE**

7 **DIRECT EXAMINATION OF DR. CHARLES VANDERKOLK BY MR. GRAHAM:**

8 **Q:** Make sure you have two exhibits there?

9 **A:** Okay.

10 **Q:** Here's why you only have one; here's the second one.

11 **DR. VANDERKOLK:** Your Honor, is it possible that I could
12 get some water?

13 **THE COURT:** Most certainly.

14 **BY MR. GRAHAM:**

15 **Q:** You ready?

16 **A:** Ready.

17 **Q:** Good afternoon, Dr. Vanderkolk?

18 **A:** Good afternoon.

19 **Q:** You have there in front of you, your CV and a report that
20 you did. Let me just ask you in the beginning, just introduce
21 yourself to the jury, tell them about yourself personally and
22 professionally?

23 **A:** You mean like education and that sort of thing?

24 **Q:** Yeah and anything you want to introduce yourself.

25 **A:** Okay. Well, I'll start with education. I went to Hope

1 College, which is a small Christian college in Holland,
2 Michigan for an undergraduate degree in psychology and then I
3 went to Michigan State University, I'm just going to pause
4 there for the basketball fans. And then I went on for a PHD
5 in psychology and rehabilitation at State University of New
6 York at Buffalo. I was a professor at State University of New
7 York in Albany for eight years and then I came to South
8 Carolina and I was a professor here in South Carolina in
9 Columbia at USC for seventeen years and then I had a short
10 term in the University of North Florida as a professor and I
11 taught in the graduate school and rehabilitation counseling,
12 which was a field of psychology. I'm a licensed psychologist
13 in South Carolina and I'm also a Nationally Board Certified
14 Rehabilitation Counselor. And Rehabilitation Counselor's work
15 with people who have disabilities, mainly on two aspects; one
16 is the kind of psychological, like if you become newly
17 disabled, you might get depressed or get anxious and worry
18 about your future, so we deal with the psychological. But
19 also the vocational, which means looking at how people with
20 disabilities either adjust to their job, if it's a new
21 disability or how do they get education and training so they
22 can be employed if the disability is from birth. So, I've
23 worked with a lot of people who have become disabled, and also
24 people who are -- have a disability at birth.

25 So, I taught all those years, I've trained Rehabilitation

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1 Counselors and Mental Health Counselors to go out and work
2 with people who have disabilities; whether they're physical or
3 psychological or cultural or whatever and I've also had a
4 private practice. I've seen and worked with people with
5 disabilities, provided counseling, provided vocational
6 evaluations, advised them on finding jobs, what kind of work
7 they can do or work could you get training. A good example is
8 somebody who is a carpenter gets in an accident, can't lift
9 more than ten pounds, can't be a carpenter. So, I work with
10 them and say, okay, let's see, can you go back to school or
11 you can get trained in something else. So, that's kind of the
12 line of work and knowing what jobs are available and what pay
13 rates go for different jobs; like how much do carpenters make
14 to start them and what's the average, what's the high range
15 for a carpenter. So, that's a big part of my background in
16 the last year -- since I retired from the University of South
17 Carolina in 1995 and I have been in private practice part time
18 as well as teaching and doing research and then when I left
19 there, I also decided that I would be a consultant and that's
20 the reason I'm here is I'm a consultant because I'd done this
21 work for probably at least forty-five years working with
22 people who have disabilities.

23 Q: I may have missed this, if so, I apologize, but have you
24 talked about your work with the social security disability
25 office?

1 **A:** I was under contract for probably fifteen to twenty years
2 with the Social Security Disability and it's in the office of
3 hearings and appeals and some of you have heard of this, but
4 when somebody becomes disabled to the extent that they can't
5 work then they can apply to the federal government for
6 disability and my task is when they would get to the hearing
7 level, before the Administrative Law Judge was to go over the
8 file and be ready to answer questions like if this person can
9 only lift ten pounds, can only be on their feet for five
10 minutes at a time, but they can work with their hands, but
11 they can't walk or run, so on and so forth, are there any jobs
12 that this person, also given their educational background, are
13 there any jobs this person can perform. Because that's the
14 whole purpose of Social Security Disability is can this person
15 reasonably work at some job either in the local or national
16 economy.

17 **Q:** Thank you. And have you written a number of articles and
18 chapters in your field related to disability of injured folks?

19 **A:** Yeah, I've written four books and I don't know, maybe
20 twenty or thirty articles and done research on disability,
21 helping people get back to work, what the problems are and
22 finding work if you have a disability. I would do evaluations
23 when you work with somebody with a disability. How you kind
24 of figure out what -- what their situation is, what their
25 limitations are, but also what they can do.

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1 Q: I want to turn now to your evaluation. It's dated
2 December 28th of 2017. Could you just tell us what
3 information you obtained and what you did with that
4 information to evaluate this child's problems?

5 A: Okay. Well, I went over the medical records that were
6 available. I wrote this evaluation in December of 2017. So,
7 I went through the medical records and established first of
8 all, that Jahmerican did have a disability and from the
9 records, he has a severe disability and disabilities are
10 considered mild, moderate to severe and his is a more severe
11 kind of disability. We talked with the mother and with the
12 father to get some information about how he was doing, what he
13 could do, what his limitations were, from the physical
14 standpoint. I did also receive a medical report from 2018,
15 late '18, so that was a report after my initial evaluation.
16 The key things, when we looked at a person being able to
17 work, the main thing we look at is what are this person's
18 functional capacities and what that means is, what can they
19 do; can they lift, can they bend, can they squat, can they
20 grasp things, can they manipulate things, can they read, you
21 know, how good is their mind so they can learn, can they only
22 learn really simple jobs or can they learn really complicated
23 jobs. And so, it's a very practical approach of what can you
24 do. So, when I looked at the medical records, I was looking
25 for what could Jahmerican do at what can't he do and in the

1 end, it turns out that there are, from a vocational
2 standpoint, there are many things that he can do with this
3 left upper extremity and he can walk fine, he has good
4 balance. And so, when I look at jobs, I'm saying, okay, he
5 has this right upper extremity and he really can't do much of
6 anything from a work standpoint with that right hand and arm.
7 He could assist, like say something was coming down a conveyer
8 belt, he might be able to hold the box or something in place
9 while the left hand did something. But as far as actually
10 pinching, grabbing, grasping, manipulating, picking things up,
11 pushing things, you know, an awful lot of things that you guys
12 do on a job, he can't do with that right upper extremity.

13 And one of the best reports was Dr. Daniel Adler,
14 November of 2018, where he compares the right hand with the
15 left hand, which gives you a good idea what should he be able
16 to do with one hand and what is he actually doing with the
17 injured arm and I'm not going to go through all of these, but
18 virtually, in all of the areas of movement, in all sorts of
19 directions and moving the wrist and the hands and so on, he's
20 really severely impaired. So, then I began to think, okay, is
21 there anything that this person can do in the future with the
22 one hand. Okay. Then ---

23 Q: Let me interrupt you just a moment?

24 A: Sure.

25 Q: I just realized that I made a mistake. I was so eager to

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1 get into your report after I asked you about it, your
2 qualifications, I neglected to proffer you as an expert
3 witness.

4 **THE COURT:** Mr. Hood, would you examine at this time?

5 **MR. HOOD:** Without ---

6 **THE COURT:** Mr. Radeck?

7 **MR. HOOD:** I'm sorry?

8 **THE COURT:** Would you like to question him on his
9 qualifications?

10 **MR. RADECK:** Without objection.

11 **THE COURT:** You're offering him as?

12 **MR. GRAHAM:** As an expert in the fields of vocational
13 rehabilitation and psychology and related matters.

14 **THE COURT:** All right. Ladies and gentlemen, I've spoken
15 to you twice about experts; I want go through that again, but
16 this witness has been found by the Court to meet a criteria as
17 an expert and he is offered as an expert in the field of
18 vocational rehabilitation and sociology?

19
20 **DR. VANDERKOLK:** Psychology.

21 **THE COURT:** Psychology. Okay. Psychology and he may
22 give an opinion in those fields under the same conditions that
23 I've explained to you already. But again, the fact this Court
24 may have determined that he meets the minimal requirements
25 does not mean that you have to accept his opinions. You are

1 free to give them such value as you believe they are entitled
2 to. Thank you.

3 **MR. GRAHAM:** And for that matter, Your Honor, we would
4 also proffer him as an expert in rehabilitation and
5 rehabilitation counseling.

6 **THE COURT:** Mr. Radeck?

7 **MR. RADECK:** No objection.

8 **THE COURT:** All right. And he's also offered in that
9 field.. Thank you.

10 **MR. GRAHAM:** Thank you.

11 **BY MR. GRAHAM:**

12 **Q:** Before you get back into the substance of your testimony,
13 let me ask you, sir, with respect to the testimony you've
14 already given, have all of those facts, opinions and
15 conclusions been those that you hold with at least a
16 reasonable degree of certainty in your field, most probably?

17 **A:** Yes, sir.

18 **Q:** And I'm going to ask you going forward, please don't tell
19 us anything unless your -- the facts, opinions and conclusions
20 you reach meet that standard, agreed?

21 **A:** Agreed.

22 **Q:** Thank you. Please continue.

23 **A:** Okay. Stating with the medical information that would be
24 good for vocational and work purposes and Dr. Adler's report
25 in 2016, he indicated that while some therapy and some surgery

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1 might allow Jahmerican to function better in activities of
2 daily living, it will not change is employability. In other
3 words, he was who he was as far as employability with his
4 limitations and that any job that requires the use of two arms
5 or two hands will be impossible for him. It would have to be
6 something with one hand. And then let's see, I had his later
7 reporter here just a second ago. Well, essentially he tested
8 him further and a lot of specific things I was saying,
9 different kinds of arm movements, you know, he couldn't raise
10 it above his head, that he was severely limited in all of the
11 area of use and movement of the hands and arm, which confirmed
12 for me that we would be talking about somebody who could --
13 would have to work with one arm and one hand if they were
14 going to get a job. Then the next thing I did was a category
15 called vocational research, to help me arrive me at my
16 conclusions. And this was significant in that I need to know
17 what are the job demands out there. Certain jobs require a
18 lot of lifting, some require a lot of movement of the upper
19 hands or use of the arms and so on. And one of -- let me just
20 give you a few examples here of what Jahmerican is going to
21 face. 96 or 97 percent of all jobs in the United States
22 require fine manipulation. He doesn't have any manipulation
23 at all, much less fine. 99 percent of jobs in the United
24 States require gross manipulations; that means more with the
25 hands than with the fingers like grasping. Reaching is

1 required frequently or constantly in 91 percent of jobs.
2 Handling, using the hands and moving things about 92 percent
3 of the jobs in the United States. So, I think you could see
4 right away what Jahmerican is facing.

5 Then some other just quick background information about
6 people with a disability in the labor force. There are only
7 about a third of people who have a disability that are
8 actually working because of all the challenges and problems
9 and trying to get jobs and that sort of thing. Whereas,
10 people who don't disabilities, it's over two-thirds of that
11 group that are in the labor force.

12 And then as far as income is concerned, the Census Bureau
13 does a collection of data about how much money do people with
14 a disability make and how much do people without a disability
15 make and some of that is based on education. In the survey
16 and tables that I looked at, people with a disability earned
17 anywhere from 24 percent less to 36 percent less than people
18 with a disability. Now, those are just the people who are
19 working with a disability. Remember, two-thirds of the people
20 with disability aren't even in the labor force. So, just
21 taking the one-third that are out there working and they're
22 making much less than people who do not have a disability.
23 So, that's pretty much the general background for my report
24 and -- and leading into my conclusions.

25 Q: Sir, I have a question. Tell us about your conclusions?

1 A: Okay. I'll try to give them to you pretty much in a
2 nutshell. You really can't predict what a five year old is
3 going to do in the future. Some of us didn't even know what
4 we were going to do when we were in high school, right? Some
5 of us didn't figure it out until we were even older than that.
6 When I did it is, I looked at a range of -- of people. I
7 assumed that given his background and his family encouragement
8 and everything that he would probably at least graduate high
9 school. He might take some college courses. He might get a
10 two-year degree in college; he might get a four-year degree in
11 college. So, I put those in two categories so as to probably
12 make up all the options for him and then I went to tables and
13 -- and looked at jobs and how jobs pay at the beginning level
14 and I found that people who had a high school degree and maybe
15 had some college, tended to start out and this was back in
16 2016, around nine to eleven dollars per hour. And the people
17 with a two-year degree to a college degree would start out at
18 least at fourteen to eighteen dollars per hour. And then
19 based on my experience and data, I assumed that if he was in
20 the group that graduated high school, maybe took a few college
21 courses, that over five to seven years, he had made thirty to
22 forty-five thousand dollars per year. The people with the
23 college degrees, after four to five -- five to seven years,
24 they would make forty to sixty thousand dollars a year. This
25 is largely based on U.S. Department of Labor data because they

1 track how much money people make at different education levels
2 and you would probably figure out just logically, if you don't
3 go to high school, you're probably not going to make as much
4 money as if you've got a high school degree and you'd make
5 more money if you get a two-year degree, you'll make more
6 money if you get a four-year degree and generally that's true,
7 not for every individual, but generally speaking.

8 So, then putting all of this data together, I concluded
9 that if Jahmerican works, I'd have to say that there's not a
10 guarantee that he's going to get hired. He has a severe
11 disability; he may not make much of any money the rest of his
12 life, but if he is able to work, let me see if I can find my
13 little notes on conclusions here about what his -- his loss
14 would be. If he's in the group of high school to some
15 college, my conclusion was that it would be a 20 to 28 percent
16 loss. Because remember, when I looked at that age group and
17 the census data, they averaged about 24 percent loss of
18 earnings if they had a high school to two years of college.
19 So, I took the 24 percent and said if that's the average,
20 let's look at a range of 20 to 28 percent loss. And then if
21 he were to get a college degree, the tables show that it would
22 be about 36 percent loss on average. So, I made a range of 30
23 percent to 42 percent. So, to try to simplify this because
24 there are a lot of numbers I just threw out, he may go to high
25 school, get some college, he's going to lose about 24 percent

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1 on average over the years, if he's able to work. If he can
2 get through college, he'll lose about 36 percent on average
3 over his lifetime because of his disability.

4 **Q:** Thank you. Have you reached any other conclusions and if
5 so, please tell us?

6 **A:** I think that's pretty much it except for the reasons for
7 not being able to make as much money is one is the physical
8 because there isn't going to be very much that he can do. I
9 would be challenged to find a job for him. Because almost
10 everything requires use of hands and he's also going to have
11 psychological challenges. One of the doctors already eluded
12 to that; that he's self-conscious about his disability and
13 that's going to be a challenge for him, especially when he
14 gets to his teenage years. Because he's going to want to fit
15 in, he wants to be accepted and he's got this arm that's
16 dangling on the side. He's already got some scars on there.
17 So, that's going to be another challenge for him and his own
18 self-concept in whether he's going to believe in himself to be
19 able to get out there and get an education and work.

20 And then of course, we have peoples' attitudes in the
21 community. I think we're doing better on our attitudes
22 towards disability, but I work with folks all the time and
23 that stigma is still there. People just generally assume that
24 if you have a disability, especially if it's noticeable,
25 you're not as good at something as the person who doesn't have

1 a disability. So, he -- he's got some real challenges in his
2 life.

3 Q: Let me ask you the Americans with Disability Act. How
4 successful, if successful at all, has that program been in
5 terms of helping youngsters like Jahmerican?

6 A: It has helped some people, but, you know, one of the
7 markers for whether the Federal law required employers to make
8 accommodation and to hire people without discriminating. What
9 we're finding is, we've still got two-thirds of people with
10 disabilities that are not in the labor force and part of that
11 is because of that discrimination, not all of it, there are
12 other factors too. So, it's helping, but it's not making a
13 real big difference.

14 Q: So, just to summarize, when you're talking about
15 disability, let me -- let me make sure I follow what you're
16 saying. Are you telling us that the injury itself will affect
17 his hourly earning capacity based on his educational level?

18 A: It will affect his hourly earning capacity level and
19 people with a disability severe like this, tend to be in and
20 out of work much more also.

21 Q: So there are two components?

22 A: There are two major ones, sure.

23 Q: Thank you. Please answer any questions Mr. Radeck may
24 have?

25 CROSS EXAMINATION OF DR. CHARLES VANDERKOLK BY MR. RADECK:

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1 Q: Doctor, don't be scared by the iPad, it's just how I'm
2 going to take notes, all right?

3 A: Okay. I'm still a little afraid of technology though.

4 Q: I am too of having a battery. Doctor, you've testified
5 in cases like this many times before, right?

6 A: I have.

7 Q: Okay. I know you've talked about private practice and
8 things like that. Have you been exclusively doing consulting
9 work since about '95?

10 A: Well, if you include the work with Social Security
11 Disability, it's been primarily this, yes.

12 Q: Okay. And so, all of the things that, and I just want to
13 get a little context to the jury as far as your purpose here
14 today. All of the things you've been describing with your
15 private practice, the way you go and give counseling to
16 clients, help them find jobs, do what you can to insure or at
17 least, to the best of your ability, find them a job in the
18 workplace; that's not what you're doing in this case, right?

19 A: No, I'm not.

20 Q: Okay. So, this case and like all the other cases in
21 litigation where you've been hired by experts, by plaintiffs
22 and you are simply looking at documents that other experts
23 have prepared who reflect some level of disability and opining
24 on whether or not, statistically, this person has limitations
25 or can find a job; is that fair?

1 **A:** That's the vast majority, but I do follow-up with some of
2 the clients to help them on their job search to try to find
3 something and in this case, like if Jahmerican were say around
4 ninth grade, I think I put it in my report that I recommended
5 that he have vocational counseling around 9th grade and the
6 State Department of Vocational Rehabilitation will provide
7 that if -- if we're at that point, I would probably call the
8 parents to remind them to make sure that he got this
9 counseling. So, it's a little more than just, you know,
10 giving opinions.

11 **Q:** Well, the majority of your cases, you do not follow-up;
12 is that fair?

13 **A:** That's fair.

14 **Q:** Okay. And in this case, you talked about how you
15 reviewed the 2016 and 2018 reports from Dr. Adler?

16 **A:** Correct.

17 **Q:** Okay. And that visit was in New York City; were you
18 aware of that?

19 **A:** It was what?

20 **Q:** That Jahmerican and his father, I believe, traveled to
21 New York City to see Dr. Adler?

22 **A:** I think that's correct, yes.

23 **Q:** Okay. And were you aware that also on that same visit, I
24 believe it was the day before he saw two other experts that
25 were hired by the plaintiff?

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1 A: I'm not aware of that.

2 Q: Okay. Did you see a report from a Dr. Price or Dr.
3 Grossman?

4 A: I did, there were earlier reports. So, you're saying
5 that he went back to them?

6 Q: No, if you noticed on their reports, I think their dates,
7 he visited then on March 4th, 2016 and he saw Dr. Adler on
8 March 5th, 2016?

9 A: Right. Oh, I thought you were referring to 2018, when he
10 saw Dr. Adler again.

11 Q: I'm sorry. Price and Grossman was just with the 2016
12 visit?

13 A: Yes.

14 Q: Okay. And they're also both located in New York City,
15 right?

16 A: Yes.

17 Q: Okay. Have you reviewed, in other cases, have you
18 reviewed affidavits or reports that were drafted by Dr. Price
19 and Dr. Grossman?

20 A: Grossman rings a bell with me, but not Price.

21 Q: Okay. Have you reviewed other cases where Dr. Adler has
22 issued an affidavit?

23 A: That's not familiar to me.

24 Q: Okay.

25 A: I may have and I'm just not remembering.

1 Q: How many other brachial plexus cases have you had with
2 Mr. Graham's law firm?

3 A: It would be a pure guess. I don't know and it's probably
4 been at least a half a dozen.

5 Q: And are you aware that, and I know you're not prescribing
6 any kind of treatment in this case, right?

7 A: No, I -- I -- I don't know if you'd call it a
8 prescription, I did make some recommendations.

9 Q: Right, but as far as actually providing a plan to assist
10 Jahmerican's mother and father in giving him the best chance
11 that he could to succeed and get a job, that's not something
12 you've done in this case?

13 A: I haven't other than the Department of Vocational
14 Rehabilitation and they're the ones that would follow through
15 for vocational purposes and I recommended that a private rehab
16 counselor intervene around ninth grade also to provide
17 vocational guidance to try to get him moving toward a job.

18 Q: Okay. Outside of the ninth grade thing you discussed, no
19 actual plan that you've drafted?

20 A: No, I think that's where you begin and that would be a
21 plan.

22 Q: Gotcha. Mr. Graham -- and just a few other quick things
23 I want to check off that I don't think you'll disagree with.
24 Mr. Graham paid you to issue your report?

25 A: He paid me to do an evaluation, yes.

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1 Q: Okay. It was for the purposes of this lawsuit only,
2 right?

3 A: Right, that's correct.

4 Q: Okay. Did your -- I didn't take your deposition, another
5 colleague of mine did, but your wife helps you with your
6 reports; is that right?

7 A: She does.

8 Q: Okay.

9 A: Actually, she doesn't help with the reports. I think she
10 interviewed Jahmerican's mother and maybe his father too.

11 Q: Okay. And that was going to be a question of mine. You
12 have not actually spoken with Mr. or Mrs. McCray, have you?

13 A: I haven't personally, but I -- my wife, by the way, is a
14 Board Certified Rehabilitation Counselor also. I didn't want
15 anybody to think she was my assistant because that might come
16 back to her and I might have implied she was my assistant, but
17 she's a professional person also. We talked before these
18 interviews and after.

19 Q: Understood. And I think your conversation was about 45
20 minutes with both of them?

21 A: That sounds like it would be correct.

22 Q: Okay. And you haven't actually met, talked to or treated
23 Jahmerican himself, right?

24 A: No, I haven't.

25 Q: Okay. And you haven't spoken with any of his treating

1 physicians?

2 A: No.

3 Q: I think, at the time of your deposition, you're aware he
4 was attending some therapy sessions; were you aware of whether
5 or not that was on a consistent basis?

6 A: I don't know.

7 Q: Okay. And obviously, there's nothing in the records that
8 you've seen that would indicate he has any sort of cognitive
9 deficiencies?

10 A: I haven't seen any evidence of it, no.

11 Q: The -- you talked about accommodations. The U.S. Labor
12 statistics that you talked about just a minute ago and that
13 you've cited in your report, the survey that collected those
14 statistics, they didn't consider whether or not the employers
15 gave accommodations, correct?

16 A: No, are you talking about whether some people were
17 employed or not?

18 Q: Exactly.

19 A: No, I didn't ask about accommodations.

20 Q: And another thing you talked about was the importance of
21 the family structure, correct?

22 A: Correct.

23 Q: And you've -- it sounds like you've given credit,
24 rightfully so, to his parents and -- and he's got other
25 siblings that provide a strong structure for him, right?

- 1 **A:** Yes.
- 2 **Q:** Okay. And so, based on that, you're optimistic for his
3 future?
- 4 **A:** Well, I must be somewhat optimistic because most
5 severely, especially severely disabled people are not employed
6 and I'm saying in here I think he's got a chance to be
7 employed and to make some money. So, I don't want to be
8 pessimistic at, you know, I think he's going on six later this
9 month. We don't like to start out at six being pessimistic.
- 10 **Q:** I agree. I've got a three year old. That would be too
11 young. So, but were you aware that he had siblings that have
12 gone to college, right?
- 13 **A:** Yes.
- 14 **Q:** And so I'm sure that's what you considered when you said
15 there's a good chance he's going to go through to at least get
16 some college, right?
- 17 **A:** Yes, sir.
- 18 **Q:** Okay. And so, you certainly hope that he's one of the
19 one-third that gets a job with a disability?
- 20 **A:** I would hope so, yes.
- 21 **Q:** Okay. And sorry, just a few points here that I wrote
22 down that -- the manipulation part, you said 90 something 8
23 percent in the workforce requires finite manipulation?
- 24 **A:** Right.
- 25 **Q:** Okay. Do you know if -- does that distinguish between

1 whether or not that's both arms or just one arm?
2 **A:** It does not distinguish.
3 **Q:** Okay.
4 **A:** I mean, most jobs are bi-manual.
5 **Q:** Okay. But he has -- you would agree, he has finite
6 manipulation in his left arm?
7 **A:** He does.
8 **Q:** That's all the questions I have. Thank you.
9 **THE COURT:** Mr. Graham?
10 **MR. GRAHAM:** I have no further questions.
11 **THE COURT:** Very well. Thank you. You may step down.
12 **DR. VANDERKOLK:** Thank you.
13 **THE COURT:** Thank you, doctor.
14 **MR. GRAHAM:** Your Honor, at this point, we will call
15 Anthony McCray.
16 **THE COURT:** Why don't we do this. Why don't we, we've
17 been here a little over an hour. Why don't we give the jury a
18 quick break before we get into another witness? Okay? All
19 right. Take them to their jury room about 10 minutes or so
20 and let them refresh themselves.
21 **REPORTER'S NOTE:** (Jury retires to jury room at 3:41pm).
22 **(COURT IN RECESS)**
23 **THE COURT:** Get my jury.
24 **MR. HOOD:** We've got a ---
25 **THE COURT:** Wait a minute.

1 **MR. HOOD:** We have a deposition of a witness whose being
2 played in our case.

3 **THE COURT:** Yes.

4 **MR. HOOD:** We don't need to deal with it now, but it was
5 in two parts, so that's why we've got two transcripts. We've
6 highlighted the portions that are designated and I tried to
7 make it as obvious as possible by highlighting the objections
8 that didn't get resolved and I just wanted to give Your Honor,
9 if you wanted to deal with them, look at them?

10 **THE COURT:** Well, why don't we do this. Why don't we do
11 this witness here, it will probably take to 5 and then we'll
12 deal with it, okay?

13 **MR. HOOD:** You got it.

14 **THE COURT:** Good. Bring the jury, please.

15 **MR. GRAHAM:** Your Honor, I was going to go ahead and put
16 these in evidence without objection, it's a summary of bills.

17 **THE COURT:** All right. It's a summary of bills admitted
18 without objection, Mr. Radeck and Mr. Hood, okay and that will
19 be Exhibits?

20 **MR. GRAHAM:** 23.

21 **THE COURT:** 23, okay.

22 **PLAINTIFF'S EXHIBIT NUMBER 23**

23 **ADMITTED INTO EVIDENCE**

24 **REPORTER'S NOTE:** (Jury enters courtroom 3:58 P.M.)

25 **THE COURT:** All right. We have everyone back in. Please

1 be seated. Mr. Graham, call your witness.

2 **MR. GRAHAM:** Thank you, Your Honor. The plaintiff calls
3 Mr. Anthony McCray.

4 **THE COURT:** All right. Mr. McCray, come around, please.

5 **CLERK:** Place your left hand on the Bible and raise your
6 right?

7 **ANTHONY MCCRAY, HAVING BEEN**

8 **SWORN TESTIFIES AS FOLLOWS:**

9 **CLERK:** Please say and state your full name for the
10 Court?

11 **MR. MCCRAY:** My name is Anthony McCray.

12 **CLERK:** Please be seated.

13 **THE COURT:** Mr. McCray, if you would, take a seat there.
14 Mr. Graham?

15 **DIRECT EXAMINATION OF ANTHONY MCCRAY BY MR. GRAHAM:**

16 **Q:** Anthony, before we get to the serious questions, I'm
17 going to ask you, could you -- is there a microphone there;
18 I'm afraid you're ordinarily quiet?

19 **A:** Yes, there is.

20 **THE COURT:** It's right in front of him.

21 **BY MR. GRAHAM:**

22 **Q:** Could you check for us?

23 **A:** Tap it?

24 **Q:** Okay. Thank you. Anthony, what is your relationship
25 with Jahmerican?

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1 A: He's my son.
2 Q: What is your relationship with Phillipa?
3 A: My wife.
4 Q: Roughly, how old are you, sir?
5 A: I am 20 -- 49; 48, I'm sorry.
6 Q: Have you ever sat in the hot seat before?
7 A: Never.
8 Q: Just take a deep breath. I want to just introduce you to
9 the jury a little bit. Where did you grow up?
10 A: In Andrews, South Carolina.
11 Q: Okay. How many parents did you live with?
12 A: My mother and my father, my sister and my brother.
13 Q: Okay.
14 A: Four of us.
15 Q: So, what did your dad do; did he work?
16 A: He worked at the steel mill. He was a supervisor at the
17 steel mill in Georgetown.
18 Q: What about your mom, did she work?
19 A: She was a supervisor in the glove factory in Andrews,
20 South Carolina.
21 Q: Thank you. Now, you mentioned you had a brother and a
22 sister, are they both still alive?
23 A: My sister, she passed away. My brother, he's in
24 Columbia.
25 Q: All right. Do you have any children other than

1 Jahmerican?
2 A: Yes, I do. I have two sons; a 21 year old, his name is
3 Josheem and Jamal, he's 24.
4 Q: How far did you go in school?
5 A: I went to 10th grade.
6 Q: All right. What did you do when you dropped out of
7 school?
8 A: To better myself, I left Andrews and went into the Job
9 Corp in Markville, Kentucky and took up a trade, a welding
10 trade and I -- I did everything. I had passed it and got my
11 diploma for combination welding. After I finished that, I
12 stayed 4 years and worked in Kentucky welding.
13 Q: All right. Where did you go after that?
14 A: I got a job at Kentucky and I stayed and worked in a
15 plant.
16 Q: Okay. But after you left Kentucky, where did you go?
17 A: Oh, I came back to Andrews, got my first job at Andrews,
18 Wax Welding in Andrews, welding.
19 Q: All right. And then when did you start at Coastal Wire?
20 A: Maybe 3 years after that. I was working there from
21 there.
22 Q: All right. Let me switch back to your sons. You dropped
23 out of school in the tenth grade?
24 A: Yes, sir.
25 Q: What value do you, as a tenth grade dropout, place on

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1 education?

2 **A:** To my sons?

3 **Q:** Yes, sir.

4 **A:** Well, with me didn't make it, to my two sons that I was

5 raising. I didn't want them to be me; I wanted them to be

6 better than me. I really drilled them to make sure they

7 finished school and all both finished college and I didn't

8 want them to be, you know, I wanted them to be better than me.

9 **Q:** Okay.

10 **A:** So, that was my job.

11 **Q:** All right. So, did one of them finish a two-year

12 program?

13 **A:** Two years, yes, sir. He's a chef.

14 **Q:** And the other one, how many years did he go?

15 **A:** He went for four.

16 **Q:** And they -- they've both been successful since college?

17 **A:** Yes, they branch off and done well.

18 **Q:** All right. Now, you told me about your wife, Phillipa,

19 is she from this country originally?

20 **A:** She's not, she's from Jamaica.

21 **Q:** Okay. How on earth did you guys meet?

22 **A:** Oh, through a friend. She was working in Myrtle Beach

23 and we started talking and meeting each other from there on.

24 **Q:** You guys been together, what, about 8, 9 or 10 years?

25 **A:** We've gone 7 going on 8 years.

1 Q: When did you get married?
2 A: 2020, 2012, I mean. 2012, I'm sorry.
3 Q: You might want to stay with a friend.
4 A: Yes. Yes.
5 Q: So, after you got married, how long before Phillipa had
6 Jahmerican?
7 A: After I got married?
8 Q: Yes, sir.
9 A: When she got -- when she was pregnant, I married her like
10 5 months after or something like that.
11 Q: Okay. And when you -- when you found out that Phillipa
12 was pregnant, what were your future plans together if she had
13 had her way?
14 A: Oh, I was happy. I was so happy because knowing my two
15 sons that grewed up and left me, I'm like, okay, I'm going to
16 start back over because of some things I didn't did when I was
17 coming up. I wanted to go to Walt Disney World. Since, you
18 know, it was going to be great for me.
19 Q: Did one of you push harder to get married and if so, who?
20 A: Me probably. Probably me.
21 Q: All right. Let's -- let's talk about that. You
22 mentioned you found out Phillipa was pregnant. Tell us about
23 you reacted to that?
24 A: Like I say, I was -- I was -- I was so happy because,
25 like I say, my two sons left me and I always like to be around

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1 my kids to -- to feel again, knowing that I'm getting older,
2 I'm like, you know, I'm getting older. I'm like this is going
3 to be better than it was before. I was just happy, really
4 happy, excited.

5 Q: Let me jump forward. Let's talk about the day of the
6 delivery.

7 A: Yes, sir.

8 Q: When you found out that your wife needed to go to the
9 hospital, what were you doing?

10 A: I was working at Coastal Wire, we was on graveyard.

11 Q: Okay. How did you find out?

12 A: She called me. My niece called me on the phone.

13 Q: All right.

14 A: To tell me she's getting ready to have a baby. So, I
15 told my supervisor, I'm gone have to leave. He said, yes, no
16 problem, go, go, go. But as they was coming from Andrews, I
17 meet them. I work in Georgetown on Gapway Road and I meet
18 them as they coming and I told her to get out the car and come
19 with me.

20 Q: All right. So, you drove her the rest of the way to the
21 hospital?

22 A: Yes, sir.

23 Q: Just tell me, between -- between getting to the hospital
24 and getting into that labor and delivery room, just tell us
25 what you remember, anything important you remember in that

1 period of time?

2 **A:** I remember a lot. As we was going to Georgetown, she was
3 saying, I think I'm having him; she called me Ant sometime.
4 She said I think I'm having him. I rushing and rushing and
5 rushing. I said okay. Okay. So, we gets to the hospital,
6 her water broke as soon as we pull in front of the place, her
7 water broke. I ran out the car and I ran -- well, a Security
8 Guard was outside, security was outside, he -- I ran to him
9 and I told him to stand to the car, I wanted to run and grab a
10 wheel chair for her. So, she got in the wheelchair and me and
11 the Security Guard, we wheeled her in the place.

12 **Q:** Okay. And somehow you got to the labor and delivery
13 room; anything exciting happen there?

14 **A:** Yes, she went in, when her water broke, well she got in
15 there it was one nurse was in there and she was like, the
16 baby's coming, the baby's coming and one of the nurse like,
17 you can't have it until the doctor get here. Because it was
18 like, when we got -- when we came, it was like 11:30, 11 to
19 11:30 when we got there.

20 **Q:** In the morning or at night?

21 **A:** Night. And she said, well I'm hurting, I got to have
22 something. So, one of the nurses say, well you can't do
23 nothing until she comes in. We waited, we waited, she said
24 I'm in pain, I'm in pain. We waited. We waited all the way
25 to 6:30 before, I think she was coming from the beach or

1 wherever and I'm like whoa, this is ludicrous, you know. And
2 we sit and wait. So, by the time when the doctor came in, I
3 wouldn't have seen her in there because I couldn't remember
4 her name, but the doctor came in and she came with a cup of
5 coffee somewhere between 6 and 6:30 she get there. We've been
6 there since about 11:30 or 12. She walks to the door, like
7 she had a cup in her hand, she, I don't know if it was coffee
8 or whatever. She was saying something to my wife, well, I
9 think we'll probably get a birth by 7, 7 in the morning.

10 My wife started going with more pain and more pain so for
11 some reason, they laid her down in a bed and started doing --
12 she had two more nurses came up and they start moving my
13 wife's stomach; one was on this side and was on this side and
14 I'm like looking. Matter of fact, I was right behind the
15 doctor, her back.

16 Q: Let me stop you just a second. Before those nurses came
17 in, where were you standing?

18 A: I was on my wife left and behind the doctor right.

19 Q: Okay.

20 A: And my wife was laying in a bed to her left.

21 Q: Was that before the nurses came or after?

22 A: Before.

23 Q: Okay. So, at that point, was Phillipa surrounded on both
24 sides or not surrounded but did she have nurses on both sides?

25 A: Yeah, she had nurses, yes and they was like moving her

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1 stomach like rubbing it, moving it and moving her.
2 Q: And you showed that motion. How many hands was each
3 nurse using?
4 A: Four, one was on this side and one was on this side and
5 they were moving like this and I'm looking.
6 Q: So, a total of how many nurse hands?
7 A: Four.
8 Q: And what did you see going on at that time, I mean what -
9 - what -- what was going through your mind?
10 A: I'm like whoa, you know, like this don't look too good,
11 you know. And I could go in with the doctor, the doctor, she
12 reached down and started talking to my wife and she reached
13 down and she stucked her hand in her like this and then for
14 some reason, she keep jerking and twisting and jerking and God
15 be my witness, y'all, I told the doctor and I know she can
16 remember it right now because I remember, I took flashbacks
17 from what happened, I really do. Every day I wake up, I think
18 about my sons, I take flashbacks. I said, Ms. Doctor, please
19 do not pull on him like that. She keep pulling backwards
20 towards like she was some type of rush or something. I said
21 please, ma'am, I hollered. I was so, so upset, I hollered and
22 said stop. She told me, I said, ma'am, I'd rather for you to
23 cut her stomach and take the baby from there. I'm right
24 behind her looking right at the same time she looking. She
25 told me, when we get to that, I'll do it. She just keep

1 jerking and I said and Lord knows, he'll hear me right now
2 today, I said please, stop. I hollered four times; don't do
3 that, don't do that, ma'am. She's steady pulling and twisting
4 and going backwards and I said this don't look good. I was so
5 upset. Right now, I'm upset right now. This really hurt me.
6 Q: And I heard you say something about seeing her hands do
7 something and you saw her pulling, but did you see her --
8 could you see Dr. Maselli's whole hands or part of her hands?
9 A: Part right here, this half or whatever.
10 Q: So, right around the ring finger or knuckles?
11 A: Yes, sir.
12 Q: Right around there?
13 A: Right there.
14 Q: And -- and the part with the thumb was where?
15 A: Out.
16 Q: You could see that part?
17 A: Yes.
18 Q: The part from the ring area toward the fingertips; where
19 did that -- where was those?
20 A: They was out virtually. She was like trying to pull back
21 like twist them, like it was his head or something. I don't
22 know. I'm like stop, stop, stop.
23 Q: All right. So, I misunderstood a little about what you
24 said about her hand. Was part of her hand sticking into the
25 birth canal?

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1 A: Yes. Yes.

2 Q: The fingertip area?

3 A: Yes, sir.

4 Q: All right. So, you can see this part of her hand, but

5 not this part of her hand?

6 A: Right.

7 Q: But what could you tell, based on what you could see ---

8 A: Right.

9 Q: --- and the movement you saw Dr. Maselli make, what could

10 you tell was going on?

11 A: Like she was trying to -- any way necessary to get him

12 out. Like in some fast, rushing movement like she's scared or

13 just jerking, she was just jerking and twisting. I'm like I

14 never seen nothing like this before like.

15 Q: All right. You're in the witness chair and I can barely

16 see what you're showing. I'm standing up, these guys -- could

17 you stand up so they can see what you're talking about?

18 A: Sure. Like this, pulling back and jerking, like jerking,

19 twisting, jerking. She seen me came down and I hollered four

20 times. I said, ma'am, don't do that; please don't do that. I

21 keep hollering, don't do that. I say I rather for you to cut

22 her stomach open and take the baby out. She said when it come

23 to that, she told me, she turn around and look at me, she said

24 when it come down to that, I'll do it.

25 Q: Did she say anything about what time it would be when she

1 would do a c-section?

2 A: She never said no time.

3 Q: Okay. But, after you said to her repeatedly in it sounds

4 like a pretty loud voice?

5 A: Oh, I said it loud. God witness, I said it loud. She

6 probably can still remember what I said. I'm like stop, don't

7 do that, don't pull hard, don't pull him like that. Do not

8 pull like that.

9 Q: All right. Did she ever switch over to a c-section?

10 A: No, she never did, but I seen her take her scissors and

11 cut her somewhere down there. She cut her to the bottom like.

12 Q: You're saying Dr. Maselli?

13 A: Yes, sir.

14 Q: Took scissors and cut who?

15 A: My wife.

16 Q: Down there?

17 A: Yes, sir.

18 Q: You described what the nurses were doing with ---

19 A: They was rolling her stomach.

20 Q: Was anybody holding your wife's legs up?

21 A: No, not as I could see, no. It seems like she was doing

22 it herself. No.

23 Q: Go on and tell us -- tell us what you remember going on

24 next?

25 A: Yeah, after she did so much pulling and jerking and

1 pulling backwards, the baby finally came out. I was standing
2 there and watched. I said, this don't look good. Some, some
3 -- another guy, he came up with a incubator and they put the
4 baby in there. I said, no, I don't like this.. I followed
5 behind the doctor in the next room.. I said, let me look at
6 that baby for a minute. I look at my son, Jahmerican McCray,
7 his arm wasn't moving or nothing. His finger -- three of his
8 fingers are trembling like that. I say -- I say -- I say,
9 what happened to my son -- my son hand and arms and stuff?

10 **MR. RADECK:** Objection, Your Honor. Objection to
11 hearsay.

12 **THE COURT:** I think he was saying what he said and it
13 would qualify as a excited utterance. I'll allow it. Okay.
14 Yes, sir.

15 **BY MR. GRAHAM:**

16 **Q:** Go ahead.

17 **A:** Oh, yeah and three of his fingers was shaking and nothing
18 moving and I looked and I turned back around and I tried to
19 talk to the doctor, I say, ma'am, can you tell me what's wrong
20 with my son and she keep walking off from me and I follow her
21 and I like ask her again, can somebody please tell me what my
22 son -- I walked to one of the nurses seemed like. I said can
23 y'all explain what -- what happened to my son; nobody would
24 speak to me. Nobody wanted to talk to me and I was just -- I
25 was disappointed.

1 Q: Now, you talked about the guy with the, what did you call
2 it, the incubator?

3 A: Yes.

4 Q: All right. Was that on wheels?

5 A: I don't think it -- yeah, it was on wheels because I was
6 following behind. He pushed it, yes, the last time I could
7 remember, yeah.

8 Q: Do you know who that was; was that the pediatrician?

9 A: I think he was. Because as a matter of fact, he talked
10 to my -- he came back in the room that next two -- nobody
11 talked to us because I spent the night, until the next morning
12 he came and talked to us.

13 Q: You spent the night where?

14 A: To the hospital and watched the baby.

15 Q: How far did you follow the pediatrician down the hall?

16 A: All the way to the next room, standing in the room with
17 him and keep looking at my baby and said, wait, doc, tell me
18 something was going on. He was -- he couldn't tell me
19 nothing. He just was ---

20 Q: At that point, what was your emotional state?

21 A: Oh, man, it was a nightmare. Like I say, I still take
22 like -- I still I think about this every day. Every time I
23 look at my son, if I could do something to -- I would have did
24 -- I would have did better, you know. I think it about it
25 every day because ---

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1 Q: When you were following the pediatrician down the
2 hallway, how loud was your voice then?

3 A: It was real loud. Nobody wants me to because I keep
4 loud. I'm like, can somebody please tell me what's going on.
5 I keep asking everybody, please. I even asked the doctor.
6 She walks off, the next thing, she went to the next room and
7 everybody like they just left.

8 Q: All right.

9 A: I had nobody to talk to.

10 Q: All right. After seeing Dr. Maselli walk off at that
11 point, how many times have you seen her again?

12 A: I never seen her no more, never seen her no more. God be
13 my witness, never seen her no more, never. I stayed to the
14 hospital.

15 Q: Did you hear from her in any way?

16 A: No.

17 Q: No contact at all?

18 A: No, sir. No, sir.

19 Q: Is there anything I haven't asked you about that's
20 important about your time in the hospital before Jahmerican
21 was released?

22 A: Just what I tell you, I come up here to tell the truth
23 and put my hand on the Bible; that's what I seen and that's
24 what I tell.

25 Q: But do you remember anything else after Dr. Maselli

1 walked off between then and when your son got discharged; do
2 you remember anything during that period of time?

3 **A:** That's it.

4 **Q:** Now, let me go forward and jump ahead. Let's talk about
5 what it's like to be a father of a brand new baby and then you
6 know, just take me through the steps. He went from being a
7 brand new baby to being, you know, about to turn six on the
8 27th of this month, just take me through -- take me through
9 those six years in terms of what it was like. Early on what
10 was it like that first 6 to 12 months?

11 **A:** It started off, anybody, any shape, form, color, it don't
12 matter, for his son, you want him -- when you see that things
13 ain't gone work out for him and he's not capable to do things,
14 sitting there like your whole life shattered. It's like what
15 I'm gone do; how am I gone be able to handle this. We've been
16 through so much. Running back and forth to doctors, taking
17 him through therapy, me watching my kid trying to -- when see
18 kids play today, he don't -- he don't even really talk to
19 nobody; he just looks at kids play and I'm more like a
20 superman for him, like no -- no man or woman want a kid that
21 they only look up to them as a friend. I tried to, I know
22 that he can't do nothing for hisself, so I try to be there
23 every time that he need me, which I'm not gone be there all
24 the time; I'm not. And he really needs me, you know, he needs
25 somebody to be with him.

1 Q: You mentioned to go to various kinds of treatment?

2 A: Yes.

3 Q: Where did you go most often for treatment?

4 A: We go to in front of the hospital, the Next Step over
5 here in Georgetown, USC, we just back and forth on the road,
6 just constantly. Sometime, everybody on my job like after we
7 know you got to do things, take off, take a day or two off,
8 just go, go, go take care of your son. I had a lot of people
9 that backed me up, but we went through so much and we're still
10 going through it.

11 Q: Let's talk about what your son can and cannot do. During
12 that first year, have you seen other children that first year
13 so you could compare Jahmerican ---

14 A: Yes.

15 Q: --- with another?

16 A: Where we live at -- where we live at it's a bunch of
17 kids. They've got basketball goals, it's all on the same
18 block. When they get from school or whenever they come out
19 the house, all of them play together. I'm like right across
20 the street so it hurts me that he wants to go play with them,
21 but most of the time, if he do try to play with them, all the
22 kids ask him what's wrong with you; what's with your arms and
23 he don't know how to, you know, you know tell them what
24 happened because which I know he'd like to keep long sleeves
25 shirts on. I say, why don't you -- it be hot, why don't you

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1 take off your shirt and put a short sleeve shirt on; I know
2 the kids be teasing him about, you know, because he never want
3 to go out the door with short sleeve shirts; he always want a
4 long sleeve. I said why you want to do that all the time;
5 which I know he getting to the age that kids always run their
6 mouth. They wasn't -- it was bad when he first coming up
7 because I was always there for him. He really don't have to
8 play with nobody, because he can't do nothing really for
9 himself. He can't.

10 Q: What have you done to try to build his self-confidence,
11 if anything?

12 A: Man, I tries to play with him, just like I can take a
13 ball and say let's try to tell him to hold his hand, one hand
14 up, I can just throw it in his one hand and let him catch it;
15 he smiles. I try to find something that we can do together
16 that, you know, he can smile, just try to keep him going, but
17 he getting older and he's figuring it out that he can't do.
18 Because one day he bring a piece of paper to me and his mom
19 saying they got a -- for fifth graders, I mean for
20 kindergarten, they got a little baseball team. He come with a
21 piece of paper saying that he want us to sign that paper for
22 him to play baseball. Well, no, he want be playing baseball.
23 He want because he can't.

24 Q: Did he want to play?

25 A: Huh? He wanted to play and that thing hurt me and my

1 wife. I mean, I wanted to cry just to tell him that he can't.
2 Q: Can he hold a bat in a swinging posture?
3 A: No.
4 Q: Could he -- could he -- could he catch a ball with his
5 glove?
6 A: No, sir, no.
7 Q: What other kind of sports or outdoor games have you seen
8 him try to do with other kids?
9 A: He can't do none really. Just like one little niece, he
10 got a little cousin about the same age as him. She like to do
11 cartwheels in the yard and I sit there and watch sometimes.
12 He want to do it too, but he, he not able to do that. You
13 know, cut a cartwheel all the time while for him in the yard.
14 He stand over there and watch her and I know, I mean, I know
15 he want to. And me being a father watching that, it's
16 painful. It's painful.
17 Q: All right. So, it sounds like you're kind of talking
18 about the whole six years since he was born.
19 A: That's what I'm gone do.
20 Q: Let me -- let me get you to kind of go through a regular
21 day. When he gets up in the morning, what's the first thing
22 he does, what does he do or where does he go?
23 A: When he gets up in the morning, we -- I take him in the
24 bathroom, get him, try to get him dressed for school. Mostly,
25 he got jean pants, but we get the pants for him, the elastic

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1 pants because we know he can't pull them up on his bottom, on
2 his self, you know. I tries to let him think he can try to do
3 it hisself, but he can get dressed for school, which he'll
4 take his hand and pull them up, not his right hand, but his
5 left hand and pull up; not the jean pants, but we got a lot of
6 elastic pants but we'll pull it up. And I -- and I pick and
7 play off with him like look that's good, that's good, which I
8 come back later on, I come behind him and straighten them up;
9 that's every morning. He can't do nothing. He can't pull his
10 pants up with two hands, but I make it look like he can do it
11 with that one hand. But later on, I grab him and straighten
12 stuff up on him.

13 **Q:** Can he -- can he put on his pants and his underwear and
14 that kind of stuff?

15 **A:** No. He tries though. He tries. We try to help him find
16 a way that he can do it. Like I say, I comes behind, I'm a
17 superman, and I -- if he get it halfway on with his left hand,
18 I play off for a while and I go back and pull the other side
19 up for him, you know.

20 **Q:** So, after you take him to the bathroom, you get him
21 dressed, what happens next; does he get anything to eat before
22 he goes off to school?

23 **A:** Sometimes. He like to eat cereal. He like the Fruit
24 Loops; he loves, we'll fix him some before he goes to school.
25 Sometimes, he like the breakfast at school; sometimes he

1 don't. When he get to school, he eat a little bit.
2 Q: Is he able to get a cereal bowl and put the Fruit Loops
3 in there?
4 A: Oh, no, I fix it. Like I said, I do just about
5 everything for him.
6 Q: Can he open a milk carton?
7 A: No.
8 Q: Can he pour milk into his bowl?
9 A: No, sir, no.
10 Q: When he goes to school, does he have some more food to
11 eat when he first gets there?
12 A: Yeah, I'm pretty sure. Well, the teachers know him real
13 good; they helps out a lot for him too. I think some of the
14 teacher tote the tray for him. I think they got this, I did
15 see them. They goes in line and get a tray and I seen, one
16 time I had went and I seen the teacher get the tray for him
17 and take it to where he eat at on the table, put it on the
18 table for him. Because he can't take ahold of the tray, the
19 lunchroom tray, he can't take it.
20 Q: When I was a little boy, they used to have these
21 rectangular trays?
22 A: Yes, sir.
23 Q: Is that what they have now?
24 A: Yeah, yes. Yes, sir.
25 Q: And he can't hold it ---

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1 **A:** No, like I say, I have went there in the morning and took
2 him and I think we got a little late, I got him there and the
3 teacher said come on, come on and eat. So, I know she's the
4 one who be taking the tray and put it to the table for him.
5 They know him real good. All the little kids, you know, they
6 looks at him a lot and laughs a lot.

7 **Q:** Are the other children old enough to cut meat?

8 **A:** Oh, yes, all the kids, yes. Yes, sir.

9 **Q:** Can your son cut meat?

10 **A:** No, sir, no.

11 **Q:** All right. What about, does anything happen at school
12 that troubles you besides not being able to being able to tote
13 his tray?

14 **A:** He gets picked on. We've noticed, but thinking little
15 kids his friend; he don't want to tell us that, that they
16 really bother him. I keep asking him, do they treat you good,
17 they been mean to you or whatever and I already know that he
18 don't really want to let us know, but I was standing out to
19 the bus one day and it was about three weeks ago, a little kid
20 hit him in the stomach and I believe it's the same little kid
21 that been bullying him on the bus and he came off the bus, he
22 didn't know I was over there and I seen him crying and I said,
23 what's wrong and he was crying coming off the bus. And he
24 said, a little guy hit him. So, another little kid say, yeah,
25 a little boy, he's pretty bad, so I took him up, I was real

1 upset. I went to the school, I told the principal. She said,
2 you know what I heard about the guy name, I'm going and run
3 and get the film to get the film from the bus and rewind it.
4 She said give me your phone number and I'll call you back
5 because you're a parent and I said well, my son got a problem
6 with his hand, he can't, you know. She said, I don't care
7 what's wrong, no kid should be bothering no kids. So, I went
8 home and it wasn't ten minutes she called me back. She said,
9 I took care of that kid for you. She said, yeah, he did bully
10 him; he didn't want your son to sit on the same bus with him
11 because they were saying something about his hand, the doo-doo
12 touch or something like that. They don't want him touching
13 them. Yes. Yes.
14 Q: They didn't want to be on the same bus with him?
15 A: Didn't want him to sit on the seat with him, yes.
16 Q: What happens after he gets home from school, any issues
17 there compared to other children?
18 A: Well, he -- I could tell you so much. He's very moody.
19 He just cries a lot. Like little things, he cries a lot. He
20 just, I don't know what it is, something really bother him or
21 I don't know. He getting older, like I said, he's gone be
22 six and I think he's really kind of feeling that he want to
23 get out there and play with the rest of the kids, you know. I
24 don't know. Because we always keep them on our side, you
25 know, with us. But I think he want to branch out a little bit

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1 and I know it's coming. It's coming, it's really coming.
2 Q: Do you guys go out as a family in public?
3 A: Yes.
4 Q: Go out to eat or ---
5 A: Yeah, we goes out a lot.
6 Q: What kind of things do you do when you go out in public?
7 A: Really with him, nothing too much we can do. We go eat.
8 We have went to the Family Kingdom and rides. You know rides
9 and stuff like that. Just, you know, it ain't too much that
10 we can do with him to play wise. Like take him to the
11 arcades, Chucky Cheese or something like that; that's not gone
12 work. Just taking him to Chucky Cheese and know he can't get
13 tickets, you know. It's gone hurt me more than anything, me
14 and his mother, just to watch him. He can't play with the
15 rest of the kids at Chucky Cheese or try and win a game or get
16 a ticket or whatever; it's, you have to be in my shoes to
17 really see that.
18 Q: Do you ever go to the movies?
19 A: Huh?
20 Q: Do you ever go to the movies?
21 A: Yeah, we go to the movies. Yes, a lot.
22 Q: All right. Is that a safe place for him?
23 A: That's -- he likes that. He likes that, yes. But
24 anything coming down the plan; we take him to a birthday party
25 and the little kids, they said, little kids, they put the

1 little thing you hit it with a stick then all the candies come
2 out, he couldn't participate with that and I was standing
3 there with him at the party. I said I know he's not able to,
4 you know, to join the rest of the kids because he can't swing
5 the stick.

6 Q: In terms of other outdoor activities, you ever tried to
7 take him down to a lake or swimming pool or anything like
8 that?

9 A: Yeah, we take him -- we take him to -- we go to Pawleys
10 Island out there and we let him sit where the water can come
11 on his legs and stuff. He'll roll over and he liked that. He
12 really liked that, the water, he rolls over a lot and act like
13 he's swimming or something, but he don't be really in the
14 water. He like to roll over in the water and that's it;
15 that's about as far as it go.

16 Q: Now, you talked about going to therapy sessions. Who
17 drove him to these therapy sessions?

18 A: Me. Me and my wife.

19 Q: Like I said, my supervisor, they know what's going on
20 with my son and it's no problem for me when it comes down to
21 my son, sometime I show them what time I got to be there and
22 when I got to leave off the job. I never had a problem with
23 them and I thank them for that today. They was like go, go
24 okay. Make sure you take care of your kid.

25 Q: Let me get you to turn to a piece of paper, I think it's

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1 in front of you to the right up there marked Exhibit 23. You
2 can stay seated, just reach in front of you; do you see a
3 piece of paper there?

4 **A:** Right here? I have no paper.

5 **Q:** Thank you. All right. All right. Okay. And I believe
6 we have the video hooked up to the T.V.; is that right, were
7 you able to display this on there?

8 **MR. GRAHAM:** And, Your Honor, we've already admitted
9 this.

10 **THE COURT:** All right. Sure. You say this, that's
11 Exhibit?

12 **MR. GRAHAM:** 23.

13 **THE COURT:** Okay.

14 **BY MR. GRAHAM:**

15 **Q:** All right. Anthony, let me just get you to go down here.
16 The first one we see on here is Tideland and I don't want to
17 take up the time to count up all these visits, but how often
18 were you going for therapy during at least in the beginning?

19 **A:** Two times a week.

20 **Q:** Okay.

21 **A:** Tuesdays and Thursdays.

22 **Q:** All right. And I asked you who took him and you said me
23 and my wife, but on Tuesdays and Thursdays, who took him?

24 **A:** It all depends on who get off; sometimes she gets off at
25 the beach; she'll get him there, but most of the time, I take

1 him.

2 Q: All right. Is that because you were off work or because
3 you had a friendly employer who let you take off?

4 A: Yeah, on my job they let me. If I have an appointment,
5 they let me go.

6 Q: The next one down here is Shriner's, but I'm going to
7 skip over that one for a minute and go to MUSC. MUSC has some
8 big numbers on it, but before we get to the first big number
9 of 85,000, it looks like there was about five bills above
10 that. Do you remember what that was for, was the first time,
11 the first several times when you were going to MUSC before the
12 first surgery; do you remember what that was about?

13 A: No, I don't.

14 Q: But you did have some visits before they would go forward
15 with the surgery?

16 A: Yes.

17 Q: All right. And then so I see the figure here of 85,000,
18 92,000, are those for the two surgeries where they actually
19 cut into his neck and dealt with the neuroma and the nerves
20 and all that?

21 A: Yes, sir.

22 Q: And tried to straighten them up?

23 A: Yes, sir.

24 Q: All right. And then you went to some more visits to MUSC
25 after that?

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1 A: Yes, sir.

2 Q: Do you remember what that was about?

3 A: I think they had to fix the two cuts; the one at MUSC --

4 we still on MUSC?

5 Q: Yes, sir.

6 A: We went quite a few times.

7 Q: All right, sir. Then, now let's back up to Shriner's?

8 A: Right.

9 Q: In terms of timeline, did you go to MUSC before

10 Shriner's?

11 A: Yeah, I went -- yes, sir, I went there.

12 Q: How did you find your way to Shriner's?

13 A: The address, I put my -- oh, when I was there at USC, a

14 lady told us that you might get some help over there at

15 Shriner's and I said what, who? So, we called Shriner's up

16 and we got some help from them. We started taking him up

17 there. All these are big also. All of them were.

18 Q: Now, there are bunch of Shriner's around; where was this

19 Shriner's?

20 A: This was Greenville.

21 Q: Who took him up there?

22 A: I did.

23 Q: Was your wife able to go on that trip?

24 A: Yes, sir.

25 Q: To the best of your knowledge, are these all the medical

1 expenses to date?

2 A: To date and he still has more to go. Still some more
3 things, his shoulders is not in line; one go forward and one
4 like one go forward and one go back. It's a lot; it's a lot
5 more to go through. Got a lot to go.

6 Q: All right. He's not quite six?

7 A: Right.

8 Q: What are you hopes and dreams for him going forward?

9 A: Oh, man, I just want him just -- if I can just wish, I
10 just wish that he could do everything that another kid can do
11 because I know how it is when I had my time of doing things
12 with kids and he gone miss a lot of that. He ain't gone get
13 to see everything that me, you and the rest of us did; play
14 and have a good time and play ball, play football, play
15 basketball; it ain't gonna happen, it's not gone happen. I
16 wish I could take my hands and just give them to him. I wish
17 I could.

18 Q: Thank you, sir. Please answer any questions these guys
19 may have.

20 A: Yes, sir.

21 THE COURT: Mr. Radeck?

22 CROSS EXAMINATION OF ANTHONY MCCRAY BY MR. RADECK:

23 Q: Good afternoon, Mr. McCray?

24 A: How you doing, sir?

25 Q: Please bear with me and I understand this is a sensitive

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1 subject ---

2 A: Yes.

3 Q: --- and I certainly do not mean to cause you any angst in
4 any way, all right?

5 A: Yes, sir.

6 Q: I want to touch on a few things that you mentioned that
7 Dr. Maselli said at the time of delivery, okay? And do you
8 remember -- well, let me ask you this. Isn't it true that you
9 really don't remember anything that Dr. Maselli said during
10 the delivery?

11 A: I remember she told me that she -- when the time come,
12 that's when she would do the cutting. I told her to cut her
13 stomach open and go ahead and get the baby and stop pulling
14 and tugging on the baby trying to get him out. I remember she
15 telling me that.

16 Q: Telling that when the time comes?

17 A: Yes.

18 Q: She'd do the cutting?

19 A: Yeah, she'd do that.

20 Q: Do you remember giving a deposition in this case?

21 A: I think I did.

22 Q: Okay. You gave your deposition on April 25th, 2017 here
23 in Georgetown; do you remember that?

24 A: Yes, sir.

25 Q: Your Honor, may I approach?

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1 **THE COURT:** Yes, you may.

2 **MR. RADECK:** May I open it?

3 **THE COURT:** Yes.

4 **BY MR. RADECK:**

5 **Q:** Do you remember taking an oath to tell the truth during
6 that deposition?

7 **A:** Yes.

8 **Q:** I'm sorry?

9 **A:** Yeah, I took an oath there.

10 **Q:** Okay. And you came to that deposition swearing to tell
11 the whole truth and nothing but the truth?

12 **A:** Yes. Yes, sir.

13 **Q:** Okay. Can you turn to page 27 please of that deposition?
14 I'm going to direct you to line 4.

15 **A:** Okay. I'm looking at it.

16 **Q:** You see line 4 there that number on the left?

17 **A:** Yes.

18 **Q:** Okay. I'm going to read it to you, it says question; do
19 you recall a comment by Dr. Maselli about something along the
20 lines of if we don't have -- if the baby is not here by 7:00
21 A.M. we'll have to do a c-section. Answer, no. Do you
22 remember that?

23 **A:** No, I don't remember that, no, sir.

24 **Q:** Okay. You also mentioned that ---

25 **A:** Said I mentioned that?

1 Q: That's your answer, no, to that question, right?

2 THE COURT: He's asking you if you remember saying that
3 in your deposition, giving that answer.

4 A: Okay. No.

5 BY MR. RADECK:

6 Q: Do you remember answering no to that question during your
7 deposition?

8 A: Let's go over it again.

9 Q: Sure. Question, okay, do you recall a comment by Dr.
10 Maselli about something along the lines of if we don't have
11 the baby, if the baby is not here by 7:00 A.M., we'll need to
12 do a c-section. Answer, no.

13 A: Yes, I remember that.

14 Q: No was your truthful answer?

15 A: No, I didn't ever heard she saying that, no. Like --
16 like I remember -- yeah, she said that.

17 THE COURT: Mr. McCray. What he's asking you is when you
18 gave your deposition and these were your answers. So, he's
19 going to read you the question and then your answer and he's
20 asking if that's what you said.

21 MR. MCCRAY: Yes.

22 THE COURT: All right.

23 MR. MCCRAY: Yes. Okay.

24 BY MR. RADECK:

25 Q: I'm sorry, I weren't clear.

1 A: I got it. I got it. Okay.

2 Q: Do we need to go over it again or was that your answer at

3 the time of your deposition?

4 A: That I said no.

5 Q: Correct.

6 A: No, I never said that. No, I never said that.

7 Q: Okay.

8 A: No.

9 Q: And earlier you testified that you saw Dr. Maselli do an

10 episiotomy; do you remember just testifying to that?

11 A: I don't know the word you're saying, sir, no, episiotomy,

12 I mean, you got to break it down for me.

13 Q: Okay. Did you testify that you saw Dr. Maselli cut your

14 wife?

15 A: Yeah, I seen her cut her down there after she was tugging

16 and the pulling, she took her scissors and cut right there to

17 the bottom, yes. Her vagina, she cut her vagina, yes, I saw

18 that.

19 Q: Okay. Again, if you could turn to page 16 of that

20 deposition.

21 A: Okay.

22 Q: And go to line 3 please and I'm going to read the

23 question and then the answer and I'm going to ask you about

24 it. Do you know if Dr. Maselli did -- do you know what an

25 episiotomy is? Answer, no, I do not. Okay. Do you know --

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1 question, do you know if Dr. Maselli cut your wife? Answer,
2 I'm not sure. Is that your answer?

3 **A:** Cut my wife as far as -- I'm thinking that you're saying
4 cut her stomach, but I know she cut down there to her vagina.
5 I know she didn't cut her stomach, no. But I seen her cut the
6 vagina. I did it was so long.

7 **THE COURT:** Mr. McCray, what he's asking you is does that
8 deposition say that that was your answer on that day?

9 **MR. MCCRAY:** Yes, okay. Yes.

10 **THE COURT:** That's all he's asking you.

11 **MR. MCCRAY:** Yes, sir.

12 **BY MR. RADECK:**

13 **Q:** Okay. Earlier you talked about Dr. Maselli's hands?

14 **A:** Yes, sir.

15 **Q:** Okay. Isn't it true that you don't really know exactly
16 where her hands were located?

17 **A:** Yeah, I watch her. I watch her hands went from here to
18 there, here. I'll tell you I was on her right behind her
19 looking at everything. She moved her hands every which way.
20 I never seen nothing like that in my life.

21 **Q:** Can you please turn to page 26 of your deposition? I'm
22 going to start at line 6. I'm going to read the questions and
23 the answers again like we've done before? You at line 6?

24 **A:** Uh-huh (affirmative response).

25 **Q:** Okay. Where were her hands in terms of were they side by

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1 side? Answer, I'm not sure. Question, okay. So, you could
2 see her hands but as we sit here today, you don't recall
3 exactly where they were. Answer, yeah, right. Question, you
4 don't recall where on Jahmerican's head they were placed?
5 Answer, I'm not sure. Were those your answers?
6 A: Those were my answers, yeah.
7 Q: I want to go back to sort of the beginning when you were
8 heading to the hospital for the delivery.
9 A: Yes.
10 Q: Obviously, you had two other sons?
11 A: Yes, sir.
12 Q: But this was the first time that you actually went into
13 the delivery room; is that right?
14 A: Yes, sir. Yes.
15 Q: So, this is the first delivery of a child that you've
16 ever seen?
17 A: Yes.
18 Q: And I've been there, it's an exciting time ---
19 A: It is.
20 Q: --- and it's a scary time, right?
21 A: Yes, sir.
22 Q: Okay. And you guys got to the hospital about 2:00 A.M.?
23 A: 2:00 A.M., no, it was between 11:30 -- from 11:00 to
24 11:30, somewhere up I there, that I can remember, right up in
25 there.

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1 Q: All right. And kind of jumping to the time of delivery,
2 do you know if it was around 8 o'clock, 8:15; do you remember?
3 A: The delivery?
4 Q: Correct?
5 A: I can't recall.
6 Q: You were there for a long time overnight, right?
7 A: Yes.
8 Q: All right. I'm sure you were tired?
9 A: No, I wasn't tired.
10 Q: Okay. Was it -- you know, obviously, being in a delivery
11 room there's people coming in and out, doctors, nurses, do you
12 remember any of that?
13 A: Yeah, I remember the first nurse was in there, then the
14 second one came in and that's when they started rolling; it
15 was me, her and they said it was a doctor, then three.
16 Q: Do you remember a pediatrician coming in?
17 A: Yeah, after the baby was born, I seen a guy, but I
18 wouldn't know if that's him or not, but if that's what you
19 want to call him.
20 Q: You didn't have any conversations with him?
21 A: Yeah, after the baby was born, I asked him what happened
22 to my baby arm.
23 Q: Before -- before he was born, do you remember a doctor
24 coming in and giving an epidural; do you know what that is?
25 A: No, I don't.

1 Q: Okay. You don't recall Dr. Maselli coming into the room
2 shortly after you guys got there?
3 A: No, she didn't come right then; she didn't got there
4 until 6 o'clock or 6:30.
5 Q: She didn't come in to do any kind of initial evaluation?
6 A: Sort of peeped their head and they moved around and hook
7 up stuff like that. They was moving around looking up
8 whatever they needed to work for it.
9 Q: You don't recall any conversations with Dr. Maselli when
10 she first came into the delivery room prior to the actual
11 delivery, do you?
12 A: No.
13 Q: Okay. And when it came time for Jahmerican to actually
14 arrive, you don't recall Dr. Maselli telling your wife to move
15 her knees back?
16 A: Move her knees back, no, I can't recall, it was so long
17 ago.
18 Q: Okay.
19 A: All like I told you, like the truth I just tell you, all
20 I know she -- she pulled and tugged and when I told her, I
21 told her -- I shouted out four times, please stop pulling hard
22 on the baby. And God knows she knows she could probably
23 remember I saying that too, because I was saying it with a
24 really attitude that's don't do that; that's not good. That's
25 as far as me and her went with it. And she's saying I rather

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1 you cut her stomach and take that baby out than to keep doing
2 what you're doing. She said well, let's wait a minute, let's
3 see. Wait. She said I will do that when the time come,
4 that's what she said.

5 Q: Okay. You're not sure if you said anything to your wife
6 during the delivery; is that right?

7 A: I can't recall, it was so long.

8 Q: And you don't -- you don't recall whether the nurses said
9 anything during the delivery; is that right?

10 A: I can't recall.

11 Q: You don't recall having any conversations with them at
12 all, do you?

13 A: No.

14 Q: All right. And you say you saw some nurses pushing on
15 your wife's stomach?

16 A: Yes, sir.

17 Q: You don't know where they were pushing, do you?

18 A: Yeah, around right on the side. One was on this right
19 and one was on the left. They molded her stomach when they
20 finished that.

21 Q: Could you turn to page 25 of your deposition please?

22 A: 25, okay.

23 Q: Okay. Can you go to line 14? Okay. Question, you
24 mentioned this already, but can you describe for me where the
25 nurses were putting their hands on your wife's body? Answer,

1 they were pushing like. Question, they were pushing down
2 underneath her breasts? Answer, I'm not sure. Question, was
3 it on her stomach somewhere? Answer, it looked like it, I'm
4 not sure really. Were those your responses?
5 A: Yes.
6 Q: You believe that Jahmerican interacts well with other
7 kids, don't you?
8 A: Interacts with other kids?
9 Q: You believe that Jahmerican interacts pretty well with
10 other kids?
11 A: No, I don't.
12 Q: Will you turn to page 31 of your deposition, please?
13 Tell me when you're ready.
14 A: Okay.
15 Q: Line 4, question, what about does he interact well with
16 other kids? Answer, I think he do. Was that your answer?
17 A: When I put it down there.
18 Q: Was that your response at the deposition?
19 A: Yes.
20 Q: Okay. And Jahmerican was going to the school called Head
21 Start, is he still there?
22 A: No, sir.
23 Q: Okay. Was he doing well at Head Start?
24 A: Yes, for a little kid, yes. Then a little kid.
25 Q: He was doing well, I'm sorry?

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1 A: Well as far as like what you're saying like for,
2 whatever, like getting his grades.
3 Q: He seemed to do well in school; he was doing pretty well
4 in school?
5 A: To me, yes, I think he was.
6 Q: And that's a good thing obviously, right?
7 A: Yes, sir.
8 Q: And obviously, there's no -- there's been no evidence of
9 any kind of brain injury that you've noticed in Jahmerican,
10 right?
11 A: No.
12 Q: And that's a good thing and that's a good result of the
13 delivery, right?
14 A: Yes, sir.
15 Q: That's all the questions I have. Thank you.
16 A: Yes, sir.. Yes, sir.
17 THE COURT: All right. Mr. Graham?
18 MR. GRAHAM: Thank you, Your Honor.
19 REDIRECT EXAMINATION OF ANTHONY MCCRAY BY MR. GRAHAM:
20 Q: Let me go back over a few of those things with you.
21 Anthony ---
22 A: Yes, sir.
23 Q: --- first of all, let's start with that last one. Mr.
24 Radeck was asking you about your answers about interacting
25 well with other children. Okay?

1 A: Yes.

2 Q: All right. Did he stop on line 6?

3 A: Yes, I think he did.

4 Q: All right. I'm going to read it to you again, all right.

5 Is this what you said; starting with line 4, what about does

6 he interact well with other kids? Answer, I think he do.

7 Question, and? Answer, playwise, yeah.

8 A: Yes.

9 Q: All right. Look up there at the top right hand corner,

10 what was the date this deposition was taken?

11 A: April 25th.

12 Q: Of 2017?

13 A: Yes.

14 Q: All right. Your son was how old then, about four?

15 A: Four, yes.

16 Q: All right. Is his ability to interact with kids stayed

17 the same for the last two years?

18 A: Yes, sir, as far as like explain it to me like, like

19 playing with him wise or I don't understand.

20 Q: Okay. Before you talked about, the question was about

21 interact.

22 A: Okay.

23 Q: You told us about a bully type kid punching your son ---

24 A: Yes.

25 Q: --- in the stomach, was that before he was four years old

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1 or after he was four years old?

2 **A:** It was after.

3 **Q:** Okay. And were some of these other things you talked
4 about, some of the play problems you've talked about, after
5 this fourth birthday?

6 **A:** Yes, sir. Oh, yeah, a whole lot changed.

7 **Q:** All right. Now, okay. On page 26, Mr. Radeck asked you
8 about the testimony starting I believe at line 2; is that
9 right?

10 **A:** Yes, sir.

11 **Q:** All right. I'm going to read that in context, all right?

12 **A:** Yes, sir.

13 **Q:** Let's go back a page. Let's start on page 25 starting on
14 line 24?

15 **A:** Okay.

16 **Q:** All right. Follow along with me. Okay. Did you see
17 from where you were standing ---

18 **MR RADECK:** Your Honor, I hate -- I hate to object,
19 that's not -- he's I didn't read the parts that he said I
20 read. So ---

21 **THE COURT:** Rephrase your question now.

22 **MR. GRAHAM:** Your Honor, I don't remember precisely where
23 we started. I know precisely what he didn't say. So, that's
24 what I'm trying to cover.

25 **THE COURT:** All right. Well just -- you can use the

1 deposition if you'd like, but you know, be careful as you say
2 Mr. Radeck may have read that.

3 **MR. GRAHAM:** Okay. All right.

4 **BY MR. GRAHAM:**

5 **Q:** Let me give you this context. Starting at line, it's
6 page 25, line 24: Question, okay. Could you see from where
7 you standing, could you see Dr. Maselli's hands? Answer,
8 yeah. Question, and I know that you said, in your estimation,
9 she was pulling for a long time or pulling too hard. Answer,
10 yes. Question, where were hands in terms of were they side by
11 side? Answer, I'm not sure. Okay. So you could see her
12 hands, but as we sit here today, you don't recall exactly
13 where they were? Yeah, right. Is that the answers that you
14 gave to those questions?

15 **A:** Yes.

16 **Q:** Sir, at the time you gave this deposition, roughly two
17 years ago, had you ever given a deposition before?

18 **A:** No, sir.

19 **Q:** What was your -- what were you -- what were you feeling
20 in terms of your emotional state as you answered deposition
21 questions that day?

22 **A:** Oh, I was upset, shocked, disappointed. The things I was
23 telling them, like, I don't understand, say that again, now;
24 how I was feeling?

25 **Q:** Yes, sir.

1 **A:** Oh, as -- as disappointed, shocked, I hope this don't
2 happen to nobody, you know, what happened to me; not just for
3 me, just for anybody. Just something hard to go through.
4 This was really hard to go through. It is.

5 **Q:** Thank you, sir.

6 **A:** Yes, sir.

7 **THE COURT:** Mr. Radeck?

8 **MR. RADECK:** No further questions.

9 **THE COURT:** All right. You may step down, Mr. McCray.

10 **MR. MCCRAY:** Yes, sir.

11 **THE COURT:** Thank you. All right, ladies and gentlemen,
12 it's 5 o'clock and that's long enough here today. Thank you
13 for your service. Be back in here in the morning please at
14 9:30. Thank you.

15 **REPORTER'S NOTE:** (Jury excused for the evening 5:03 P.M.)

16 **THE COURT:** All right, gentlemen, I understand we have
17 some motions in limine now or some objections as they relate
18 to some depositions that were taken; is that correct?

19 **MR. HOOD:** That's right, Your Honor.

20 **THE COURT:** Are those yours, Mr. Hood? Are they your
21 matters and Mr. Graham's objections or vice versa.

22 **MR. HOOD:** They're Mr. Graham's objections. It's one of
23 our expert witnesses whose de bene esse deposition was taken
24 over the course of two days. So, we've exchanged designations
25 with each other.

1 **THE COURT:** Right.

2 **MR. HOOD:** And counter designations and objections. I
3 think we've worked out everything except for the things that
4 are left on here.

5 **THE COURT:** Okay.

6 **MR. GRAHAM:** I haven't had a chance to look at the
7 countered designations yet. I got them, but we've been in
8 court.

9 **THE COURT:** These are your designations?

10 **MR. HOOD:** It's a whole deposition. So, what we did is
11 that we just highlighted in the column those portions that are
12 designated; we've highlighted the text on the objections.

13 **THE COURT:** Okay.

14 **MR. HOOD:** And we did it like trial, so the objections
15 are set out in there.

16 **THE COURT:** The objections are on the record in the
17 deposition?

18 **MR. HOOD:** They are.

19 **THE COURT:** So, you did not reserve them, right?

20 **MR. HOOD:** Right, we just did it like a trial deposition.

21 **THE COURT:** Okay. All right. Do you want me -- does
22 someone want to point me to something and kick it off?

23 **MR. HOOD:** Yep. That would be great. What I can do is I
24 can announce where the objection is and ---

25 **MR. GRAHAM:** First, I'd like to find the email that was

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1 sent to me. What day and time did you send it?

2 **MR. HOOD:** It was today, let me try to resend again.

3 **THE COURT:** Was this a video deposition?

4 **MR. HOOD:** It is and that's why we'd like to deal with it

5 now, so we can edit the video tonight and be ready to go.

6 **THE COURT:** Okay. All right. And you're gone go back

7 and redact all objections that are withdrawn at this point, if

8 there are any withdrawn, right?

9 **MR. HOOD:** Yes, sir. I mean, I think the way that we

10 handled the designations is we designated out objections that

11 were pursued.

12 **THE COURT:** Okay.

13 **MR. GRAHAM:** I just got it.

14 **THE COURT:** So, someone is going to be into the wee hours

15 redacting and editing, right?

16 **MR. GRAHAM:** Your Honor, we have a technology guru here

17 to my left.

18 **THE COURT:** Well, Mr. Graham, that guru is going to need

19 some guidance, so we got to do these today, tonight, right

20 now.

21 **MR. GRAHAM:** We've agreed to accommodate ---

22 **THE COURT:** Yes, sir.

23 **MR. GRAHAM:** --- Jamie to get that done.

24 **MR. HOOD:** Do you mind if I address the Court from my

25 seat?

1 **THE COURT:** Certainly. Help yourself, stay right there.

2 **MR. HOOD:** Our first objection, Your Honor, is in the --
3 all of the objections are actually in the first transcript at
4 page 39, line 12.

5 **THE COURT:** 39, 12. All right. Okay. I think I have
6 it. And this is Dr. Duchowney?

7 **MR. HOOD:** Yes, sir. It is the first objection is page
8 39 line 12.

9 **THE COURT:** Okay.

10 **MR. GRAHAM:** I don't know if Your Honor wants us to talk,
11 but to me it's obviously leading.

12 **THE COURT:** I don't think so. How does he suggest his
13 answer?

14 **MR. GRAHAM:** Oh, I'm sorry, I misread that last line,
15 Your Honor. I hear you.

16 **THE COURT:** Okay. All right.

17 **MR. GRAHAM:** I do not disagree.

18 **THE COURT:** All right. So, the objection is overruled.
19 Okay? Now, what else do we have?

20 **MR. HOOD:** Page 42, line 13, Your Honor?

21 **MR. GRAHAM:** Say that again, Jamie?

22 **THE COURT:** 42 line, line 18 or ---

23 **MR. HOOD:** It's 13, Your Honor.

24 **THE COURT:** 13. All right, Mr. Graham, as I read the
25 question at line 13; all right. With respect to informing you

1 of mechanisms of injury and or as we've talked about.
2 generally, is this some of the body of literature with which
3 you are familiar? He just asked him if he's familiar with an
4 article. I mean, that in and of itself, how is that
5 objectionable?

6 **MR. GRAHAM:** Well, all I see, Your Honor, is the
7 question. So ---

8 **THE COURT:** I mean, that seems to be the only -- he just
9 asked him if a particular article and it was spontaneous
10 vaginal delivery a risk factor for Erb's Palsy. Is an article
11 or some of the body of literature with which you are familiar?

12 **MR. GRAHAM:** Yes, sir, and then go to the next page. He
13 starts his answer it's, but I don't know what the rest of it
14 is. I don't see an objection, so I have no idea what we're
15 talking about.

16 **THE COURT:** It says as part of the body of literature
17 that I am familiar with; yes. Okay. So, I mean, starting --
18 your objection starts on page -- line 19 of 42 and your
19 objection, it's improper use for a learned treatise and I also
20 object to the use of that treatise, the article on the basis
21 that it fails to make a distinction between temporary and
22 permanent injuries. Well, I mean, we're not there yet are we?
23 He simply asked the question was to the doctor, are you --
24 essentially, are you familiar with this article, periodical,
25 whatever it is; that's all he's asking?

1 **MR. GRAHAM:** Okay. I understand, Your Honor and I'd just
2 like to explain one thing. When I was confused a moment ago,
3 I was working off of an email I just got, which is different
4 from what Jamie's now showing me. So, we ought to be able to
5 understand each other better forward.

6 **THE COURT:** Okay. But why -- what I'm saying here is ---

7 **MR. GRAHAM:** I agree with you, Your Honor.

8 **THE COURT:** I see nothing objectionable about simply
9 asking are you familiar with this body of literature.

10 **MR. GRAHAM:** Yes, sir, I agree with you.

11 **THE COURT:** Okay. So that's overruled.

12 **MR. HOOD:** The next one, Your Honor, is 43, line 19.

13 **THE COURT:** 43, 19?

14 **MR. HOOD:** Yes, sir.

15 **THE COURT:** Well, now ---

16 **MR. GRAHAM:** Your Honor, it's really two things; one is
17 this guy is a neurologist and he's testifying about
18 obstetrics. The same thing we ran into the other day with
19 objections to Dr. Adler. He was not allowed to get into
20 obstetrics.

21 **THE COURT:** But he testified at length about brachial
22 plexus palsy and ---

23 **MR. GRAHAM:** But to the best of my recollection, he was
24 not allowed to talk about expulsive forces and uterine,
25 intrauterine forces ---

1 **THE COURT:** Let me hear you, Mr. Hood?

2 **MR. HOOD:** Sure, Your Honor. Dr. Adler discussed
3 mechanism of injury. Those actually were the exact same words
4 that came from my questions a few weeks ago. And he
5 eliminated -- he said that none of these things were the
6 explanation. Therefore, the remaining is the excessive or not
7 excessive lateral traction of the baby's head after it was --
8 the head was delivered. So, what we're talking about here is
9 an article where a foundation has been laid that is reasonably
10 reliable ---

11 **THE COURT:** Well, let's look at line 19. Line 19
12 suggests, suggests, that the witness had already testified
13 without objection concerning intrauterine or origin and being
14 a mechanism for the injury; is that what line 19 and 20 are
15 saying that he had already testified to that and what you're
16 asking him is this body of literature part of the origin of --
17 of that hypothesis?

18 **MR. HOOD:** So, my question really was -- I provided -- I
19 directed him to a certain portion of learned treatise and I
20 asked him the statement from the learned treatise.

21 **THE COURT:** What was the statement that you asked him to
22 look at or read?

23 **MR. HOOD:** It's listed above.

24 **THE COURT:** I mean, I'm having trouble finding it. I see
25 on line 12 of 43, you tell him or tell Mr. Graham that it's on

1 page 23, second paragraph of that document, but ---

2 **MR. HOOD:** Maybe I can just walk you through it. So, I
3 asked him if he was familiar with the body of literature; he
4 says that he is.

5 **THE COURT:** Yes.

6 **MR. HOOD:** And I say, well, I want to, you know, ask you
7 if you agree with this statement and Mr. Graham says wait a
8 second; hang on, I don't know where you are; tell me where you
9 are. So, we stop and deal with that and now I've explained to
10 everyone where we are on page 23, second paragraph and my
11 question to the doctor is do you agree with this statement,
12 sir.

13 **THE COURT:** Okay. Now, I understand. Recent literature
14 supports the hypothesis of some cases of brachial plexus palsy
15 may have an intrauterine origin. That's the statement that's
16 in the document, right?

17 **MR. HOOD:** Yes, sir.

18 **MR. GRAHAM:** May I?

19 **THE COURT:** Yes,

20 **MR. GRAHAM:** Your Honor, what's not clear, I don't think,
21 is what the document is they're talking about. As best I can
22 remember and Jamie can correct me if I'm wrong, but I think
23 it's an ACOG publication that talks about obstetrical issues.
24 So, here we have a neurologist opining about the significance
25 of obstetrical issues, the very same thing that Dr. Adler was

1 not allowed to do yesterday.

2 **THE COURT:** Well, he's simply -- this is what he's
3 testifying to. He's not testifying that he's an expert in
4 obstetrics, what he's saying is that in the course of his
5 work, that he is familiar with that article that was
6 referenced and that recent literature supports a hypothesis
7 that some cases of -- of brachial plexus palsy may have
8 intrauterine origin. He's a neurologist, correct?

9 **MR. GRAHAM:** Pediatric Neurologist.

10 **THE COURT:** Okay. And he is simply familiar with the
11 fact that there is some support for the hypothesis that it may
12 have -- that some cases it can be caused by, is essentially
13 what he's saying, intrauterine origin or be of an intrauterine
14 origin. I mean, he's not testifying to the mechanics of it,
15 he's just testifying, yes, there's some support for that
16 hypothesis.

17 **MR. GRAHAM:** Yes, Your Honor.

18 **THE COURT:** Now, if he wants to go into how it occurs, if
19 he wants to go into the forces involved in a contraction and I
20 guess that's what we're talking about, maybe so, but all he's
21 saying is yes, I'm familiar with the body of literature.

22 **MR. GRAHAM:** Yes, sir.

23 **THE COURT:** Is he testifying anywhere as to that?

24 **MR. GRAHAM:** He keeps -- he keeps referring to
25 obstetrical literature; that's the problem. We've got a

1 neurologist who's saying this obstetrical literature, which is
2 not in my field, is reliable and that's the basis for my
3 opinion. I mean just from this one context, you can't grasp
4 all of that.

5 **THE COURT:** Well, you know, I don't think that that's --
6 I think you're looking at it from the context of it being some
7 sort of learned treatise. I don't see Mr. Hood's questioning
8 as being exactly that. Mr. Hood's simply asking him if he's
9 familiar with this document and he's asking him if it's part
10 of the body of literature that he is familiar with, but he
11 never asked him really to read from it or anything, does he?

12 **MR. GRAHAM:** Yes, sir, he does. If you look at this is
13 page 43 starting at line 10, I say can you identify the page
14 and paragraph in the obstetrical text.

15 **THE COURT:** We've talked about this for two days now.

16 **MR. GRAHAM:** I realize that. And then he reads from the
17 document saying do you agree with these statements, sir,
18 recent literature supports the hypothesis that some cases of
19 brachial plexus palsy may have an intrauterine origin.

20 **THE COURT:** I'm going to allow it. We've talked about
21 that very thing through four witnesses today or three so far.
22 It's all over this record. I don't think that it is -- he's
23 getting beyond his field. I'm going to let him do it. He's
24 just simply saying yes, there's a theory out there. I'm an
25 expert, I'm a neurologist and there's a theory that this is

1 one of the causes of it. I'm going to let him go with that.

2 Let's go onto the next thing.

3 **MR. HOOD:** Yes, sir. The next one is just down on page
4 44, line 8. This is basically the same objection talking
5 about.

6 **THE COURT:** Well, the objection -- the objection is -- it
7 looks like it starts on line 3, doesn't it and again, it said
8 the objection is that it fails to distinguish between
9 temporary and permanent injuries, not the objection that I'm
10 hearing today. What about that objection that Mr. Graham
11 makes?

12 **MR. HOOD:** So, Judge, that's a cross examination point
13 and I think Mr. Graham did that with his expert on redirect
14 today because I read portions of articles to him and the gist
15 of it is really that and I think it's clear that there's a
16 dispute about the mechanism of injury and at one point in
17 time, it was generally believed that excessive lateral
18 traction and it's applied after the head is delivered. Since
19 then there's been research and studies and reported cases that
20 creates this sort of other explanation. What the fundamental
21 challenge here is that Mr. Graham is trying to draw a bright
22 line in saying a neurologist can't read a publication from an
23 obstetrical society or an obstetrical journal. Well, a
24 neurologist has to treat a neurologic injury. The
25 complication is being reported ---

1 **THE COURT:** And certainly he could explore causation.

2 **MR. HOOD:** That's all this is. I mean this doctor doesn't
3 opine like Dr. Duchowney with respect to standard of care. He
4 was never asked standard of care questions.

5 **THE COURT:** I'm going to allow it. Okay?

6 **MR. GRAHAM:** May I ask one clerical question, Your Honor?

7 **THE COURT:** Yes.

8 **MR. GRAHAM:** May we leave in my objection. I understand
9 you overruled it, but may we leave it in?

10 **THE COURT:** No. What purpose does that serve to leave in
11 an overruled objection?

12 **MR. GRAHAM:** It would just -- it would save the Court
13 time just by not having to keep going through cross
14 examination about all those different failures.

15 **THE COURT:** No, you're going to have -- I'm convinced
16 that you will cross examine about it anyway. Okay? Let's go
17 ahead. What's the next thing?

18 **MR. HOOD:** So, the next one is 45 at 2 and really, you'll
19 see, Your Honor, that depending on your inclination, a lot of
20 this is consistent in terms of the basis of the objection.

21 **THE COURT:** I'm going to allow it. Let's go ahead.
22 What's the next one?

23 **MR. HOOD:** 45, 17, it's just the next few down.

24 **MR. GRAHAM:** Your Honor, on that one ---

25 **THE COURT:** Which one are we on?

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1 **MR. HOOD:** The objection to the question at 45, 17.

2 **THE COURT:** Okay.

3 **MR. GRAHAM:** So, he's talking about susceptibility to
4 pressure. He's talking about the pressure in the birth canal,
5 the maternal pushing and uterine contractions. He's just all
6 over the topic of obstetrics.

7 **THE COURT:** Mr. Hood, what do you say about that; I'm
8 almost ---

9 **MR. HOOD:** I would say just look at line 22. What he's
10 doing is explaining, he said, on the integrity of the nerve.
11 He's talking about the integrity of the myelin coating and the
12 neuro anatomy of the brachial plexus.

13 **MR. GRAHAM:** As affected by obstetrical factors that are
14 outside of his field.

15 **THE COURT:** I think what he's doing there and is he's
16 talking about what we've heard so much of so far and that
17 would be the integrity of the nerve. We heard witness after
18 witness talk in terms of a -- the integrity of the muscle,
19 which protects the nerve, the mobility of the nerves, nerves
20 that may not be well in their own right, being more
21 susceptible to injury. It would appear to me that all he's
22 saying is all of that can be different in different babies,
23 not necessarily the birth of a child. I think it's
24 admissible. I'm going to allow it in. I'm going to allow
25 this line of questioning unless you can show me something

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1 else. What else do we have?

2 **MR. GRAHAM:** I don't want to beat a dead horse, Your
3 Honor, but he's talking about unavoidable, intrapartum or
4 antepartum events.

5 **THE COURT:** Well, what we've got is a neurologist here,
6 who is familiar with the condition, who treats it and I just
7 believe that he is entitled to testify concerning the
8 available literature that might explain causation. I just
9 think it's admissible and I'm going to allow it.

10 **MR. GRAHAM:** I understand.

11 **THE COURT:** Okay. All right. Go ahead. It's sort of
12 like the ER Doctor, who treats a bullet wound. He doesn't
13 have to be an expert on guns to know what happened. You just
14 know why the hole is there, why the injury is there; he
15 understands it and I think that's what these Pediatric
16 Neurologists are doing; they're simply looking at it and say
17 from the literature, we know what causes this.

18 **MR. GRAHAM:** Your Honor, this next one, which is page 46
19 starting at line 16.

20 **THE COURT:** It's which one?

21 **MR. HOOD:** 46 line 17.

22 **MR. GRAHAM:** It's consistent with what Your Honor has
23 already ruled.

24 **THE COURT:** Okay.

25 **MR. GRAHAM:** So, I don't think we need to belabor the

1 point.

2 **THE COURT:** Okay. I'm going to allow those. All right.

3 **MR. GRAHAM:** I mean it, based on Your Honor's prior
4 rulings, I am suspecting that we will get the same ruling
5 there, so I want belabor the point.

6 **THE COURT:** All right. Let's go on down.

7 **MR. GRAHAM:** That one is going to be your same ruling,
8 Your Honor.

9 **THE COURT:** All right. Where are we now?

10 **MR. HOOD:** We are looking 48, 07.

11 **MR. GRAHAM:** Same thing, Your Honor.

12 **THE COURT:** All right.

13 **MR. GRAHAM:** I think that is pretty consistent.

14 **THE COURT:** I'm going to allow it. Okay.

15 **MR. GRAHAM:** I mean, that one is a leading objection,
16 Your Honor.

17 **THE COURT:** Let me see here.

18 **MR. HOOD:** He's referring to -- he's looking at 50 line
19 6.

20 **THE COURT:** I assume you're talking about the question
21 beginning on 49, 21; is that right?

22 **MR. HOOD:** 49, 21, yeah, this is leading up to like two
23 objections.

24 **THE COURT:** All right. All right. That first objection
25 is leading and I do not believe it's leading and the next

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1 objection was what?

2 **MR. HOOD:** 50, 23 is what the plaintiff counsel has.

3 **THE COURT:** 50, 23. 50 and 23 I have a question and then
4 from that point, would they transition to, pause, answer,
5 usually they're stable at that point. I'm even sure they
6 transition. Okay. By that point, they're like, I think, is
7 pretty well set. I mean, the objection begins at line 7 on
8 51; is that right?

9 **MR. HOOD:** Yes, sir.

10 **MR. GRAHAM:** Yes, sir.

11 **THE COURT:** Okay.

12 **MR. GRAHAM:** Here's my point there, he's a Pediatric
13 Neurologist, he sees children and even into their late teens,
14 but he is projecting what their future treatment needs will be
15 after he has nothing else to do with them.

16 **THE COURT:** Well, certainly it could testify as to the
17 prognosis for a patient, could it not; I mean, my goodness.
18 He may be a Pediatric Neurologist, but I am certain that any
19 physician is going to be concerned with the long range
20 prognosis of their -- of their patient and could comment on
21 that. And basically, what he's saying is that they're pretty
22 much set and that basically they reach maximum medical
23 improvement after age 20; isn't that what he's saying, after
24 age 20, he's pretty much.

25 **MR. GRAHAM:** That's a fair interpretation.

1 **THE COURT:** Well, I haven't heard that also from your
2 witnesses as well? Didn't we have one that said that number
3 is my mind that care would be needed.

4 **MR. GRAHAM:** We did have. So, I understand your ruling.

5 **THE COURT:** Yeah, I mean he's saying that, you know, he's
6 going to be 20 years old before he reaches maximum medical
7 improvement.

8 **MR. GRAHAM:** Yes, sir, I understand. We don't need to
9 belabor that.

10 **MR. HOOD:** The next objection, the next to the last one
11 in this deposition is page 52 line 1.

12 **THE COURT:** Okay.

13 **MR. GRAHAM:** I was just -- there was a lot of editorial
14 comment at the beginning of the sentence that is what I was
15 objecting to.

16 **THE COURT:** I think the statement is harmless. You know,
17 children are different and it's hard to predict anything with
18 any degree of accuracy, but can you give us some general
19 perspectives on your experience indicating -- how your
20 experience indicates children are born with a significant
21 defects are able to adapt or cope with those. I don't see
22 anything wrong with that. I'm going to allow it.

23 **MR. HOOD:** And the last one is page 52, line 23 continues
24 to 53, 12.

25 **THE COURT:** Do we have any sort of foundational

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1 questioning on that?

2 **MR. HOOD:** Yeah, this is a follow-up question, Your
3 Honor, to the last objection actually. So, after that
4 objection, he goes in and provides my experience with children
5 with brachial plexus is they adapt well. He goes through and
6 explains that and he basically is describing a difference
7 between people that suffer an injury late in life versus if
8 they're born with it and that's what I'm eluding to is the
9 economy and to follow it up and I said it's the economy that
10 you just discussed; do you see that in your day to day
11 practice? So this is the -- the foundation for what he's just
12 described in terms of economy.

13 **THE COURT:** Well, I think if you'll look at the response
14 from say line 10 on 52 to 21, he's talking about his
15 experience with his patients. But, if we look over at page
16 53, beginning on line 4, I also find that their peers are very
17 tolerant of their injury and generally speaking, they don't
18 get into trouble with peer relationships because of their
19 brachial plexus injury. You know, that -- I'm not sure about
20 that. What do you say about that, Mr. Graham?

21 **MR. GRAHAM:** Well, to me, Your Honor, it's
22 what he's familiar with in his own practice, has no relevancy
23 to Jahmerican McCray. It's speculative to the extent it has
24 any minimal relevance, it's outweighed by confusion,
25 prejudice, waste of the Court's time.

1 **THE COURT:** Well, I think that he, in the first part of
2 the response beginning at line 10 on page 52, he's saying that
3 in the experiences he's had at birth problems, brachial plexus
4 injury, they adapt better than an injury that would occur
5 later because it was acquired at birth and he goes on to say
6 that if it happens at a later time, as a teenager, it has more
7 significant emotional overtones. I think that he can testify
8 to that, but as to the inter-relationship with peers and how
9 peers may react to them, and Mr. Hood, I just, I think that's
10 beyond his -- his expertise. You would need some
11 psychological testimony from someone to and I think we've kind
12 of heard that.

13 **MR. HOOD:** And, Judge, you asked me one question about
14 context or foundation, and I refer you to above. I think in
15 response to that objection, I tried to address that objection
16 in the next question, which is not objected to, which goes to
17 when you treat patients, his patients, do you ask them
18 questions about how they're doing and now he provides the
19 basis for his -- his opinions about patients he deals with
20 interface, interacting, deal with their problems. I'm sorry,
21 I should have pointed you to that the first time.

22 **THE COURT:** I'm going to allow that from 12 to the end of
23 the page, but I am going to limit you on 1 through 10 on page
24 53. Okay?

25 **MR. HOOD:** Got it.

1 **THE COURT:** All right.

2 **MR. HOOD:** So, I will delete the question at line 23
3 through the answer -- on page 52 through the answer 53, 1
4 through 10.

5 **MR. GRAHAM:** No objection.

6 **THE COURT:** So, we'll go from actually line 21 on 52 or
7 excuse me, let's say 24 on 52 to 12 on 53, right? Take it up
8 at that point, right?

9 **MR. HOOD:** Yes, sir. So, what I'm going to do, I start
10 my question on 23 to which Mr. Graham has objected and I'll
11 just delete that entire question at page 52 line 23 and I'll
12 continue the deletion until the next question starts on 53,
13 12.

14 **THE COURT:** That was unobjected. Okay. All right. What
15 else do we have?

16 **MR. HOOD:** All right. So, then the second volume, Your
17 Honor, we're now on that shorter or smaller transcript. It's
18 still continuing on with Mr. Graham's objections. The first
19 one on page 7, line 4. I'm sorry, that's not an objection.
20 Excuse me, I'm sorry.

21 **THE COURT:** Page 7? Where exactly are we and what are we
22 looking at?

23 **MR. HOOD:** We are speaking two different languages
24 technologically here. I think we're finished if you'll just
25 give us one minute. I believe that we have addressed all of

1 the outstanding objections.

2 **THE COURT:** Okay. Yes, sir.

3 **MR. HOOD:** Okay, Judge, we have one more related to a
4 counter designation for context. We're in the skinny or
5 smaller transcript, which is the second one on the 19th of
6 March. And the plaintiff has a designation during his cross
7 examination that says on line 15, 23. Well, as you sit here
8 today, you recognize that folks can sustain a loss of oxygen
9 for 15 ---

10 **THE COURT:** One second. It's page what?

11 **MR. HOOD:** 15 line 23.

12 **THE COURT:** Okay. I got you. All right.

13 **MR. HOOD:** So, people can do 15 to 30 minutes without air
14 with no brain damage and he got an answer. So, then we did
15 our counter designations and the plaintiff has objected to a
16 counter designation in response to that portion starting at
17 page 41, line 4.

18 **THE COURT:** Okay. Give me a moment. 41, 4, right?

19 **MR. HOOD:** Yes, sir.

20 **THE COURT:** Okay. All right.

21 **MR. HOOD:** And ---

22 **MR. GRAHAM:** Would you like me to explain my objection?

23 **THE COURT:** I mean, you want to tell me -- it's page 41,
24 line 4 in terms of relation to this case, what is the
25 anecdotal evidence of incidence of people in other

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1 circumstances surviving for long periods with oxygen
2 deprivation have to do with your assessment in this case; is
3 that what we're talking about? The counter designation will
4 be for what? It's ---

5 **MR. HOOD:** Some counter designating Mr. Graham's cross
6 examination.

7 **THE COURT:** Okay.

8 **MR. HOOD:** He says, hey, you know there are 15 to 30
9 minutes people live without air?

10 **THE COURT:** Yes.

11 **MR. HOOD:** Now, I'm on redirect.

12 **THE COURT:** Yes.

13 **MR. HOOD:** And this is my redirect and Mr. Graham is
14 objecting to it.

15 **THE COURT:** But -- but I don't have it marked on this
16 page, you just said line 4.

17 **MR. HOOD:** Oh, I'm sorry, page 41, line 4 continuing on
18 until 42, line 2.

19 **THE COURT:** Okay.

20 **MR. HOOD:** And that's Mr. Graham's objection to that Q
21 and A.

22 **MR. GRAHAM:** So, here's the context, Your Honor. I asked
23 the witness are you familiar with the, you know, are you
24 familiar that all -- that people, folks, I said, are you
25 familiar with the fact that folks can -- can survive this long

1 without oxygen. I didn't say have you heard some anecdote
2 that somebody -- you know, he's answering in the context we're
3 talking about what he knows from the literature and then Jamie
4 asked him, now let me ask you about this anecdotal evidence
5 that Graham has been talking about and goes on and on. I
6 wasn't talking about anecdotal evidence, I was talking about -
7 --

8 **THE COURT:** Where were you, Mr. Graham?

9 **MR. GRAHAM:** With the first part?

10 **THE COURT:** On page 15, line 23, you asked, well as you
11 sit here today, do you recognize that folks can sustain a loss
12 of oxygen for 15, even 30 minutes without suffering any degree
13 of brain damage. His response was, it does occur. It
14 certainly does occur, yes. And the counter designation is Mr.
15 Hood asked in terms of relation to this case, what is the
16 anecdotal evidence of incidents of people in other
17 circumstances surviving for long periods of oxygen
18 deprivation, which have to do with your assessment of this
19 case. He objects about anecdotal evidence. The witness says
20 well, I mean, I think that a shoulder dystocia represents a
21 medical emergency just because again, the baby hasn't been
22 delivered. There could be a compromise of oxygen and even
23 though -- even though an infant could potentially do well
24 without oxygen being supplied, it is always a medical
25 emergency, I think. I think that is the way I -- it is

1 regarded by pediatricians, neo-natalists and neurologists. It
2 is a very dangerous situation. One in which all the
3 practitioners seek really to avoid.

4 **MR. GRAHAM:** So, now he's gone beyond talking obstetrics
5 and testifying to what pediatricians and neonatologists think
6 about these issues. He's a Pediatric Neurologist. He's
7 trying to tell the jury what people in other fields of
8 medicine ---

9 **THE COURT:** I mean, isn't that axiomatic, he says all
10 these other doctors are concerned about oxygen deprivation.
11 That seems sort of fundamental to me. I am too. I'm not even
12 a doctor. I mean, it's sort of basic. I don't think you have
13 to be a neonatalist or neurologist or pediatrician to say,
14 these guys, like me, are concerned about oxygen deprivation.
15 That is so fundamental. I don't think that it requires
16 expert. I think it's something I could testify to before this
17 jury if I were a witness here or a lay person. I'd say you
18 know, those doctors are pretty, pretty conscious about getting
19 your oxygen cut off. I mean it's sort of basic. It doesn't
20 even require expertise to make that statement, does it?

21 **MR. GRAHAM:** I hear you loud and clear, Your Honor.

22 **THE COURT:** Okay. I mean, I think that's fine. It's
23 just not something that requires any level of expertise. I
24 can guarantee it's true; I promise you. Okay. What else we
25 got?

1 **MR. HOOD:** That's it, Judge.

2 **THE COURT:** Okay. Thank you.

3 **MR. HOOD:** Thank you.

4 **(COURT IN RECESS)**

5 **THE COURT:** All right. We, I think, had Dr. Woods
6 testimony coming up and we discussed in Chambers, an issue
7 concerning his use of information provided by a life planner
8 in making his or giving his opinions as to economic loss; is
9 that a correct statement of the issue, Mr. Graham?

10 **MR. GRAHAM:** Yes, sir. Present value of loss of earning
11 capacity and the life expectancy.

12 **THE COURT:** Okay. And, Mr. Hood, it's my understanding
13 that essentially the objection made is that while 703 may
14 indicate that he can use information normally relied upon by
15 experts that in the field that 602, which would require
16 foundational testimony would supersede that. 703 very clearly
17 says that the information need not even be admissible in
18 evidence, the information he relies upon, and 602, while I had
19 a chance to look at it, 602 has an exception for 603. I
20 looked at this Hunley case and quite frankly, the case seems
21 to be directly on point in that case. Same witness, Dr.
22 Woods, testified in a case using a -- a life care plan that
23 was prepared by some other professional, I think it was a
24 nurse with a master's degree, who had been certified in
25 rehabilitative patient care and she neither testified, nor was

1 her -- her life care plan introduced into evidence. In that
2 case, Dr. Woods used that plan under 703 to support or as a
3 foundation for his analysis, his economic analysis and the
4 Court, in that case, found that the Trial Judge was correct in
5 admitting the evidence. Now, what other issue might you have,
6 Mr. Hood, I think under Hunley, that 703 and 602 analysis, the
7 -- the -- the testimony would be admissible if he could
8 certainly use that. Tell me where we are, okay?

9 **MR. HOOD:** Thank you, Your Honor. So, I think it's, to
10 me this is not an objection based on 703. If it were, I think
11 Hunley would be on all four squares here.

12 **THE COURT:** I think the objection would be that 703 is
13 counterintuitive as the 602, which requires some foundation,
14 but where are we going with your objection; give me something
15 novel here?

16 **MR. HOOD:** So, part of the problem that we have is Mr.
17 Wood, in conducting his work as an expert, takes these numbers
18 and gives us a present value; that's not the issue. The issue
19 is the numbers themselves partially, but the real issue is
20 what is indicated as being necessary. This is a life care
21 plan, it projects the future medical costs and modalities of
22 treatment. In order to do that, a life care plan needs to
23 have a medical foundation or have had an expert witness, not
24 an expert, but a physician or someone with that expertise who
25 is going to opine they've reviewed it, they've indicated that

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1 they have seen the life care plan and they think that it's
2 medically necessary and appropriate.

3 At that point, we would be able to, through that witness,
4 contest the necessity, the appropriateness and the indication
5 for the duration of those modalities of treatment. In this
6 case, the plaintiff had Dr. Adler testify and Dr. Adler
7 testified about some treatment needs that would be necessary
8 like I think if I recall correctly, he said ---

9 **THE COURT:** Who did the life care plan?

10 **MR. HOOD:** The life care planner's name is Vargus.

11 **THE COURT:** Okay. Let me tell you an issue I have. In
12 Hunley the life care planner or the author of the, excuse me,
13 the life care plan was actually, I mentioned a moment ago, a -
14 - a -- a nurse, who had a master's degree and was certified as
15 a rehabilitation care specialist. Now, there was no testimony
16 offered by the nurse. The care plan was not even introduced
17 into evidence. Would that exact same issue not have been
18 present in Hunley?

19 **MR. HOOD:** I don't believe so. Well, the things that you
20 just described were present, but the other issue is the
21 absence here of someone to say that it's medically necessary
22 or that these are items that this child will likely need to a
23 reasonable degree of certainty into the future.

24 **THE COURT:** But there was no one who testified to that in
25 Hunley either. I've read the case and there's no indication

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1 that that was present in that case. We simply have a health
2 care planner. Now, if -- if Mr. -- Dr. Wood were to take the
3 stand and said I had a health care plan that was made by the
4 guy who's pumping gas down at the -- at the corner gas
5 station, I would have a real problem with that. But, if he
6 testifies that this is a health care plan provided by a
7 professional who is recognized in my field as a the
8 appropriate person to prepare a health care plan and folks who
9 do the work I do routinely rely on such plans prepared by such
10 people, then I think it's admissible and that's as far as we
11 have to go with it. Now, of course there could be a counter-
12 testimony by -- offered by the defendants saying, you know,
13 you heard Dr. Woods say that we had to have this, that or the
14 other; have you reviewed these records, you know of medical
15 experts, says yes, I do; is that necessary? No, it's not and
16 I think that would be the way in which it could be approached
17 under the Hunley case. 703 simply says he can rely on it, got
18 to put in the magic words. Yes, this is the type of stuff we
19 rely on. It supersedes 602, which normally requires
20 foundational testimony, but even 602 makes a specific
21 exception for 703. So, I think it's admissible. Generally,
22 I'm going to see if -- what Dr. Woods' testimony is going to be
23 concerning the use of such documents in his field. We'll just
24 see how that goes. All right?

25 **MR. HOOD:** Your Honor, I respect your decision. You

1 asked a direct question, I did not provide you the answer. I
2 don't want you to have made a final decision without having
3 that information.

4 **THE COURT:** I'm sorry. I thought you were done and I
5 apologize.

6 **MR. HOOD:** No, it's -- if you look at the -- in that case
7 at the page, the end of page 298 of the Reporter, right before
8 299.

9 **THE COURT:** I actually, okay. So, 299. Mine is actually
10 not by pages. They're numbered a little bit -- can you give
11 me ---

12 **MR. HOOD:** It would be on 16 of the -- no, that's the
13 Lexus number. Here, let me just hand you a copy.

14 **THE COURT:** I have a Lexus printout here and ---

15 **MR. HOOD:** Do you mind if I just point you in the right
16 direction?

17 **THE COURT:** Yes. Yes, I would. You say it's over near
18 the end of it?

19 **MR. HOOD:** Yeah.

20 **THE COURT:** See, I only go to 14, so I don't have 16.

21 **MR. HOOD:** Let me borrow this for just a second.

22 **THE COURT:** Yes, sir. Everybody's is different.

23 **MR. HOOD:** They've got different headings.

24 **THE COURT:** Yeah, they're different headings and page
25 numbers are different. Let me, I think you're referring now

1 to the paragraph just before Roman Numeral II. It says in
2 each of these cases, the evidence was excluded because it did
3 not meet the criteria set forth under 703. It was not
4 information upon which an expert in the field would reasonably
5 rely in reaching an opinion and/or did not form the basis of
6 the expert's own opinion. Here the evidence does not meet the
7 -- the criteria set forth under 703. Consequently, we find no
8 abuse of discretion. Is that what we're talking about?

9 **MR. HOOD:** Yes, sir. I'm driving you in the wrong spot,
10 I'm sorry.

11 **THE COURT:** The wrong one. Okay. After all that.

12 **MR. HOOD:** I'm sorry. Yes, this paragraph. So, it's the
13 last paragraph of your page 4. Sorry about that.

14 **THE COURT:** The last of 4? All right. Okay. I see you
15 now. Okay. In each of these cases, information was provided
16 to expert and formed a part of the basis for the expert's
17 opinion. The information was of a type relied upon by the
18 experts in their respective fields and that reliance was
19 reasonable. In this case, Dr. Wood testified that the cost
20 figures contained in the life care plan were the type of
21 information relied upon by experts in the field of economics
22 and the Court determined that reliance to be reasonable. As
23 in the -- as to the medical necessity of the future care,
24 there was ample testimony from other witnesses to substantiate
25 the basis for including these elements of damages. Dr.

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1 Tideler, a board certified child adolescent and forensic
2 psychiatrist testified at length. Well, don't we have
3 testimony from Dr. Adler concerning the need of future PT,
4 difficulties that the child will have that will continue,
5 don't we have that sort of thing? I'm not sure exactly what
6 you might want to address in Dr. Woods report or in his
7 analysis; could you help me out on that; is there something
8 that you're saying?

9 **MR. HOOD:** Yes, sir. As you see in that sentence, I
10 think that the last portion of it goes on to say that -- that
11 that Dr. Tideler, Tideler, however you pronounce his name,
12 testified at length as to Gabriel's need for each of the items
13 included in the economists computations.

14 **THE COURT:** Okay.

15 **MR. HOOD:** All right. So, in this case, there's the
16 large component is a \$300,000 item for in home care. To this
17 point at the trial, there's been no testimony from anyone with
18 respect to in home care. That would be the largest ---

19 **THE COURT:** Let's talk with Mr. Graham about that. Mr.
20 Graham, has there been any testimony about the necessity of in
21 home care in the future?

22 **MR. GRAHAM:** Your Honor, may I step up and get the life
23 care plan?

24 **THE COURT:** Sure you can.

25 **MR. GRAHAM:** Thank you, Your Honor. It was marked as a

1 Court's Exhibit as I recall.

2 **COURT REPORTER:** Number 25 and they're in order.

3 **MR. GRAHAM:** Thank you.

4 **COURT REPORTER:** You're welcome.

5 **MR. GRAHAM:** Your Honor, we have the life care plan that
6 Dr. Wood relies upon is in evidence for identification only,
7 Exhibit 25.

8 **THE COURT:** Yes.

9 **MR. GRAHAM:** I tried to get Dr. Adler to talk about his
10 role in creating this and I was -- an objection was sustained.

11 **THE COURT:** My understanding is that he had little or no
12 role in the actual preparation of that document. He had just
13 been provided that document; wasn't that the way it was?

14 **MR. GRAHAM:** Well, no, sir. I mean, I was ---

15 **THE COURT:** Refresh me, refresh my memory.

16 **MR. GRAHAM:** Well, I asked the question words to this
17 effect, what role did you play in the creation of this. There
18 was an objection and I couldn't go into that. I said his name
19 is mentioned in here and it is. So, we've got reports from
20 multiple physicians that the Life Care Planner relied upon as
21 she is allowed to do under Rule 703. Dr. Adler opined the
22 following vocational restrictions; no heavy lifting or
23 carrying, no overhead elevation of right upper extremity, no
24 bi-manual tasks, an inference from that that's proper for a
25 Life Care Planner applies to the home environment as well.

1 That's on page 2 of the report; there's similar comments by
2 other doctors. So, far I haven't seen anything that uses the
3 exact words that Mr. Hoods talking about, but it uses words
4 that permit that inference and are of a type that a Life Care
5 Planner can reasonably rely upon under 703. And then Dr. Wood
6 can reasonably upon those issues that she said and there's an
7 exception under 602 for all of that. So ---

8 **THE COURT:** All right. I'm going to admit it. I think
9 it goes to the weight, not necessarily the admissibility and
10 I'll allow him to testify. Thank you. All right.

11 **MR. HOOD:** Your Honor, I'm not going to reargue. I just
12 want to bring up one more thing.

13 **THE COURT:** You may certainly.

14 **MR. HOOD:** I just wanted to note that the Life Care
15 Planner, Vargas, issued a report in December of 2018 and
16 counsel for the defense requested her deposition to be made
17 available prior to being provided that opportunity, counsel
18 for the plaintiff withdrew her as a witness. So, the
19 defendant has received no discovery other than the Life Care
20 Plan.

21 **THE COURT:** Uh-huh (affirmative response).

22 **MR. HOOD:** We have not received the ---

23 **THE COURT:** But that doesn't block you from still taking
24 her deposition.

25 **MR. HOOD:** If she's no longer their expert, testifying

1 expert, I can't -- I can't depose her.

2 **THE COURT:** Why not?

3 **MR. HOOD:** She's not a witness. There would be no basis
4 to depose her.

5 **THE COURT:** Call her as your own.

6 **MR. HOOD:** Well, the explanation that we got was that she
7 wasn't available; therefore, she was not going to be presented
8 at trial. If she's not available for me, then it's not
9 available. It wasn't that she's no longer -- she's
10 withdrawn. So, I just wanted the record to reflect all the
11 circumstances surrounding this particular creation of a Life
12 Care Plan.

13 **THE COURT:** All right.

14 **MR. HOOD:** And we sent a subpoena for her deposition, I
15 believe, and we never got a response nor did we need one
16 because she wasn't being deposed.

17 **THE COURT:** All right.

18 **MR. HOOD:** And there was no supplemental discovery
19 response from the plaintiff providing underlying material.
20 There should be if they're going to be trying to present her
21 testimony.

22 **THE COURT:** All right.

23 **MR. HOOD:** Or her report, excuse me.

24 **THE COURT:** Thank you.

25 **MR. HOOD:** Either directly or indirectly.

- 1 Q: Good morning, Dr. Wood?
- 2 A: Good morning.
- 3 Q: Could you state your name and address please, sir?
- 4 A: Oliver G. Wood, Jr. Columbia, South Carolina.
- 5 Q: Where are you from originally?
- 6 A: I grew in Greer.
- 7 Q: How long did you live there?
- 8 A: Eighteen years.
- 9 Q: So, tell us about your educational background?
- 10 A: I have a Bachelor's of Science Degree in Business
- 11 Administration from the University of South Carolina; a
- 12 Master's Degree in Economics, University of South Carolina;
- 13 and a Doctorate in Economics from the University of Florida.
- 14 Q: How about tell us about your professional background?
- 15 A: I was hired by the University of South Carolina to teach
- 16 Economics and Banking and Finance courses. I taught at the
- 17 university for 29 years. I'm now Distinguished Professor
- 18 Emeritus translated, that means I'm retired from teaching.
- 19 Q: Have you served in the military?
- 20 A: Yes, I served on active duty with the United States Navy
- 21 from 1959 to 1961.
- 22 Q: What about the reserves?
- 23 A: I served in the Naval Reserve from 1961 to 1987 when I
- 24 retired from the Navy.
- 25 Q: When you retired, what was your rank?

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1 **A:** Captain.

2 **Q:** Do you have any experience, any practical experience in
3 the business world?

4 **A:** I've helped start nine banks and 2 savings and loan
5 associations; served on the Board of Directors of Republic
6 National Bank until we sold that bank; served on the Advisory
7 Board for the Lexington State Bank until it was sold to BB&T;
8 served on the Advisory Board for First South, Bank Meridian,
9 Edisto Farm Credit in Orangeburg; we made farm loans in the
10 lower part of the state; I served on the Investment Policy
11 Committee at the Ag 1st Bank; that's the Federal Land Bank
12 over on Hampton Street. That committee set investment policy
13 for about 1900 active and retired employees. Lastly I own a
14 farm in Tennessee, which is a business.

15 **Q:** Do you have any special experience in the field of
16 investments and if so, tell us about that?

17 **A:** At University of South Carolina, I taught Bank
18 Management; I taught Commercial Bank Management; I taught
19 Money and Capital Markets; and various other courses around
20 finance. In the summers, I taught MBA Field Studies or
21 directed them; those were studies that MBA students went out
22 and performed a total analysis of a business and set some
23 policy up for them; I taught South Carolina Banker's School
24 for 25 years. All of those dealt with investments directly or
25 peripherally.

1 Q: Have you written any books in the field of economics or
2 finance?

3 A: I've authored or co-authored 7 books or monographs.

4 Q: What's your experience in terms of estimating the present
5 value of economic loss in various court cases, personal
6 injury, wrongful death, business loss, those types of cases?

7 A: For the last 50 years, I've made studies of economic loss
8 in cases involving wrongful death, personal injury, business
9 loss, employment termination due to either race, age, sexual
10 discrimination and reported on the results of those studies.

11 Q: What experience have you had in terms of instructing,
12 teaching lawyers about these issues relating to economic
13 evaluation of loss?

14 A: Since 1972, I've appeared in about 25 seminars
15 sponsored by the various bar association groups from 1970 to
16 2004, I was Guest Lecturer in the damages course at the
17 University of South Carolina Law School. In 2004, the
18 professor that taught the course retired and went to
19 Charleston to help start the Charleston School of Law and
20 since then, I have been a Guest Lecturer at Charleston School
21 of Law and seven or eight years ago, they named me their
22 Economist in Residence.

23 Q: How about your methodology, is it in conformity and
24 consistent with them methodology used by others in your field?

25 A: Yes, the basic methodology is one of determining present

1 value and present value is at the heart of modern finance
2 theory. Period. Period.

3 Q: Pardon me?

4 A: I said period. Period.

5 Q: Period. Period. No more questions about that. Your
6 Honor, I would submit Dr. Wood as an expert in the field of
7 evaluating economic loss in personal injury cases?

8 MR. HOOD: No objection.

9 THE COURT: All right. Without objection, he's admitted
10 and ladies and gentlemen, I have explained to you several
11 times during this case the rules concerning experts and the
12 giving of expert opinions and the reasons therefor and that
13 would apply to Dr. Wood as well.

14 BY MR. GRAHAM:

15 Q: Have you been hired by my firm to evaluate the economic
16 issues in this case?

17 A: Yes.

18 Q: What facts have you considered?

19 A: All right. In this case, this child on April 27th, 2013.
20 The alleged injury occurred on that date. The life expectancy
21 of that child at that time was 76.62 years and that's
22 determined by using South Carolina Code Section 19-1-150.
23 That is the code section that specifies life expectancy for
24 men and women. I've assumed that this child, if he had not
25 been injured, had no reason to expect less than a normal life

1 expectancy. Dr. Charles Vanderkolk, a licensed counseling
2 psychologist and certified counselor, evaluated Jahmerican's
3 before injury and after injury earning capacity. According to
4 Dr. Vanderkolk, the expected before injury earning capacity if
5 Jahmerican had not been injured, he would have had the full
6 range of opportunities with regard to physical demands
7 required on occupations listed and found in the American
8 economy. According to Dr. Vanderkolk, the following are two
9 scenarios that Jahmerican would have followed had he not been
10 injured. Scenario One, assuming he would have graduated from
11 high school, taken some college courses and would have begun
12 working at about 9 to 11 dollars per hour. Federal minimum
13 wage is 7.25 per hour, but as we all know, Federal minimum
14 wage is out of date. McDonalds and Walmart have entry levels
15 of about 11 dollars per hour. After 5 to 7 years, he most
16 probably would have earned from in the range of 30 to 45
17 thousand a year or 15 to 22.50 an hour.

18 Scenario Two, assuming that he would have attained a 2 or
19 4 year college degree, he would start at about 14 to 18
20 dollars an hour and after 5 to 7 years, he would have earned
21 in an range of 40 thousand to 60 thousand per year.

22 According to Dr. Vanderkolk, with respect to after injury
23 earning capacity, due to the many problems related to his
24 disability, such as restricted use of the upper extremity,
25 employer attitudes towards persons with a disability,

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1 psychological factors, and a possible need for more medical
2 intervention, it is concluded that there is a real possibility
3 that Jahmerican will suffer a 50 to 100 percent loss of
4 earning capacity. According to Dr. Vanderkolk, it is stated
5 again, that most persons with a disability are not
6 participating in the labor force and Jahmerican has a severe
7 disability. According to Dr. Vanderkolk, at best, however, he
8 is going to be at a distinct disadvantage. He's going to have
9 more difficulty finding an appropriate job and will have more
10 difficulty in participating in competitive jobs on a
11 consistent basis. According to Dr. Vanderkolk, the following
12 two conclusions are meant to follow the occupational
13 projections presented in the previous section on earning
14 capacity if Jahmerican were not disabled.

15 Scenario One, assuming that Jahmerican is able to
16 participate in some level after accomplishing high school
17 graduation, taking some college courses, it is concluded that
18 he will experience a 20 to 28 percent loss in his earning
19 capacity. The other side of that equation is he will offset
20 80 to 72 percent of his loss; it's called mitigating earning
21 capacity.

22 Scenario Two, assuming Jahmerican attains a 2 year or 4
23 year college degree and is able to participate in the labor
24 force, he has concluded that he will experience a 30 percent
25 or 42 percent loss in earning capacity. The other side of

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1 that is he will offset 70 percent or 58 percent of his loss.
2 So, according to these two scenarios, Jahmerican has not
3 experienced 100 percent loss; he's offsetting a big part of
4 that.

5 According to Dr. Vanderkolk, these two scenarios describe
6 the most optimistic future for Jahmerican. Lastly, Ms. Maria
7 Vargas, who has a Master's Degree, Certified Rehabilitation
8 Counselor and Certified Life Care Planner ---

9 **MR. RADECK:** Judge, just for the record, we would like to
10 renew our prior objection.

11 **THE COURT:** Noted. All right. You may continue.

12 **BY MR. GRAHAM:**

13 **A:** Ms. Vargas, has a Master's Degree, Certified
14 Rehabilitation Counselor and Certified Life Care Planner,
15 prepared a Life Care Plan for Jahmerican. Those are the facts
16 taken into account.

17 **Q:** Thank you, sir. Clearly, you obtained those reports
18 before the trial.

19 **A:** Yes, sir.

20 **Q:** Is the information contained in that Vocational Report
21 and that Life Care Plan the type of facts and data that
22 professional in your field would reasonable rely upon?

23 **A:** Yes.

24 **Q:** Is the cost information provided in that Life Care Plan
25 material that you could have found on your own from various

1 sources available to you?

2 **A:** Yes. You want me to go over these first?

3 **Q:** Oh, I'm sorry, sure. Doctor, you've done these
4 calculations, would you kindly, with His Honor's permission,
5 step down in -- in front of the jury and explain your process
6 and calculations if you would please, sir?

7 **A:** Can everyone see these charts? This first chart here, is
8 preparation for other charts. It's entitled Present Value of
9 the After Trial Loss of Earning Capacity under Scenario One,
10 which is the high school scenario compared from age 19 to age
11 67 for a period of 61 years. There is no loss of earning
12 capacity now until 2034.25 when he would start in the labor
13 force. The first step is to take his earning capacity and
14 project that earning capacity over his full life. I would
15 assume that he would receive normal pay increases averaging
16 2.91 percent. 2.91 percent is the average increase in the
17 private sector from 1992 to 2017. It's a period of relatively
18 low pay increases. Over his full life under this high school
19 scenario, he would have earned 5,339,747.

20 However, our court system requires that if we have to
21 look at the money flows today, but those money flows are not
22 going to occur until the future, they have to be discounted to
23 what is called present value. In fact, every state's court
24 system requires that and I've done that. I've discounted all
25 future earning capacity and made it 5 percent compounded

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1 annually. So, for example, in this first year, 14,088 is the
2 present value of what he would have earned. So, when we go
3 through the whole work life of Jahmerican, the present value
4 under the high school scenario is 756,307; that's what we're
5 going to be working with under scenario 1.

6 Chart number 2 is medical care inflation in the United
7 States. The reason we're looking at this chart is because in
8 this case, we have a Life Care Plan and that has future
9 medical expenses in it. So, what does history show; the
10 Bureau of Labor Statistics an arm of the Federal Government
11 collects this kind of data and we go back to 1960, that index
12 was 22.3 and to make it realistic, I set that equal to 100 and
13 then compiled that index from 1960 to 2018. What costs 100
14 dollars in 1960, by the year 2000 costs 1169 dollars and by
15 2018, 2,173. In other words, medical care items are up 21
16 fold in the last 58 years. That's a rate of 5.45 percent per
17 year. You don't have to be a professional economist to
18 understand that we've all experienced medical inflation, and
19 this is the chief index that we measure that by.

20 In this Life Care Plan, we only have 4 items really that
21 are subjected to future inflation. All of these components
22 come from that index I just showed you. There are about 10
23 different sub-indices in it. By way of reference, the general
24 consumer price index has gone up 2.26 percent since 1992.
25 Historically, this is low. We've been in a period of low

1 inflation for 26 years. If we go back to the Vietnam War
2 period, it's up around 5 or 6 percent. One year it even hit
3 13. All right. By comparison, the medical CPI is 3.67. The
4 general CPI includes food, clothing, shelter and everything.
5 Part of that is medical, 3.67. Professional services, this
6 means services provided by doctors, dentists and so forth,
7 2.99. Now, your first question is, why are doctor bills
8 etcetera less than the general medical CPI. The answer is
9 hospital care. Hospital care is up around 6 percent. It is -
10 - it kicks the ball down the field, if you will for medical
11 inflation. It is the most expensive part of the general
12 medical CPI. Special services, medical care commodities, this
13 is the stuff that injured people have to use in their day to
14 day living, 2.76. Services by other medical professionals,
15 2.29. These are the inflation rates we used in this Life Care
16 Plan.

17 Ms. Vargas, the author of this plan, is a Certified Life
18 Care Planner. They go through training and have experience on
19 how to prepare Life Care Plans. A Life Care Plan is a game
20 plan detailing the future medical needs for an injured person.

21 **MR. RADECK:** Objection for the record, Your Honor.

22 **THE COURT:** All right. Thank you. You may proceed and
23 your objection is noted and continuing.

24 **BY MR. GRAHAM:**

25 **A:** This Life Care Plan is relatively short. There is some

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1 plans that go 70, 80 and 90 different elements that are
2 needed. Say for a quadriplegic or a paraplegic. In this one,
3 we have four basic sections. First, is future medical care
4 and needs; physical therapy, occupational therapy, orthopedic
5 evaluation, family counseling and individual counseling. A
6 Life Care Plan has four dimensions. One, the elements; two,
7 the frequency; three, the costs and four, the duration, how
8 long will you need it.

9 Well let's take this physical therapy. She's got it from
10 2019 to age 21. The same with this other, but here in number
11 three, the orthopedic evaluation is every year, 250. This
12 individual counseling and family counseling, one is needed to
13 age 21; the other is needed for life. B, adaptive equipment;
14 these are the things in a Life Care Plan that help the
15 injured, disabled person get through the world better. And
16 you can read down here, what are they; computer one time;
17 grips, bow rings; horn; pulley; toilet seat; hand splint and
18 so forth. The costs of these is not that great, as you can
19 see. How long will she need them; it is specified here she
20 will need them the rest of her life, it's 2019 through life.
21 C is home assistance; the Life Care Plan specified that this
22 child will need assistance for about 2 hours a day for the
23 rest of her life doing things around the house. The annual
24 cost of that is 15,120. Transportation; she's got a one-time
25 number here of a driving evaluation, 3700 dollars. All right.

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1 These are the elements in the Life Care Plan. The element,
2 the frequency, the cost and the duration.

3 We take those different parameters; my job then becomes
4 to figure out what is the costs of financing or funding that
5 Life Care Plan. Here on Chart 5, I have these listed line by
6 line that match up with the Life Care Plan. On the future
7 medical care and needs, 147,000; on the adaptive equipment,
8 7500; the home assistance, the most expensive part, 306,204,
9 that's 2 hours a day for the rest of his life; and then
10 there's a one-time on this transportation evaluation. You add
11 that up you get 462,523. That is the present value of the
12 costs of paying for all of those things she will need the rest
13 of her life.

14 All right. Now, we get to evaluating the loss of earning
15 capacity and we've got two scenarios, as I've said. When we
16 evaluate economic loss, we look at the before trial period and
17 the after trial period. In this case, there is no before
18 trial loss; this is a child, the child is not working. So,
19 there is no loss of earning capacity now. In the after trial
20 period, there is. Step one, if you recall back on Chart
21 Number One, the present value of the earning capacity under
22 the high school scenario is 756,307. This child, under Dr.
23 Vanderkolk's projection, will offset -- he had down here 80 to
24 72 percent of that loss. I took the mid-point. In other
25 words, the child is not totally suffering a total loss of

1 earning capacity. That's the present value that he will
2 offset 574,793 leaving a gap of 181,514. That's the net loss
3 in earning capacity, not either one of these.

4 The cost of that Life Care Plan is 462,523 making the
5 total 644,037. This is scenario one. Assuming that
6 Jahmerican is a high school graduate, works and offsets 72 to
7 80 percent of that offset.

8 Here's scenario two. This is the we'll call it the
9 college scenario. The present value of the earning capacity
10 for this child now is 955,318. But, Dr. Vanderkolk says that
11 the child will offset 70 percent down to 58 percent of that
12 loss.

13 So, you subtract the mitigating or offsetting earning capacity
14 of 611,404 forcing out the net loss of 343,914. The cost of
15 the Life Care Plan is the same 462,523 making the total loss
16 806,437.

17 Now, my job is to present information. I express no
18 opinion of whether scenario one is more appropriate or
19 scenario two. My job is to present the cost evaluation and
20 here it is. The high school scenario is 644,037 up to
21 806,437. And all of these are in present value terms.

22 **Q:** Dr. Wood, are the various facts, opinions and conclusions
23 that you have expressed today, been based on a reasonable
24 economic certainty as to those future economic losses?

25 **A:** Yes.

1 Q: Do your figures include anything for past medical care
2 costs?

3 A: No, past medical care costs are what they are and what
4 tends to happen in these cases is they start out and they add
5 day by day year by year up to the time of trial. It's not my
6 job to go tally those past medical costs. They are what they
7 are.

8 Q: Do your figures include anything for pain and suffering?

9 A: No, pain and suffering is a non-economic loss and I don't
10 evaluate non-economic losses. This is economic loss.

11 Q: Do your figures include anything for the child's loss of
12 enjoyment of life?

13 A: No, same answer, loss of enjoyment of life is a non-
14 economic issue and I have not dealt with non-economic issues
15 in this case.

16 Q: Thank you. Your Honor, we would offer the evidence, the
17 chart, a copy of the charts presented by Dr. Wood?

18 THE COURT: All right. Mr. Hood, he's offering that. I
19 note your prior objections, subject to that ---

20 MR. RADECK: That's correct, Your Honor.

21 THE COURT: All right. I would admit it. Thank you.

22 **PLAINTIFF'S EXHIBIT NUMBER 37**

23 **ADMITTED INTO EVIDENCE**

24 COURT REPORTER: Number 37.

25 MR. GRAHAM: Thank you. Your Honor, we're introducing

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1 Plaintiff's Exhibit Number 37?

2 **THE COURT:** Yes, sir. We just did that.

3 **MR. GRAHAM:** All right.

4 **BY MR. GRAHAM:**

5 **Q:** Dr. Wood, please answer any questions counsel may have.

6 **THE COURT:** Mr. Radeck?

7 **MR. RADECK:** If it please the Court?

8 **CROSS EXAMINATION OF OLIVER G. WOOD, JR. BY MR. RADECK:**

9 **Q:** Dr. Wood, as an economist, your job is to simply
10 calculate the numbers that others provide to you; is that
11 right?

12 **A:** Yes.

13 **Q:** Okay. You're not making any determination in this case
14 about liability or fault; is that right?

15 **A:** Correct.

16 **Q:** Okay. You've worked with Mr. Graham about 20 times?

17 **A:** Yes.

18 **Q:** Okay. And this is -- today in court, this is about a
19 thousand and something times you've testified in trial; is
20 that right?

21 **A:** Yeah, over 50 years.

22 **Q:** About 90 percent of your work in personal injury cases
23 were on behalf of the plaintiff; is that right?

24 **A:** That's right. Under our court system, they have the
25 burden of proof.

1 Q: And you charge 425 an hour?
2 A: Yes.
3 Q: Okay. And how much are you charging for your time here
4 today?
5 A: Whatever the hours are times 425; so, 10 hours.
6 Q: Okay. And you talked about the Life Care Plan by Ms.
7 Vargas. You're not commenting on the appropriateness of that
8 plan, are you?
9 A: No.
10 Q: Okay.
11 A: In cases like this, we accept those Life Care Plans and
12 they are appearing in more and more cases because severely
13 injured people do have huge medical bills.
14 Q: But we're talking about this case ---
15 A: Yes.
16 Q: --- not those other cases, right?
17 A: Correct.
18 Q: And earlier, you said that you couldn't comment on
19 whether scenario one or scenario two was appropriate; do you
20 remember that?
21 A: Yes.
22 Q: Okay. But in reality, you can't comment on whether
23 either one of those are appropriate, right?
24 A: Well, given the facts that I have, those are the two
25 options that I calculated. So, to the extent that that's my

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1 opinion regarding option one and scenario two, yes, that's my
2 opinion. But I said as far as high school scenario or college
3 scenario, I can't comment as to which one is more appropriate.
4 Q: Well, you can't -- you can't comment to whether or not
5 either of those scenarios are medically necessary, right?
6 A: You mean vocationally necessary?
7 Q: No, you're not a doctor, are you?
8 A: No.
9 Q: Okay.
10 A: We're talking about the vocational impairment, that's the
11 earning capacity.
12 Q: Okay. Are you a vocational rehabilitation specialist?
13 A: No.
14 Q: Were you here during trial when we had questions for that
15 rehab specialist?
16 A: No, I read his report.
17 Q: Okay. So, just to be clear, you're playing with the
18 cards that you're dealt and you're not -- you're assuming the
19 facts that have been given to you from this?
20 A: Yes, I assume the correctness of the vocational
21 assessment and the Life Care Plan.
22 Q: Okay. And so the costs in the Life Care Plan could have
23 been obtained by you, right?
24 A: I probably could have gotten it, yes.
25 Q: Okay. But you're not able to determine, again, the

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1 medical necessity of the items in that Life Care Plan, true?
2 **A:** No, you know I am not a graduate of medical school. You
3 know that.
4 **Q:** True is in that I am correct?
5 **A:** That's true.
6 **Q:** Okay. Were you -- did you just get to trial today?
7 **A:** Yes.
8 **Q:** Okay. Do you know whether or not Ms. Vargas has
9 testified in this case?
10 **A:** It's my understanding, she has not.
11 **Q:** If something is not needed in the Life Care Plan and we
12 just simply remove it from your figures?
13 **A:** Exactly, because I have it line by line. If you take any
14 line item and say I don't think we need that, all you have to
15 do is go to the right side, take the number and subtract it
16 from the bottom line. Likewise, if you say you need twice as
17 much of it, you could double it and add it to the bottom line.
18 So, yes, because it's line by line, you can add and subtract
19 very easily. The jury can do that.
20 **Q:** Right and if there hasn't been testimony about in home
21 care, we would just remove that from your figures, right?
22 **A:** If that's not needed, you can just subtract it from the
23 bottom line.
24 **Q:** No further questions.
25 **THE COURT:** Thank you.

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1 are you, ma'am?

2 A: I'm 42 years of age.

3 Q: And where were you born?

4 A: Kingston, Jamaica.

5 Q: When did you first come to this country?

6 A: This country meaning ---

7 Q: The United States?

8 A: Okay. I came here in 1997 in the United States of

9 America.

10 Q: All right. And have you visited Jamaica since then?

11 A: Yes, I came here, to work and go back and forth.

12 Q: So, how long have you been in the United States

13 consistently?

14 A: 6 years.

15 Q: Other than Jahmerican, do you have any other children?

16 A: Yes, sir.

17 Q: Tell us just briefly about them?

18 A: I have a son, his name is Mitchell, he's 26; he's in

19 Jamaica.

20 Q: Any others?

21 A: Yes, Gabrielle, she's here, she's 25; she lives in

22 Florida.

23 Q: Thank you.

24 A: And Shashanka Frances, which is here with me in Andrews.

25 Q: How long have you lived in Andrews?

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1 **A:** For the past 6 years.

2 **Q:** We heard your husband talk about how you guys met. Tell

3 me from your point of view, about getting married?

4 **A:** We met through a mutual friend. He paid her for my phone

5 number and then we start talking over the phone and we became

6 friends.

7 **Q:** And one thing led to another?

8 **A:** Yes.

9 **Q:** How far did you go in school?

10 **A:** I dropped out of high school.

11 **Q:** What grade?

12 **A:** 9th grade.

13 **Q:** And what did you do after that?

14 **A:** In Jamaica, we just -- I just do a little odd jobs here

15 and there until I start doing housekeeping.

16 **Q:** What kind of work do you do currently?

17 **A:** I'm presently a housekeeper still.

18 **Q:** Where do you work?

19 **A:** The Sea Mist Resort.

20 **Q:** And where is that?

21 **A:** It's on Myrtle Beach.

22 **Q:** How long have you been a housekeeper?

23 **A:** Since '96, I've been a housekeeper.

24 **Q:** When you realized that you were pregnant with Jahmerican,

25 what were your reactions to that?

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1 **A:** I was happy, overjoyed, because when I met Anthony, we
2 always talked about like, for me, I was happy because it's the
3 first time I ever planned like a family. All of my children
4 like I was young, so we just -- but with Anthony, it was like
5 planned; we wanted to have a baby.

6 **Q:** Did you have any major problems during the pregnancy?

7 **A:** No, sir.

8 **Q:** Now, I'm going to fast forward to the day when you --
9 well, before we do that, did you get prenatal care?

10 **A:** Yes, sir.

11 **Q:** And where did you get that?

12 **A:** At the clinic next to Food Lion right over there; I don't
13 remember what it's called. I was at -- I went to the church
14 first in Pawley's Island, that's where I went first. Dr.
15 Hletko, Hletko in Georgetown down here, but I don't know which
16 way it was if I went to the clinic first or to Dr. Hletko, but
17 I know it was between those two.

18 **Q:** Okay. Is Dr. Hletko with Dr. Maselli's Office?

19 **A:** No, sir, it's the pediatric center in Georgetown.

20 **Q:** I see. At one point, did you obtain prenatal care from
21 Dr. Maselli's office?

22 **A:** To be honest with you, that clinic, there was so much, I
23 -- I didn't even know -- I don't think I remember who was Dr.
24 Hletko, but I mean, Dr. Maselli, but I know it was at that
25 clinic and that's where they say she's from.

1 Q: Tell me how that would go; would you have a regular
2 doctor there that you would see every time; or did they just
3 rotate doctors and you'd just get whoever was there, whatever
4 doctor or mid-wife was there?

5 A: Like again, sir, I'm not sure because I don't know who
6 was doctors or who was nurses there, I just know I was seen by
7 people on different occasions.

8 Q: Had you ever seen, to the best of your memory, had you
9 ever seen Dr. Maselli during that prenatal period when you
10 were going to her office?

11 A: I cannot recall if I've seen her before or if I've not
12 seen her before. I don't recall.

13 Q: Let's move forward to the day or night when all of a
14 sudden, you knew something important is getting ready to
15 happen. How did you figure out that you were close to
16 delivering Jahmerican?

17 A: Well, based upon experience from my other kids, there was
18 this form of pressure in my lower part, my vagina, if could
19 say, my vagina area. So, I called Anthony mom and I told her
20 I feel like I want to go to the bathroom, but it's
21 uncomfortable. I want to sleep and I can't sleep. I'm
22 feeling like it's peeing down here and I don't know what to
23 do. So, she said, how often is that. So, I said, well I get
24 like a 5 minutes break every now and then it stops. So, she
25 called Anthony niece, she called me and she said, Phillippa,

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1 how are you feeling; so I explained to her there is this
2 pressure every 5 minutes, 10 minutes, I'm not sure at a time
3 because when you in pain, I don't know what anybody is, but
4 when I'm in pain, there is no time, I just need something to
5 get that relief. That's me.

6 **Q:** Let me ask you something. You talked about calling
7 Anthony's mom; why didn't you call Anthony?

8 **A:** Because he was at work. He was on the graveyard shift
9 and for he works with machine and I know if you call him, he's
10 not going to hear unless he's on break or something like that
11 and I didn't know what he was doing at the time. So, I called
12 his mom.

13 **Q:** When is the first time that you saw Anthony after you
14 talked to your mom or after you talked to Anthony's mom?

15 **A:** Well, his niece, she left from work and she came and got
16 me because she was coming off work. So, she came and got me
17 on the way to the hospital. His mother, I suppose, I don't
18 know who reached him, but somebody called him and we saw his
19 truck speeded, so she put on her lights, blinking lights and
20 stopped and I went in the car. That was like halfway coming
21 out of Andrews, coming into Georgetown.

22 **Q:** So, from that point on, who drove you the rest of the way
23 to the hospital?

24 **A:** Anthony.

25 **Q:** Now, let's just pick up there from when you arrived at

1 the hospital. What happened, what do you remember during
2 those initial moments in the hospital; tell us about what
3 stands out?

4 A: Well, I got over to the car. My water broke and I'm not
5 sure if it was police officer or if it was a security guard,
6 but it was somebody in a uniform who came up to us and said, I
7 was apologizing for the mess and the person said, don't
8 apologize, it's okay. Go, he tell Anthony to go and get a
9 wheelchair, hurry up. Anthony said please stay with her,
10 please stay with her. And they said they would and he got a
11 wheelchair and he pushed me up to the -- the hospital and the
12 delivery room.

13 Q: Once you got to the delivery room, was there anybody
14 there besides you and Anthony?

15 A: A lady came in, which I suppose would be a nurse.

16 Q: Okay. So, was she there before you got there, or she
17 came in later?

18 A: She came in just right as they pushed me in.

19 Q: And from that point forward, what stands out in your
20 memory?

21 A: She had this, I'm not familiar with it because she had
22 this big thing look like a computer thing, she was putting
23 something and Anthony was over on this side. So, I keep
24 telling her, ma'am, I need to have the baby because this
25 bearing, it was overbearing coming down. She said, you can't

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1 have the baby, you can't have the baby, you cannot push; wait
2 until the doctor gets here, wait until the doctor gets here.
3 I said, well I'm having the baby, I'm having the baby. So,
4 she keep telling me, don't push, I can't have the baby, just
5 breathe. Being her as a professional and I just did what she
6 told me to do.

7 **Q:** After that?

8 **A:** Well, after that, we keep -- I keep feeling the pain and
9 she said, you can't have the baby, you've got to wait for the
10 doctor. I said, where is the doctor coming from? Well, I was
11 feeling pain, but Anthony was more upset than me because he
12 keep telling her, somebody go get the doctor out there,
13 somebody go call the doctor. She have to wait on a special
14 doctor or whatever, but then, I don't know what time it was,
15 but that's when I saw the doctor. She came and she had a like
16 a cup or something in her hand. She stood at the door and
17 peeped in like this. And then from there on, I start calling
18 for this thing. I said somebody please here all of my
19 girlfriends are at work so they talk about this thing where --
20 that you can get so you can don't feel any pain when you're in
21 delivery. I'm not familiar with it, but at this time, I
22 needed anything, anything or everything they could give me to
23 stop the pain because Anthony was in the corner; he was crying
24 and getting upset, but I needed the pain to stop so I asked
25 that, can you please put the thing in my back because they

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1 said they get a stick, like they stick them in their back, but
2 I didn't know it was like, because I'm afraid of needle, but
3 at that point, I wanted whatever it was. So, this gentleman
4 came and he said I had to sign a paper and he told me to stay
5 still and they placed something in my back.
6 Q: Do you now know that was an epidural?
7 A: Yes, sir, yeah.
8 Q: Did it help?
9 A: To be honest, I'm not sure of the feeling that it gave
10 me. It somewhat, it -- the pressure, the pain that I was
11 feeling eased.
12 Q: I take it then, it did continue ---
13 A: Yes, it did continue.
14 Q: --- at some degree?
15 A: At some point, yes. Not right away, but it did help.
16 Q: Then please take us forward, what do you remember after
17 that?
18 A: I remember then the doctor came back and she said when
19 you -- she peep over like this and she said, anytime you start
20 feeling any pressure, you let us -- you let me know and then
21 she -- she said if you don't have the baby by 7, we will have
22 to do a c-section. I was there still in the thing. By this
23 time they had -- they had two things on the side of the bed; I
24 don't know what it's called, but there was two things for my
25 legs. So, she said, then after that, she said she would have

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1 a c-section so she said if I feel any pressure I should call
2 her. So, I start feeling this tremendous pressure, so I keep
3 calling, I said I'm having baby, I'm having the baby and
4 that's when she came and she sat in front of me. There are
5 two things that they placed my leg in, the bed was like this,
6 so I could see her.

7 **Q:** Let me interrupt you just a moment. Earlier, Dr. Pliskow
8 talked about this photo of another woman in the delivery
9 position. You see where this lady's legs are up on some black
10 objects?

11 **A:** Yes.

12 **Q:** How do -- how do these black objects compare with what
13 you were describing?

14 **A:** Can you turn it?

15 **Q:** Yes.

16 **A:** The difference is this lady, she's laid all the way down
17 and the nurse was standing up, but I was like all the way
18 down, like a little bit up.

19 **MR. RADECK:** Objection.

20 **A:** --- the nurse is standing up, but I wasn't like all the
21 way down. I was like a little bit up.

22 **Q:** Okay. But in terms -- in terms of where you said your
23 legs were located and resting on -- on something that you
24 didn't know what to call?

25 **A:** Yes.

1 Q: Does it look this and this or are you talking about
2 something different?

3 A: It -- I'm not sure if they're that big, but it was the
4 thing that your leg go on.

5 Q: When -- when you put your legs on those, I think they
6 call them stirrups, anyway, when you put your legs resting on
7 top of those things, who all was in the room besides you and
8 your Anthony?

9 A: There was the same nurse, like I said, I don't know if
10 they changed -- if it was the same one that was there all the
11 time or it was a different one, but it was the lady on the
12 computer looking thing.

13 Q: And so there was just that one nurse at that time?

14 A: Yes, sir.

15 Q: Tell us what you remember after that?

16 A: Then the doctor started telling me to push, push, push.
17 So, I keep pushing. Then I remember seeing a next lady. I
18 don't know how she got there, I don't know if they call her
19 before but I didn't hear anybody call for somebody else to
20 come, but by this time, there was two and I was pushing. So,
21 one was on my left side with her arm like this, like this and
22 the other one was on the right side. The lady that came here
23 over here on my left side, earlier she tell Anthony, could you
24 move because he was right next to me and she asked him if he
25 could move. By this time, he went around behind the doctor.

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1 He was right on her right shoulder.

2 Q: Okay. Wait a minute. Let me stop you. Right and left
3 sometimes confuse me. When you say right shoulder, you
4 talking about Dr. Maselli's right shoulder?

5 A: Dr. Maselli's right, yes. So, I start pushing and these
6 two ladies was doing their -- I don't -- I'm not sure if
7 somebody told me or just my normal reaction to try and I stand
8 up, Your Honor? To try to hold right here on my legs to try
9 to prop it so I could help them get the baby out because
10 Anthony -- the -- the -- the doctor, Anthony was shouting at
11 her. I heard stop, stop, why you -- why you pulling like
12 that, why you pulling, stop, stop. I rather you cut her, cut
13 her stomach because I was pushing, pushing and they were doing
14 this in my stomach.

15 Q: Excuse me just a moment, when you say they were doing
16 this; who is they?

17 A: It was two nurses or two doctors.

18 Q: So, how many hands were doing that in total?

19 A: It was four hands; two on this side and two on this side.

20 Q: At that point, was there any other nurse in the room?

21 A: Apart from the two nurse and the doctor and Anthony, I
22 don't remember anybody else.

23 Q: When the two nurses had a total of four hands pushing
24 down on your belly, what was going on with your legs?

25 A: The -- the thing that my leg was in, like I tell you, it

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1 was always there, my leg was in the holder.

2 Q: What I called the stirrup a minute ago?

3 A: Yes, sir.

4 Q: And you said something about, if I understood you, you
5 said something about and I'm sure somebody told you to do
6 this, but you moved it and you tried to lift your legs up
7 towards your ---

8 A: Yeah, like, the nurses was here, but the holder was
9 propped like to try to go like this, but I don't know why they
10 had did that, but I just wanted it to get over because it was
11 hurting and Anthony was kind of getting frustrated. He was
12 cursing and keep telling the doctor, stop pulling, why you --
13 why you doing that, that don't look right, what you doing,
14 don't, don't pull, stop, stop, and I keep saying please,
15 please, please, and ---

16 Q: In terms of what you were doing, were you using either
17 one of your hands or both of your hands to try to keep your
18 legs up?

19 A: Like I told you, what I had each leg trying to help
20 myself to.

21 Q: And as you were doing that, when the nurses were down
22 here pushing and you were trying to hold your legs, did your
23 legs stay in the stirrups or were you able to pull them out of
24 the stirrups?

25 A: No, I don't remember taking them -- I just hold

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1 underneath the leg just trying to help. I don't know what I
2 was doing.

3 Q: You, show us again what your position was; a minute ago
4 you leaned back in your chair, I'm not sure what you were
5 telling us, but can you lean back?

6 A: I wasn't all the way though like the bed -- this part of
7 the bed was a little bit up like this. So, it was kind of
8 like that, not ---

9 Q: All right. But was it parallel with the floor or
10 leaning?

11 A: Leaning a little.

12 Q: All right. Let me do this. I'm going to just hold out
13 my arm parallel to the floor and I'm going to lift it up until
14 you tell me to stop, that's the angle, okay?

15 A: Why you taking your arm up like that?

16 Q: Can you -- can you, Your Honor, is it possible that she
17 can take her chair down here for a second just to demonstrate
18 how far back she had to go?

19 A: I cannot do it with this chair.

20 Q: Okay.

21 A: I'm not able to do it, but it was like in a slant but the
22 bed was a little bit propped up. My back was a little bit
23 more up than that lady that's on the sheet.

24 Q: So, I think are you telling us this, that the bed wasn't
25 flat ---

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1 A: Yes.

2 Q: --- the back part of the bed, that would be your head,
3 was tilted up?

4 A: Yes.

5 Q: All right. Were you able to see anything about what the
6 Dr. Maselli was doing?

7 A: Yes, I could have seen her.

8 Q: Tell us, from your angle now, tell us what you could see?

9 A: She was sitting down. She wasn't standing like the
10 doctor. She was sitting and she was -- I see -- I'm sure I
11 see her movement like this and she would go like -- she would
12 keep -- I don't know what you would say, like you know when
13 you try to put a corkscrew or something and it's fighting you.
14 I don't know how to describe like, what can I use to describe
15 it other than I see like she turning and going like this and
16 that's when like Anthony he getting upset, but as for me, I
17 just wanted it to come out, the baby to come out so I could
18 stop feeling the way I was feeling.

19 Q: All right. I'm going to turn sideways, okay? Could you
20 tell whether her back stayed straight up and down or whether
21 she pulled it back ---

22 MR. RADECK: Objection to leading, Your Honor.

23 THE COURT: Just rephrase it.

24 BY MR. GRAHAM:

25 Q: Yes, sir. Could you tell us please, whether you could

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1 see Dr. Maselli's back and she was pulling and if so, tell us
2 what you saw?

3 **A:** She was facing me. So, like I told you, I could see her
4 like this. I'm like this. This and this and this. So,
5 that's what I could see, sir.

6 **Q:** In terms of -- of gently guiding the head versus pulling
7 forcefully ---

8 **MR. RADECK:** Objection, leading.

9 **THE COURT:** I'll allow it. Go ahead.

10 **BY MR. GRAHAM:**

11 **Q:** In terms of just very gently guiding the ---

12 **MR. RADECK:** Objection, lack of foundation as well.

13 **THE COURT:** Restate your question please.

14 **BY MR. GRAHAM:**

15 **Q:** Could you see how hard this lady was -- what -- let me
16 ask you this. How far down Dr. Maselli's body could you see?

17 **A:** She was on a stool just like you see me like this. I
18 could see this, this part of her.

19 **Q:** Okay. And describe what you saw in terms of what you
20 could see of her arms and her face and you know, her muscles
21 in terms of whether it was on the gentle guidance type of
22 description we heard before or more of a muscular force?

23 **A:** Sir ---

24 **MR. RADECK:** Objection.

25 **THE COURT:** Just ask her what she saw, what she was able

1 to observe?

2 **BY MR. GRAHAM:**

3 **Q:** What did you see?

4 **A:** In the terms of being gentle or like forceful, I'm not
5 sure what a doctor should use because like I'm not sure but
6 the pulling, the twisting, the pulling, honestly, until now, I
7 thought those were normal. Because I don't know what you call
8 this a baby is supposed to be like. I know a baby is supposed
9 to be treated gentle, but she's a professional, so me seeing
10 her doing that, Anthony was getting upset, in my head, it was
11 normal.

12 **Q:** Who could see what was going on better, you or Anthony?

13 **A:** Anthony could see ---

14 **MR. RADECK:** Objection, Your Honor.

15 **A:** --- what was going on better down there, what's going on
16 down there, what I could see her movement; he could see what's
17 going on between my legs, but I could see. Like I tell you, I
18 could see her doing this, this, this. I could see all of that
19 because I can see her body. This top of her body.

20 **Q:** All right. And you had -- you had the epidural that was
21 causing some numbness down there?

22 **A:** Yes, sir.

23 **Q:** So, you -- you couldn't -- what do you remember after
24 that?

25 **A:** Well, after, like I said, when she was doing that, I was

1 thinking it was normal because I couldn't feel if I was being
2 teared, ripped apart or something, but I know what she was
3 doing. Then after the baby came out, I see this gentleman
4 coming with a like a crib thing. So, he put -- she put -- she
5 give him the baby. So, Anthony followed that person and I
6 hear him say, what's wrong, what's wrong, why is the baby arm
7 not moving, why is the baby arm not moving, this arm not
8 moving. Everything else is moving, why because I could hear
9 him. So, by this time, the -- the -- the person that I told
10 you he was with, Anthony was all over the hospital. I was in
11 the room and I could hear the tone and the force because he
12 was real upset by that time. By this time, I don't know what
13 was wrong. I couldn't tell you, but I know I keep hearing him
14 talking about the arm not moving, but as for me, I didn't
15 know, because I didn't even see. The only time I see the baby
16 was when that gentleman, I didn't know what was going on.

17 Q: Before that man rolled out the -- the warmer bed, before
18 he rolled that out, were you allowed to hold Jahmerican or get
19 a good look at him?

20 A: Like I tell you, sir, no, as soon as he come out, she
21 gave him to that man. Then Anthony -- that's when Anthony
22 start following that person.

23 Q: In terms of the movements that you described Dr. Maselli
24 doing, were you -- you said something about not being sure or
25 thinking this might be normal, do you know what's normal or

1 were you trusting your own delivery doctor to know how to
2 treat your baby safely?

3 A: Like I said to you, sir ---

4 MR. RADECK: Objection, Your Honor.

5 THE COURT: I'm going to allow that one, go ahead.

6 BY MR. GRAHAM:

7 A: --- like I said to you, sir, I'm not a doctor; she's a
8 professional. I think what she was doing it was okay, because
9 I don't know how to deliver a baby.

10 Q: Were you just trusting her?

11 A: Yes, I supposed to.

12 Q: When did you first see your baby?

13 A: I saw my baby after they took me to the room.

14 Q: What room are you talking about?

15 A: The hospital room where you -- after they took out the
16 delivery room, they take me down. I think I saw him the next
17 day. It was the same day, you know, but in the -- the -- the
18 brighter day.

19 Q: At some point, did Dr. Maselli come in to talk to you?

20 A: Honestly, to my recollection, I remember we spoke briefly
21 after I had the baby. She -- when Anthony was out there being
22 frustrated and agitated, I remember her saying to me, this is
23 her exact word, aren't you glad I saved your baby life and I
24 said thank God, he's alive. I didn't know what was wrong with
25 my baby. I was just referring to life.

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1 Q: Was, I mean when -- when you had that conversation about
2 being glad your baby was alive, is that something that you
3 just initiated on your own?

4 A: Like I told you, sir, the doctor said to me, aren't you
5 glad I saved your baby's life. I said, because she was
6 telling me something about doo doo inside of me or because she
7 said the baby feces inside of me or something like that and
8 she told me, aren't you glad I saved your baby's life and I
9 said thank God.

10 Q: Did you know whether or not she saved your baby's life?

11 A: Sir, like I told you, Anthony was with the baby talking
12 about his hand. I didn't know if he was dead or alive or the
13 hand was moving or arm wasn't moving, by that time. She told
14 me, so I told her thank God he's alive.

15 Q: Did you have any way to -- to know if the information she
16 gave you was accurate or were you just trusting her as a
17 professional or what; how would you describe your reaction to
18 what she said?

19 A: Like I said, sir, if you are sick, to get better you go
20 to the doctor and you have to trust them because you want to
21 get better and you know they know better. So, I was trusting
22 her everything she said.

23 Q: If the question to you is are you glad your baby's alive,
24 I mean, is there any other answer to that question besides
25 sure, sure I'm glad my child is alive?

1 **A:** I don't know of no other answer.

2 **Q:** Let me show you what's been marked as demonstrative

3 exhibit 2-A and I'm going to read you these first words. I'm

4 just going to read it and I'm going to hold it over here and

5 I'll show it to you in a moment.. We've got PPD1, which I

6 believe has been described as postpartum day 1, meaning the

7 first day after birth. Up here is shoulder dystocia. The

8 patient and especially her husband are appropriately concerned

9 regarding the baby's movement. Mom grateful baby is "alive".

10 Is -- did you have any conversation with Dr. Maselli about

11 being glad your baby was alive other than the one you just

12 told us about?

13 **A:** If I told her thank God my baby's alive, I guess she

14 interpreted it that way.. Yes, I was happy he was alive.

15 **Q:** But that's the same conversation you described to us?

16 **A:** That's the same conversation.

17 **Q:** Well, let's go forward. Well, is there anything else

18 that you believe was important that you remember before you

19 and Jahmerican were discharged from the hospital?

20 **A:** Yes, I remember the pediatrician told me. I was crying

21 because I mean, you have -- you've been guilty, everything, I

22 was wondering if I did something because the arm wasn't

23 moving. They bring the baby. They placed the arm, I couldn't

24 see the arm, I had to pull the thing off, so I could see the

25 arm. And he came in and he said, why are you crying and I

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1 said, did I do something, why is he not -- why the arm is like
2 that and he said, oh, don't worry about it, one in every 10
3 baby born that way. It will be okay. So, I was assuming
4 maybe like that's what he was the pediatrician, so I was
5 assuming this too was normal and baby in a couple of weeks or
6 maybe a month or so that the baby will be fine because that's
7 what he told me.

8 **Q:** All right. Let me make sure I understood part of what
9 you said. It sounded like you were giving us some figures
10 about how often this happens; is that ---

11 **A:** Yes, sir.

12 **Q:** Tell us -- tell us how many times out of how many times
13 did he tell you this happens?

14 **A:** He said 1 out ---

15 **MR. RADECK:** Objection, Your Honor.

16 **A:** --- of every 10 babies born that way. Whatever the
17 figure is, he said 1 out of every 10 babies; that's what he
18 told me.

19 **Q:** Anything else important occur in the hospital before you
20 and Jahmerican left?

21 **A:** Not that I remember.

22 **Q:** Okay. Let's move forward.

23 **THE COURT:** Now, I'm going to give this jury a break now,
24 Mr. Graham. The jury can be taken to their jury room. We
25 seem to be at a point that they can have a mid-morning break.

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1 Take them to their jury room.

2 **REPORTER'S NOTE:** (Jury retires to jury room 11:38 A.M.)

3 **THE COURT:** No, ma'am, stay right there please.

4 We're going to take a ten minute break. Do not discuss
5 your testimony with your attorney please. Thank you.

6 **(COURT IN RECESS)**

7 **THE COURT:** Get the witness back on the witness stand and
8 try to proceed, okay? Come back around, Ms. McCray. Get my
9 jury for me, please.

10 **REPORTER'S NOTE:** (Jury enters courtroom at 11:48A.M.).

11 **MR. GRAHAM:** Please be seated please.

12 **THE COURT:** Well, the jury is coming in. All right. We
13 have our jurors and our alternates back in. You may continue,
14 Mr. Graham.

15 **MR. GRAHAM:** Thank you, Your Honor.

16 **BY MR. GRAHAM:**

17 **Q:** I believe the last thing we talked about was a
18 conversation you had with Dr. Maselli in the hospital. Was
19 anyone else there; was Anthony there personally?

20 **A:** What conversation?

21 **Q:** I'm sorry, the one where --

22 **A:** Where the pediatrician met with us.

23 **Q:** --- she asked you if you were glad your baby was alive,
24 but she didn't save his life; was Anthony there then?

25 **A:** I cannot recall, but the last conversation we had was

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1 when I spoke with the pediatrician.

2 Q: Could you say that a little bit louder please?

3 A: You -- what was your question, sir?

4 Q: I had asked you if Anthony was in the room, I believe you
5 said you don't know and then you were starting to say
6 something about I remember ---

7 THE COURT: That wasn't your question. Ask the question
8 again. I don't think she remembered the question. The
9 question was, was anyone else in the room?

10 MR. GRAHAM: Oh, I see. I thought there might have been
11 one more.

12 BY MR. GRAHAM:

13 Q: Was there anyone else in the room?

14 A: On which conversation?

15 Q: The one ---

16 A: With Dr. Maselli or with the pediatrician?

17 Q: Oh, I see. With Dr. Maselli, when you were talking about
18 are you glad she saved your son's life or words to that
19 affect?

20 A: I mean, honestly, I'm not sure if it was just both, I'm
21 not really sure.

22 Q: Any other memories stand out in your mind for the rest of
23 the hospital stay before you and your son were discharged?

24 A: Apart from the conversation with the pediatrician.

25 Q: Oh, tell us about that? Oh, or have you already told us

1 about that?

2 A: Yes, I did. Yes, I did, sir.

3 Q: That was the one in ten?

4 A: Yes, sir.

5 Q: Now, I want to make sure we cover one point. When you

6 were -- when the ladies were pushing on your stomach area, was

7 there ever a time when the doctor or the nurse told you to

8 stop pushing?

9 A: No, sir.

10 Q: Tell us whether or not you were instructed to keep

11 pushing?

12 A: Yes, sir.

13 Q: By whom were you instructed to do that?

14 A: The doctor.

15 Q: Let's fast forward, did you see Dr. Maselli again after

16 you left the hospital?

17 A: Yes, sir.

18 Q: What was the occasion for that?

19 A: That was my 6 weeks.

20 Q: What did she ask you at that time about Jahmerican and

21 how he was doing?

22 A: The doctor didn't even -- she -- she didn't ask me

23 anything about Jahmerican. She just look after me, check me

24 up, said I was doing fine and me being smart mouthed, I said,

25 and my baby is fine too. I was being -- I don't know what you

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1 call it, but to me, I think I was being smart.

2 Q: Okay. What was your -- what were your feelings when she
3 didn't ask about Jahmerican?

4 A: I felt disrespected, I felt bad because when I -- when I
5 went for the 6 weeks, to be honest, she was checking me while
6 I was still thinking in my mind, she would have asked
7 something like how was your baby doing in the condition he
8 left the hospital, but she never did.

9 Q: Have you ever seen again until this trial?

10 A: Yes, I've seen her before today.

11 Q: Okay. When was that?

12 A: We were somewhere at Myrtle Beach.

13 Q: All right.

14 A: Yeah, with you and everybody.

15 Q: Oh, you're talking about a legal proceeding?

16 A: Yes, sir.

17 Q: All right. Apart from a legal proceeding, have you seen
18 her anywhere else?

19 A: I don't remember seeing her.

20 Q: All right. Let's move forward. Were you involved in the
21 treatment that Jahmerican received over the last six years or
22 so?

23 A: Involved meaning?

24 Q: Did you either attend those visits with various
25 healthcare providers or you and Anthony both went or you went

1 or something like that?

2 **A:** Okay, sir. I asked you where involved because I think
3 that's my duty, yes, I was always there.

4 **Q:** I'm going to -- I'm going to ask you some questions ---

5 **REPORTER'S NOTE:** (Bench conference with counsel).

6 **MR. GRAHAM:** I beg your indulgence, Your Honor.

7 I offer into evidence at this time, a summary of various
8 treatment dates and the type of treatment from 2013 to 2018.

9 **THE COURT:** Well, I'll let you mark it for identification
10 right now, but we're going to have someone testify to it.

11 **MR. GRAHAM:** Okay. Could you mark that as our next
12 numbered exhibit for ID only at this point?

13 **COURT REPORTER:** That will be number 38.

14 **MR. GRAHAM:** Thank you.

15 **BY MR. GRAHAM:**

16 **Q:** Excuse me, Phillippa, I hand you a document that's been
17 marked Exhibit 38 showing -- showing the dates and the
18 provider, the services, the notes and did you provide some
19 assistance to my office in terms of the creation of this
20 document?

21 **A:** Yes.

22 **Q:** Based on the work that you did with Eugene, to the best
23 of your knowledge, are these dates and other information true
24 and accurate?

25 **A:** Yes, sir.

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1 **MR. GRAHAM:** Your Honor, at this time, we would move it
2 into evidence?

3 **THE COURT:** All right. Subject to your objections.
4 Okay.

5 **MR. RADECK:** Rule 1006, Your Honor.

6 **THE COURT:** All right.

7 **PLAINTIFF'S EXHIBIT NUMBER 38**

8 **ADMITTED INTO EVIDENCE**

9 **MR. GRAHAM:** Thank you.

10 **BY MR. GRAHAM:**

11 **Q:** Do you have the exhibit in front of you?

12 **A:** No, sir.

13 **Q:** I'm sorry. I hand you Exhibit 38. We have here a
14 calendar of 2013 and we've started with April 7, I'm sorry,
15 April 27th is marked in green. Anything important happen on
16 that day?

17 **A:** The birth under April.

18 **Q:** All right. Now, after that, we've got a number of
19 colored notations here. Is it your understanding that the
20 reddish color represents therapy visits?

21 **A:** Yes, sir.

22 **Q:** Is it your understanding that the yellow, most of the
23 yellow means doctor visits?

24 **A:** Yes.

25 **Q:** Is it your understanding that yellow with an S on it

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1 means surgery?
2 A: Yes, sir.
3 Q: So, does -- do these dates and color codes match the
4 dates that Jahmerican had the therapy and doctor visits and
5 the surgeries?
6 A: As far as I can remember, yes, sir.
7 Q: So, his first surgery was on September the 11th; does
8 that sound right and you can fill free to look at this if you
9 want to, but ---
10 A: You're asking me?
11 Q: Yes, ma'am?
12 A: Okay. I think you were saying it.
13 Q: Okay. Was Jahmerican's first surgery at MUSC on -- on?
14 A: The 9th and the 11th, sir.
15 Q: I'm sorry, the 9th?
16 A: The consultation was the 7th.
17 Q: Okay. And the surgery was a few days later. All right.
18 And then the second surgery was in ---
19 A: In October.
20 Q: --- October?
21 A: Yes.
22 Q: Just past the middle part of October?
23 A: Yes.
24 Q: All right. So, there was therapy before the surgeries
25 and therapy after the surgeries?

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1 A: Yes, sir.

2 Q: I'm going to display some pictures. Hopefully the
3 technology will work. Do you have a screen?

4 A: Yes.

5 Q: All right. So, could you put the first photo up there
6 please? All right. Look at what you have in front of you on
7 the screen there and tell us what that is?

8 A: The one -- the one on the bottom was after the surgery.
9 The one on the top, where he's in the photograph was when we
10 brought him home and the one with the brace on his arm and his
11 leg propped up, that's when we took him to the clinic.

12 Q: Let's move on to the next year, 2014. These are therapy,
13 I mean, you've got the -- you've got the page in front of you.
14 So, these reddish numbers on these days represent the days
15 that you took Jahmerican into therapy, you or Anthony took him
16 in for therapy?

17 A: Yes, sir.

18 Q: And there's only two yellow numbers or dates on here, are
19 those some physician visits?

20 A: Yes, sir.

21 Q: And let me just let me go with these real fast. This,
22 well, do we have any photos. All right. Let's go -- please
23 go through the photos in front of you, ma'am, and tell me what
24 you can see or tell me what is -- what is shown on those
25 photographs?

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1 A: The one that he's dressed in a suit was we took him to
2 church. And the one he was eating something his father gave
3 him something.
4 Q: Okay. And are those photos taken the year we just went
5 over, 2014?
6 A: Yes, sir.
7 Q: All right. Now, I'm going to hold up the calendar for
8 2015. We've got the same color coding; does this represent
9 therapy visit dates?
10 A: Yes, sir.
11 Q: And one yellow indicating a doctor visit?
12 A: Yes, sir.
13 Q: Do we have those photos to show? All right. Look at the
14 photos in front of you now from 2015; well, are they from
15 2015?
16 A: Yeah, this one is Easter.
17 Q: Okay. Tell us -- tell us about those photos?
18 A: Anthony brother lives in Columbia. So, normally we would
19 go to church, we would visit his church sometimes. So, we
20 went for the Easter.
21 Q: Is that the only photograph or are there more?
22 A: We have photograph, but I'm not sure if you have all of
23 them, but this is one photograph. It's only one right here.
24 Q: Okay. I don't have a screen to see. So ---
25 A: Yes, sir.

1 Q: There's only one photograph there?

2 A: Yes, sir.

3 Q: All right. All right. Now, I'll hold up 2016. Again,

4 we've got red for therapy visits. Are those -- is that your

5 understanding?

6 A: Yes, sir.

7 Q: And then there is, right in the middle or close to the

8 middle of this year, there's a yellow with a red S on it; is

9 that the first surgery that was at Shriner's?

10 A: Yes.

11 Q: All right. Do you have photos from 2016 that you can

12 show us, just to get an idea of what was -- some images from

13 his life at that point? Please describe those.

14 A: He's now wearing a blue brace because each stage of his

15 life, when he goes for therapy or they try to change the brace

16 to accommodate his growth or whatever. The top picture, his

17 grandma was with him because he doesn't like taking pictures

18 unless we are there. So, this was a school photo his grandma

19 went with him. She help him fix up so he could pose for the

20 picture. He was fine. And he was at school one morning his

21 father took him to school.

22 Q: Any other photos?

23 A: Yes, the bottom one.

24 Q: Did you just tell us about the bottom one?

25 A: Yes, I did.

1 Q: Okay.

2 A: That's when his father took him to school.

3 Q: Thank you. And in 2017, we've got all red, so these are
4 therapy visits?

5 A: Yes, sir.

6 Q: All right. Do you have photos that give us some idea of
7 some events in his life in 2017?

8 A: Well, for Jahmerican, his father is his best friend
9 because -- we would go to like restaurants because he is
10 really afraid because children talk about his arm and he
11 doesn't want to wear like short sleeve unless he's with us or
12 close to us with his father. He always said his father is his
13 best friend. For me, it -- it -- it kind of, I mean every boy
14 growing up, you know their father is their hero or whatever,
15 but I wish like we could have like other children that would
16 accept him, because the arm don't have no feeling, so
17 sometimes we'll see like, maybe he will fall and hurt himself
18 sometime, maybe we'd see like a scratch or something on our
19 son and when we asked and he'd say, he would tell you, I don't
20 want to talk because they're not gone play with me. You have
21 to explain to him, that's not playing; that's hurting, because
22 he doesn't know what his arm feeling will get closed in the
23 door and don't even know until you probably will see the door
24 and try to move and then, but this is one of them day we just
25 try to go somewhere.

1 Q: Any other photos up there?

2 A: There is two; one with his father in the pool because he
3 loves the water. He wants to learn to swim, but we don't know
4 how to go about getting somebody to teach him or because he
5 loves the water and the other one we went to the restaurant.

6 Q: And the last one we have for 2018, just has one entry and
7 that's for the surgery; is this the second surgery at
8 Shriner's?

9 A: Yes, sir.

10 Q: All right. Do you have photos there; we have photos
11 shown for 2018, can you confirm those are from 2018?

12 A: Yes, sir.

13 Q: All right. Tell us about those please?

14 A: The one to the top, that's his father and his niece, his
15 grandniece. That will be Anthony and his grandniece and
16 that's Anthony his birthday, we took him for dinner because he
17 doesn't -- we don't -- because he doesn't like being around
18 children now that he's growing -- we will take him because
19 right now, the bottom was a picture with a service dog; that's
20 after his surgery and this is the happiest place he has been
21 with children because everybody look alike. So, even when we
22 went -- when we got to Shriner's, he doesn't want to come
23 home. He asked if he could stay there. We have to explain to
24 him, I let him know this is not a home, baby, this is a
25 hospital. He's -- he's more comfortable there because

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1 everybody looks, I mean, not to be like trying to talk about
2 kids like, you know, trying to say, everybody just look like
3 what he wants them to like. He talks to them, he plays with
4 them, he's so happy when he's there.

5 The other one is the top one with the Santa Claus, that
6 was like one of the hardest pictures for him to take because
7 he didn't want to go with Santa Claus; he said he was a
8 stranger. And though I take picture with stranger, because
9 he's like that and kind of conservative; he's shy though.

10 And the bottom one, after the surgery, for us to try to
11 make him feel good for going back home because every time he
12 visits Shriner's, he doesn't want to come home. He doesn't --
13 he just want to stay there because what they does when he go
14 there, they will make him stay for the night or so or two
15 night, whatever they have rooms. So he feels comfortable
16 there. So, sometimes for us to trick him to get him to go
17 back home, we tell him, we go take you to the zoo and we will
18 take you back. So, the bottom picture here where you see the
19 number on his shirt with an animal behind him where we take
20 him to the zoo, so we could get him to come home without like
21 crying or being upset or anything.

22 Q: When he is around other children outside the hospital,
23 have you observed how they treat him and if so, please tell us
24 about that?

25 A: Well, to be honest, we kind of shadow him a lot because

1 it -- because of his uncomfortableness. Around kids now
2 that's he's growing, he's more aware and we will try to take
3 him to the park, his father and I, there's a park in Andrews
4 we take him, but he doesn't want to slide, he doesn't want to
5 do anything because the kids, I remember there's a what do you
6 call it, like an apartment in Andrews. I have a girlfriend
7 live there. So, I took him there one day and the kids they
8 were playing and he try to go up on the -- the monkey bar and
9 he fall out because when he go on the monkey bars, his father
10 is always there to prop him, like hold him, make him feel like
11 he's got it, you know. The children, them sometimes, they
12 would laugh. Sometimes they -- they said they want to touch
13 him because his arm is like a doo doo, but we try to kind of
14 shelter him a little bit apart from when we, Anthony and I
15 will discuss it, if we were educated enough we probably would
16 have home schooled him just to. Because when we went to the
17 Shriner's, I remember before his surgery, we was trying to
18 explain to him and we were praying and his father always say
19 Jahmerican, it's our time to say a prayer. I -- he's only 5
20 and he said, Jesus, can you please give me a new arm so my
21 mommy and daddy can be proud of me. We always proud of him.
22 We try to explain to him that you're not different and we're
23 proud of you, but I don't know if I, it's a day to day
24 challenge for us because he's happy some days and some days
25 he's not. He's like just different. Sometime, we don't even

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1 know what to tell him to make him feel like -- we just have to
2 tell him you're special and you're going to be okay.

3 Q: Thank you. Please answer any questions counsel may have.

4 THE COURT: Mr. Radeck?

5 MR. RADECK: If it please the Court?

6 CROSS EXAMINATION OF PHILLIPPA SMALLING MCCRAY BY MR. RADECK:

7 Q: Good afternoon, Ms. McCray?

8 A: Good afternoon.

9 Q: During the delivery of Jahmerican, Dr. Maselli was
10 sitting on the stool the entire time; is that correct?

11 A: When I was pushing, yes, sir.

12 Q: When you were pushing, she was never standing up,
13 correct?

14 A: Yes, sir.

15 Q: I'm sorry?

16 A: She was never standing, sir.

17 Q: And earlier, you described seeing Dr. Maselli from what
18 appeared to be the waist up?

19 A: Yes, sir.

20 Q: And you were not able to see her hands, correct?

21 A: I could not see her hands, but I like I told you, I could
22 see her, this upper part of her body, the movements, I could
23 not see what her hands was doing.

24 Q: Okay.

25 A: I could see this.

1 Q: So, you couldn't see whether her hands were moving to the
2 side?

3 A: Sir, again, I couldn't see her hands, but she was doing
4 this. So, that's what I saw.

5 Q: I just wanted to make clear because what you're doing on
6 the stand is you're using your hands like this. I just want
7 to make sure I'm clear, you can't see whether her hands are
8 doing this, right?

9 A: The reason why I place my hands like this because is the
10 way you hold a baby, I suppose. I'm just doing my hands, all
11 right, can you show me or can I show you her movement without
12 me doing my hand like that; can you please show me?

13 Q: No, that's fine. I'm just confirming. I understand, but
14 you're -- you're assuming that they may have been happening
15 below your level of vision, you weren't seeing what her hands
16 were doing; whether they were standing still, whether they
17 were moving; is that right?

18 A: All right. She was like this. Can you -- you understand
19 me now?

20 Q: Is -- is that demonstration consistent with what you did
21 earlier with your lawyer?

22 A: Sir, I only place my hand like that because her hand was
23 inside or right down here. So, I placed my hand like this and
24 I was showing you the body movement; your left hand, that's
25 what I was doing. But for me seeing this part of her hand, I

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1 did not.

2 Q: So, she was -- her body was swaying?

3 A: Yes. and pulling back like this.

4 Q: Okay.

5 A: So, she had her hand like this and doing this and this, I
6 guess that's what I could see. I was just doing my hand like
7 that just assuming that you're holding a ball, that's what I
8 was doing.

9 Q: I'm going to move on. Prior to the delivery, you didn't
10 have any criticisms of Dr. Maselli or her practice, correct?

11 A: Like again, sir, I don't recall seeing Dr. Maselli, but
12 if that was her clinic, no, I did not.

13 Q: On these demonstratives you were showing earlier by Mr.
14 Graham, I noticed here at the end of 2015, it looks like from
15 August there's no -- no -- on to the end of the year in
16 December, there's no markings for any sort of therapy visits
17 or anything, right?

18 A: All right. In 2015, there was like a break because in
19 2015, when the -- the therapist that he had, she was going out
20 to have a baby, she was gone leave. So, we was instructed by
21 the -- the -- the next day, as soon as they get a replacement,
22 they would let us know, but they gave us like a chart or a
23 piece of paper what it's called for us to do home therapy.

24 Q: And going into 2016, there's also no visits from January
25 until through May of 2016; is that right?

1 **A:** When we went -- when we call them, we told them about the
2 Shriner's. So, we was visiting the Shriner's. So, they say
3 it was okay and as soon as we get done, we should get back
4 with them.

5 **Q:** And in 2018, it looks there was the surgery on April 5th
6 and no other -- no other doctor's visits or therapy visits in
7 2018, correct?

8 **A:** In 2018, there should be marks for the therapy in 2018
9 for the Shriner's. But in 2018, we -- they told us they would
10 make appointment and get back. They gave us, like again I
11 told you, the -- there was a new lady that came to the next
12 day. We went there, she also left. They told us they would
13 get back in touch with us and they gave us a chart like this
14 so we could do home therapy. We do every single day as much
15 as we can. They tell us to do it at least two to three times
16 a day and we did. We spoke to Dr. Z after his surgery and I
17 guess they will inform us from that because they said he needs
18 surgery -- he needs therapy.

19 **Q:** Did you -- did you help prepare the summary that led to
20 the creation of this demonstrative?

21 **A:** I was with not, Mr. Graham, with the other man.

22 **Q:** Okay. All the times that you interacted with Dr.
23 Maselli, she was never impolite or rude to you, correct?

24 **A:** Apart from the -- to the one where she said aren't you
25 glad I save a life, your baby's life and the next time we

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1 spoke was just like I tell you, I was being smart mouthed.

2 She was never rude to me.

3 **Q:** So, your response to my question unequivocally was has
4 Dr. Maselli ever been rude or impolite to you; your answer is
5 no?

6 **A:** No, she has never.

7 **Q:** Thank you. That's all the questions I have. Thank you.

8 **THE COURT:** All right.

9 **MR. GRAHAM:** No questions, Your Honor.

10 **THE COURT:** Very well. You may step down. Thank you.

11 Ladies and gentlemen, it's 12:30. I'm going to let you
12 go to lunch and I would ask you to be back at 2, okay?

13 **REPORTER'S NOTE:** (Jury excused for lunch 12:27 P.M.).

14 **THE COURT:** All right. Back at 2. Brett, have they been
15 sent a charge?

16 **LAW CLERK:** No, sir.

17 **THE COURT:** We have prepared a skeleton, a base charge
18 for this case. I'd ask you to please familiarize yourself for
19 it. I made it abundantly clear that I always give my jurors a
20 transcript of the charge. If you have additional charges that
21 you want to have added, I need to know that. I do not add
22 another charge simply -- that is simply redundant. Please,
23 read the charge; if I have covered it, I'm not going to put it
24 in two or three times. I charge it once. That keeps my charge
25 concise and clear. But if you have additions or exceptions to

1 the charge, let me know well in advance so we can have this
2 prepared and ready to give to the jury immediately upon or
3 after your arguments. Thank you very much.

4 **MR. GRAHAM:** Thank you, Your Honor.

5 **(COURT IN RECESS)**

6 **MR. HOOD:** Judge, I think we've resolved the technology
7 issue.

8 **THE COURT:** Mr. Graham, why don't you go ahead and rest
9 on the record then and let's go ahead and address these
10 motions and as I said, when the jury comes back in, you can
11 rest and we can, if we need to, we'll go forward at that
12 point. All right?

13 **MR. GRAHAM:** Yes, Your Honor. The plaintiff rests.

14 **THE COURT:** All right. Mr. Hood, Mr. Radeck?

15 **MR. HOOD:** Your Honor, Jamie Hood, on behalf of the
16 defendants at this time, pursuant to Rule 50 of the South
17 Carolina Rules of Civil Procedure, plaintiff has closed their
18 evidence in their case in chief and we would respectfully move
19 for a directed verdict as to all claims with particular focus
20 on the causation component, the plaintiffs identified Dr.
21 Adler, who came in and testified about his opinion. In his
22 opinion is that there was excessive lateral traction and in
23 his opinion, that caused, approximately caused the harm.

24 The reliance that he has to formulate that opinion is not
25 based on what happened in the delivery room, but is a function

1 of the fact that the injury occurred and I don't think that
2 the injury is speaking for itself is sufficient under South
3 Carolina Law to prove causation.

4 **THE COURT:** Okay. I think the jury may consider all the
5 evidence and any inference which may reasonable inference may
6 be reached from the evidence and I think, in that regard,
7 there is evidence upon which the jury could reach a verdict
8 for the plaintiff and I'm going deny the motion on those
9 grounds. Who do you have other grounds?

10 **MR. HOOD:** I do. With respect to the allegations or
11 claim for punitive damages, Your Honor, plaintiff hasn't
12 presented evidence sufficient to warrant the charge or award
13 of punitive damages in the absence of willful, wanton, or
14 reckless conduct. I don't think it's appropriate; they
15 haven't closed the evidence. I think now would be the
16 appropriate time to move for that.

17 **THE COURT:** Well, let me talk to you each about that.
18 First of all, if the jury were to determine this was an
19 emergent situation and there's certainly been evidence even
20 from the plaintiffs' side to indicate that that might
21 certainly be the case. In that case, the statute would
22 require, as I understand the statute, in an obstetric
23 situation, a finding of gross negligence; am I correct?

24 **MR. GRAHAM:** Yes, sir.

25 **MR. HOOD:** Yes, sir.

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1 **THE COURT:** Okay. What is the standard of proof, the
2 proper standard of proof in a finding of willful, wanton,
3 reckless, gross negligence? Now, if we were looking at -- if
4 this were a normal or an ordinary personal injury case and the
5 jury was asked to determine punitive damages, which are of
6 course, it follows from a finding of gross negligence,
7 recklessness and what is the standard there; the standard
8 there of course is clear and convincing. Okay? Now, does
9 that standard apply to a finding of gross negligence in a case
10 like we have before us here, should the jury determine that it
11 was an emergent situation?

12 **MR. HOOD:** Your Honor, I don't think you would apply the
13 clear and convincing standard to the ---

14 **THE COURT:** If find nothing to indicate that.

15 **MR. HOOD:** The statute is silent on it and I think under
16 our procedural law and our interpretation of legislation ---

17 **THE COURT:** Preponderance.

18 **MR. HOOD:** Preponderance.

19 **THE COURT:** Okay.

20 **MR. HOOD:** I think if you go to punitive damages, you
21 then go back to the clear and convincing.

22 **THE COURT:** Okay.

23 **MR. GRAHAM:** Moreover, they have the burden of proof of
24 that.

25 **THE COURT:** Yes. All right. Now ---

1 **MR. HOOD:** It's hard for me to say that because they
2 should have fixed that when they wrote the statute, but they
3 didn't.

4 **MR. GRAHAM:** They should have fixed lots of things.

5 **THE COURT:** Yes. Now, Mr. Graham, talk to me about
6 punitive damages. Tell me about the requirement, tell me
7 about the limitations on damages; what do you think?

8 **MR. GRAHAM:** We're talking according to the common law or
9 emergency statute?

10 **THE COURT:** Either because I think both could apply here.

11 **MR. GRAHAM:** Well, in terms of -- it seems to me, in
12 terms of the statute, first of all, we've got the words of the
13 statute are grossly negligent and this may be a very -- well
14 certainly one thing about it is they've got the burden of
15 proof; the only standard is preponderance as to gross
16 negligence.

17 **THE COURT:** Isn't a jury then going to be asked to apply
18 two standards?

19 **MR. GRAHAM:** It seems to me, they would be if -- if -- if
20 emergency statute is a jury question and we argue that it will
21 not be, but their evidence hasn't come in yet.

22 **THE COURT:** But that would be a jury question as well, I
23 believe. Whether the jury deems it to be an emergent
24 situation.

25 **MR. GRAHAM:** Yes, sir, but it has to be not only an

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1 emergency has to be a genuine emergency; that's not defined.
2 It has to be an absence of medical stability; that's not
3 defined, but there's evidence in the record that there is
4 medical stability and I know what the depositions are going to
5 say about that. Also, we have immediate threat. Immediate is
6 not defined. And then we've got grossly negligent.

7 **THE COURT:** But those are fairly simple terms. I mean,
8 they're given their plain and ordinary meaning absence some
9 other defining statute or -- or case law. I mean, isn't that
10 the rule?

11 **MR. GRAHAM:** If, Your Honor, please, we've got the
12 multiple appeals. I just had an oral argument with Court of
13 Appeals the other day about some of these very issues.
14 Charlie Henshaw has one going up about some of these issues.
15 I personally believe, until we have Appellant Law, we can't be
16 sure what it is.

17 **THE COURT:** But then, don't we go to the -- to the -- the
18 common meaning then?

19 **MR. GRAHAM:** Well, if -- it's a -- it's a statute in
20 derogation of the common law as much in derogation of common
21 law as any statute I've ever seen. So, we -- we contend that
22 the statute should be narrowly construed and every word in
23 there needs to have independent meaning or it would just be
24 mere surplusage. So, we know what, pretty much know from
25 dictionary definitions what an emergency is, but the General

1 Assembly added the adjective genuine. If the word genuine
2 just means a real emergency, it hasn't added anything. So,
3 what does genuine mean?

4 Then we've got the question of medical stability. The
5 definition of emergency includes, a dictionary definition
6 includes a lack of medical stability. So, when you say that
7 there is qualified immunity for the doctor if there is an
8 emergency, which is genuine and there's no medical stability
9 and there's an immediate threat of harm, all of those words
10 except emergency have no meaning. And so, there's a lot of
11 issues going up on appeal about how on earth you're supposed
12 to construe this statute. These -- these words that have no
13 independent meaning, were put there by the legislature. They
14 have to mean something under standard of statutory
15 construction rules and the legislature didn't tell us what
16 they mean because they didn't define them. So, we've got all
17 kinds of issues like that.

18 Plus, we've got two definitions of gross negligence in
19 the law; one is the very defense oriented absence of slight --
20 -

21 **THE COURT:** Slight care.

22 **MR. GRAHAM:** --- degree of care. Then we've got another
23 definition that is a bit more plaintiff friendly and it seems
24 to me that because this is a statute in derogation to common
25 law, we should be entitled to the less -- less arduous

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1 standard of in terms of charging the jury about gross
2 negligence. We should not be limited to an absence of slight
3 care. We should be entitled to that broader statute, which
4 includes the phrase, it depends on the circumstances.

5 So, that's our -- our view about the statutory issue in
6 terms of punitive damages under our standard law. I mean,
7 I've been involved in two appeals on this very issue; Mitchell
8 v. Fortis case pretty much set the new standard for punitive
9 and how the Court should do the post-verdict review. I was
10 involved in that case ---

11 **THE COURT:** The Gambill reviews, right?

12 **MR. GRAHAM:** Excuse me?

13 **THE COURT:** A Gambill review, is that what you're talking
14 about?

15 **MR. GRAHAM:** No, we changed the Gambill review ---

16 **THE COURT:** Okay. All right.

17 **MR. GRAHAM:** --- in Mitchell v. Fortis.

18 **THE COURT:** Right.

19 **MR. GRAHAM:** It changed the Gambill review and then I'm
20 trying to remember the name of the case, I think it was
21 Burbarage v. somebody, it went up on appeal about in a
22 comparative negligence situation, how you compare mere
23 negligence against heightened wrongdoing and the Court, in
24 that case, defined everything except gross negligence;
25 willful, wanton, reckless and so, I think we would be bound by

1 the definitions in the Burbarage case to the extent that there
2 are definitions there. It doesn't include gross negligence,
3 as I recall, which was interesting, but because there are two
4 definitions out there, I think we should get the more
5 favorable one that least deviates from the common law. But, I
6 mean, we're stuck with the clear and convincing on proving
7 those and so it -- it's kind of hard to wrap your brain around
8 it really, but I think it's a preponderance with a defense
9 burden under the statute; it's clear and convincing with the
10 burden on plaintiff as to punitive.

11 **THE COURT:** All right. His motion is for a directed
12 verdict as to punitives?

13 **MR. GRAHAM:** Yes, sir. In finishing, Your Honor, I
14 don't think we have put up a clear and convincing case of
15 punitives.

16 **THE COURT:** Very well then. I will grant the motion as
17 to punitive damages. Thank you. Mr. Hood?

18 **MR. HOOD:** I think you covered all my motions, Your
19 Honor. Just for fear of our procedural rules, I think I would
20 maybe move for a directed verdict on the OB Emergency Statute
21 at this time. I'm not sure that that's technically required.
22 I know I need to do it at the end of my case, but there are a
23 few words I don't like to hear, like not preserved for appeal.
24 So, I just want to make sure I do that now. I think the
25 nature of the incident itself, that the circumstances

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1 surrounding it ---

2 **THE COURT:** Well, I viewed your first motion as covering
3 that, but ---

4 **MR. HOOD:** Okay. Thank you.

5 **THE COURT:** --- yeah, that was my perception of the
6 motion.

7 **MR. HOOD:** Okay.

8 **THE COURT:** Okay.

9 **MR. HOOD:** Thank you, Your Honor. Then thank for hearing
10 all my motions.

11 **THE COURT:** Okay. All right. All right. And ---

12 **MR. GRAHAM:** We skipped over some of our motions in
13 limine the other day because we were just dealing with that
14 witness.

15 **THE COURT:** Okay.

16 **MR. GRAHAM:** May I just glance at that to see if ---

17 **THE COURT:** I'm going to give you just a moment. Let me
18 step out just a second while you do that. All right.

19 **MR. GRAHAM:** Yes, sir.

20 **(COURT IN RECESS)**

21 **THE COURT:** All right, Mr. Graham, let's -- let's try to
22 move forward. You know, it's 2:30. I told that jury we'd
23 bring them back at 2.

24 **MR. GRAHAM:** Yes, sir.

25 **THE COURT:** Pardon?

1 **MR. GRAHAM:** Do you still have a copy of our motions in
2 limine?

3 **THE COURT:** No, I don't here. No, I don't believe so.
4 I've got everything up here and I don't see that, no.

5 **MR. GRAHAM:** It will take me just a moment to get it.
6 When we argued the other ones the other day, I thought we had
7 ---

8 **THE COURT:** No, I don't have it.

9 **MR. GRAHAM:** We'll find another one. Your Honor, would
10 you like me to cover the ones that just relate to this
11 witness?

12 **THE COURT:** Well, let's start and see what we've got.
13 Okay?

14 **MR. GRAHAM:** Number 1, Your Honor, we had moved to
15 exclude Dr. Maselli as an expert witness. She testified at
16 her deposition that she was not an expert witness on causation
17 issues. So, we didn't delve into that in terms of her
18 knowledge about those issues. Now, I believe, I'm correct,
19 that Jamie does not intend -- well, let me back up. We just
20 found that they intended to call her as an expert witness on
21 like Friday or Thursday of last week and since that was
22 contrary to what she said in her deposition, we made this
23 motion. Since then Jamie and I have talked about it, I think
24 we have an agreement that she will not address causation
25 except in one sense that's in controversy and that is, I

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1 think, Jamie intends to have illicit testimony where she says
2 I didn't violate the standard of care and nothing I did caused
3 the injury. I don't think she should be allowed to say that
4 second part. She's no causation expert.

5 **THE COURT:** Mr. Hood?

6 **MR. HOOD:** I think there's two different -- two
7 differences there. If you want to bring in an expert to talk
8 about that, I think she can talk about whether based on her
9 observations, her hands being on the baby's head, her
10 affecting the delivery, whether those actions ---

11 **THE COURT:** I think they're different. Number one, you
12 could have an expert who could testify as to the causes of the
13 injury like we have heard. These things caused these
14 injuries. But, Dr. Maselli can testify as to the fact that I
15 did nothing, nothing I did caused that. I'm not sure what
16 causes all that, but nothing I did.

17 **MR. HOOD:** And that's where she'll stop.

18 **THE COURT:** Okay. I mean, I'm going to let her do that.

19 **MR. GRAHAM:** Moving on, Your Honor.

20 **THE COURT:** Okay.

21 **MR. GRAHAM:** Number -- number 2 has to do with records
22 that don't really relate to the issues in this case. Jamie
23 just handed me several individual records that I have no
24 problem with. He's also handed me what I believe to be a
25 complete set of records from the hospital and certain other

1 institutions. Those contain all kinds of things that don't
2 relate to this injury, they're irrelevant, they're -- I
3 haven't had a chance to look at them carefully, but they --
4 they most probably include some hearsay that would not meet
5 the hearsay rule. They -- I mean the hearsay exceptions.
6 They -- the relevant records we used and Jamie is getting
7 ready to use, we're putting in twice just because they're in
8 two different computer systems. But, we know what the
9 relevant records are because we're putting them in
10 individually and talking about them. They're just a risk that
11 the jury would go through, you know, a big stack of medical
12 records without medical knowledge ---

13 **THE COURT:** I normally don't let that in and this is how,
14 you know, when you're faced with a -- a -- the question of
15 admissibility of evidence, you know, I just sort of go through
16 a formula. First of all, I look at it and see if it's
17 relevant and then I'll look at it and see if it's more
18 probative than prejudicial under 403 and then I look at it and
19 see if it's hearsay and if it's hearsay, then I look to see
20 whether there's an exception to it. That covers about ninety
21 percent of the problems you would have with an evidentiary
22 ruling. But, the question here is usually when I see this sort
23 of thing, when someone wants just to put in a bunch of bulk
24 records, first of all, many of them are not relevant.
25 Secondly, there may be information in there that is not nearly

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1 as probative as prejudicial. There could be references to
2 insurance, it could be all sorts of things like that in there
3 and -- and thirdly, there may be improper -- there might be
4 improper hearsay in it. Now, I don't know what's in these
5 records. I don't know what the records show. You know, it's
6 hard for me to say at this juncture whether it's admissible or
7 not without looking at it. You know, what specifically, you
8 know, what is proposing to offer. Is he proposing to offer
9 it? Is he proposing to use it in the direct examination of a
10 witness, does he want to introduce it; I'm not sure. You
11 know, I need some more specifics.

12 **MR. GRAHAM:** Well, if Your Honor, please, we have one set
13 this size they just handed to us. We had another set this
14 size just handed to us. The larger set, just looking through
15 it, it has all kinds of references to the child having ---

16 **THE COURT:** Talk to me about it, Mr. Hood. What do we
17 have there; why do you offer it?

18 **MR. HOOD:** I have 3 large exhibits, Exhibits 1, 2 and 3.
19 Exhibit Number 1 comes from the doctor's chart. It's the
20 practice where the patient received prenatal care. I don't
21 know if we're going to discuss that on direct testimony.

22 **THE COURT:** By statute it is. It's relevant, prenatal
23 care, whether there was prenatal care, right?

24 **MR. HOOD:** Yes, sir. A large number, Exhibit Number 2,
25 is a large exhibit. This constitutes the medical records from

1 Georgetown Memorial Hospital as it relates to mom at the
2 delivery.

3 **THE COURT:** Okay.

4 **MR. HOOD:** Exhibit Number 3, which is the other large
5 exhibit, is the hospital chart for Georgetown Memorial
6 Hospital for the delivery as it relates to the child. They
7 keep two different charts.

8 **THE COURT:** I understand. Do you propose just to enter
9 them in bulk?

10 **MR. HOOD:** Those 3 I do. I have individual separately
11 identified ones. The reason ---

12 **THE COURT:** I'm just not going to let you do that. I'm
13 not going to let you just let you put it in in bulk. I don't
14 know what's in it. There's information that no one is
15 testifying to. You can certainly use it for your witnesses,
16 but just to put that in subjects the -- the -- the
17 deliberation in this case to a jury's interpretation to what
18 might be written in there, what might be correct, what might
19 not be correct, I mean it's so dangerous to do that. If you
20 want to have someone testify from it and I'll let you ask them
21 about anything in those records, but I'm really concerned
22 about the possibility of there being hearsay matters in it,
23 there could be prejudicial matters in it. I'm just -- I'm not
24 in a position that I'm going to allow that. It's just a bulk
25 exhibit absent consent by the plaintiff and, you know,

1 sometimes that happens. I have put them in under those
2 circumstances. But otherwise, it's like putting in the Sears
3 Roebuck Catalog.

4 **MR. HOOD:** You know, Judge, part of the problem we have
5 is that we all know from prior experience that we identify
6 what we think are important exhibits and then some other
7 witness may go ask other questions and now we've got documents
8 that are not in evidence that we may not have a person to move
9 them into evidence through to be used during the course of the
10 trial. That's customarily in these cases why we agree to
11 produce and provide a clean set of the chart.

12 **THE COURT:** But no one is agreeing to do that here.

13 **MR. HOOD:** Well, I'm not sure ---

14 **THE COURT:** So, how do we get by with doing it.

15 **MR. HOOD:** Well, I think Mr. Graham has said that there
16 could be hearsay in here. I don't believe that he's
17 identified anything that's hearsay with respect to the
18 redactions I agreed with you, we made every effort with two
19 sets of eyes to redact these and if Mr. Graham identifies
20 anything else that he want's redacted that we missed on our
21 two passes, I'm glad to do that.

22 **THE COURT:** But he needs a day to go through those.

23 **MR. HOOD:** These are the same -- but we could
24 conditionally admit them subject to that. Redactions are easy
25 to take care of if there are problems, just like his

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1 highlights that were all over his exhibits. I said, just let
2 them in and make sure ---

3 **THE COURT:** I'll tell you what I'll do. I'll tell you
4 what I'll do. I'll let you mark it for identification. I'll
5 let you reference it. Okay? I will conditionally let you
6 introduce it, but I'm going to first thing in the morning give
7 Mr. Graham the opportunity to object to any matters in there.

8 **MR. HOOD:** Thank you, Your Honor.

9 **MR. GRAHAM:** And it will give me an opportunity to ---

10 **THE COURT:** Overnight to look at those records and if
11 there's anything objectionable in it, I'm going to let you
12 object to it in the morning and we'll rule on that. If
13 there's anything in there that you think is improper.

14 **MR. GRAHAM:** Yes, sir. Well, I mean, I can tell you
15 right now, I think everything in there that hasn't been
16 introduced individually is either completely irrelevant or any
17 minimal relevance ---

18 **THE COURT:** And that's a good objection. That may be a
19 perfectly good objection. Nobody's talked about this and
20 we're going off on some other tangent. I don't think it's
21 relevant, Judge. In that case, I'll probably exclude it. But
22 we'll look and see. That way, I get to move forward this
23 afternoon. Okay?

24 **MR. GRAHAM:** I understand. Thank you, Your Honor.

25 Number 3, it's about eliciting testimony regarding the

1 veracity, believability or credibility of any other witness.
2 The only reason I bring this up, Your Honor, is in the
3 deposition of Dr. Duchowney ---

4 **THE COURT:** Bolstering and pitting is just not, well,
5 proper.

6 **MR. GRAHAM:** May I tell you about one back door way I'm
7 worried about?

8 **THE COURT:** Okay.

9 **MR. GRAHAM:** In his deposition, Dr. Duchowney and it's a
10 trial deposition, he often would say, I'd ask him a question,
11 do you know if you have knowledge as to how far the head can
12 move in the birth canal, meaning you can't stretch it, that
13 kind of thing and he would say, no, I don't and nobody else
14 can either. We have heard that phrase over and over and over.
15 No, I can't, but nobody else can either. The part nobody else
16 can either is -- is a direct -- well, it's a back door attack
17 on someone else's knowledge ---

18 **THE COURT:** That's nothing more than his opinion. In his
19 opinion, he doesn't think anybody else can do it. It goes to
20 the weight of what it said. You know, not in its
21 admissibility.

22 Okay. What else do we have?

23 **MR. GRAHAM:** I skipped over some, Your Honor. Some of
24 these, we probably don't need to deal with until maybe before
25 closing arguments.

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1 **THE COURT:** Okay.

2 **MR. GRAHAM:** But, I know Your Honor wants to move on
3 today.

4 **THE COURT:** Uh-huh (affirmative response).

5 **MR. GRAHAM:** Any comment by the defendant which
6 incorporates criminal case terminology like I've been charged,
7 I've been accused, they say I'm guilty, it's a civil case. We
8 believe they should be precluded from using a criminal type
9 language which inferentially can make them confuse the jury
10 about the standard of proof.

11 **MR. HOOD:** If he's going to go through these motions,
12 first, he ought to pay \$25 for each one. Second, if these
13 things he's asking about the way I'm asking questions, he can
14 object, you'll sustain them and I know these are sustainable
15 objections. When I'm asking the question, I don't like
16 looking back. I'm not going to ask her if she's been charged
17 with crime. If it comes up and it's improper, I just think he
18 needs to object.

19 **THE COURT:** Okay. Well, how many more have you got
20 there, Mr. Graham, we need to really, our jury has been back
21 there 45 minutes waiting.

22 **MR. GRAHAM:** Yes, sir. I'm -- I'm skipping it, skipping
23 a lot.

24 **THE COURT:** Okay.

25 **MR. GRAHAM:** So, any expression of sympathy or kindness

1 like I'm so sorry this happened. It's such a nice boy, such a
2 nice family. They don't blame it on me would be irrelevant
3 and an attempt to prejudice the jury against the plaintiff and
4 has no bearing on any element of medical malpractice action.
5 It's not relevant to any affirmative defense they've pleaded
6 and just an attempt to have the jury render a verdict on
7 impermissible grounds.

8 **THE COURT:** Well, wouldn't it be relevant to a defense to
9 -- I mean to your case. What is gross negligence, wanton
10 indifference? I think that it's relevant. I'm not going to
11 stop someone from saying that.

12 **MR. GRAHAM:** The next one is number 14, Your Honor,
13 improper usage of character or reputation evidence of
14 defendants. What I usually run into in these cases is
15 comments about how wonderful the defendant doctor is to the
16 community and many times it's an appeal to some connection
17 with an individual juror.

18 **THE COURT:** Didn't you talk about this child's parents.
19 I get the impression that they're wonderful people and that
20 came from your testimony. Why is it any different?

21 **MR. GRAHAM:** Well, because I didn't elicit any testimony
22 that the community is so lucky to have them, that, you know,
23 we need to protect our doctors to keep them here. They might
24 leave town if they get verdicts against them and this, you
25 know, they're so wonderful to volunteer and this and that.

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1 **MR. HOOD:** I'm not going to go into that.

2 **THE COURT:** He's not going to go into that. He just said
3 he wasn't.

4 **MR. GRAHAM:** This is a very important one to me, but I
5 don't think it's going to come up with her.

6 **THE COURT:** Okay.

7 **MR. GRAHAM:** So ---

8 **THE COURT:** All right.

9 **MR. GRAHAM:** You want to hear it?

10 **THE COURT:** Yes?

11 **MR. GRAHAM:** Okay. Statements that the child's nerves
12 were weaker than normal or more vulnerable to injury than
13 normal without any evidence to support that contention. Dr.
14 Duchowney is there only pediatric neurology expert. He says
15 there's no evidence of that, that's not an issue in the case.
16 I don't want to have an obstetrical expert sneak in the back
17 door and make some comment, excuse me?

18 **THE COURT:** Did you ask her that on her deposition; how
19 do you know that she doesn't harbor that thought?

20 **MR. GRAHAM:** Well, she may harbor any number of thoughts,
21 but she's admitted that she knows nothing about causation, it
22 would require someone who's qualified on causation to address
23 anything like the condition of a nerve and whether it's normal
24 or abnormal.

25 **THE COURT:** Mr. Hood?

1 **MR. HOOD:** Mr. Graham designated portions of this exact
2 testimony for Duchowney, who is going to be played. So, he's
3 bringing the issue up; he's already brought the issue up. I'm
4 not intending to do it with this witness, I'm not sure how
5 that motion in limine really applies, because he's actually
6 eliciting the testimony from my expert.

7 **MR. GRAHAM:** The only thing, I mean, I'll stand corrected
8 if my memory is at fault, but the only thing I remember asking
9 him about that is do you have any evidence of this and he said
10 no, but we can pull out the deposition to be sure.

11 **THE COURT:** Well, it seems that Mr. Hood is saying that
12 he doesn't believe that he's going to go into that, but it
13 depends on how you use Duchowney's testimony.

14 **MR. HOOD:** I think it's already out there. It's not
15 going to get pursued further, the issue of whether the child
16 had particular nerves or not, I think it's already been put in
17 the can and will be played.

18 **THE COURT:** Okay.

19 **MR. HOOD:** You've already ruled on that.

20 **MR. GRAHAM:** And I'm not talking about Dr. Duchowney and
21 I didn't think I was talking about Dr. Maselli, because she
22 admits and Jamie confirmed she's not going to testify on any
23 causation issue of which this would be one. I'm concerned
24 about the witnesses the rest of the week. We don't have to
25 deal with it now, I just brought it to Your Honor's attention

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1 because it was an important issue to me, and I'll argue it now
2 or later.

3 **THE COURT:** Well, I'm inclined to let the witness testify
4 as to what the witness will. I'm not going to just take an
5 expert witness and because you don't think it's helpful to
6 your case, to limit them. I'm just not going to do that.

7 **MR. GRAHAM:** Well, it -- it's not a matter of whether
8 it's helpful to my case or not. I'm just asking Your Honor to
9 be a gatekeeper and keep obstetricians ---

10 **THE COURT:** The gate swings both ways, Mr. Graham and I
11 am not going to limit these witnesses. If they have given
12 expert, I mean deposition testimony, it's contrary to that,
13 okay. You cross examine them. But if they haven't been asked
14 and if they're qualified to give an opinion, I'm going to let
15 them give an opinion. Now, I don't know if they're qualified
16 or not; if they're not qualified, I want let them give the
17 opinion.

18 **MR. GRAHAM:** All right. And that's really where I was
19 going.

20 **THE COURT:** Okay, sir, well that's where we are with
21 that.

22 **MR. GRAHAM:** I'll save that issue for later.

23 **THE COURT:** Okay.

24 **MR. GRAHAM:** Thank you, Your Honor. A very closely
25 related issue and that is statements that the mother's uterine

1 contractions or pushing were unusually strong without any
2 evidence to support that. It is just pure speculation.

3 **THE COURT:** Not, not by someone who's there. Someone who
4 -- if Dr. Maselli, who I haven't heard her testimony, but I
5 bet she's delivered a lot of babies and she would certainly be
6 in a position, if she could, I don't know if she made these
7 observations or not, but she would be a person who could
8 testify as to whether contractions were strong or weak or she
9 could describe them and you're asking me to say she can't do
10 it; I'm not going to do that. Or a nurse, an obstetric nurse
11 who was there, I'm going to let her do it as well. I don't
12 know if anyone is going to testify, but they are in a position
13 where they can evaluate, judge the contractions and I'd let
14 them testify to that.

15 **MR. GRAHAM:** All right. The next one, Your Honor, is
16 similar to one you've already ruled against me on. I'll be
17 happy to state it if Your Honor wants me to.

18 **THE COURT:** Go ahead?

19 **MR. GRAHAM:** Expression of apology or references or
20 suggestions to the jury that the defendants are sorry or
21 regret the outcome, but don't blame me for having anything to
22 do with it.

23 **THE COURT:** Wait a minute. I'm sorry about the outcome,
24 but don't blame me for it.

25 **MR. GRAHAM:** Right, I mean what we expect -- well, what -

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1 --

2 **THE COURT:** Well, wouldn't that be what you would expect
3 from any defendant to say, I mean, I'm sorry this happened, it
4 wasn't intentional. Whether they're admitting liability or
5 not?

6 **MR. GRAHAM:** Well, you're right, Your Honor, I do expect
7 it, but I don't think it's proper. It invites juries to make
8 decisions on matters that are not germane to the -- to the
9 elements of the case that they're supposed to be focusing on.

10 **THE COURT:** Well, that's a matter for you to -- to
11 address in your closing argument, I think. I'm going -- I'm
12 not going to limit that.

13 **MR. GRAHAM:** Okay. Number 23, Your Honor, to bar
14 misstatements of the legal standard of care. What I have
15 heard many times from Jamie's firm, other members of his firm,
16 other defense lawyers is when it comes to standard of care
17 questions, they -- they kind of truncate the words and just
18 say was what she did reasonable; instead of saying you know,
19 reason -- that which a reasonably prudent physician would do
20 under the same or similar circumstances.

21 **THE COURT:** Well, then it's your job just to eat them up
22 on cross examination when they do that. That's what a good
23 lawyer will do.

24 **MR. GRAHAM:** Similarly preclude statements by Dr. Maselli
25 that she did her best. I mean, it's irrelevant, it's

1 prejudicial.

2 **THE COURT:** That's part of my charge that that's -- the
3 fact that they did their best is not necessarily enough.

4 **MR. GRAHAM:** All right. The first witness tomorrow is
5 the pediatrician we heard about. Actually, you ruled on this
6 at a sidebar the other day.

7 There's one related to a Life Care Plan, are you planning
8 to -- that's what I thought. I don't think we need to argue
9 that.

10 **THE COURT:** Okay.

11 **MR. GRAHAM:** We haven't admitted the Life Care Plan,
12 Jamie tells me he's not going to ask any questions about that.
13 So, we don't need to go there.

14 **THE COURT:** All right.

15 **MR. GRAHAM:** That's it, Your Honor.

16 **THE COURT:** Okay.. Very well. Let's bring the jury in.
17 Thank you.

18 **REPORTER'S NOTE:** (Jury enters courtroom 2:58 P.M.).

19 **THE COURT:** All right. We've got everyone back in now.
20 You may be seated. Mr. Graham, I believe the plaintiff now
21 rests; is that correct?

22 **MR. GRAHAM:** That is correct, Your Honor.

23 **THE COURT:** Thank you very much.

24 Mr. Hood.

25 **MR. HOOD:** Thank you, Your Honor. May it please the

1 Court?

2 **THE COURT:** Yes.

3 **MR. HOOD:** Defense calls Dr. Lisa Maselli.

4 **DR. MASELLI, HAVING BEEN FIRST**
5 **DULY SWORN, TESTIFIED AS FOLLOWS:**

6 **CLERK:** Can you please state and spell your name for the
7 Court?

8 **DR. MASELLI:** Lisa Renee Maselli. L-I-S-A R-E-N-E-E M-
9 A-S-E-L-L-I.

10 **CLERK:** You may be seated.

11 **DIRECT EXAMINATION OF DR. MASELLI BY MR. HOOD:**

12 **Q:** Good afternoon.

13 **A:** Good afternoon.

14 **Q:** All right. We've heard a lot of talk about you, now's
15 your turn. Why don't you tell us where you're from and maybe
16 a little bit about your educational background, please.

17 **A:** Thank you. Good afternoon. I'm Doctor Lisa Maselli. I
18 am an obstetrician/gynecologist for the past 19 and a half
19 years here in South Carolina with a group -- my group,
20 Carolina OBGYN. We're a private OBGYN practice. I moved here
21 in early 2000 after finishing my residency. I grew up in the
22 eastern panhandle of West Virginia in a town called
23 Martinsburg. I went to West Virginia University for my
24 undergraduate. I received bachelor's degrees in psychology
25 and biology. I then did my medical school training at

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1 Marshall University in West Virginia as well. I then went on
2 to Allegheny University in Pittsburg where I did my OBGYN
3 residency which was a four-year program and afterward moved
4 down here.

5 Q: All right. So let me back up. I don't want to go in to
6 too much detail but I want you to explain to us, when you went
7 to West Virginia University did you always want to be a
8 doctor?

9 A: No, actually I didn't. When I started I was a psychology
10 major. I really enjoyed psychology and that was my plan, to
11 get a PhD in psychology. However, as I started going through
12 the program, I had more interest in other options for
13 treatments for psychology patients, so I decided psychiatry
14 maybe a way to go. So, I switched or double majored with
15 biology so I could have my credits to get into medical school.

16 Q: Well, I saw in West Virginia it took you five years to get
17 through.

18 A: Correct, with two majors.

19 Q: I just didn't know if you wanted to squeeze another
20 football season out or something.

21 A: That's always good too.

22 Q: All right. Well in all seriousness,
23 psychology/psychiatry, which one is the doctor and which one
24 is the PhD?

25 A: So, a psychiatrist is a medical physician. A psychologist

1 has a PhD in psychology. They both can be called doctor by
2 those degrees but that's the difference. So, a psychiatrist
3 could prescribe medications and certain therapies and a
4 psychologist could not. That's where my interest initially
5 would lay.

6 Q: It doesn't sound like your plan went very well. How did
7 you end up doing an OB residency?

8 A: So, after I started medical school, it is a four-year
9 program and we have two years of didactive training which is
10 book learning, classes, anatomy labs, cadaver labs. And then
11 we have clinical rotations for two years and once I did my
12 OBGYN rotation I became just in love with the job and that's
13 where I then continued my pursuits. And this was almost 25
14 years ago, and I thought that there should be more women in
15 the field taking care of other women and that was where my
16 interest lied and that's what I pursued.

17 Q: So, you go through your residency program in Allegheny.
18 Can you just briefly describe what residency is after you
19 graduate from medical school?

20 A: Sure. So, residency is what all physicians go through
21 after medical school. Residency programs are designed to a
22 subspecialty that you desire. It could be medicine, it could
23 be surgery, it could be OBGYN, it could be psychiatry and that
24 is dependent on how long the residency program is. For OBGYN
25 it's a four-year program and that's where you learn and train

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1 under other attending, what we call attending physicians, who
2 are skilled and have decided to stay at an academic
3 institution and teach new doctors.

4 **Q:** Are those the young people in Grey's Anatomy?

5 **A:** Those are residents, yes.

6 **Q:** So, let me ask you, I mean, your residency for four-years,
7 what are you practicing at that point?

8 **A:** So, at that point in time during your four years obviously
9 a majority 90 percent of our focus is on obstetrics and
10 gynecology, care of women and care of pregnant women. We also
11 do some internal medicine and emergency room medicine
12 requirements. But, basically what we're doing is learning to
13 go out in the world and take care of patients on our own
14 without that supervision.

15 **Q:** Do you deliver babies during residency?

16 **A:** Yes, absolutely.

17 **Q:** How do you go from graduating from medical school to being
18 able to facilitate a birth?

19 **A:** And that's -- the first couple are always the most
20 interesting, but you have these physicians that are there to
21 train you. They're standing next to you, behind you, they're
22 helping you, they're telling you everything to do and then as
23 you get more comfortable they step further and further back
24 and let you do it on your own under observation. So, until
25 your forth year almost every procedure or delivery that you do

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1 is observed and criticked.

2 Q: Do you deliver many babies during this residency program?

3 A: Yeah, absolutely. I would say probably nearly 1,000
4 deliveries between C-Sections and vaginal deliveries.

5 Q: All right. And I saw on your CV that you were chief
6 resident, what does that mean?

7 A: So, chief resident -- I think one of the other doctors
8 spoke of this, during your last year of residency you are
9 designated a chief resident. You've completed your first
10 three years and you're given additional responsibilities to
11 help with the other residents. It could be supervision. It
12 could be teaching, we're responsible for giving lectures, and
13 also administrative duties, scheduling and things like that.

14 Q: All right. Now this residency program that you're talking
15 about, is this training performed pursuant to any sort of
16 national standard?

17 A: Yes, all residency programs need or are guided by
18 something called CREOG. That's an acronym for The Counsel on
19 Residency Education in Obstetrics and Gynecology and all OBGYN
20 residencies must meet all of those standards to stay certified
21 and keep running.

22 Q: Okay, so we've heard about ACOG and we'll talk about that
23 later, but CREOG is that the sort of program for residents?

24 A: For residents.

25 Q: Now, things like traction, did you learn about that as a

1 resident?

2 A: Yes, absolutely.

3 Q: Did you learn about shoulder dystocia?

4 A: Yes, absolutely.

5 Q: Did you learn about other emergencies like uterine

6 ruptures?

7 A: Yes, absolutely.

8 Q: How did you learn to deal initially with a should

9 dystocia?

10 A: So, similarly to a normal, uncomplicated vaginal delivery

11 that doesn't entail any type of emergency, it's the same way.

12 Somebody else's hand are on our hand, they are monitoring us,

13 watching us, helping us walk through the steps to alleviate

14 any complication.

15 Q: All right. And we've heard and we'll talk in great detail

16 about this particular delivery in a few moments but we've

17 heard about a series of external and internal maneuvers,

18 things like that. Were those topics ever covered during your

19 residency?

20 A: Yes, absolutely.

21 Q: All right. So let's stop. You finish your residency, how

22 do you end up going from Pittsburg --- is it Pittsburg?

23 A: Yes.

24 Q: To Georgetown?

25 A: So, when I was looking for programs, or jobs I guess I

1 should say, after finishing my program, you know, Pittsburgh
2 weather is not South Carolina weather. So, I've always wanted
3 to live in the southeast and I started looking at certain zip
4 codes and areas. I had a head hunter help me and I
5 interviewed at probably four or five different locations and
6 chose this one.

7 Q: All right. And this one is?

8 A: Carolina OBGYN. I've been there since 2000.

9 Q: All right. We'll come back to Carolina OBGYN in just a
10 minute. Now, you live in the Murrells Inlet area or up near
11 Pawleys Island?

12 A: Pawleys Island.

13 Q: All right. And who do you live with?

14 A: I live with my husband, Rob, and we have a son, Harrison,
15 who's 12.

16 Q: All right. Are you licensed to practice medicine in the
17 State of South Carolina?

18 A: Yes.

19 Q: Do you have privileges to deliver babies at the local
20 hospitals?

21 A: Yes.

22 Q: All right. Do you have any board certifications?

23 A: Yes, I do. I am board certified by the American College
24 of OBGYN. That takes two specific testing procedures. One is
25 a written exam that you take after you finish your residency,

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1 and the second is as you go into your first two years of
2 practice whether it's private practice or at a university
3 setting you collect cases, patient lists, procedures, things
4 that you did and you compile this list and then you go for an
5 oral exam and sit similarly to this typically in front of
6 typically four examiners and are asked questions about your
7 cases.. To acknowledge your knowledge and if you pass then
8 you're board certified.

9 Q: All right. And did you maintain that certification since
10 2002?

11 A: I have.

12 Q: And what do you have to do on an ongoing basis to maintain
13 that?

14 A: So, there's a procedure by the American Board of OBGYN,
15 ABOG, that we do a maintenance certification yearly and this
16 is new probably over the past eight or nine years where every
17 year we have to do so many continuing medical education
18 requirements. They give us a list of articles and things that
19 we need to read and then answer questions on and you must get
20 an 80 percent to continue your yearly certification and every
21 six years you have to take another written exam.

22 Q: All right. And you're recertified and up to date?

23 A: Yes.

24 Q: All right. So you've been in the obstetrical field for
25 roughly 20 years?

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1 A: Correct.

2 Q: About how many babies do you ballpark deliver a year?

3 A: I'd say about -- a year? 100 - 115 babies a year.

4 Q: So, it's like 3,000?

5 A: 3,000 - 3,500.

6 Q: All right., we'll let's talk about Carolina OBGYN for a

7 second. You all have an office here in Georgetown and one up

8 in Murrells Inlet?

9 A: That's correct, and we have a satellite office in the

10 southern Myrtle Beach area as well.

11 Q: And who are your partners?

12 A: I have three partners, Dr. Gayle Richmond, who started the

13 practice about 30 years ago, Dr. Cindy Binder, and Dr. Valerie

14 Lasry.

15 Q: And do you have nurse midwives?

16 A: We do. We currently have two nurse midwives who work with

17 us, they're certified nurse midwives. So, they are RN's,

18 registered nurses who then have gone on and taken midwifery

19 courses, gone to midwifery school. These are not lay

20 midwives. We do not do home deliveries. These are certified

21 nurse midwives and we have two with a third coming next month.

22 Q: All right. So the reason I'm asking about that, was one

23 of the midwives involved in the care of the plaintiff in this

24 case?

25 A: Yes, she was.

1 Q: And what was her name?

2 A: Her name was Ann Virelia.

3 Q: Say that again.

4 A: Virelia. V-I-R-E-L-A -- V-I-R-E-L-I-A.

5 Q: All right. We'll come back to her in a little while when
6 start talking about the treatment records. Tell use about
7 your practice. I mean, what does your week look like?

8 A: So, typically our office is open five days a week, Monday
9 through Friday. We don't have weekend hours. However,
10 there's always one of the physicians and typically one of the
11 midwives on call to take care of our patients. We deliver at
12 both Georgetown Memorial Hospital and Waccamaw Community
13 Hospital and that's where we do our surgeries and deliveries
14 and admit our patients if needed. A typical day, or a typical
15 week for me is three days in the office 9 - 5 and I have one
16 day when I'm in the operating room on the morning until about
17 1:00 and then see patients in the office. I typically have
18 one day a week off.

19 Q: How do y'all figure out who is going to handle a
20 particular delivery within your group?

21 A: So, we have a call schedule. I'm actually in charge of
22 the call schedule where we have a board certified physician on
23 call every night. And since we deliver at two hospitals,
24 obviously, emergencies, things can be going on at both
25 hospitals so we also have a backup call system. So, we cover

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1 call with another group in the area. It's a hospital group
2 and right now there are four of them so right now there are
3 eight doctors in the call schedule and that's a 24/7 call,
4 weekdays, weekends, holidays, everything.

5 Q: All right. And were you on call the night that the
6 plaintiff went into labor?

7 A: I was.

8 Q: All right. So at these hospitals do you hold any
9 positions within the hospitals dealing with the field of
10 obstetrics?

11 A: I do. I've been privileged to be one of the co-perinatal
12 directors at Beach Hospital. We oversee all perinatal or
13 obstetric issues. We have co-directors because we have two
14 hospitals, sometimes there might be going on at each so we run
15 a monthly meetings and quarterly meetings with the other
16 practitioners. I'm also co-director of the women and
17 children's services along with a pediatrician and that's where
18 the obstetricians and pediatricians get together quarterly to
19 discuss issues, policies, procedures that might affect our
20 patients. And I've also been privileged to work with the IHI
21 with is the Institute for Healthcare Improvement and we
22 brought in Baby Friendly. Some of you may have seen
23 billboards or signs to both hospitals about five or six years
24 ago. And actually we were the first and third hospitals to
25 get that designation in South Carolina.

1 Q: What does that mean?

2 A: So, Baby Friendly is a certification by the World Health
3 Organization and it basically means that the hospital has set
4 certain standards that we do to make mom and baby bonding
5 better and to help the babies have better initial outcome.
6 So, it's things like something called skin to skin when the
7 baby is born, we latch them onto the mom, we encourage breast
8 feeding, you can no longer get a pacifier in the hospital
9 because it may interfere with breastfeeding, so things like
10 that.

11 Q: What is the State OB Task Force Committee, and what would
12 your roll, if any, be with it?

13 A: The State OB Task Force Committee was something that I was
14 involved with early on in my South Carolina career for about
15 four or five years and that was a group of obstetricians from
16 all over the state. We would meet monthly in Columbia and
17 address state issues. These meeting were in conjunction with
18 the Department of Health and Human Services, DHEC and
19 Medicaid.

20 Q: All right. I want to ask about one thing I saw on your
21 CV. It's called the Lewis Blackman Safety Award, what's that?

22 A: The Lewis Blackman Safety Award is an award given to
23 various people in the State of South Carolina each year. They
24 have different categories, some are nursing, some are
25 physician, administrative that honor you and acknowledges you

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1 for your efforts and improvement in patient safety. And one
2 of my partners at the time about six years ago received that
3 award in our efforts for the Baby Friendly.

4 Q: All right. So we were talking about Carolina OBGYN and
5 that's where you're employed, right?

6 A: I'm a partner there.

7 Q: Okay, and you were a partner there back at the time of
8 this delivery in 2013?

9 A: That's correct.

10 Q: Let's shift gears for a second. I want to talk about the
11 chart that is part of exhibit number one.

12 MR. GRAHAM: Your Honor, we object to the relevancy of a
13 bulk filing.

14 THE COURT: All right. I'm going to allow it to be
15 introduced or marked for identification as we discussed
16 earlier and she may reference it during her testimony.

17 BY MR. HOOD:

18 Q: All right, so I've handed to you what's been marked as
19 exhibit number one. Would you just tell the jury what that
20 is, please?

21 A: This is Ms. Smalling's prenatal records from our office.
22 This includes all of her prenatal visits, blood work,
23 laboratory values, ultrasound. It also includes her labor and
24 delivery record, her postpartum discharge record and there's
25 some ultrasound photographs and some billing information.

1 Q: All right. Let me ask you, is exhibit number one related
2 only to Ms. Smalling's interaction with your medical office as
3 it relates to the birth, or the pregnancy of Jahmerican?

4 A: Yes, that's correct.

5 Q: That's her medical chart, her prenatal chart and documents
6 that the hospital sent related to the delivery?

7 A: Yes.

8 Q: So, using that chart, let me steer you a little bit if I
9 could and walk us through some of these medical records.
10 Could you look at page 16 of that, please.

11 A: Okay.

12 Q: Everyone else has screens but the lawyers don't. All
13 right. So what are we looking at here?

14 A: This is her first visit with us where she already had an
15 established pregnancy, positive pregnancy test and I believe
16 an early ultrasound at an outside facility.

17 Q: All right. I'm going to stand back here so I can look
18 over John's shoulder.

19 A: Okay.

20 Q: Allright. So, if you can't hear me let me know. Could
21 you pull up the history of present illness, please?

22 MR. GRAHAM: Your Honor, may we approach?

23 THE COURT: Yes.

24 You may proceed, Mr. Hood.

25 MR. HOOD: Thank you, Your Honor.

1 **BY MR. HOOD:**

2 **Q:** All right. We're zooming in towards the history of
3 present illness, do you see that?

4 **A:** Yes.

5 **Q:** Why do you call pregnancy illness, by the way?

6 **A:** Well, history of present illness just means why is the
7 patient visiting the office that day. It can be any medical
8 issue.

9 **Q:** Okay, and what we're looking at here, is this the first
10 visit to your office for Ms. Smalling?

11 **A:** Yes, it is.

12 **Q:** And so with that first visit, what is significant to you
13 as the OB ultimately delivering the baby, looking at the
14 initial visit?

15 **A:** So the initial visit tells us her age, that she was
16 considered advanced maternal age, that is any woman who will
17 be 35 years old or older at the time of delivery. It's called
18 advanced maternal age. The reason that's important is because
19 it does increase your risk of certain chromosomal
20 abnormalities such as down syndrome and we offer additional
21 testing for that. She was unsure of her menstrual cycle which
22 is one of the best ways we have to date a pregnancy and give
23 someone a due date. And so we already had a record that she
24 had an ultrasound done at approximately 10 weeks gestation.
25 Your due date is about 40 weeks so that was a good estimation

1 of how accurate her dating was. It was a first trimester
2 ultrasound, that's good. And moving down there was no, we
3 didn't have to talk to her about any tobacco or alcohol use,
4 that was all negative. She wasn't having any complication
5 with this pregnancy as far as bleeding, cramping or feeling
6 ill. Her medical history was otherwise uncomplicated. Her
7 past pregnancies have been uncomplicated.

8 Q: All right. Let's then jump to the second page. There's a
9 section titled reproductive history.

10 A: Yes. So, that tells me that the total number of
11 pregnancies, which include the current one for this visit is
12 four. And she's had three vaginal deliveries so she's called
13 gravida four and para, three.

14 Q: What does gravida mean?

15 A: Gravida means currently pregnant.

16 Q: Okay.

17 A: So how many times. And we ask specifically about a
18 patient's previous deliveries, date, how far along they were,
19 complications, how big was the baby and those were all
20 uncomplicated.

21 Q: All right. With respect to risk factors for shoulder
22 dystocia in particular is there anything that jumps out for
23 this particular patient right at the outset when she
24 established her relationship with your office?

25 A: Yes. The only issue that stood out was her weight and we

1 look at BMI which is body mass index and that's based on a
2 certain person's weight and height and you get a number and
3 any number of BMI 35 or over is considered medically obese,
4 which is a medical term and that is a risk factor.

5 Q: Is that why it's checked off on a sheet that we see later?

6 A: Yes, it is.

7 Q: All right. So the last page of this document, or this
8 particular visit is page 19 at the bottom right of your thing
9 there. Who's it signed by?

10 A: This is by one of our certified nurse midwives, Ann, who
11 saw the patient and through review of the records was someone
12 who she established and saw essentially throughout her
13 pregnancy.

14 Q: Okay. So, she came and saw the midwife, got an initial
15 visit, moving forward here we go.

16 A: Correct.

17 Q: Looking through the chart, you had the opportunity to do
18 that before today, right?

19 A: I did.

20 Q: And the visits, do they indicate any problems or concerns?
21 Anything that you felt needed to be addressed prior to
22 delivery?

23 A: Nothing that I could see. The most important part was
24 that her diabetes, pregnancy diabetes was normal so we did not
25 have that medical issue.

1 Q: All right. So to be clear did you have any interaction
2 with Ms. Smalling prior to the delivery?

3 A: I did not.

4 Q: All right. So let's go to the day of the delivery. I've
5 marked for identification purposes at this time are exhibits
6 two and three, the mom's chart and the baby's chart from the
7 hospital. Don't look at them yet. All right. I'm going to
8 hand to you what's been marked as defendant's exhibit number
9 22.

10 A: Okay.

11 Q: Could you tell us what 22 is, please?

12 A: Exhibit 22 is a part of the patient's medical record from
13 the medical record itself. This is taken out of the computer,
14 our obstetrical system that we use for all of our labor and
15 delivery patients called OBIX. These are the nurses notes
16 from the time she was admitted to the hospital until the time
17 she left labor and delivery to go to a post-partum room which
18 is a different room from where you deliver in.

19 MR. HOOD: All right. Your Honor, we'd offer exhibit
20 number 22 into evidence.

21 THE COURT: Those are the records?

22 MR. HOOD: These are.

23 THE COURT: All right, and I would mark them for
24 identification. Conditionally admit them and we're going to
25 discuss that further after this witnesses' testimony, all

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1 right. I just want to make sure that Mr. Graham has an
2 opportunity to review them. Those were the records that we
3 were discussing at ---

4 **MR. HOOD:** These are specific ones, not bulk.

5 **THE COURT:** Okay, those are the specific ones that she
6 has testified as to?

7 **MR. HOOD:** Right.

8 **THE COURT:** All right, Mr. Graham?

9 **MR. GRAHAM:** Your Honor, we just need a date stamp
10 please.

11 **THE COURT:** And I'm sorry, Mr. Hood, I was under the
12 impression that those were the bulk records.

13 **BY MR. HOOD:**

14 **Q:** All right. Exhibit 22 ---

15 **THE COURT:** All right, are they ---

16 **MR. GRAHAM:** No objection.

17 **THE COURT:** All right, they're admitted. Thank you. And
18 that's exhibit, defense one?

19 **MR. HOOD:** It's defendant's 22, Your Honor.

20 **THE COURT:** Okay, 22, all right. Thank you.

21 **DEFENDANT'S EXHIBIT 22**

22 **ADMITTED INTO EVIDENCE**

23 **BY MR. HOOD:**

24 **Q:** All right. Dr. Maselli, we're not going to go through all
25 15 pages of this, but this appears to be a log of details from

1 the electronic medical records.

2 A: That's correct.

3 Q: And on the far left hand side, we've got a note,
4 date/time.

5 A: Yes. So, every line has the date and the time that the
6 nurse entered in information.

7 Q: Okay.

8 A: And then the nurses name that entered in.

9 Q: All right. So I want to use this as sort of a road map
10 for us and we'll refer back and forth to exhibit 22.

11 A: Okay.

12 Q: But, for example, if you look three lines down it
13 indicates at 0200 on 4/27/13, it says admit instructed to
14 gown.

15 A: So, that would be the time and date, so 4/27/13 at 2AM was
16 the time the patient was received on labor and delivery and
17 was admitted, changed into a gown, placed in the bed and the
18 nurses started evaluation at that time.

19 Q: I'm going to hand to you what's been marked as defendant's
20 exhibit number 24, please. Are you familiar with that medical
21 record?

22 A: I am.

23 Q: Just before you say what it is, I've got to see if there's
24 any objections to it.

25 MR. HOOD: We offer that, defendant's 24, Your Honor.

1 **MR. GRAHAM:** No objection.

2 **THE COURT:** Without objection.

3 **DEFENDANT'S EXHIBIT NUMBER 24**

4 **ADMITTED INTO EVIDENCE**

5 **BY MR. HOOD:**

6 **Q:** All right., John can you pull up 24 for us? What I'm
7 trying to do is build out a timeline of the events leading up
8 to the delivery because there been a lot of testimony about
9 that and I want to make sure we all understand what the
10 records reflect since this was six years ago.

11 **A:** Right.

12 **Q:** All right, so we're looking at exhibit 24. We all are
13 looking at it. Tell us what this is.

14 **A:** So, this is labor and delivery orders. This is before we
15 went computerized six years ago, so this is a paper chart.
16 And basically, it has the patient's hospital stamp on the top
17 right corner and NKA means no known allergies for an allergy
18 medication. Admission time, 02AM. Diagnosis PUND means
19 pregnancy undelivered. It has my name as the attending, the
20 date and time, examination by the nurses. So, if you see down
21 at the bottom it says providers signature and this was a voice
22 order by me over the telephone by the nurse and they accepted
23 my voice order admission over the phone at 2:25AM.

24 **Q:** Okay, just one second, let me grab a pen. All right. So,
25 I'm going to build out this timeline. So, what time was the

1 patient admitted?

2 **A:** The admission time was 0200.

3 **Q:** 2AM.

4 **A:** Correct.

5 **Q:** All right, anything else about exhibit 24?

6 **A:** Nothing, that's all.

7 **Q:** All right. So, let's look back to exhibit 22 if we could,

8 John. And I'd like to go down about a third down to where it

9 says obstetrician paged. So, if you go down the line at

10 2:09AM it says by the nurse, obstetrician paged.

11 **A:** That was me. And at 2:11 I responded to the page. I

12 called back and spoke to the nurse.

13 **Q:** So, you were paged at 2:09.

14 **A:** I responded at 2:11. The nurse gives me a report on Ms.

15 Smalling that she's there, how far along she is, what's

16 happening with her pregnancy. She's in labor, she's in active

17 labor and told me that this was her forth baby.

18 **Q:** All right. Stop right there. What does that mean? You

19 hear it's a fourth baby.

20 **A:** It means to me that things may be happening pretty quickly

21 because they just examined her again prior to calling me and

22 she was seven centimeters and remember we talked about getting

23 to 10 to deliver or start pushing to deliver. So, at seven

24 centimeters that's active labor and being her forth baby means

25 it might happen quickly.

1 Q: Okay, so you called back. Did you give them any orders?
2 A: I gave them orders to admit and told them that I was on my
3 way to the hospital.
4 Q: Okay, eight lines down there's a comment entered at 2:15.
5 A: Yes.
6 Q: Tell us what that says, please.
7 A: At 2:15 the comment by the nurse is, patient instructed on
8 breathing with UC which is uterine contraction. Patient
9 trying to push.
10 Q: All right. Let me stop there. We heard testimony
11 previously about the morning you delivered the baby. Would it
12 be appropriate for a nurse to instruct a patient to wait at
13 this point in time given the patients clinical picture?
14 A: Yes.
15 Q: Why?
16 A: Yes. It would be very important for the nurse to
17 instruct her not to push at this time because she was just
18 examined and was only seven centimeters.
19 Q: What does that mean?
20 A: So, if your cervix is seven centimeters and needs to be 10
21 to deliver, if you start bearing down and pushing at seven,
22 you have a high risk of a cervical laceration or tear which
23 could cause bleeding or complications.
24 Q: Okay, and let's flip over to the second page of exhibit 22
25 if we could. And let's focus in at time 2:41.

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1 **A:** Okay, the first notation at 2:41AM says obstetrician at
2 bedside, that was me. So, I was there 41 minutes after the
3 patient arrived and I examined her myself, vaginal
4 examination. She was 7.5 centimeters; her cervix had thinned
5 out or effaced and she was uncomfortable and I ordered an
6 epidural for her.

7 **Q:** Okay, so this is 2AM. We know that the baby is not
8 delivered until 8:00. I don't want to be here for six hours
9 so let's flip to the next page and before we get to the
10 anesthesia, I wanted you to address a comment at 3:07.

11 **A:** At 3:07 the nurse put variables present, variability
12 present, no further prolonged decelerations since patient
13 stopped pushing with uterine contractions.

14 **Q:** Okay.

15 **A:** Oxygen was turned off.

16 **Q:** Does this reflect the patient listened to the instructions
17 and stopped pushing?

18 **A:** Yes.

19 **Q:** Okay. Now, a few lines down at 3:20. Do you see that
20 where it says anesthesia at bedside. What does that mean?

21 **A:** At 3:20 anesthesia at bedside means that the
22 anesthesiologist who is the physician who places the epidural
23 and helps her pain management was at her bedside talking to
24 her about the procedure, getting consent and then proceeded to
25 place the epidural.

1 Q: Okay. Now, let's fast forward 25 minutes to the next page
2 at 3:45AM. At 3:45AM the nurse documented that I was at the
3 patient's bedside so I was talking to the nurse and the
4 patient. We were looking at the fetal monitoring. She was
5 now comfortable with her epidural. And because her cervix had
6 not changed and I don't have the strip in front of me, perhaps
7 her contractions had slowed down. Sometimes that happens with
8 an epidural, we ordered Pitocin, which is a medication that
9 you receive through your IV to help contractions to help her
10 labor.

11 Q: Okay, so 3:45 is she ready to have a baby?

12 A: She is not.

13 Q: All right. Let's look at 3:53 on the same page. It says
14 comment, patient CO complains of increase in pressure, SVE,
15 which stands for what?

16 A: Sterile vaginal exam.

17 Q: Done for no change.

18 A: Yes, so essentially the patient felt pressure, maybe the
19 urge to push and so the nurse checked her again but there had
20 still been no change in her cervix. She was not ready to
21 push.

22 Q: So, what happens to soon to be mom when they get an
23 epidural? When you talk about pressure, what do they feel?

24 A: So, the epidural blocks pain receptors so you don't feel
25 the pain from the contractions that she had coming in active

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1 labor. It doesn't take away all the pressure sensations,
2 which is good when it's time to push she can feel that
3 pressure. So, she started feeling the pressure, so we
4 rechecked her to see if she was ready to push and it was not
5 time.

6 Q: And in terms of a mom that's had an epidural, what kind of
7 help are they with, you know, during the birthing process?
8 For those of us who have never birthed a baby.

9 A: So, with an epidural typically the patients feel numbness
10 from about the belly button down even if you prick their skin
11 all the way down it might feel dull but not like a sharp prick
12 with a pen. Their legs can feel very heavy. They're hard to
13 move. It's something that you can't get up and walk around
14 with because you're so numb you would just fall over. You
15 don't have that muscle control.

16 Q: All right. Let's flip to the same page just a little
17 further down, 3:55 in the morning where it says OB at bedside.

18 A: Yes. 3:55 in the morning obstetrician at bedside, that's
19 me. I checked her again essentially no change. It looks like
20 I was actually called in because the baby's heart rate had
21 dropped. We did various maneuvers to help recover the baby's
22 heart rate to a normal heart rate. We gave the patient
23 oxygen, we turned her to the side, and we turned off the
24 Pitocin. But again, her cervix was still unchanged.

25 Q: Okay, so flipping over two pages to 4:50 in the morning.

1 Does that look like the next time you were in the room?

2 **A:** Yes, at 4:50 it says examined by Dr. Maselli, no cervical
3 change. And it looks like we tried some position changes to
4 facilitate that.

5 **Q:** Yeah, it says patient placed in sitting position. What
6 were you trying to do there?

7 **A:** So, in that position we're trying to let gravity help us.
8 The baby's head is still very high in the pelvis and we want
9 the baby to come down, so she doesn't have to push as long
10 when it's time. So, we change positions and gravity can help.

11 **Q:** All right. Let's skip two more pages to the time of 6:01.

12 **A:** At 6:01 there's some vital signs, patient was comfortable,
13 tolerating labor well. Again, examined by me at 6:02 and she
14 was nine centimeters, 90 percent effaced so almost completely
15 thinned out and in station, the baby's head had come down.
16 So, she was making progress.

17 **Q:** All right. At this point was she ready to start pushing?

18 **A:** She was not.

19 **Q:** All right. It looks like you had her pull her knees into
20 her chest, more position changes at 6:10.

21 **A:** No, placed in the chest means that the patient actually is
22 -- so, if you're lying in a bed, you're actually turned to
23 face the bed and you're on your knees with your hands like
24 this. The labor bed's can move, the bottom can move down, the
25 top can move up and that's to help rotate the baby and

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1 facilitate the baby coming down in the birth canal and
2 dilating the cervix.
3 Q: All right. Let's flip to the next page and go to 7:00 and
4 in that time frame it looks like he charting goes from Teresa
5 Baxley to Kathy Cossentino.
6 A: Yes, at 7:00 is when the nurses change shifts every 12
7 hours so 7AM and 7PM. So, that was the night nurse leaving
8 and the daytime nurse coming in. The daytime nurse was Kathy
9 Cossentino.
10 Q: All right. So she started at 7AM?
11 A: Yes.
12 Q: And the other one, Teresa Baxley, would have been going
13 home at that time?
14 A: Yes.
15 Q: All right. Let's look a little further down at 7:06. It
16 looks like you were back in there for another exam.
17 A: Yes. 7:06 obstetrician at bedside. Her cervix is still
18 at nine centimeters, 90 percent effaced, minus one station.
19 Q: And how about at 7:10, four minutes later?
20 A: That was the timing document of the examination.
21 Q: Okay, so that would have been a vaginal examination?
22 A: Yes, that I performed.
23 Q: All right, let's go to the top of the next page at 7:13.
24 The first two entries there.
25 A: It states that the patient is comfortable with her

1 epidural. She has no complaints to the nurse.
2 Q: All right., so the epidural is working?
3 A: Correct.
4 Q: All right., let's look a little bit farther on that same
5 page at 7:46. What's going on at 7:46?
6 A: 7:46 the nurse documents some moderate acceleration, some
7 variable decelerations. The patient was again comfortable, no
8 complaints. It looks like I came in shortly thereafter to
9 check her again at 7:49 and now she was 9.5 centimeters and
10 zero station, which means the baby was moving down in the
11 birth canal.
12 Q: So, making some progress.
13 A: Correct.
14 Q: All right. Next page at 7:59.
15 A: At 7:59 she was examined again by myself and she was 10
16 centimeters and at a zero station and so we prepared the
17 patient for delivery.
18 Q: It says up for delivery.
19 A: Yes, and also both myself and the pediatrician were in the
20 room at 7:59.
21 Q: Is that normal to have a pediatrician in the delivery room
22 with you?
23 A: No, we don't typically do that. In this case with Ms.
24 Smalling when she had come to the hospital, right before she
25 was admitted her water broke and there was meconium, which is

1 a medical term for the baby having a bowel movement inside the
2 fluid or inside her abdomen before it was delivered. So, the
3 fluid is stained either green or brown and anytime you have
4 that we have a pediatrician at delivery so that they can
5 deeply suction the baby. Typically we would deliver a baby
6 and use the bulb suction to suction out any fluid in the mouth
7 and nose, but with meconium they need to be suctioned much
8 deeper so that the baby does not aspirate or suck in when it
9 takes its first breath, suck in any of that meconium.

10 Q: All right. And then shortly thereafter, you get -- you
11 get to the delivery?

12 A: Yes.

13 Q: At 8:14?

14 A: Yes.

15 Q: It says here, 7:14, comment MLE per Dr. Maselli. What
16 does that mean?

17 A: So, just a -- just above that, if I could just make a
18 comment, at 8:05, the patient was pushing, she was coached on
19 her pushing, effectively pushing and at 8:14, we document
20 delivery of the baby's head and during that same minute, MLE
21 is medial lateral episiotomy, which I performed. And 8:15 was
22 delivery of the body of the baby.

23 Q: Okay. Stop there for a second. All right. So, we're
24 just now into the delivery and you've been in the room. Let's
25 see, you received a page at 09, called them back 2 minutes

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1 later, 30 minutes later, you're at the patient's bedside,
2 right?

3 **A:** Yes.

4 **Q:** You're at the bedside a second time at 3:45, a third time
5 at 3:55, fourth time at 4:50, fifth time at 6:01, sixth time
6 at 7:06, seventh time at 7:46, eighth time at 7:59 and never
7 left?

8 **A:** That's correct.

9 **Q:** All right. So, I want to just ask about a couple of
10 miscellaneous records that have been discussed previously, but
11 you haven't had a chance to comment on them. I'm going to
12 hand you what's been marked as defendant's exhibit 4. Can you
13 tell us what that is?

14 **A:** There's two sides.

15 **Q:** Okay. Tell us what it is?

16 **A:** Oh, I'm sorry. This is a photocopy of a progress note, a
17 labor and delivery progress note that we write in the
18 patient's chart during their admission on labor and delivery.

19 **Q:** Did you write in that?

20 **A:** I did, on 4/27/13 at 2:45 A.M. was my first admission
21 note of the patient.

22 **Q:** Okay. Your Honor, we'd offer defendant's exhibit 4 into
23 evidence?

24 **THE COURT:** Mr. Graham?

25 **A:** It's not on the screen, Jamie.

1 **MR. HOOD:** I know, he's got to get it in evidence before
2 we can pull it up.

3 **MR. GRAHAM:** Your Honor, we have no objection to the
4 front. We didn't realize that there was another page on the
5 back. No objection.

6 **THE COURT:** All right. Without objection.

7 **DEFENDANT'S EXHIBIT NUMBER 4**

8 **ADMITTED INTO EVIDENCE**

9 **BY MR. HOOD:**

10 **Q:** All right. So, these are two progress notes. The
11 earliest is at what time?

12 **A:** That's the second. On the second one? There we go. So,
13 this is my written admission notifications. We get the time,
14 the date, the patient's age, how many pregnancies, how many
15 deliveries, how far along she is in the pregnancy, her
16 cervical exam, presentation, the V stands for Vertex, that
17 means the baby's head is down, so the baby's in the right
18 position. My note says patient presents in active labor, 7
19 centimeters after contracting for about one hour. Spontaneous
20 rupture of membranes, that's what SRM is. She's very
21 uncomfortable at the time of this note. Meconium was noted.
22 P&L stands for prenatal labs. So, this says that she was O
23 positive blood type. Negative Group B strep, which is a
24 bacteria that is normal in the vagina. We check all pregnant
25 women for that, because thought it's not an infection for the