

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of General Sessions

Honorable Joseph Derham Cole, Circuit Court Judge

Appellate Case No. 2014-000764

RECEIVED

JUN 22 2015

SC Court of Appeals

The State, ... Respondent,

vs

Stephanie Irene Greene, ... Appellant.

RECORD ON APPEAL
VOLUME TWO

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Kaushik Kotecha
Direct examination by Ms. Poulos

1 KAUSHIK KOTECHA, having been
2 first duly sworn, testified as follows:

3 DIRECT EXAMINATION BY MS. POULOS

4 Q If you would, please state your name for the record.

5 A Kaushik Kotecha.

6 Q And where are you employed?

7 A I'm -- currently I'm employed with Smith's Drug
8 Company. It's a wholesale drug company.

9 Q And back in November of 2010 where were you employed?

10 A I was working for the state bureau of drug control. A
11 lot of times it's known DHEC drug control. And I was the
12 district director for the drug control.

13 Q And what type of work did you do at DHEC?

14 A What we did was we did both regulatory and law
15 enforcement. Regulatory work would be where we go over
16 there and do inspections of the pharmacy, make sure their
17 records are correct. And then we also try to do education
18 along with that.

19 And on the law enforcement side is when someone
20 violates the law like forges a prescription, a doctor
21 diverting drugs, pharmacists diverting drugs. We did
22 investigation, install cameras. And then of course we also
23 look at any other violations like forged prescription or
24 anything like that.

25 Q Can you tell the jury about your educational

1 background and any certifications that you have?

2 A I was a -- I started out as a uniform police officer
3 in Spartanburg, and I got burned out and decided to go to
4 pharmacy school. So I became a pharmacist, practiced
5 pharmacy for about three years at Mary Black Hospital as a
6 staff pharmacist. And then I became an oncology pharmacist
7 with Drs. Bearden, Bradoff and Nelson.

8 Q So how long have you been a licensed pharmacist?

9 A Since 1989, so about --

10 Q About 25 years?

11 A Yes.

12 Q Are you a member of any medical or scientific groups?

13 A I'm a member of the South Carolina Pharmaceutical
14 Association.

15 Q And can you please describe what the study of pharmacy
16 is?

17 A Pharmacy is basically -- what you do is you look at
18 the -- well, first of all, you review the doctor's
19 prescription and make sure the doctor has got the
20 information.

21 And then what you do is -- is dispense the drug. And
22 then you look at interaction, if there is any interaction
23 with the drugs, and make a determination. If there's
24 interaction, you call the doctor and say, hey, doctor, did
25 you know that this was going on or this is -- probably

1 contraindicated for this patient.

2 I've seen -- I've had where someone was allergic to
3 penicillin and the doctor wrote a prescription for
4 penicillin. And so you call them up and correct it and
5 stuff like -- so you're kind of like the gatekeeper and
6 make sure the patient gets the correct drug.

7 Q Have you ever been qualified by this court as an
8 expert in the field of pharmacy?

9 A I have.

10 Q Do you remember which judge?

11 A Judge Cole.

12 MS. POULOS: Your Honor, at this time I would offer
13 Kaushik Kotecha as an expert in the field of pharmacy.

14 MR. WISE: No objection.

15 THE COURT: He is so qualified.

16 BY MS. POULOS

17 Q Did you begin your investigation in this case by
18 running a report through a prescription monitoring system?

19 A I did. It started out I received a call from the
20 Spartanburg County Solicitor's Office, asked me to look
21 into this matter.

22 And the first thing, what we do is South Carolina has
23 a program called script. But what it is, it's a
24 prescription monitoring program.

25 In other words, all of the controlled substances that

1 are filled in South Carolina are sent to the department of
2 health and environmental control where they keep a record
3 of who is getting what drugs. So therefore we can look at
4 doctor shopping or any kind of trends or anything like
5 that.

6 So if we -- if we're investigating a case we punch in
7 a person's name and find out, hey, what pharmacy are they
8 going to so we can look at that, because what we had was a
9 lot of people were going to different pharmacy and getting
10 the same drug.

11 Q And after receiving that information did you then go
12 talk to Dr. Kovacs?

13 A I did.

14 Q And what did you learn from that meeting?

15 A Well, from that meeting I learned that Dr. Kovacs was
16 not aware that --

17 MR. WISE: Your Honor, I would object to his
18 testifying to what Dr. Kovacs said as being hearsay.

19 THE COURT: Well, Dr. Kovacs has already testified.
20 So if we need to recall her, we can.

21 MR. WISE: All right.

22 BY MS. POULOS

23 A Dr. Kovacs say that she was not aware that Stephanie
24 Greene was pregnant, and of course she was not aware that
25 she was getting Vicoprofen from Dr. Kooistra who is a

1 neurologist.

2 Q And just to clarify again for the jury, which drug had
3 Dr. Kovacs been prescribing?

4 A Oxyco -- I mean, I'm sorry. MS Contin, which is
5 morphine.

6 Q Then did you also go to speak with Dr. Kooistra?

7 A I did.

8 Q And what was the drug, again, for the jury's
9 understanding that she had been prescribing?

10 A She had been prescribing Vicoprofen for her.

11 Q And what is the difference between mor -- I'm sorry --
12 hydrocodone and Vicoprofen?

13 A Vicoprofen is a drug. Hydrocodone is the -- is the
14 active ingredient, which is a pain reliever. Lortab is
15 a -- is a hydrocodone. But it's got acetaminophen in it.

16 Vicoprofen has got hydrocodone in it, but it's got
17 ibuprofen in it. So people who -- you know, say, have a
18 liver problem and stuff like that, a lot of times what
19 they'll do is they will give ibuprofen instead of Lortab.
20 That's the difference.

21 Q So basically just so the jury will understand better,
22 Vicoprofen has got the active ingredient of hydrocodone, is
23 that correct?

24 A That's correct.

25 Q Okay. And what are morphine and Vicoprofen or

1 hydrocodone usually prescribed for?

2 A Analgesic, pain.

3 Q And are they considered controlled substances?

4 A They are.

5 Q If you could, tell the jury. What is a controlled
6 substance?

7 A A controlled substance is they have -- and if -- if
8 you don't mind I can -- may I step out there and show that
9 provided the judge doesn't mind?

10 MS. POULOS: Your Honor, may the witness step down and
11 make a drawing?

12 THE COURT: Okay. Sure.

13 (Whereupon, the witness left the stand.)

14 A We have drugs right here, and then divided into O.T.C.
15 and prescription. I'm sorry. Thank you.

16 THE COURT: Be sure that the court reporter can see
17 your face as you testify so she can be certain to take down
18 what you say.

19 THE WITNESS: Okay.

20 A Or-and the other side of the drugs I call legend drug
21 or R.X. drug. All it means, it requires a prescription.
22 That's all it means.

23 Legend drug I subdivided into two other categories.
24 One category is called noncontrolled and the other category
25 is called controlled.

1 So noncontrolled drugs are drugs like antibiotics,
2 Prednisone, 800 mg ibuprofen. All of those drugs are
3 noncontrolled drugs.

4 Then you have controlled drugs which is -- which is
5 regulated by D.E.A. And in the state of South Carolina
6 it's DHEC drug control. And these drugs are divided,
7 subdivided, into five different categories.

8 Well, the first one is C-1. Controlled substance
9 Schedule I drugs are heroine, methamphetamine and stuff
10 like that, which has no medical use. So that's why they're
11 called Schedule I drugs. They're potentially highly
12 addictive.

13 Then you have C-2 drugs. C-2 drugs are highly
14 addictive, but they do have medical use. An example, C-2
15 drugs are further subdivided into two categories. You've
16 got narcotic and nonnarcotic.

17 Narcotic drugs are the drugs like morphine, Dilaudid,
18 oxycodone. Those are the Schedule II narcotics.

19 The nonnarcotics are drugs like Methylphenidate used
20 for A.D.D., Adderall. Those are nonnarcotic. So these are
21 opioids.

22 Then you have C-3 drugs. Again, they're subdivided
23 into two categories, and those are, again, narcotic and
24 nonnarcotic.

25 And narcotic in that situation will be drugs like

1 Vicoprofen, Lortab. Those are narcotic drugs. Nonnarcotic
2 drugs on those are some of the weight loss prescriptions
3 that they have, and those are nonnarcotics.

4 Then you have Schedule IV drugs. And an example of
5 Schedule IV drugs would be like benzodiazepine, Valium,
6 Alprazolam, Lorazepam, Temazepam. All of those are
7 Schedule IV drugs. And, again, as you move forward, move
8 down to higher number, the less addictive they are.

9 And then of course, then you have C-5 drugs, which has
10 got the codeine. A lot of times used to be if you'd have a
11 cough you can to a pharmacy and the pharmacy will sell you
12 dextromethorphan. This was a codeine.

13 The only exception to the rule on this one is --
14 that's cocaine. Cocaine is a Schedule II. Technically,
15 it's a nonnarcotic. But the D.E. has pointed as a -- as a
16 narcotic. That's the only difference that we have.

17 Q If you could, show where on your chart that morphine
18 would fall under.

19 A Morphine --

20 Q Write it down.

21 A Okay. Morphine would be right here. It'd be a
22 narcotic.

23 Q And where would Vicoprofen and hydrocodone be?

24 A Vicoprofen and hydrocodone would be Schedule III
25 narcotic drug right here.

1 Q And which of those two drugs are more addictive?

2 A Morphine. Then just Clonazepam -- that's the
3 benzodiazepine -- and that falls as Schedule IV.

4 (Whereupon, the witness returned to the stand.)

5 Q If you could, tell the jury about some of the side
6 effects of morphine.

7 A Again, morphine is a very good analgesic. As
8 oncologist I'd dispense a good bit of that. It is a very
9 good drug.

10 The problem with morphine of course you have -- I
11 usually when I was practicing pharmacy, I would tell them
12 that this is a very strong drug. And what you -- you
13 cannot drive. You need to be careful. Don't operate any
14 machinery or anything like that. Sometimes you'd be
15 unstable on your feet.

16 One of the biggest problems with morphine and
17 Vicoprofen is constipation. That was my general pharmacy
18 information that I passed onto the patient when I was
19 practicing.

20 Q As a pharmacist would you recommend someone who is
21 pregnant and/or breastfeeding to be taking morphine?

22 A I would -- I would say that, one, they would need to
23 check with their doctor because that's very important.

24 But it depends on the dose. If it's a high dose, I
25 certainly would have said, hey, this is too high of a dose,

1 you really need to check with your doctor. In other words,
2 I'd be more -- more assertive on my information in that
3 situation.

4 Q Is MS Contin a form of morphine?

5 A MS Contin means it's a continuous release. And that's
6 why they use that morphine -- continuous release.

7 Q And how is MS Contin different from other types of
8 morphine? Is it -- is it what you just said?

9 A Yeah. It's a continuous release versus immediate
10 release.

11 Immediate release, you get immediate pain relief right
12 there. And when it's a continuous release it just goes on
13 slowly. It builds up and then continues through the
14 timeframe. Usually it's -- you know, it depends on the
15 drug. Sometimes it goes through over eight hours.
16 Sometimes it's 12 hours.

17 Q And after you went and spoke with the doctors and got
18 your information did you then go to the pharmacies to
19 collect all of the prescriptions?

20 A I did.

21 Q And which pharmacies did you go to?

22 A C.V.S. in Inman and Rite-Aid in Inman.

23 Q And you actually -- you took the actual prescriptions
24 in evidence?

25 A I did.

1 MS. POULOS: For the record, Your Honor, they're
2 Exhibits 37 through 55 that have already been admitted into
3 evidence through stipulation.

4 Q Some of the prescriptions -- and we saw yesterday --
5 for hydrocodone were call-in prescriptions. Is it -- is it
6 common to call in a prescription for hydrocodone?

7 A It is, yes. It is not uncommon to call in a
8 prescription for hydrocodone because it's a Schedule III.
9 You can call in a prescription for Schedule III through V.

10 Q Let me show you some of these photographs here that
11 have already been admitted into evidence. This is -- let
12 me get you to go through each one of these. This is
13 State's Exhibit No. 7. What is that drug?

14 A Says morphine sulfate ER, which is extended release.

15 Q And, again, is that a drug that you would recommend to
16 someone who is breastfeeding to be taking?

17 A I certainly would have had additional questions, and I
18 would want to talk to the doctor if I knew they were
19 breastfeeding.

20 Q This is State's Exhibit No. 9.

21 A Again, this is the same thing. Hydrocodone is
22 sometimes used in pregnancy -- not pregnancy but when --
23 well, in pregnancy. But if you're breastfeeding I would
24 want them to know about it. And I'd probably give them --
25 you know, I would call the physician and tell the

1 physician, hey, you know, she's breastfeeding, you know,
2 just make sure that the -- the patient and the physician
3 are aware of that.

4 Q This is State's Exhibit No. 10. Is this just -- is
5 that just the back side of that prescription?

6 A I can't see what --

7 Q Could you read out the warning label?

8 A Oh, I'm sorry. "Do not take this medication in the
9 third trimester of the pregn -- pregnancy. Consult your
10 doctor -- your doctor or your pharmacist. May make you
11 drowsy, dizzy especially with alcohol. Use care with car
12 and machinery." And that's what I would have said. That's
13 correct.

14 Q This is State's Exhibit 11. What is that prescription
15 for?

16 A It's Clonazepam 2 mg. That's a Schedule IV drug, and
17 it's used for anxiety.

18 Q And this is just State's Exhibit 12, the back side.
19 Would you read the warnings on the label?

20 A "May cause drowsiness. Alcohol intensifies the
21 effect. Use care using machinery. May cause dizziness.
22 Do not use if pregnant or suspect you are pregnant or
23 breastfeeding."

24 Q And is that a drug that you would recommend to someone
25 who is pregnant and/or breastfeeding to be taking?

1 A Obviously, there's a warning. I would -- I would
2 certainly -- and, you know, I'm not saying that you would
3 not, but I would certainly be inquiring as a physician and
4 talking to the patient, hey, you need to -- you should be
5 considering this.

6 Q This is State's Exhibit 13. What is that drug?

7 A Keppra XR.

8 Q What is that typically prescribed for?

9 A You typically -- it's prescribed for seizures.

10 Q This is State's Exhibit 14, just the back side. If
11 you could, read out those warning labels.

12 A "Make you drowsy, dizzy." I -- I can't read the part.
13 It's folded just a little bit. But, "With alcohol use care
14 with car and machinery. If pregnant or become so discuss
15 use of drugs with your doctor. Do not chew or crush.
16 Swallow whole."

17 Q And, again, is this a drug that you recommend to
18 someone who is pregnant?

19 A Again, you know, if this was all combination together,
20 I would have probably had a lot of heartaches on dispensing
21 this drug.

22 Q This is -- sorry -- State's Exhibit 15. And what is
23 that drug?

24 A Baclofen. And it's used for muscle relaxer.

25 Q Sixteen is just -- just the back of that.

1 We'll move on to State's Exhibit 17. What is that
2 drug?

3 A Amlod -- Amlodipine. And usually that's used for
4 blood pressure.

5 Q This is State's Exhibit 19.

6 A That's Ro -- Ropinirole. And that is used for
7 restless leg syndrome.

8 Q Okay.

9 A And also used for people with Parkinson too sometimes.

10 Q This is State's Exhibit 20, just the back side of
11 that. Can you read the warning label?

12 A "Breastfeeding not recommended while using drug.
13 Consult doctor or pharmacist."

14 Q State's Exhibit 21.

15 A This is Keppra again. That's the same drug we had
16 earlier.

17 Q Okay. This is State's Exhibit 23.

18 A Gabapentin. This is used for neurological pain and
19 sometimes also used for seizures.

20 Q Would you recommend someone who is breastfeeding
21 and/or pregnant to be taking this drug?

22 A I probably would not. I would need to look at the
23 side -- side effect because it is -- it does have
24 drowsiness as one of the -- the problems with it. Side
25 effect.

1 Q State's Exhibit 25. How about this drug?

2 A Savella 50 mg. And, again, that's used for restless
3 leg syndrome too.

4 Q And, again, would you follow the same protocol as far
5 as your recommendations on whether or not to dispense this
6 to someone --

7 A That is correct.

8 Q -- when they're breastfeeding?

9 A That's correct. And there's another use for this one
10 too, which is Parkinson.

11 Q State's Exhibit 27.

12 A Carisoprodol. And the brand name is Soma. And this
13 is a muscle relaxer. This drug is converted into
14 meprobamate and is -- again, this used to be a legend drug
15 like I was telling you did not require -- it was not a
16 controlled substance rather, but today it is a controlled
17 substance. It's Schedule IV controlled substance today.

18 Q And this is State's Exhibit 30. And what is that
19 basically?

20 A Looks like some kind of caffeine tablet.

21 Q Is caffeine recommended for someone who's
22 breastfeeding?

23 A You know, I haven't done enough study on that one. I
24 have dispensed caffeine for neonatals when -- when their
25 heart's slow to increase the heart. So I really don't know

1 about that one.

2 Q If you could, tell the jury. What is synergistic
3 effect?

4 A Synergistic effect is one plus one equals five, or one
5 plus one equals three. You may be taking -- you know, like
6 alcohol. When you mix alcohol with Benadryl it's -- you're
7 going to be even more drowsy, you know, because if you took
8 Benadryl you're going to be drowsy. But when you mix it
9 with alcohol, then all of a sudden you're going to be even
10 drowsy. So that's what synergistic effect is.

11 Q Could a combination of all of these drugs together
12 cause a baby to stop breathing?

13 A Yes.

14 Q I'm going to show you what was already admitted into
15 evidence. This is State's Exhibit 60, and this is the pill
16 inventory that the coroner's office did. Have you had a
17 chance to take a look at that?

18 A I made a mistake on one of the drugs that you showed
19 me. That's Savella.

20 Q On the pictures?

21 A In the pictures, yes. And I was looking through, and
22 I was trying to remember it. It's a -- it's a S.S.R.,
23 serotonin serum inhibitor. And I made a mistake on that
24 one. I wanted to correct that. I'm sorry about that.

25 Q You need to clarify that for the jury?

1 A Yes. The drug that's Savella is S.S.R., yes. And I
2 did do that.

3 Q Okay. And in looking at the pill inventory of the
4 medications that were located in the residence, I want to
5 ask you specifically about the second one here, the
6 morphine.

7 A Uh-huh.

8 Q According to the chart -- the 90 and the 12 -- what
9 did the 90 mean typically? Is that the number that the
10 original prescription was for?

11 A That's what -- that's the information that I received
12 from the coroner's office, that the prescription originally
13 was for 90, which I validated with the prescription that we
14 had. And that was original prescription issued for 90
15 tablets.

16 Q And according to this chart there were only 12
17 remaining, correct?

18 A That is correct.

19 Q And so in doing the math about how many -- well, how
20 many of the morphine pills had been taken since the date
21 the prescription was filled on 10/20/10?

22 A According to the chart that I have she had -- if she
23 was supposed to take it normally it would have been 72
24 pills.

25 Q And based on your calculations with the number of

1 pills that were supposed to be taken per dose can you tell
2 us she was taking them as prescribed or more than
3 prescribed?

4 A The remaining --

5 MR. WISE: I object. I don't think he can conclude
6 anything from that other than that's the number of pills in
7 that bottle.

8 THE COURT: Sustained.

9 BY MS. POULOS

10 Q well, let's go down to the hydrocodone again.

11 A Okay.

12 Q How many total pills were originally prescribed for
13 that medication?

14 A Ninety tablets.

15 Q And, again, looking at this there were 42 left, is
16 that correct?

17 A That is correct.

18 Q So in doing the math how many were missing?

19 A Ninety minus 42 is, what, 48?

20 Q Okay. So between November 4th of 2010 when the
21 prescription was filled --

22 A Uh-huh.

23 Q -- and November 13th, nine days later, you say that
24 was how many pills were gone?

25 A Forty-eight pills.

1 Q Over a period of nine days.

2 A Over a period of nine days, that's correct.

3 Q And on -- later on after a few months after this case
4 had developed did you have the opportunity to interview the
5 defendant?

6 A I did.

7 Q And was Investigator William Gary also present during
8 that interview?

9 A Yes, he was.

10 Q And what did the defendant tell you about her
11 educational background and prior experience?

12 A That she was a B.S.N. in nursing. She -- she talked
13 about her automobile accident. And then of course when we
14 started talking about the drugs and the death of Alexis,
15 she finally confessed or admitted to me that, yes, she did
16 not tell the doctor what -- well, it was part of the reason
17 she didn't tell the doctor, was if she was pregnant and
18 then the doctors knew they would not prescribe the
19 medication.

20 Q Did she admit to being addicted to pain killers?

21 A Yes, she did.

22 Q Did she admit to lying to her doctors so that she
23 wouldn't lose her prescriptions?

24 A Yes. That's what I meant.

25 Q So did she admit that she was so addicted that she

1 didn't tell the doctors because --

2 MR. WISE: Objection, Your Honor. She's leading the
3 witness.

4 Q What -- if you could, just explain to the jury. Tell
5 us exactly what she admitted to you.

6 A She admitted -- we know -- of course I explained to
7 her that I had been doing this for a long time, addiction
8 was a horrible thing, I've dealt with doctors who are
9 addicted and everything. So I kind of went through those
10 steps. And I said is this -- is this why you didn't tell
11 your doctor that you were pregnant, so you wouldn't get the
12 morphine. And she said that's part of the reason but/and
13 then, you know, that's basically where we were.

14 Q What was she like emotionally during that time?

15 A She was crying, wanting to know what was going to
16 happen to her, upset.

17 Q Did the defendant tell you anything about any pills in
18 her purse?

19 A She did.

20 Q What did she tell you about that?

21 A She said when the coroner's office was counting there
22 were pills in her purse and -- and they told the coroner's
23 office about those pills because of the numbers being
24 out of -- out of what I was looking for.

25 Q Okay. Thank you. Please answer any questions the

1 defense may have.

2 CROSS-EXAMINATION

3 BY MR. WISE

4 Q Pronounce your last name again for me.

5 A Kotecha.

6 Q Kotecha?

7 A Yes, sir.

8 Q Thank you.

9 DHEC monitors pharmacists as well as doctors.

10 A I'm sorry?

11 Q DHEC monitors pharmacists as well as doctors.

12 A Monitors? You mean regulate?

13 Q Regulate.

14 A I just want to make sure we are --

15 Q Okay. They regulate pharmacists as well as doctors.

16 A Right.

17 Q And one thing a pharmacist is supposed to do is report
18 suspicious prescriptions, aren't they?

19 A Yes, sir, they are supposed to report them.

20 Q Okay. So if a patient came into a pharmacist with a
21 prescription for a 30-day supply of -- of oxy -- of
22 Oxycontin and then came in two days later with a
23 prescription from another doctor for a 30-day supply of
24 Oxycontin the pharmacist is not supposed to fill that one.

25 A I -- I think that the pharmacist's responsibility is

1 to call the doctor and inquire, hey, doctor, I just
2 received this prescription from doctor A and now I have got
3 this prescription from doctor B. There may be a reason why
4 they wrote the --

5 Q Sure. Prescription.

6 A So, you know, again it's just kind of you have to look
7 at the totality.

8 Q But y'all -- but y'all basically tell pharmacists when
9 you see something like that check it out.

10 A Absolutely. I think that's -- most pharmacists do
11 that.

12 Q Now, another thing. I don't know if y'all do it or
13 pharmacists do it. People are encouraged to use the same
14 pharmacy, aren't they?

15 A Yes, sir.

16 Q And why is that?

17 A So you can kind of monitor the side effects of drugs.
18 You know, you may be getting one drug that may counter the
19 effect of another drug or, you know, you may have a drug
20 that's synergistic effect, so yes.

21 Q That doctors may have forgotten about.

22 A Yeah, or it could be multiple doctors, right.

23 Q Basically, the pharmacists I think are trained that
24 they're responsible for making sure you don't take drugs
25 that interact with each other adversely.

- 1 A That is correct.
- 2 Q Okay. And -- and pharmacists -- okay. You know, some
3 of these prescriptions you talked about were called in.
- 4 A Yes, sir.
- 5 Q So pharmacists will actually in many cases see the
6 patient more times than a doctor will.
- 7 A Yes, sir.
- 8 Q All right. Now, in this particular case where did you
9 go to find all of the prescriptions for Stephanie Greene
10 except one?
- 11 A Majority of them were at C.V.S. in Inman.
- 12 Q A majority or all but one?
- 13 A All but one.
- 14 Q All --
- 15 A That's what I'm saying, yeah.
- 16 Q The one at the Rite-Aid.
- 17 A Right.
- 18 Q All of the rest of them is C.V.S. in Inman.
- 19 A That's correct.
- 20 Q Use the same pharmacy for everything.
- 21 A Yes, sir.
- 22 Q You didn't found -- you didn't find a pharmacy over in
23 Greenville for her.
- 24 A No, sir.
- 25 Q You didn't find a pharmacy down in Spartanburg.

Kaushik Kotecha
Cross-examination by Mr. Wise

1 A No, sir.

2 Q All of them in Inman.

3 A Yes, sir.

4 Q Now, when people engage in or when addicts engage in
5 drug-seeking behavior do they frequently go to different
6 pharmacists?

7 A They do.

8 Q And the reason for that is?

9 A Because they don't want pharmacy A to -- one pharmacy
10 to know that they're going to different doctors. So they
11 go to different pharmacists so they can't look at the data.

12 Q They can't get caught.

13 A Right.

14 Q Through your system they'll -- sounds like they'll
15 eventually get caught.

16 A Yeah. Again, the system is 30 days behind. So if you
17 got the prescription filled today -- and obviously a change
18 here recently -- but it would have been 30 days before you
19 got the information.

20 Q Now, in your investigation of this you learned that
21 Ms. Greene had some pretty complex pain problems.

22 A Certainly.

23 Q So she was taking a lot of pain medicine for different
24 things.

25 A Yes, sir.

- 1 Q For fibromyalgia and everything.
- 2 A Right.
- 3 Q Recklessly -- reckless -- excuse me -- sleepless leg
4 syndrome.
- 5 A Right.
- 6 Q Pain from the wreck --
- 7 A Right.
- 8 Q -- she had. Fibromyalgia. All of these things
9 require different type medications, right?
- 10 A That is correct.
- 11 Q Right. And when you're dealing with this many
12 different medications the prudent thing of course is to go
13 to the same pharmacy.
- 14 A That is correct.
- 15 Q which is what she did.
- 16 A Yes, sir.
- 17 Q Okay. Did anybody from C.V.S. pharmacy ever notify
18 DHEC of any unusual prescriptions on her?
- 19 A No, sir.
- 20 Q Okay. Now, treating pain is a complex problem?
- 21 A That's what they say, yes, sir.
- 22 Q You're familiar with that fact that treating pain is a
23 complex problem?
- 24 A Yes, I am.
- 25 Q Okay. And people stigmatize people who get treated

1 for pain too sometimes, don't they?

2 A Yes, sir.

3 Q They're referred to as addicts when they're not.

4 A Yes, sir.

5 Q Because a lot of the public perception is that if you
6 take some pain pills and you're walking around you must not
7 really need them.

8 A Well, that -- that may be public perception.

9 Q I understand that.

10 A Healthcare professionals --

11 Q It's not true.

12 A It's not true, yes, sir. So I would say --

13 Q So people who are taking pain medicines tend to get
14 stigmatized by people, don't they?

15 A I would think so, yes, sir.

16 Q And particularly when you take a lot of them --

17 A Yes, sir.

18 Q -- such as this type of case, right?

19 A Right.

20 Q And people become very defensive about their pain
21 medications in a sense, don't they? Because they think
22 they really need them and believe and know they really need
23 them.

24 A I think that if -- if they're talking to their
25 healthcare professional they already know that.

1 Q Right.

2 A But if I was talking to someone like Timi or Barry or
3 anything like that I may be -- I may not tell them that I'm
4 taking pain medication. I don't think it's -- it's their
5 business to know.

6 Q Right. I mean, you -- people who take pain medication
7 tend to want to hide it from people who are not medical
8 professionals.

9 A If you say so, sir.

10 Q I'm just asking you has that been your experience.

11 A I -- I don't know that -- I don't know that.

12 Q Okay. If you don't know, you don't know.

13 Now, have you got the toxicology report in front of
14 you?

15 A I can get it, sir. Yes, sir.

16 Q All right. There's no codeine found in that
17 toxicology report, is there?

18 A No, sir. I don't see any codeine.

19 Q The drug for restless leg -- sleepless leg syndrome is
20 Rip and Roll? I'm mispronouncing it?

21 A I think it's Requip. That's the brand name if I'm not
22 mistaken, but yes, sir.

23 Q All right. Is any of that in the tox report?

24 A No, sir.

25 Q And those two were recommended that you don't take

1 while breastfeeding.

2 A Yes, sir.

3 Q Is that correct?

4 A That is correct.

5 Q And neither -- neither of those two drugs were found
6 in the tox report.

7 A The two drugs that are found were not found in the tox
8 report? Is that what you're saying?

9 Q The -- the reckless -- the sleepless leg syndrome --

10 A No, sir. They were not.

11 Q -- was not found in the tox report.

12 A No, sir. It's not in the report.

13 Q And the hydrocodone was not found in the tox report.

14 A That is correct.

15 Q All right. And those are two of the drugs on the
16 label that said don't take while breastfeeding.

17 A That is correct.

18 Q Do you know what the third one was?

19 A I'm sorry?

20 Q Do you know what the third drug was?

21 A Clonazepam? Is that what you're talking about in
22 the --

23 Q The one they say don't take while breastfeeding.

24 A There were -- there were several drugs that you
25 wouldn't want to take while you're breastfeeding.

1 Q I'm asking about warning on the label. Let me see if
2 I can find it for you quicker.

3 A Probably Baclofen, but I'm not sure, because it's a
4 muscle relaxer.

5 Q Do you know if that drug was found in the tox report?

6 A No, sir, it was not.

7 Q It was not.

8 A No, sir.

9 Q So the three drugs that say don't take while
10 breastfeeding were not found in the tox report.

11 A Can you put Clonazepam? I believe Clonazepam is one
12 of those drugs that -- can I look at that, sir?

13 Q You may look at it. You can find it quicker than I
14 can.

15 A Thank you.

16 (Pause.)

17 A Clonazepam was found in there.

18 Q Okay.

19 A And that's the drug that -- that's the other one.
20 This is the Keppra that you were talking.

21 Q Right. The other two were not.

22 A Yes, sir.

23 Q Correct?

24 A Yes.

25 Q All right. And the Clonazepam, how much of that was

1 found?

2 A .01.

3 Q .01.

4 A Milligram per liter.

5 Q And the therapeutic level is what?

6 A Of course this is an adult therapeutic letter --

7 level -- which is .007 to .028.

8 Q So maybe on the low end of therapeutic.

9 A I'd say it's a little bit higher, because on 007, and
10 this one is zero -- .01.

11 Q Right.

12 A So .007 is --

13 Q .00 --

14 A -- a thousand. And then this one is hundred.

15 Q There's a .003 difference.

16 A There's one zero different, in other words, yes, sir.

17 Q Correct. Kind of low end.

18 A Yes.

19 Q Okay. Now, you're not saying you don't take morphine
20 while breastfeeding, are you?

21 A No, I'm not saying that. I think it's a -- it's a
22 very -- you have to weigh the risks versus the benefit and
23 then make a determination. And of course I'm not a
24 prescriber.

25 Q Right.

1 A But if I was a pharmacist I would certainly -- would
2 inquire about the risk versus benefit.

3 Q And you'd ask --

4 A I would ask.

5 Q -- the customer about it.

6 A Right. Well, I don't know if the customer was there,
7 but I would certainly -- if I knew -- if she was pregnant I
8 would call the physician and talk to the physician about
9 it.

10 Q Well, and if -- if you saw the customer and you knew
11 she'd just had a child, I assume you would ask her a little
12 bit about how much pain you're in and so forth, or would
13 you call the physician?

14 A I probably would call the physician.

15 Q You wouldn't have any discussions with the -- with the
16 customer.

17 A I probably would not, because I probably would not
18 have the whole history about what's going on.

19 Q Well, if you'd been dealing with this customer for a
20 period of years you would have a little more knowledge.

21 A Absolutely, absolutely. But/and I know where
22 you're -- what you're saying. But in this situation there
23 are several different pharmacists coming through there. So
24 I may not see a customer, you know, for months on because
25 the other pharmacist is filling the medication.

1 Q But she had been going to the same pharmacy as far
2 back as you've got records.

3 A Yes, sir.

4 Q Which is a good practice.

5 A Absolutely.

6 Q A smart practice.

7 A Yes, sir.

8 Q And there's not a person in the world you would
9 encourage to do anything differently.

10 A No, sir.

11 Q Because it's important for your health to know what --
12 how drugs inter-react.

13 A Right, right.

14 Q And pharmacists in many cases know better about that
15 than the doctors who prescribe the drugs.

16 A Well, I don't want to say that because I might upset a
17 lot of the doctors here, sir.

18 Q But sometimes they do because sometimes the physicians
19 don't know of the drugs a person is getting.

20 A That is correct.

21 Q Through either inadvertence or whatever.

22 A Right.

23 Q And so the pharmacist is the one that can catch all of
24 that.

25 A Right.

- 1 Q If you funnel it all through one place.
- 2 A Right.
- 3 Q Do doctors have access to your script network?
- 4 A Do doctors have access to prescription monitoring?
- 5 Q Yes.
- 6 A Yes, they do.
- 7 Q And how long have they had access to it?
- 8 A I want to say since 2007.
- 9 Q So a number of years.
- 10 A Yes, sir.
- 11 Q And so that means that if a doctor has a patient they
- 12 can just put the patient's name in that computer and find
- 13 out what prescriptions -- what controlled substance they're
- 14 getting.
- 15 A That is correct.
- 16 Q And it would not give you over-the-counter.
- 17 A I'm sorry?
- 18 Q Of course it would not give you over-the-counter.
- 19 A No, it would not give you over-the-counter
- 20 information.
- 21 Q And so if somebody puts Stephanie Greene's name in the
- 22 script network they would have a list of everything she's
- 23 taking that's been prescribed by C.V.S. pharmacy.
- 24 A They would have everything that she got anywhere in
- 25 the state of South Carolina, yes, sir.

1 Q Anywhere in the state of South Carolina.

2 A Anywhere in the state of South Carolina. So that way
3 they have an idea of what patient -- what they're dealing
4 with with the patient.

5 Q Is that something you encourage doctors to do?

6 A We do encourage doctors to do.

7 Q Thank you very much. Excuse me one second.

8 (Pause.)

9 Q Thank you very much.

10 MS. POULOS: Just a couple of questions.

11 REDIRECT EXAMINATION

12 BY MS. POULOS

13 Q In collecting all of these prescriptions did you learn
14 that the defendant had been getting the prescriptions under
15 two different names?

16 A There were two different names. There was one where
17 it's under Stephanie Neet and one under Stephanie Greene.
18 And there was some confusion about that.

19 Q And she had gotten mostly all of her prescriptions
20 from which pharmacy?

21 A C.V.S.

22 Q All but one?

23 A Yes. And when I -- and she -- she gave me an
24 explanation that the reason she went to Rite-Aid was
25 because Rite-Aid had a drive-through.

1 Q And which prescription was that for?

2 A Morphine.

3 Q For morphine. Okay. And he asked about the
4 toxicology report. In addition to morphine being found in
5 the baby's system was Clonazepam also found?

6 A Yes, it was.

7 Q And would those drugs have a synergistic effect?

8 A Yes.

9 Q Thank you.

10 THE COURT: You may step down.

11 MR. WISE: Just one second. A couple of questions.

12 RECROSS-EXAMINATION

13 BY MR. WISE

14 Q And you also found numerous morphine prescriptions
15 through C.V.S.

16 A Yes, I did.

17 Q So she'd got morphine from C.V.S. also.

18 A Right. And -- and, again, I think that you hit the
19 nail on the head.

20 Pain is subjective, that you, long-acting medication,
21 and then they give you medication for breakthrough pain.
22 And the only thing I can -- and when I talked to the
23 pharmacist at that time she felt like --

24 Q Well, you can't tell me what the pharmacist said. I'm
25 sorry.

1 A Okay. But basically what it was was for breakthrough
2 pain and that's why --

3 Q But the -- the breakthrough pain is the hydrocodone.

4 A That's correct.

5 Q Okay. And that's what you take for breakthrough pain.

6 A That's correct.

7 Q So it's not unusual to see the MS Contin and the
8 hydrocodone prescribed together.

9 A That is correct.

10 Q All right. One. Now, this morphine was time release?

11 A Yes, sir.

12 Q And so it's a 30 mg time release.

13 A Yes, sir.

14 Q And then it lasts eight hours, correct?

15 A Some people eight. A lot of time doctors will be
16 concerned. They give twice a day so they want to see last
17 12 hours, right.

18 Q Somewhere in that range.

19 A Right, right.

20 Q And so just a little bit of 30 mg gets into the system
21 at a time.

22 A That's correct.

23 Q And so you don't take it and get 30 mg.

24 A No, sir.

25 Q And you take it and you -- you get 30 mg over eight

1 hours.

2 A That's correct.

3 Q Is that correct?

4 A Yes, sir.

5 Q So the first hour you would maybe get a seventh of
6 30 mg.

7 A That I don't know. I mean, I just --

8 Q How it breaks down exactly, but it's designed to
9 release a little bit over a period of eight hours.

10 A That's correct.

11 Q Thank you.

12 MS. POULOS: Nothing further, Your Honor.

13 THE COURT: You may step down.

14 THE WITNESS: Thank you, sir.

15 MR. BARNETTE: Your Honor, I'd like to call Dr. David
16 Eagerton to the stand.

17 DR. DAVID H. EAGERTON, having
18 been first duly sworn, testified as follows:

19 DIRECT EXAMINATION BY MR. BARNETTE

20 Q Doctor, if you will, give your full name for the
21 record, please.

22 A David H. Eagerton.

23 Q And where do you work at, sir?

24 A Currently I work at Presbyterian College School of
25 Pharmacy.

1 Q And what is your position there, sir?

2 A I'm assistant professor.

3 Q Okay. And if you would, tell the jury a little bit
4 about your educational background and experience, sir.

5 A Well, I have a B.S. in biology from the University of
6 South Carolina.

7 After that I went to the pharmacy school for a year at
8 the University of South Carolina College of Pharmacy. And
9 then I went -- basically I never -- I didn't finish
10 pharmacy school. I went directly to graduate school where
11 I received a Ph.D. in pharmacology in 1992.

12 Upon graduation I -- I got a job with SLED, the South
13 Carolina Law Enforcement Division, as a forensic
14 toxicologist. Went through the training as a forensic
15 toxicologist. Through my years at SLED I became board
16 certified for forensic toxicology.

17 And approximately five years after I started work
18 there I became the chief toxicologist where I was for
19 about -- I don't know -- 12 years until I retired in 2009
20 to be a founding faculty member at the Presbyterian College
21 School of Pharmacy.

22 Q And you teach pharmacy at the pharmacy school there.

23 A Well, I teach biochemistry, patho -- or some in
24 pathophysiology, some pharmacology. I teach toxicology and
25 drugs of abuse.

Dr. David H. Eagerton
Direct examination by Mr. Barnette

1 Q How many times have you been qualified in state court
2 as a forensic toxicologist and a pharmacologist?

3 A Between 80 and a hundred times.

4 MR. BARNETTE: Your Honor, I would move him as an
5 expert in pharmacology, as well as forensic toxicology at
6 this time.

7 MR. WISE: No objection.

8 THE COURT: He is so qualified.

9 BY MR. BARNETTE

10 Q Dr. Eagerton, did you receive some information
11 concerning this case involving the defendant and the death
12 of her child?

13 A Yes, I did.

14 Q Could you tell the jury what information you did
15 receive?

16 A Well, I don't have an exact account of it, but I
17 received some information involving just the case history
18 around it, the toxicology report, some medical records,
19 incident reports, coroner's reports, things like that.

20 Q And did you receive the information of the drugs that
21 she had been prescribed, as well as the drugs that was
22 found in the baby in this case?

23 A I believe so, yes, sir.

24 Q And did you also receive information about the
25 coroner's office's investigation concerning what the

1 defendant had told them prior to the death of the child --
2 what happened?

3 A Yes, sir.

4 Q Let me show you State's -- what's been marked as
5 State's Exhibit 62. I believe this is a toxicology report
6 that's been testified to several times already entered into
7 evidence.

8 A Okay.

9 THE COURT: Be careful of the microphone.

10 Q You're familiar with SLED. And you're familiar with
11 SLED. Let me do this. Why don't you just step down if you
12 would.

13 A Okay.

14 Q That'd be easier to step down.

15 (Whereupon, the witness left the stand.)

16 Q And let me start from the bottom up, I guess is the
17 better way to do it at this time or whatever. And you're
18 familiar with SLED's protocols and everything obviously
19 working there.

20 A Well, I'm familiar with it until at least October of
21 2009. It's changed a little bit but not a lot.

22 Q But, obviously, the first substance from the bottom of
23 the page is the morphine.

24 A That's correct.

25 Q And the amount that you've seen there -- and,

1 obviously, you've had a chance to review the findings of
2 SLED and everything. Are you in agreement with that number
3 that they came up with?

4 A Yes, sir.

5 Q And would you consider that a lethal level?

6 A I would.

7 Q And this -- and these amounts, are these for adults?

8 A Typically, that's where we have most of our
9 information, is from adults. We really have very limited
10 information on even children and even little -- even less
11 information on D.N.A. in some younger children.

12 Q So we're looking at -- I guess Alexie was a little bit
13 over six weeks and she weighed a little bit over 7 pounds.

14 A Right, right.

15 Q But, obviously, it's a lethal -- well, it'd definitely
16 be a lethal weapon for a child that size.

17 A Absolutely.

18 THE COURT: Excuse me just a minute.

19 Let me ask you, Dr. Eagerton, if you will. Do you see
20 this microphone hanging down from the ceiling there? Let
21 me ask you if you'll stand close to that, and because the
22 court reporter is having difficulty picking your voice up.

23 THE WITNESS: How about that?

24 THE COURT: Maybe a little bit closer. You don't
25 really have to look up at it. It should pick it up.

1 THE WITNESS: Okay. Thank you.

2 THE COURT: Okay.

3 BY MR. BARNETTE

4 Q Okay. And if you would, tell the jury about these
5 other substances that's found above the morphine.

6 A Well, I'm going to skip up to Methorphan and
7 Methorphanin.

8 Those are basically -- Methorphan is the active
9 ingredient that states through Methorphan. At the SLED's
10 methods we can't tell the difference between Dextro and
11 Levo. And it's a big difference. We can tell it's
12 Methorphan. It's consistent with Dextromethorphan. But
13 there is another drug to the Levo. So that's why it's
14 reported out as Methorphan.

15 Methorphan is the primary metabolite of the
16 Methorphan. And, again, we don't know whether it's Dextro
17 or Levo. But, again, that's -- that's a -- a medication
18 that would be used in over-the-counter cough medicine.

19 Q You're talking about these two substances here.

20 A Right. Methorphan and Methorphanin.

21 Q And go the next one if you would, sir.

22 A The next one is Chlorpheniramine. Chlorpheniramine's
23 an antihistamine. It's also -- it's used over the counter
24 as a -- you know, for allergies, runny nose, watery eyes,
25 itching, things of that nature.

1 Diphenhydramine is also an antihistamine. It is used
2 for the same treatment.

3 Q And above that.

4 A Acetaminophen is Tylenol. It's a nonnarcotic
5 analgesic. It's used primarily for aches and pains.

6 Q Turn to the back page of the report. If you would,
7 tell us about this substance here, sir.

8 A Clonazepam is Klonopin. It's a benzodiazepine. It's
9 very potent. It's a newer generation benzodiazepine. It's
10 a lot more potent than our classic Valiums or Xanax, and so
11 therefore it's a lot stronger. You use a lot less to
12 achieve the same effects. But it has a lot of -- it has a
13 lot of use in psychopharmacology, but it also has uses as
14 to treatment for anxiety or different things like that.
15 Could be even a muscle relaxer. It has a lot of different
16 uses.

17 Q And obviously this is the adult levels for blood --

18 A Yes.

19 Q -- from that standpoint. This amount here, would it
20 definitely have an affect on this child?

21 A Absolutely. That's a significant -- that's a
22 significant amount in anybody. But, you know, in and of
23 itself you can't really say.

24 As a general rule benzodiazepines are a lot -- they're
25 safe drugs. You have -- you can overdose on them and you

1 can die from them, but you have to take a lot of them
2 typically.

3 Unless you mix it in combination with some other
4 similar reacting drug like some other what we call central
5 nervous system depressant, something like alcohol or even
6 some of these other drugs that we've talked about have some
7 central nervous depressant activity, certainly the morphine
8 does because it causes respiratory depression. So it has
9 some activity like that. But when you -- alone it's fairly
10 safe, but in combination it certainly can be deadly.

11 Q Okay. So based -- I think that's my next question
12 from that standpoint.

13 In your opinion all of these drugs, would they have an
14 effect on each other -- the morphine as well as the -- I
15 guess those are the two main ones we'll look at, is the
16 morphine and the Cla -- Klonopin. I'm sorry.

17 A Well, they don't really have an effect so much on each
18 other, or if they do I'm not really sure of the direct or
19 physical interaction. But the actions of one and the
20 actions of the other are certainly like they can be
21 synergistic or they are synergistic. Therefore when you
22 take them together they -- they can increase the effect
23 of -- that you would expect from either one alone or even
24 putting the two together. You would see a much greater
25 effect.

1 It's hard to quantify exactly how great that effect is
2 because that may vary from individual to individual.

3 Q But it could be like one-plus-one-equals-three type
4 situation.

5 A It could be one plus one equals three, or it could be
6 one plus one equals five. It could be one plus one equals
7 something greater than that.

8 Q Right. So but they definitely have an effect on --
9 what I guess is they add effect to each other.

10 A It's more than that. It's -- it's at least added.
11 It's probably synergistic. It's greater than that.

12 Q Okay. And based on your opinion is this what this
13 child died from, was the effects of the special dose drugs
14 and morphine in this case?

15 A Well, it's -- it's really hard, you know. In
16 toxicology they ask us a lot, you know. It's -- it's hard
17 to exactly pin down, you know, a cause of death, especially
18 with a drug like morphine in an adult, because you can have
19 some tolerance if you're taking morphine for a long period
20 of time.

21 You can have some changes in your physiology that
22 can -- you can adapt and you can take higher levels of it.
23 And that's usually what you see with people on it
24 chronically for chronic pain and stuff like that. You have
25 to give them higher and higher levels to achieve the same

1 effect.

2 So in those kind of people you can see higher levels
3 of morphine. That's why you see a therapeutic range that's
4 really a vast range.

5 In the literature it's nice to see -- if we could do
6 these studies in animals and stuff they'd look at things
7 like LD50. That's how much it takes to kill 50 percent of
8 your population of animals.

9 In humans we can't do that. We're only concerned with
10 how much it takes to kill one person. And so what we do is
11 we start the range at the lowest level where it's been
12 reported that one person has even died from it.

13 So you can see that a drug like morphine is a fairly
14 dangerous drug. I know it's used a lot commonly, but it
15 can be dangerous drugs.

16 Whenever you dispense it you need to monitor it to
17 make sure that the person is taking that properly. If
18 you're given this drug in a hospital one of the things
19 they're going to do is they're going to monitor your
20 respirations.

21 This is a primary thing that we worry about in
22 toxicology, is to increase your respiration, that is your
23 ability to breathe. It's going to increase your ability to
24 do that. So that's one of the things you monitor.

25 And sometimes if you've ever seen people in the

1 hospital they may have a little thing on their finger.
2 It's actually measuring how much oxygen is in their blood
3 or in their hemoglobin so they can get a -- an idea of how
4 well they're breathing. And if it drops below a certain
5 level they have to take action. So it's something you
6 really want to monitor, especially if you're getting a high
7 dose or extended doses.

8 A lot of times morphine or drugs like morphine are
9 indicated for acute pain, that is if you break your leg or
10 you sprain your ankle or something. You're going to have
11 pain for a day or two. You could be prescribed this drug
12 to take it, say, for a few days, and then you quit taking
13 it because you don't need to take it forever and ever.

14 That's less of a problem. You have -- less likely to
15 have respiratory depression so you don't worry as much
16 about it. But if you're given higher doses for more severe
17 pain or for more chronic pain over a longer period of time
18 you have to watch out, and that you should monitor that in
19 my opinion.

20 Q I understand. And obviously we're talking about a
21 six-week-old-year-old child, 7 pounds, and now you've got
22 these amounts in that -- that body.

23 A That's -- that's -- that's -- that's a -- that's a
24 significant amount in my opinion absolutely.

25 Q All right. And in this case -- if you would, have a

1 seat, Doctor.

2 (Whereupon, the witness returned to the stand.)

3 Q And I believe you found the prescription morphine was
4 MS Contin, is that right, from --

5 A That's what the records indicate, yes.

6 Q From there. And let me show you something here.

7 Actually, MS Contin produces this. I think I've given a
8 copy to the defense yesterday. I'll be glad to give them
9 another copy. And this I believe is approved by the United
10 States Food and Drug Administration. Is there -- what does
11 it say about MS Contin on that if you would, sir?

12 A Well, it's -- it gives a good bit of information, but
13 basically it says it's a strong prescription pain medicine
14 that contains an opioid narcotic used to treat moderate --
15 moderate to severe around-the-clock pain. Do you want me
16 to read the entire thing or --

17 Q No, just about the pregnancy and the -- the
18 breastfeeding if you would, sir, what it says -- what you
19 should tell your healthcare provider.

20 A "Before taking MS Contin tell your healthcare provider
21 if you have a history of it." It gives several histories.
22 And then in bold again it says, "Tell your healthcare
23 provider if you are pregnant or planing to become pregnant.
24 MS Contin may harm your unborn baby. If you're
25 breastfeeding MS Contin passes into the breast milk and may

1 harm your baby. Taking prescription or over-the-counter
2 medicines, vitamins or herbal supplements." Also warnings
3 for that.

4 Q Thank you.

5 MR. BARNETTE: Your Honor, I'd like to move this into
6 evidence at this time.

7 MR. WISE: No objection.

8 THE COURT: It's admitted.

9 (F.D.A. warning marked State's Exhibit No. 67.)

10 MR. BARNETTE: May I publish it to the jury, Your
11 Honor?

12 THE COURT: You may.

13 BY MR. BARNETTE

14 Q I know you just read this, Doctor, but I believe the
15 area that you just read was right here, is that correct?

16 A Yes, that's correct.

17 THE COURT: Is that Exhibit 66?

18 MR. BARNETTE: Sixty-seven, Your Honor.

19 Q And if I could show you on the bottom of that, and it
20 says this -- can you read that, sir? I don't know if you
21 can see it or not.

22 A It's approved by the U.S. Food and Drug Administration
23 and issued July of 2012.

24 Q Yes, sir. I'd like to show you this, sir. Who -- who
25 has had a trademark concerning MS Contin?

1 A Perdue Pharma [sic].

2 Q Okay. And was this their product monograph concerning
3 their product?

4 A This appears to be a copy of it, yes.

5 Q Okay. If you would, go to page four of that, please.

6 MR. WISE: Your Honor, if -- if I may, my first
7 objection is he had nothing to do with preparing this
8 document. It doesn't take an expert to read this document.
9 And, thirdly, the document is dated October the 31st of
10 2012, which was about two years after this incident.

11 THE COURT: Let me see the document.

12 MR. BARNETTE: See the form, sir.

13 THE COURT: Let me see the lawyers just a minute,
14 please.

15 (Bench conference held off the record in the presence
16 of the jury but out of the hearing of the jury.)

17 THE COURT: Let me see the lawyers just a minute.

18 MR. BARNETTE: Yes, sir.

19 (Bench conference held off the record in the presence
20 of the jury but out of the hearing of the jury.)

21 BY MR. BARNETTE

22 Q Doctor, MS Contin -- basically Perdue now says that it
23 can't -- obviously, they don't recommend giving it to
24 breastfeeding women in this situation.

25 A That's correct.

1 Q As a matter of fact, there's been studies done I
2 believe concerning opiate drugs such as morphine, codeine,
3 things like that that's been done by the American Academy
4 of Pediatrics concerning the use of those drugs with
5 children now. I guess that was just done this past year,
6 is that correct?

7 A That's what the more recent studies are showing, that,
8 you know, definitely they're coming out and taking a
9 stronger stand, absolutely do not use this.

10 But -- but that's the recommendation from what I can
11 gather from the literature and from my knowledge, is
12 basically that even prior to 2012 or 2013 -- these more
13 recent studies -- sustained release in high doses for a
14 longer period of time has never been, even though they may
15 not have necessarily come out and said absolutely do not do
16 this, they said be really, really careful and don't -- we
17 don't recommend that you do this, you can do it if you're
18 monitored appropriately.

19 Most of the time whenever you're looking at the -- at
20 the studies of -- look -- using opiates or opioids such as
21 morphine, codeine, things like that in breastfeeding,
22 they're usually talking about acute either with epidural
23 pain prior to or during delivery or postpartum pain by
24 something. It's usually an acute pain and it's usually
25 going to last for a very short period of time.

1 And I think the general consensus back around
2 2010-2011 was it's probably all right, just be careful and
3 pay attention and look for the signs of lethargy and
4 respiratory impression in the infant, and the mother as
5 well.

6 But then if you look at the fine print they -- they
7 talk about sustained release and -- and continued use of
8 these products. It -- it drops it down to an un -- an
9 uncertain level or an unsafe level, and they don't -- they
10 didn't recommend it even prior to these studies.

11 Q So it was prior to when this occurred that that was
12 their recommendation to do that --

13 A That's right.

14 Q -- from there. And in this case I notice you -- you
15 did get to review the coroner's office records --

16 A I did.

17 Q -- in this case. And obviously she was having
18 problems I believe on November 10th if I remember right.
19 She was lethargic, had breathing problems at that time. As
20 a matter of fact, they even called the doctor's office
21 about that.

22 A Right. They called the doctors about that, yeah.

23 Q And is that signs of possible overdose at that time?

24 A It could be consistent with that, yes.

25 Q And obviously the child died. Obviously, it is

1 consistent with that. Through the breastfeeding and
2 everything a child -- can it metabolize drugs like an adult
3 does?

4 A No. They don't.

5 Q If you would, tell the jury about that, especially a
6 six-week-year-old.

7 A Okay. Typically, whenever -- just to kind of back up
8 a little bit how -- you have to understand what drugs do in
9 your body.

10 Once -- once you take them they don't stay there
11 forever. They go through a cycle. And in pharmacology we
12 use the acronym ADME absorption. You have to get the drug
13 into your system. So how do you get it in there?
14 There's -- there's lots of different ways. You can -- most
15 things we're talking about now is you think of it orally.
16 But you can give it, you know, as a shot either just under
17 your skin, in your muscle. You can give it IV directly in
18 your veins. You can absorb some drugs through the skin,
19 different things like that. So you have different routes
20 of administration depending on what you're trying to do and
21 what the drug is.

22 Once you absorb it it's going to distribute throughout
23 your body based on its chemical and physical properties,
24 that is whether it likes water or whether it likes fat, or
25 it distributes into one of those two areas in the body

1 primarily.

2 Certain tissues may pick up drugs preferentially,
3 things like that. So it's going to distribute throughout
4 your body.

5 Then the next step is metabolism, which is more
6 correctly termed biotransformation. Basically, your liver
7 is responsible for that, and it has enzymes that develop
8 over time that basically take these foreign compounds that
9 you're taking and make it usually more water ciable [sic],
10 and the idea is to make it either less toxic or more
11 readily excreted. But the idea it to make it more
12 readily -- more water ciable [sic] typically so that it
13 could be more readily excreted from your body. And that's
14 the last stages of elimination. And it's eliminated --
15 it's eliminated -- most drugs are going to be once
16 they're -- especially once they've been metabolized and
17 made more water ciable [sic] they're going to be eliminated
18 throughout the water in your body -- urine, feces, sweat,
19 saliva, tears, things like that is how it's going to be
20 eliminated primarily. There are other ways too.

21 Q Does a six-week-year-old child metabolize at all?

22 A No, not typically because it take times for your liver
23 to develop. It takes time for these -- the genes that code
24 for these enzymes to turn on and be expressed. And you
25 don't -- even a child doesn't metabolize things the same as

1 an adult.

2 Usually you don't -- whenever you go through puberty
3 is whenever most of the things that are going to turn on
4 for an adult is going to turn on.

5 And, in fact, it even goes the other way. As you get
6 old, become aged, some of these genes can become
7 nonfunctional. Some -- you may not have the same metabolic
8 capacity.

9 Your kidneys may not work as well, things like that.
10 So you have to take into consideration age certainly
11 whenever you're looking at the effects of drugs and how
12 long they're going to stay in your body.

13 Q Obviously, the baby Alexis showed signs of this before
14 the death.

15 A Right. The -- the lethargy, maybe trouble breathing.
16 I -- I don't know how to interpret that exactly, but there
17 some -- there were some symptoms that were conveyed that
18 were consistent with morphine toxicity.

19 Q And basically if she was continuously breastfeeding
20 and things like that could she reach a level, especially if
21 she didn't metabolize it nearly as fast as the mother, for
22 example, could it reach the levels of toxicology --
23 toxicity of the level?

24 A Yes. And that's one of the things that if you can't
25 metabolize it, then the drug may build up in your body and

1 you become -- you have a toxic dose whenever you wouldn't
2 normally have a toxy dose.

3 Q And obviously there was another drug that you would
4 recommend not -- or, obviously, need to talk to your doctor
5 about these things, isn't that right?

6 A You know, any drug -- any time you take any drug for
7 any reason there's always risks associated with it.
8 There's nothing you're going to put in your body that's
9 going to alter your physiology that is totally safe.

10 Everything -- even Tylenol has risks and it does some
11 damage to your body. And you have to weigh do -- do the
12 benefits we're going to get from taking this drug outweigh
13 the risks that we're going to get from it or the damage
14 that may occur.

15 And that's what you have to do for every drug, and
16 that's why the physician has to be involved and they need
17 to know what all is going on so that they can make that
18 clinical decision.

19 Q And obviously -- the Klonopin is also another drug
20 that is not recommended for breastfeeding.

21 A That's correct. I don't think so.

22 Q From that standpoint. And that was something also
23 that showed up in Lexi's blood or in the baby's blood.

24 A That's correct.

25 Q And if I understand right it is your opinion based off

1 what you've seen and the studies and so forth -- and, like
2 I said, even the American Academy of Pediatrics have
3 changed their view on this I believe from the study that
4 Dr. Sachs [sic] has done on that.

5 A It looks like -- it looks like over time at least that
6 they've at least strengthened their view and come out and
7 become, whereas before it was maybe they categorize these
8 things.

9 It may have been a C where there's potential harm, you
10 gotta be careful, or it's a moderate risk. They assign it
11 some sort of risk. And I -- I have nothing to do with
12 that.

13 But it seems now that the stance is because of the
14 information that we have, especially over the past years,
15 that the stance is a lot stronger where they're coming out
16 and saying we don't recommend it. At least that's what it
17 looks like.

18 Q And, as a matter of fact, they've changed the
19 warnings. I think the articles refers to the National
20 Library of Medicine database. And they talk about the use
21 of morphine during lactation.

22 A Right. They do.

23 Q And once a mother's milk comes in what is their
24 recommendation concerning that? Did you get a chance to
25 read that --

1 A I have. I don't -- I don't have it memorized, and I
2 don't know exactly where, but the -- the general
3 recommendation without quoting specifically is that it's
4 not recommended.

5 Q Right. Basically, you're supposed to be a non --
6 nonnarcotic analgesic and limit the maternal intake with
7 meth -- morphine to a few days or low doses and close
8 infant monitoring.

9 A And that's the key to all of this. Again, in their
10 clinical -- you know, I'm not going to guess what they're
11 going to -- I'm not a physician. I don't prescribe. But,
12 again, they have to weigh the risk with the benefits. And,
13 again, even a dangerous drug can be acceptable if you
14 monitor just like -- like I was talking about in the
15 hospital. They're giving you dangerous, potentially
16 dangerous, levels to adults, but if they monitor you,
17 you're all right, because if you actually -- if you start
18 showing signs of respiratory depression there's -- No. 1,
19 there's an antidote that can reverse it, and, No. 2, they
20 can just stop giving you the drug or slow it down. And if
21 it -- you had it bad enough they can give you the antidote
22 to reverse the toxicity, or at least the respiratory
23 depression. And that's -- that's why if you monitor
24 closely you can handle it potentially. But, again, you --
25 you have to -- you have know about it and you have to

1 monitor it and you have to really be aware of it.

2 Q So the doctors definitely need to know about this.

3 A Absolutely.

4 MR. BARNETTE: One moment, Your Honor, please.

5 (Pause.)

6 MR. BARNETTE: If you would, please answer any
7 questions defense may have for you, sir.

8 CROSS-EXAMINATION

9 BY MR. WISE

10 Q Dr. Eagleton?

11 A Eagerton.

12 Q Eagerton. Is there a single peer review article that
13 discusses an admission to a hospital by an infant, a young
14 baby, from an overdose of morphine through breast milk?

15 A There is one in the -- published in the Lancet where
16 they were taking hydroco -- not hydrocodone -- codeine.

17 Q Let me phrase my question again -- rephrase my
18 question. We'll discuss that one later.

19 For a mother taking morphine is there a single peer
20 review, reviewed article, that discusses a child being in
21 the hospital with a toxic level of morphine in the system?

22 A I haven't seen one.

23 Q Yes.

24 A There could be, but I don't know.

25 Q Could it be because it doesn't exist?

1 A No, probably not.

2 Q Well, let's go back to that article that you just
3 cited. All right. The more current view you said of the
4 American Academy of Pediatrics. Have you got it?

5 A I don't know. Which one?

6 Q It's that one right there.

7 A Okay.

8 Q The August 26th of 2013. All right. You got it?

9 A Yes, sir.

10 Q Turn to page 801.

11 A E801?

12 Q E801, yes.

13 A Yes, sir.

14 Q Middle column, last paragraph or kind of last
15 paragraph. They're not really divided into paragraphs very
16 well. Where it begins, "For these reasons." All right?

17 A Yes, sir.

18 Q All right. Well, first of all, above that if you go
19 back and glance at it -- you've read this article, haven't
20 you?

21 A I believe I have.

22 Q Okay. Above that they discuss the Canadian case about
23 the child who took codeine.

24 A Right.

25 Q And that evolved, came about, because of a unique

1 genetic problem with the mother.

2 A She was a fast metabolizer.

3 Q Right. And somebody had the good sense to check and
4 see is there a genetic problem here, correct?

5 A Well, the genetic problem was with the mother.

6 Q Right.

7 A And basically she was taking codeine and it was
8 turning into morphine a lot more readily than --

9 Q Than --

10 A Than somebody that doesn't have this genetic
11 deficiency.

12 Q And that happens in a very relatively small amount of
13 population, does it not, except for apparently in Saudia
14 Arabia where it's 16 percent? Right above it are the
15 figures and it's -- in this country it would be in the one
16 percent range.

17 A It's a fairly small percent.

18 Q But it's still as a result of that someone learned it
19 could happen.

20 A That's correct.

21 Q Because somebody had the good sense to check the
22 genes.

23 A Yes, sir.

24 Q Correct? All right. So as a result of that the
25 American Academy of Pediatrics, you say, modified their

1 position, didn't they?

2 A Well, I don't know if it was totally a result of that,
3 but I believe that was in part.

4 Q In part because they -- the next paragraph, would you
5 read it with -- look at it with me?

6 A Yes, sir.

7 Q And it says there, "For these reasons when
8 narcotics -- narcotic agents are needed to treat pain in
9 breastfeeding women agents other than cocaine" --

10 A Correct.

11 Q And then they give examples -- Butorphanol, morphine
12 and Hydromorphone -- are preferred, is that correct?

13 A That's what it says, yes, sir.

14 Q So in August 13th of -- August the 26th of 2013 the
15 position of the American Academy of Pediatrics says on the
16 abundance of caution don't use codeine with the mother, use
17 morphine.

18 A It -- it says that is one of the things. But if you
19 look at it further their recommendation is this is for
20 nonsustained release and noncontinued use.

21 Q What does it say?

22 A If you look -- if you look at the recommendations they
23 say that for like MS -- drugs such as MS Contin they don't
24 recommend it.

25 Q What does it say there?

1 A It doesn't say that in this article.

2 Q Well, where is the article that says that?

3 A I don't have it with me, but there are -- there are
4 several.

5 Q You didn't -- you didn't bring it to court today with
6 you.

7 A No, sir.

8 Q The article that tells this jury that the American
9 Academy of Pediatrics says don't prescribe MS Contin you
10 didn't bring to court today with you.

11 A No, sir.

12 Q Did you think it was important?

13 A I think Mr. Barnette has it.

14 Q Did you think it was important? Does he have it?

15 MR. BARNETTE: Yeah.

16 Q All right.

17 A Actually there are several that --

18 Q That is -- that is -- that is not a peer review
19 article though, is it?

20 A No, sir. That's not the one I was talking about.

21 Q Okay.

22 A There's another one that refers to the Lancet
23 publication that says that. I can get it for you.

24 Q Sure. Please do.

25 A You have it. May I?

1 THE COURT: Yes, sir.

2 Q Sure.

3 (Whereupon, the witness left the stand.)

4 MR. WISE: Your Honor, if you want to take a little
5 break since we've been here a while, I'm going to --

6 THE COURT: We can do that.

7 Let me ask the jury to please go to your jury room.
8 Don't talk about the case. I'll bring you back shortly.

9 (The following takes place outside the presence of the
10 jury.)

11 THE COURT: All right. Before we take that break let
12 me caution Dr. Eagerton.

13 While you are permitted to discuss with Mr. Barnette
14 the location of the finding of that article, you're not
15 permitted to discuss the article or any of your other
16 testimony with anyone during the break because you're still
17 on the witness stand.

18 THE WITNESS: Yes, sir.

19 THE COURT: Okay. We'll be at ease for 15 minutes.

20 (Whereupon, a recess was taken.)

21 THE COURT: Are we ready for the jury?

22 MR. BARNETTE: The state's ready, Your Honor.

23 THE COURT: All right. Bring them in.

24 (The following takes place in the presence of the
25 jury.)

1 THE COURT: All right. Mr. Wise.

2 BY MR. WISE

3 Q Did you find an article?

4 A I found the one that I was thinking of, but I was
5 mistaken. It is essentially -- it was -- is Canadian, in
6 the Canadian journal. I believe it is peer review. But it
7 refers basically to that codeine.

8 Q So --

9 A So basically the same report that we were talking
10 about, so.

11 Q So what you're telling me is there is no peer review
12 publication based upon your research that ever says a
13 mother taking morphine can create a toxic level of morphine
14 in the child through breast milk.

15 A No, sir. That's a different question I believe than
16 what you asked me. I believe I do have one for that.

17 Q Let me get back to the other question.

18 Does that peer review article talk about MS Contin
19 being potentially dangerous creating a toxic level of
20 morphine through breast milk?

21 A I don't believe I've seen one those of those, no, sir.

22 Q All right. So what do you have on a -- on a peer
23 review article that says a mother can spread -- who is
24 taking morphine can spread a -- give a child a toxic level
25 of morphine through breast milk?

1 A Well, this is just one report. This is in the Journal
2 of Clinical Toxicology --

3 Q Okay.

4 A -- published in 1990 where it talks about basically
5 levels of morphine in breast milk after mother taking it.

6 Q And how many of them got to the toxic level?

7 A Well, I don't know -- exactly know what a toxic level
8 is for a six-and-a-half-week old.

9 Q All right. Well, let's say -- what's the highest
10 level you've got in that article?

11 A I don't know. Well, the con -- they measured the
12 concentration in the milk, and it was varied at different
13 times as you would expect. It was a hundred nanograms per
14 mil, 10 nanograms per mil and 12 nanograms per mil.

15 Q And --

16 A And in the -- in the infant morphine was at around 4
17 nanograms.

18 Q Four nanograms. And you've had plenty of studies
19 where infants had 4 nanograms that are doing well.

20 A There are studies where it has come up and they've
21 seen it at that level and with medical treatment they're
22 doing well.

23 Q And there are studies where without medical treatment
24 they're doing well.

25 A And that's considerably lower than what we have here,

1 yeah.

2 Q I understand that's considerably lower, but I'm asking
3 you where -- the question here is how did this morphine get
4 into this child, right? Do you understand that?

5 A well, yeah.

6 Q Okay. And the question is did it come through the
7 breast milk.

8 A Okay.

9 Q All right. And have you ever seen any study where a
10 level of .10 or greater was given to a child through breast
11 milk.

12 A A level of what?

13 Q .10.

14 A Give me some units.

15 Q Nanograms per liter. Is that the proper term?

16 A Point -- well, no, sir. Nanograms per mil.

17 Q Per mil. Okay. Milliliter.

18 A .10 or greater?

19 Q Yes.

20 A Yes, sir.

21 Q where?

22 A This one that I just said was 4 nanograms per mil.

23 Q Four nanograms?

24 A Yes, sir.

25 Q All right. Let me. You and I are miscommunicating.

1 It's my error and not yours. All right. The reading here
2 is .52.

3 A These are milligrams per liter.

4 Q All right.

5 A And we've got to get our units right and that's --

6 Q So what would that be in milligrams per liter?

7 A Would be .004 milligrams per liter.

8 Q So it would be -- basically this would be about 125
9 times higher.

10 A This level?

11 Q Right.

12 A Yes, considering.

13 Q Is that correct?

14 A Well, I'm not going to -- I didn't do the math, but
15 it's considerably higher, yes.

16 Q Would you trust me if I done the math?

17 A I trust you.

18 Q Okay. So have you ever seen any peer review
19 reports -- and if we deal with milligrams it may help me
20 because all of the charts in there, it helps me.

21 A Well, just for the record, that's -- that's what I'm
22 used to too, and that's why I have to convert it in my
23 head. That's why I pause every time.

24 Q Have you seen any reports then that talks about a
25 level of 10 milligrams per liter being passed to a baby

1 through breast milk with the mother taking morphine?

2 A Okay. Let me see. I don't recall. I'm looking
3 through, but I don't recall any, no, sir.

4 Q You will agree that in 2000 the Journal of the
5 American Academy of Pediatrics listed morphine as safe to
6 take while breastfeeding.

7 A Yes.

8 Q Is that correct?

9 A With a caveat.

10 Q Well, let's go to that caveat. This is the -- do you
11 recognize this as the Journal of the American Academy of
12 Pediatrics?

13 A Yes, sir.

14 Q Do you have it there?

15 A Yes, sir.

16 Q Very good. Turn to page 781. First of all, let's go
17 back. We're looking at table six, correct?

18 A I don't know.

19 Q All right. Table six is listed in the American
20 Academy of Pediatrics, "Maternal medication is usually
21 compatible with breastfeeding." It is on page 780.

22 A 780?

23 Q Well, try my copy. Is that the same one you've got?

24 A No, sir.

25 Q Okay.

1 A That's why.

2 Q Are you clear with that copy of the American Journal
3 of American Academy of Pediatrics?

4 A Okay.

5 Q All right. On page 780 they've got a table six.

6 A Yes, sir.

7 Q And table six lists medications that are usually
8 compatible with breastfeeding.

9 A Yes, sir.

10 Q All right. Go to the next page under morphine.

11 A Yes, sir.

12 Q What does it say?

13 A Well, it says morphine is a drug, and it says reported
14 sign or symptom and infant effect on lactation. None.
15 Infant may have measurable blood concentration.

16 Q None meaning what?

17 A I don't know. It says effect on lactation. That may
18 mean it has no effect on lactation.

19 Q Has no effect on lactation.

20 A Correct.

21 Q That's what the American --

22 A Lactation is the production of milk, not the
23 breastfeeding, just --

24 Q Okay. But then they say may have some -- may get
25 some --

1 A "Infant may have measurable blood concentrations."

2 Q All right. So what the American Academy of Pediatrics
3 tells you is that if you take morphine you may get
4 measurable amounts in the child, but that's it, correct?

5 A That's what that says, yes.

6 Q That's what that says.

7 All right. The American Academy of Pediatrics cautions
8 against oxycodone, don't they?

9 A I would imagine.

10 Q Well, let's look at the article on August 26th of
11 2013, the highlighted portion in the right-hand column.
12 Read that for us.

13 A The extreme right?

14 Q It's the highlighted portion.

15 A "Other narcotic agents such as oxycodone, pentazocine,
16 propoxyphene, and meperidine are not recommended in the
17 lactating mother. Relatively high amounts of oxycodone are
18 excreted in human milk, and therapeutic concentrations have
19 been detected in the plasma of a nursing -- nursing
20 infant."

21 Q So that's kind of a precaution against oxycodone.

22 A It is.

23 Q All right. You've got the -- we've got the lab report
24 of that, don't we?

25 A Yes, sir.

1 Q How much oxycodone was found in this child?

2 A None.

3 Q None, correct?

4 A That's correct.

5 Q She had a prescription for oxycodone, correct?

6 A No, sir.

7 Q What?

8 A I don't know.

9 Q She had a prescription for hydrocodone.

10 A Hydrocodone.

11 Q Okay.

12 A Totally different drug.

13 Q Hydrocodone. What's the recommendation on it?

14 A Don't know.

15 Q You don't know.

16 A I would -- I would say that it's probably the same as
17 with all of the other opioids.

18 Q Okay. But the hydrocodone had a warning label saying
19 don't breastfeed with it.

20 A I believe it did.

21 Q Okay. Are you familiar with LactMed?

22 A I am.

23 Q What is that?

24 A It's a -- a database for substances that -- and their
25 connection with breastfeeding and lactating mothers.

1 Q Okay. And it's put out by whom?

2 A It's from toxnet. I don't know if it's a national
3 database.

4 Q National Institute of Health?

5 A I believe it is an N.I.H. subserve, yes.

6 Q All right. well, I hand you -- look here at the
7 highlighted portion about the LactMed website and see if
8 that refreshes your memory.

9 A Yes, sir.

10 Q The National Institute of Health.

11 A Yes, sir.

12 Q Did you access that website in preparation for your
13 testimony here today?

14 A I did.

15 Q And which article on the National Institute of Health
16 website did you find that says a mother who breastfeeds can
17 give her child a toxic level of morphine?

18 A I don't recall.

19 Q Didn't find one.

20 A I don't recall.

21 Q Because it doesn't exist.

22 A May not.

23 Q Do you think if it existed you would have found it?

24 A I would hope so.

25 Q All right. Now, LactMed is a good source not only for

1 doctors but for breastfeeding mothers to go check, correct?

2 A Yes, sir.

3 Q All right. Now, Journal of Human Lactation. Are you
4 familiar with it?

5 A Not expressly.

6 Q You've heard of it.

7 A Just now.

8 Q That's the first time you've heard of it?

9 A Yes, sir.

10 Q You didn't research any of it in anticipation for the
11 testimony here today?

12 A I don't know. I really didn't pay attention to the
13 name of the journals when I was looking at it.

14 Q Well, let me ask you if you're familiar with that
15 journal.

16 A No, sir. I'm not.

17 Q You're not. Do you know if it's a peer reviewed
18 article?

19 A I don't.

20 Q Okay. So you didn't read any of this.

21 A I didn't say I didn't read it. I don't know. I don't
22 know that I read it or not. You just asked me if it was
23 peer reviewed.

24 Q You don't know.

25 A I don't know.

1 Q You don't know if you read it or not either.

2 A If I could see it again I could tell you.

3 Q No problem.

4 (Pause.)

5 A I don't remember seeing this one specifically, but I
6 believe that this was referred to perhaps in one of the
7 ones that I read. But, no, I don't remember that one
8 specifically.

9 Q Okay. Now, you have reviewed -- let me find my other
10 article. You're familiar with the Journal of Toxicology?

11 A I am.

12 Q Excuse me. Let me rephrase that. It's the Clinical
13 Toxicology --

14 A Journal.

15 Q -- Journal. Just gives me clinical toxicology.

16 A Yes, sir.

17 Q Look in upper right-hand corner.

18 A Yes, sir.

19 Q You're familiar with that.

20 A Yes, sir.

21 Q Okay. Something you subscribe to?

22 A Yes, sir, I actually do.

23 Q Have access to that at Presbyterian college.

24 A I do.

25 Q Let me borrow it a second. Did you read this article

1 in anticipation for your testimony here today?

2 A I don't know. Can I see that article? I can I see
3 the title of it?

4 Q Sure. And what's the title of it?

5 A "Is maternal opioid use hazardous to breastfed
6 infants?" I don't think so.

7 Q You don't think so.

8 All right. Let me borrow it a second. I should have
9 made you a copy.

10 Look on page six of this journal. And this is a peer
11 review journal, correct?

12 A That's right.

13 Q All right. Something that people in the field of
14 toxicology rely upon --

15 A Yes, sir.

16 Q -- to get further educated --

17 A Yes, sir.

18 Q -- and to form their opinions.

19 A Yes, sir.

20 Q All right. Look there if you would on this
21 highlighted portion on the right-hand side where the little
22 star is.

23 A Okay.

24 Q Read that to us.

25 A "The medical literature describes scant evidence of

1 opioid toxicity in breastfed infants."

2 Q Do you have any evidence that's contrary to that?

3 A No, sir. That's --

4 Q That's true.

5 A That's true, yes, sir.

6 Q So there's scant evidence.

7 A That is correct.

8 Q Which is pretty close to none.

9 A Yes, sir..

10 Q Right?

11 A That's right.

12 Q So you're in no position to say then that that number
13 came through breast milk.

14 A I don't believe I've said one way or the other.
15 Nobody's asked me.

16 Q Okay. But you don't have any basis for saying that it
17 came through breast milk.

18 A Had to get into the baby somehow.

19 Q That's not my question. You have no basis for saying
20 that number came into the baby through breast milk.

21 A I don't know that I'd say I have no basis. I'd say
22 the basis is the mother is taking MS Contin, which is
23 morphine. She is breastfeeding. We know that based on the
24 literature we've already talked about that at least small
25 amounts certainly do pass through into the breast milk. So

1 I don't think I have basis to say that it didn't, or at
2 least some of it.

3 Q Well, I'll concede some of it.

4 All right. Did you do any calculations to determine
5 what level would have to be in the mother to get to that
6 level in the baby?

7 A No, sir.

8 Q So you don't know.

9 A I don't know that anybody can calculate that.

10 Q You don't -- you don't know how much morphine she
11 would have had to take to get that level, correct?

12 A I believe there's scant evidence in the literature
13 that allows us to do that, so I --

14 Q I understand.

15 A I don't --

16 Q So you -- we -- you cannot make a conclusion today as
17 to how that morphine got into the baby.

18 A No, sir. I think I can make a conclusion as to how.
19 Like I said, at least some of it I believe within a
20 reasonable degree of scientific and medical certainty had
21 to come through the breast milk.

22 Q .04 mg?

23 A Like I said earlier, I can't quantitate how much.

24 Q .01 mg, or are you going to agree with the literature
25 that says basically a very small amount?

1 A Well, I don't disagree to the very small, that it's a
2 very small amount. I -- I don't disagree with that. But
3 it doesn't take much to kill a little baby.

4 Q Takes more than .04 mg though, doesn't it?

5 A May not.

6 Q You have studies in front of you that show children
7 with .04 mg.

8 A Right. And like I said a long time earlier, we in
9 forensic toxicology aren't concerned with the amount that
10 people can survive on. We're -- we're concerned with the
11 amount it takes to kill one person. And if you look at
12 the -- the level -- the levels of morphine -- if we slide
13 it back up -- it's a range. And people can die at much
14 lower levels, and people can survive. I can't really
15 predict that. I can only say as a forensic toxicologist
16 that this is a lethal level or this is consistent with a
17 lethal level, this is consistent with a toxic level. I
18 can't tell you specifically what levels somebody's going to
19 survive with and what level's going to kill somebody.

20 Q Let's go to another question, another area.

21 A Okay.

22 Q There is a concept known in toxicology as
23 redistribution of drugs after a person dies.

24 A Postmortem redistribution, yes, sir.

25 Q Is that correct?

1 A Yes, sir.

2 Q Morphine is one of the drugs that will redistribute.

3 A Yes, sir.

4 Q And redistributing drugs after dies means it comes out
5 of the fat tissue into the blood.

6 A That's one way.

7 Q And the body tries to get a state of equilibrium, so
8 to speak.

9 A Well, the body's not trying anything. The body is
10 dead.

11 Q Right.

12 A I mean, but it's natural --

13 Q The natural body --

14 A The chemistry is moving toward equilibrium, yes.

15 Q More accurate way of putting it.

16 A Yes.

17 Q All right. Naturally moving toward equilibrium. And
18 in 12 hours time you can start the process of
19 redistribution of drugs.

20 A You can.

21 Q All right. And here we have a list of several drugs
22 here, correct. --

23 A Yes, sir.

24 Q -- you said were synergistic with each other?

25 A Well, I said most of them are, not all of them.

1 Q Okay. Most of them are. And all of those drugs will
2 redistribute after death.

3 A I don't know.

4 Q Well, tell me which one won't.

5 A I'm not sure about Tylenol.

6 Q Okay. Tylenol.

7 A Or acetaminophen.

8 Q Okay. Well, let's eliminate Tylenol then. The others
9 will.

10 A I don't recall the exact amount, so just because it
11 can redistribute doesn't mean that it's significant. And
12 that's a -- again, that's why we look at it in multiple
13 tissues. We don't just -- we -- we prefer. That's why we
14 look at the tissues --

15 Q None of these --

16 A The liver and brain and things like that.

17 Q But none of these other drugs were looked at in
18 multiple tissues.

19 A No, not according to the report, no.

20 Q So you're in no position to sit here today and say
21 that these levels of drugs found, other than the morphine,
22 were not caused strictly by redistribution of drugs.

23 A I don't really understand your question.

24 Q All right. Let's go to the first one up there. What
25 is it? You can pronounce it better than I can.

1 A Well, the first one is Acetaminophen, but we ruled
2 that out.

3 Q Okay.

4 A So we're going to go to Diphenhydramine, right?

5 Q Right.

6 A All right.

7 Q What is it again?

8 A It's Diphenhydramine.

9 Q All right. Dip --

10 A Diphenhydramine.

11 Q Okay. All right. That's a .03.

12 A Yes, sir.

13 Q That will redistribute after death.

14 A It's possible.

15 Q All right. At what rate will it redistribute after
16 death?

17 A I don't know.

18 Q Nobody knows.

19 A I don't know that either.

20 Q Well, you haven't checked it with this anyway.

21 A No, sir. I looked -- and we could go down all of
22 these things and I can tell the same thing. I didn't
23 really look at -- to any great level of the postmortem
24 redistribution of those drugs because it doesn't really
25 matter.

1 Q And it doesn't matter because the only thing you're
2 really looking at is morphine.

3 A Well, when you're looking at postmortem redistribution
4 you can do -- do one of two ways. Either your blood level
5 can be higher than it was before death, or lower. It can
6 go either way. Drugs redistribute both ways.

7 Typically, when you think of classically postmortem
8 redistribution you think of drugs that are -- are typically
9 for whatever reason taken up preferentially by the heart,
10 because a lot of times in autopsy -- or the heart is where
11 the most easiest blood to get to oftentimes, and so that's
12 where classically they'll -- the pathologists will go into
13 the heart blood and get heart blood.

14 Then we found out that heart blood differed if we
15 measured the levels it differed from the levels in the hart
16 blood versus peripheral blood.

17 Some -- some -- some levels were really, really high
18 and it looked like an apparent overdose when, in fact, it
19 really wasn't. So that's why we started -- in forensic
20 toxicology we recognize this phenomena. And so we started
21 asking for peripheral -- peripheral blood, as well as
22 central blood, and then tissues as well, so that if we get
23 an apparent overdose we can go to those other sources and
24 confirm or not confirm that this is a legitimate overdose.
25 And that's why we look at the tissues.

1 And in this case the only one that you're really
2 concerned about would be the one that's an apparent high
3 level, an apparent lethal level. So you want to confirm
4 that.

5 So that's exactly what the analysts at SLED did, was
6 they looked at the tissue levels of it to confirm or to
7 even show to say, hey, this is a really high level but the
8 levels in the tissue don't support that as an overdose so
9 my opinion would be it's not an overdose.

10 Q But you came in here and said the synergistic effect
11 of all of these drugs is one and one equals three or five
12 or ten or whatever, correct?

13 A That's right.

14 Q But you don't know what those levels were in that
15 child at the time of death because of redistribution of
16 drugs after death.

17 A You know, for most drugs the redistribution is not
18 that great. There's only a few drugs where it's really --
19 whenever you're looking at things -- the classic example is
20 going to be your tricyclic antidepressants. That's where
21 you really -- those were the first, some of the first,
22 drugs that we noticed was a big difference.

23 If you look at that level, .5, even if you had a -- a
24 twofold difference in it, that still, no matter if you cut
25 .5 in half, it's still a lethal level for this -- for this

1 person.

2 Q I'm not talking about morphine right now.

3 A So -- so it doesn't -- my point is the post -- the
4 postmortem redistribution, while it's real and while it
5 happens, really doesn't play that big of a role in my
6 interpretation or any -- in my interpretation of -- of this
7 being a death from a morphine overdose.

8 Q Leave the morphine out for a moment.

9 A Okay.

10 Q You testified earlier that the synergistic
11 inter-reaction of all of these drugs, you know, led you to
12 the conclusion that's what killed this child in part.

13 A They contributed, yes, sir.

14 Q But you're sitting here today saying that you don't
15 know -- forget the morphine for a moment. All of the other
16 drugs, you have no way of telling what their levels would
17 have been when the child was alive.

18 A I believe we have a pretty good representation. Like
19 I said, I don't believe that the postmortem redistribution
20 is going to be significant in these drugs.

21 Q Well, in those drugs.

22 A That's right.

23 Q All right. Where are those drugs stored, do you know?

24 A Do you mean in the body?

25 Q In the body.

1 A They're going to distribute pretty well throughout the
2 body. I don't know their volumes of distribution, so.

3 Q They're going to be in the fat cells.

4 A No.

5 Q Some of them are?

6 A Most of those are pretty -- they'll -- they'll be
7 some -- really, no, not -- not -- none of those are really
8 extremely lipophilic that I would say they would be in the
9 fat cells in any greater concentration than in the other
10 nonfat cells.

11 Q And you've done some studies on that or researched
12 that issue? You didn't do that for this.

13 A I haven't researched it, but I can look at a structure
14 and tell whether it's hydrophobic or hydrophilic.

15 Q And those that tend to get in the fat get in there
16 quicker than those that don't.

17 A Obviously if --

18 Q Obviously?

19 A If they tend to not get in the fat, they're not going
20 to get in there at all.

21 Q None -- none of those drugs will never go into the
22 fat.

23 A They'll -- they'll go to some. They have some.
24 They're going to get into the brain, and so in order to get
25 into the brain you've got to have some lipophilicity. But

1 they're not going to be preferentially sequestered there.

2 They're going to be distributed I think more evenly.

3 Q woman that gives delivery is frequently given morphine
4 in the hospital, correct?

5 A Okay.

6 Q I mean, is that correct?

7 A I don't know what that -- what all they give them in
8 the hospital. I don't -- wouldn't be able to tell you how
9 frequently.

10 Q Not necessarily this case but in general.

11 A I don't know. I know morphine is given in the
12 hospital, but I don't know exactly. I'm not a physician.
13 I don't --

14 Q Have there been women who have had morphine pumps that
15 have breastfed their baby?

16 A I don't know.

17 Q Is it in the literature anywhere, or do you know?

18 A I don't recall.

19 Q Now, there's also a problem with the -- what they call
20 the blood-brain barrier.

21 A That's not a problem. It exists.

22 Q It exists.

23 A And protects us.

24 Q And it's a problem. All right. It's a problem in the
25 sense that a blood-brain barrier is what keeps some drugs

1 from getting to the brain.

2 A Yes, sir.

3 Q All right.

4 A It's a good thing.

5 Q It's a good thing. But heroine has -- goes through
6 the blood-brain barrier pretty quickly.

7 A It does.

8 Q And Oxycontin goes through pretty quickly.

9 A Relatively.

10 Q Now, morphine not so much.

11 A Not as much as those two, but it gets in there pretty
12 good -- concentration.

13 Q I understand it gets in there eventually, but it's
14 going to be slower getting in there than the other two.

15 A Yes.

16 Q So in any toxicology report then you would expect --
17 well, let me back up a second. And the liver has a lot of
18 blood in it obviously, correct?

19 A If it's a normal healthy liver and not cirrhotic,
20 yeah.

21 Q All right. And nothing to indicate in this case it
22 wasn't a normal, healthy liver.

23 A I didn't recall seeing anything.

24 Q So you would find a greater concentration of blood
25 obviously in the liver than, frankly, except for the heart,

1 any other part of the body.

2 A I don't know.

3 Q Okay. So with the blood-brain barrier would you not
4 expect to find the morphine level for the brain to be less
5 than the morphine level for the liver?

6 A I don't think that has anything to do with the
7 blood-brain barrier.

8 Q Well, back up a second.

9 The blood-brain barrier keeps morphine from getting to
10 the brain.

11 A It's not just morphine but --

12 Q Or it retards it.

13 A It is -- it is another membrane or barrier that a drug
14 would have to cross to get there, yes.

15 Q Correct. And it doesn't cross that barrier as quickly
16 as it would at the liver.

17 A I don't know how fast it will cross, but I would guess
18 not.

19 Q Okay. The blood-brain barrier slows down the
20 absorption of morphine into the brain.

21 A Yes.

22 Q All right. Then you would expect on any typical
23 report for the liver-morphine level to be higher than the
24 brain morphine level.

25 A No.

1 Q And even with the barrier.

2 A Well, the barrier -- that's not really how it works.

3 There are receptors in the brain that the morphine's going
4 to be attracted to. So it's going to concentrate there.

5 Once it -- it's going to take a little longer to
6 concentrate. And that's probably why the general consensus
7 is if you take morphine or these kind of drugs acutely with
8 breastfeed, then it's probably okay because you don't get
9 that good penetration into this, into the brain. That's
10 probably one of the reasons.

11 Once it gets in the brain it -- there are receptors
12 there. These -- these opioid receptors there that are
13 responsible for the actions of the drug are going to bind
14 to it, and it's going to stay there longer than just
15 regular blood.

16 There are no opioid receptors that I'm aware of in the
17 liver. It's going to bind it. It's going to metabolize it
18 or not and pass it on. You've got to have that circulation
19 moving because that's your systemic circulation. You can't
20 stop the blood there or you're going to have problems.

21 So the other thing is whenever you take a -- a -- a
22 portion of brain, obviously, from a dead person, you can
23 measure levels of drugs throughout different areas of the
24 brain. You're going to get different levels.

25 So the levels of the drug in the brain are not that

1 impressive to me. Specifically to me my interpretation of
2 those is that they're just consistent with a large amount
3 of morphine being in that -- this little baby's body.
4 Okay. So that's consistent with that high overdose level,
5 lethal level, of morphine.

6 The better tissue to look at that you have more
7 literature is the liver itself. And that's why you want to
8 look at the liver primarily when you're talking about
9 postmortem redistribution. You look at liver because
10 that's going to give you your -- your impression of whether
11 you've got a [sic] artificially high level in the blood.

12 So you gotta take all of these things into account.
13 The fact that the level in the brain may be lower than the
14 liver really has no bearing whatsoever in my opinion.

15 Q So you're not able to tell this jury how this morphine
16 got into this child.

17 A It had to -- most commonly it had to get there by the
18 oral route.

19 The other thing was somebody could have put it in a
20 syringe and given it to it subcutaneously, perennially as
21 we call it, not through the mouth.

22 I mean, there's any number of ways you can get
23 morphine into somebody. Those are the primary ways. I
24 don't recall seeing any track marks or anything where
25 somebody would have injected it. So it's the natural

1 thing, is that it got ingested.

2 Q And if someone were to give this child a pill you
3 would see remnants of that pill in the stomach.

4 A More than likely.

5 Q More than likely. All right. And --

6 A This is a six-and-a-half-week old. I don't think a
7 six-and-a-half-week-old could swallow a pill. I mean, I'm
8 not an expert on that, but I just kinda think that they're
9 going to probably choke on it. I have -- I have a problem
10 swallowing pills, so I don't know.

11 Q And you're a little older --

12 A I'm a little older than six and a half weeks.

13 Q But you don't know for sure.

14 A I don't, but, I mean, I did -- I find that hard to
15 believe.

16 Q If it were cut in half would you still find it --

17 A Now, now, if you take it and crush it up and put it in
18 the formula or something and fed it to the baby that
19 would -- that certainly, that can happen.

20 Q And you would find in the stomach contents.

21 A You could. I don't think that the -- I thought about
22 that initially. I don't think that's as likely in this
23 case because this -- the morphine we're talking about is MS
24 Contin, which is a sustained release product.

25 If you crush up or cut a sustained release product it

1 won't be sustained release any more. It'll dump it all at
2 once.

3 If that were the case in my opinion and then you
4 crushed it up and you gave it to an infant, the infant
5 would probably become toxic and leth -- and die within 30
6 minutes to an hour. They're going to absorb it. That
7 level's going to get high into the blood.

8 I think what we see here is -- is more of a chronic
9 type exposure, which is more consistent with through the
10 breast milk. Or it could be some combination of both. I
11 don't know.

12 Q All right. But you have no literature anywhere to
13 support your opinion that a chronic type of exposure to
14 morphine through breast milk would create a toxic level in
15 a child.

16 A I believe -- I believe that if we take the reports
17 that we have where it comes through in small levels that
18 means if it -- if you're getting a small dose of it you
19 gotta to take it longer over a period of time.

20 If we've got evidence that the -- these little babies,
21 this six-and-a-half-week-old -- probably can't metabolize
22 and get rid of the morphine as fast, so therefore it's
23 going to build up in its body. So that would suggest the
24 more chronic type of exposure. And I believe that's what
25 the literature that we've already gone over -- in my

1 opinion that's what it points to.

2 Does it come out and out and say that? No. I don't
3 believe I've seen any literature that says that. But for
4 everything there's got to be a first.

5 Q Now, you'll also agree that at somewhere between two
6 and three months a child is pretty much adult-liver
7 function.

8 A No.

9 Q You don't? Excuse me one second then.

10 A I believe it's closer to six months.

11 Q Closer to six months. And certainly one month is much
12 greater than after birth.

13 A Well, by definition it would be 30 days.

14 Q Is that correct?

15 A Yes, sir.

16 Q All right. Now, you talked about the medical history
17 of this child, and you found that it was called in that the
18 child had a temperature, correct?

19 A No, sir.

20 Q Well, did you review the fact that there was a call to
21 the pediatrician about the child?

22 A Yes, sir. I -- and what I recall was that it did not
23 have a temperature, that's why they didn't want to see it.
24 If it had had a temperature I think they would have.

25 Q I believe it was a temperature the day before.

1 A I don't -- I -- I recall that there was some talk
2 about that, but I believe that -- at least my impression
3 was that it did not have a temperature.

4 Q Okay. All right. And that -- what report was that
5 you relied upon?

6 A I don't recall.

7 Q Have you got it with you?

8 A I don't recall specifically. No, sir, I don't have it
9 with me.

10 Q Have you got that one with you?

11 A If you want to show it to me I'll be happy to look at
12 it.

13 MR. BARNETTE: I can provide it, Your Honor, if that's
14 okay.

15 MR. WISE: That will be fine.

16 THE WITNESS: Thank you.

17 BY MR. WISE

18 Q Have you got it?

19 A I've got one. I believe I've seen it referenced in
20 several places, but I've got one in particular, yes, sir.

21 Q And what does it basically tell you?

22 A Basically, this is in the Spartanburg County Coroner's
23 investigative report. It says that Stephanie stated that
24 infant had a cold on Wednesday, November 10th, and was
25 congested, not eating well, is somewhat lethargic that day.

1 Q That's Wednesday, correct?

2 A Yes, sir, Wednesday, November 10th. Her rectal
3 temperature was 99.0. She called the pediatrician, Landrum
4 Family Physicians, the following morning, Thursday,
5 11/11/2010, and was told by the nurse that as long as Lexi
6 was not running a fever she did not need to bring her in to
7 be seen. She was instructed to get a vaporizer and baby
8 rub to use.

9 Q And no report about her being lethargic on Thursday or
10 Friday, just Wednesday.

11 A I don't see any --

12 Q Okay.

13 A Any note of that. I don't see anything that says she
14 wasn't. I don't see anything that says she was.

15 Q Well, you see in the report that says she was on
16 Wednesday, correct?

17 A That's right.

18 Q All right. And the absence of such statement in
19 Thursday and Friday would imply that it wasn't there.

20 MR. BARNETTE: Objection, Your Honor. Asking the
21 witness to speculate.

22 THE COURT: Sustained.

23 BY MR. WISE:

24 Q You see no report saying that she -- she was --
25 nothing in that report says she was lethargic on Thursday

1 and Friday.

2 A No, sir.

3 Q Okay. In fact, I think some reports said she was
4 alert and doing well on Friday, I believe.

5 A I don't see anything that says she was alert and doing
6 well. It says -- it seems to say that she was getting
7 better.

8 Q Okay. Getting better on Thursday and Friday, correct?

9 A Right.

10 Q Okay. Now, you're familiar with clinical toxicology.

11 A Yes, sir. We've already said that.

12 Q All right. Looking at July 1 of 2011.

13 A Okay.

14 Q And it's a topic entitled, "If maternal opioid use
15 hazardous to breastfed babies or breastfed infants."

16 All right. And the bottom of the left paragraph is a
17 marked thing. What does it say?

18 A I believe we've already discussed this one, but it
19 says we're not aware of any reports of suspected infant
20 toxicity from maternal morphine used while breastfeeding.

21 Q All right. Thank you. Give me one second.

22 (Pause.)

23 Q Just -- just one other question.

24 Do you -- have you done any studies on liver functions
25 of infants?

1 A Not specifically, no, sir.

2 Q So you're going by what generally is talked about when
3 you say that infants don't have a good liver function.

4 A I believe there's literature that supported that.

5 Q On that point. All right. Thank you.

6 MR. BARNETTE: Just a couple on redirect, Your Honor.

7 REDIRECT EXAMINATION

8 BY MR. BARNETTE

9 Q He talked about LactMed, about it's well recognized.

10 A Yes, sir.

11 Q And obviously you're familiar with it from there.

12 A Yes, sir.

13 Q This is on morphine. If you look under summary of use
14 during lactation --

15 A Yes, sir.

16 Q -- if you would, read what they say about using
17 opiates or pain killers.

18 A "Epidural morphine given to mothers for postcesarean
19 section analgesia results in trivial amounts of morphine in
20 their colostrum and milk. Intravenous or oral doses of
21 maternal morphine in the immediate postpartum period result
22 in higher milk levels than with epidural morphine. Labor
23 pain medication may delay the onset of lactation. Maternal
24 use of oral narcotics during breastfeeding can cause infant
25 drowsiness, central nervous system depression and even

1 death."

2 Q This is a narcotic we're talking about -- morphine.

3 A Yes, it is.

4 Q And as well as the other substance. I believe it's
5 the Klonopin in there, but the morphine specifically. And
6 that's what LactMed says.

7 A Yes, sir.

8 Q And that's recognized nationally, and obviously you're
9 familiar with it too.

10 A Yes, sir.

11 Q And that's what they say about it.

12 A Yes, sir.

13 Q He was asking you about scant evidence. A lot of
14 these -- not going to intentionally -- I mean, with
15 children and so forth, little ones like this, you've got to
16 be -- you've got to monitor them when they're given
17 morphine, don't you, or keep an eye on them, because
18 obviously they can fall very quickly.

19 A Yes, sir.

20 Q And has there ever been any studies with a chronic
21 user of morphine that uses MS Contin or anything further?

22 A I think that's what we're -- no. I agree there's not
23 a lot of literature out there. It -- it -- no doubt.

24 Q But based off the history you've seen with this
25 defendant and everything obviously she's used morphine for

1 a long period of time.

2 A That's what it would indicate, yes, sir.

3 Q And obviously do they build a tolerance over that
4 period of time to those drugs?

5 A You talking about the -- the mother using it?

6 Q Right, the mother.

7 A Yes, yes, sir.

8 Q And so a lot of times when they keep using drugs over
9 and over again they need more of it to sustain themselves.

10 A Yes, sir. That's correct.

11 MR. BARNETTE: One moment, Your Honor, please.

12 (Pause.)

13 Q Thank you sir. Please answer any questions the
14 defense has for you.

15 RECROSS-EXAMINATION

16 BY MR. WISE

17 Q What page is that statement you read on?

18 A I don't know if the page number is right. It says
19 page one of five, or I think that's a five. I can't really
20 tell.

21 Q I think it is too. And what paragraph is that?

22 A It's the very first paragraph, summary of use during
23 lactation.

24 Q Summary.

25 A Yes, sir.

1 Q At the end of the article if you go back to page looks
2 like three of five --

3 A Yes, sir.

4 Q All right. It says, the paragraph under effects in
5 breastfed infants --

6 A Yes, sir.

7 Q It says there that, "Breastfed newborns of mothers
8 using intervenous P.C.A. morphine," right, "for
9 postcesarean -- word I can't pronounce -- anal --

10 A Analgesia.

11 Q -- analgesia were more alert and better oriented after
12 postpartum day three than infants of mothers using
13 intravenous P.C.A. meperidine and nonbreastfed control
14 infants," correct?

15 A Yes, sir, that's what it says.

16 Q So the children using morphine were more alert and
17 better oriented day three than children given -- mothers
18 giving on the drug.

19 A Again -- again, this is an acute. A P.C.A. is a
20 controlled dose. You can't overdose on it.

21 Q I understand.

22 A No matter how much you hit the button it'll only give
23 you so much.

24 Q Okay.

25 A So that's a very low level control for an acute

1 situation.

2 Q And where is the article that discusses the alleged
3 death that occurred that's mentioned in the opening
4 paragraph?

5 A I don't know. I didn't look at the reference and see.

6 Q Do you want to look at the reference?

7 A Well, it's not specifically referenced. That's --

8 Q It's not specifically referenced, is it? That is
9 someone's opinion and not based upon any case study.

10 A That's my opinion.

11 Q But that statement and that article is not based upon
12 any specific case study, is it?

13 A I don't know. Like we said, it's not referenced.

14 Q It's not referenced.

15 A Right.

16 Q If you're going to make a statement like that it
17 should be referenced.

18 A I -- I think that that's pretty common knowledge
19 actually.

20 Q Will you agree with the statement that clearance of
21 morphine is decreased in -- in infants younger than one
22 month and approaches 80 percent of adult values by six
23 months of age?

24 A Yes, sir.

25 Q All right. So the time you have to be careful, really

1 careful, about clearing morphine is the first month.

2 A Less than six months.

3 Q Well, the first month. And how much liver function
4 does a person need to function?

5 A I don't know.

6 Q You don't know?

7 A No, sir.

8 Q So if the function -- if the liver on a child is
9 functioning at 33 percent you don't know if that's enough
10 to clear morphine or not.

11 A Well, that's a different question. You said the
12 function. Obviously, the -- the function means to live.
13 If you're talking about to clear a specific drug, that's a
14 different question. I don't know the answer to that
15 either, but it's is a different question.

16 Q Okay. But you don't if -- if a young six-week-old
17 infant has 50 percent liver function you don't know how
18 much morphine would be cleared with that.

19 A Not precisely, no.

20 Q All right. Thank you.

21 MR. BARNETTE: No further questions.

22 THE COURT: You may step down.

23 MR. BARNETTE: We'd ask the witness be excused, Your
24 Honor.

25 THE COURT: He may be.

1 MR. BARNETTE: Thank you, Your Honor.

2 (Whereupon, the witness was excused.)

3 THE COURT: We'll break for lunch.

4 Remember the caution. No discussion, no research, no
5 investigation, no media exposure.

6 Have a good lunch. Please report to your jury room at
7 2:30 this afternoon, 2:30 this afternoon.

8 Again, if you'll give those notepads to the bailiff
9 they'll put them in an envelope, and you'll be provided
10 those when you come back.

11 (The following takes place outside the presence of the
12 jury.)

13 THE COURT: Court is in recess until 2:30.

14 (Whereupon, a recess was taken.)

15 THE COURT: Any matters to address before the jury
16 comes in?

17 MR. BARNETTE: None from the state, Your Honor.

18 MR. WISE: None from the defense.

19 THE COURT: Are you going to use that exhibit, or has
20 that just been up here since lunch?

21 MR. BARNETTE: I guess that's been up since lunch,
22 Your Honor.

23 THE COURT: Let's take it down.

24 MR. BARNETTE: Yes, sir.

25 (The following takes place in the presence of the

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1 jury.)

2 THE COURT: Good afternoon, ladies and gentlemen.

3 We're going to continue with the state's presentation.

4 Mr. Barnette.

5 MR. BARNETTE: May it please the Court, Your Honor.

6 I'd like to call Dr. Wren to the stand please.

7 DR. JOHN DAVID WREN, having
8 been first duly sworn, testified as follows:

9 DIRECT EXAMINATION BY MR. BARNETTE

10 Q Dr. Wren, if you would, give your name, please.

11 A It's John David Wren.

12 Q And where do you work at, sir?

13 A I work at Spartanburg Regional Medical Center.

14 Q And what is your position there, sir?

15 A I'm a clinical -- I'm the clinical laboratory medical
16 director at Spartanburg Regional and at Spartanburg
17 Hospital for Restorative Care.

18 I oversee all of the hospital clinical laboratory, and
19 I also do anatomic pathology. I'm a general pathologist by
20 the nature of where I work.

21 Q If you would, give the jury some of your educational
22 background and experience, please.

23 A Yes. I have a bachelor's degree, a master's degree
24 and a doctor of philosophy degree in chemical engineering
25 from university -- Clemson University.

1 I did my doctoral dissertation on rate kinetics and
2 biological systems.

3 I then worked in industry for five years in research
4 and development and also did process control by digital
5 methods back in its infancy and process modeling.

6 I then went to the Medical University of South
7 Carolina where I majored in medicine, got my M.D. degree in
8 three years and four months.

9 I went directly into an anatomic clinical pathology
10 combined residency. I finished that in three years and ten
11 months getting credit for my research both at the medical
12 school and at Clemson University.

13 I then -- while I was there I was assistant medical
14 examiner for Charleston County from July 1st of 1979 until
15 January the 31st of 1983.

16 while I was doing that I did forensic autopsies for
17 the state of South Carolina, which a lot of the autopsies
18 were sent to the medical university under the supervision
19 of board certified forensic pathologists. And I got credit
20 for that time as a prerequisite to taking my boards if I
21 wanted to.

22 I then came to work in Spartanburg on October the
23 18th, 1982, because I had some vacation built up. And I've
24 been a pathologist in Spartanburg since that time.

25 At one time I was at Mary Black for a while, but I've

1 been at Regional since 1989.

2 I was the department chairman of pathology at that
3 until a few years ago when they actually made us -- you
4 couldn't be succeeded, so I had to step down as the
5 department chairman. But I retained the clinical
6 laboratory directorship.

7 I'm board certified in anatomic and clinical pathology
8 on my first attempt. I took the boards in two parts
9 because, simply because, I was working. I had a family at
10 that time. And even when I was in medical school and I
11 took the first boards on anatomic pathology in September --
12 I mean -- November of 1983. Then I took the clinical
13 boards in November of 1987. As I said, I passed them on
14 the first attempt.

15 I never took the forensic boards because I simply
16 didn't have enough time to do it with the duties that I
17 had, but I have been qualified as a forensic all over this
18 state, as an expert in forensic pathology all over this
19 state. I can name most of the counties if anyone is
20 interested, but at least half of the counties in South
21 Carolina.

22 Q Yes, sir. So you've been qualified by numerous state
23 courts throughout the state.

24 A Yes.

25 Q And as a forensic pathologist.

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1 A Yes, sir.

2 MR. BARNETTE: And, Your Honor, at this time I'd move
3 him as an expert in forensic pathology.

4 MR. WISE: No objection.

5 THE COURT: He is so qualified.

6 BY MR. BARNETTE

7 Q Dr. Wren, did you perform the autopsy on Alexis
8 Greene?

9 A Yes, I did. I performed an autopsy on Alexis
10 Katherine Greene in the Spartanburg Regional Medical Center
11 on November the 13th of 2010. I began that autopsy at
12 4:45 p.m.

13 Q If you would, tell the jury about that autopsy if you
14 would, sir.

15 A Well, a forensic pathology -- I mean, a forensic
16 autopsy entails a history as much as can be provided,
17 although it's never completely accurate. It's just to give
18 you some indication of what is known prior to the autopsy.
19 I record that in my report so I can remember a little bit
20 about it. It's up to eight or ten years later sometimes.

21 We then -- I ask for the person that's brought for
22 autopsy to be left exactly like they are, no movement or
23 removal of any clothing or anything of that nature, exactly
24 like the coroner's office finds it.

25 I describe the clothing, look for any trace evidence

1 on the clothing. Then I unclothe the body, and then I do
2 an external description.

3 In this case this infant was normally developed. She
4 didn't -- I didn't see any abnormalities, although it was
5 reported that she had a congenital cyst of the eye, was
6 part of the history given to me.

7 She weighed 3,345 grams, which for those people that
8 are not real good in the metric system that's 7 pounds and
9 6 ounces, which is normal for a 16 -- a
10 six-and-a-half-week-old infant.

11 She measured 37.8 centimeters from crown to rump and
12 54.3 centimeters from head to heel. Her head circumference
13 and chest circumference were relatively normal.

14 She had some rigor mortis and some posterior
15 non-blanching livor mortis, which is settling of the blood
16 in the tissues of the back. And when we say non-blanching
17 we mean that it's -- the person had been probably dead long
18 enough for that to start to where it won't blanch out.
19 It's settled into the tissues.

20 So in that case one can get an indication of where the
21 person -- the position they were in when they passed away
22 if it's become fixed. And, in other words, if you had a
23 person that was lying on their back and they have anterior
24 non-blanching livor mortis you could pretty much assume
25 that they have been dead for some time for it to not blanch

1 on the chest, and then they were turned over.

2 It becomes more difficult when it's on both sides
3 because then you have to -- you have to correlate that with
4 what the history has given you.

5 She had cyanosis of her right ear. It was bluish
6 discoloration of her ear, which is an indication of some
7 settling of blood. And she had no acute injuries. And she
8 had a little bit of cyanosis of her nail beds, which is an
9 indication of respiratory problems usually, or it can be
10 heart failure with blood backing up in the system.

11 And that was all I found. No evidence of any trauma,
12 and I might say none externally or internally.

13 I then go to the internal examination where we open
14 the body with an infant's -- a crutch-shaped incision --
15 remove the chest plate, look into the thoracic and
16 abdominal cavity and examine what we see for any
17 abnormalities.

18 And I have to add that before you find out what an
19 abnormality is you have to know what normal is, and you
20 hardly ever get to -- to autopsy a normal person, so it's
21 based on experience as to -- as to what you see.

22 In her case she had a little bit of paleness of her
23 musculature which can go along with anemia in the chest.
24 She had no effusions, no adhesions, meaning no
25 accumulations of fluid in the chest, abdominal cavity, no

1 evidence of scarring causing the lungs or any other tissues
2 to adhere to something that it wasn't supposed to. And
3 there were no masses.

4 She had a little bit of fluid on her pericardial sac,
5 which one has to have some because the pericardial sac has
6 to move. It's more rigid than the heart is, and it has
7 to -- the heart has to move within the pericardial sac. So
8 there was -- but there were no adhesions, indicating that
9 the heart was not freely moveable.

10 And her small intestine was a little bit dilated with
11 gas, a postmortem change.

12 Do you want me to continue?

13 Q Yes, sir.

14 A So there was nothing grossly externally or internally
15 that was very significant.

16 I might add that in SIDS death, which everyone is
17 familiar with -- sudden infant death syndrome -- the
18 telltale features of a possible SIDS death are petechial
19 hemorrhages on the thymus, on the heart and on the lungs.
20 She had none of those.

21 I always look for those in an infant because that's
22 one of the -- if you see no anatomic or other reasons for a
23 cause of death, like they didn't have pneumonia or heart
24 problems or infection or any other thing, and you have no
25 explainable anatomic cause of death and the toxicology is

1 normal, we usually stop there and call it a SIDS death if
2 they have petechial hemorrhages. In other cases we just
3 call it sudden unexplained death in an infant, which is a
4 little bit different to a pathologist.

5 Now, her thyroid gland looked normal. Her thymus
6 gland was -- weighed 15.2 grams, which is within normal
7 range for an infant. Her heart weighed 20.6 grams. It
8 arose in a normal location. It had no anomalies of the
9 external circulation, meaning that the gray vessels came
10 off in a normal location. They weren't occluded or small
11 or any way involved with possible constriction. Her valves
12 and valve cusps were normal. The foramen ovale and the
13 ductus arteriosus were both closed.

14 And I'll have to explain what that means. I'm
15 having -- a patent foramen ovale and a patent ductus
16 arteriosus are both essentially necessary in children
17 before they're born, in fetuses.

18 And what it does is it bypasses the lungs because the
19 infant, I mean the fetus, does not breath air, and the
20 mother's already actually providing the oxygen for the
21 child.

22 So the blood goes into the heart already oxygenated.
23 It goes through the foramen ovale, which is an opening
24 between the right ventricle and the left ventricle, I mean,
25 the -- excuse me -- the right atrium and the left atrium.

1 So the blood does not go into the right ventricle and
2 then out to the lungs. It goes directly through to the
3 left atrium, goes into the left ventricle, and then it's
4 pumped out to the body.

5 There is also a partial recirculation through the
6 ductus arteriosus which is between the pulmonary artery and
7 the aorta that does the same thing. It helps bypass the --
8 the lungs.

9 After death -- I mean, excuse me -- after birth since
10 the baby is starting to breathe oxygen and is producing
11 carbon dioxide, that carbon dioxide stimulates the tissues
12 around the foramen ovale and around the ductus arteriosus
13 to close. And that causes -- that then becomes normal
14 circulation. It occurs within three to four weeks of an
15 infant being born. If it's -- if it's residually there,
16 then there's a chance of circulatory problems later, and
17 heart failure. But these were closed.

18 She had no -- no septal defects. The heart was a
19 normal size, essentially within the normal range of
20 infants. And there was nothing else as I could see wrong
21 with the circulation.

22 Her respiratory system, she had a little bit of mucoid
23 material within her trachea, which is not -- and the major
24 bronchi which comes off of the trachea, which is not
25 unusual, although it is -- can be an indication of some

1 congestion.

2 And her lungs were slightly heavy. They were
3 diffusely congested meaning that I could -- a normal lung
4 if a person is breathing like anybody in this room if they
5 don't have -- if they have a normal lung, or even infants,
6 their pleural surfaces of their lungs are pink and the
7 heart's fluffy.

8 I -- the only thing I can liken it to is if you cut
9 into a normal lung that's not congested, then it looks to
10 me -- it gives me the impression of angel food cake. It's
11 real soft, and you can push it together, and it doesn't
12 have any blood or fluid exposed.

13 But in her case it was congested. And not only was it
14 congested. It was what I called mottled, meaning that
15 there were some areas that were darker than others. That's
16 the way I described it.

17 And then the G.I. system. As I told you previously,
18 her small intestine was dilated with gas, and it was
19 slightly distended in the rectosigmoid colon, which is the
20 distal colon.

21 And she also had a small amount of white to focally
22 dark mucoid material within her stomach, not very much at
23 all. Surprising if she died within 90 minutes after she
24 was last fed, but it can vary, so.

25 Her liver looked -- weighed 146.1 grams, which I

1 believe is within normal range. And it was, again,
2 slightly pale but not unusual for a child, I mean, a
3 newborn, young infant.

4 Pancreas and spleen were normal. The adrenal glands
5 were -- they weighed 3.1 grams together. That's a little
6 small for a child, an infant, but not particularly
7 bothersome.

8 Her kidneys were -- looked normal. They had what we
9 call persistent fetal ovulations. As the kidney is being
10 formed in an infant there's coalescence of epithelial
11 cells, and they come together in little clusters. And they
12 eventually form the kidney that everybody knows looks like
13 a swimming pool. And I was just kidding. Looks like a --
14 it's little knobby on the outside. But it has little
15 grooves in it. That's called fetal ovulations. In about
16 50 percent of the people they will persist even into late
17 adulthood, and even some people die with that, that fetal
18 ovulations. But it's not unusual.

19 She had about 3 ccs of urine in her bladder. And
20 internal genitalia were normal.

21 She had -- in her lymphoid system and bone marrow she
22 had some lymph nodes that are usually identifiable in a
23 mesentery of the small intestine, which is the -- actually,
24 the suspending area of the intestine is actually profused
25 with blood for absorption and maintenance. And whether any

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1 resorb nutrients leave through the -- through the vascular
2 system and go onto the liver. There are usually lymph
3 nodes there and up -- up until several years of age
4 they'll -- they'll be there. So that was no evidence of an
5 infection.

6 And then her scalp. We -- I didn't find any
7 contusions or hemorrhages there. She didn't have any
8 hemorrhage in the space above the brain, between the dura,
9 it's called, and the -- the skull cap. That's called a
10 epidural hemorrhage. There was none there.

11 Beneath there down to the brain is subdural space.
12 There was none there. And there was no subarachnoid
13 hemorrhage, which is -- which is blood in the -- there's a
14 thin, several-layer transparent covering over the brain
15 that's called the -- various people call it different
16 things -- leptomeninges or piarachnoid space. Sometimes
17 you get hemorrhage beneath there if there's a brain
18 problem. There was none there.

19 It was congested, which is unusual in SIDS death.
20 It's unusual. I don't think I've ever seen a real SIDS
21 death that had subarachnoid congestion, and I've done over
22 4,000 cases, not all infants of course. But I've done over
23 4,000 autopsies in my career.

24 It was edematous, had some grooving of the spaces,
25 places, where the brain rests up against the dura mater in

1 the base of the brain. There was -- there was a little
2 edematous there, but there were no internal lesions on
3 sectioning of the brain. That's all I found.

4 Now, I have to look at that with a microscope. And I
5 perform a final necropsy diagnosis after I've gotten the
6 toxicology and look at that. In this case I said that she
7 had acute passive congestion -- that means that it's more
8 acute than chronic -- with some intra-alveolar hemorrhage
9 in the lungs bilaterally, and that's -- that means that
10 blood was backing up in the lungs.

11 She had diffused multifocal subarachnoid congestion of
12 the brain with acute cerebral edema. And then the only
13 other thing was the toxicology, which I guess the best
14 thing to do rather than try to tell you everything is to
15 read what I -- I said.

16 I've got to add also that when we do an autopsy we
17 examine the eyes. We take the eyes out of the sockets. We
18 section those and look for what are called retinal
19 hemorrhages, which are indicative but not always
20 pathognomonic, meaning if you see them it's not absolutely
21 the case. But in infants that have whiplash sudden infant
22 death syndrome or shaking baby syndrome you'll find those
23 hemorrhages in the retina of the eyes. I did not see any,
24 although I noticed I didn't record them. I have no idea
25 why I didn't, but I did not record it, but I always -- we

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1 have to check those.

2 I said the only significant findings at autopsy were
3 defuse acute passive congestion and mottle of the lungs
4 bilaterally. And mild cerebral edema was prominent.
5 Subarachnoid congestion.

6 There was no evidence of petechial hemorrhages
7 commonly seen in SIDS death.

8 And I said the microscopic examinations confirmed the
9 congestion with no evidence of significant pathology
10 elsewhere.

11 And then the toxicology was, as everyone probably
12 knows by now, that's just -- that just walked in, that's
13 the problem here. Toxicology was abnormal.

14 Q Dr. Wren, let me ask you before you get into the
15 toxicology reports. Did you take blood samples from the
16 victim in this case?

17 A Yes. I do. I have to do that because the morgue
18 attendants often take it.

19 We have 24-hour coverage in the morgue. As soon as
20 they bring the body into the morgue if they can the
21 technicians are trained to first off draw blood. And they
22 draw blood from the furthest point that they can get blood
23 from. And we start at the femoral arteries, which is right
24 in the crease of the legs, and go proximally from there.

25 If they cannot retrieve blood from the femoral arties

1 I usually tell them to stop, and I sample it if I have an
2 autopsy. Otherwise, I sample it myself from other areas so
3 I'll know where it is.

4 They also take vitreous humor which is the -- they
5 push a little needle into the corner of the eyes, remove
6 some of that fluid. And we send it to the lab for a basic
7 metabolic profile and -- and alcohol level.

8 The importance of that is mainly in people that are
9 diabetics -- is one indication for doing it as quick as you
10 can. If a person dies with hyperglycemic -- well, let me
11 go back.

12 If a person has a normal glucose level, regardless of
13 whether it's normal or abnormal, it decreases after death.
14 It continually goes down until it's not even measurable.

15 So what we -- if we have a normal or a less than
16 normal level we -- we discard the result because we don't
17 know what it was before that.

18 If it's extremely high, then we know they had a
19 diabetic problem. At least they have hyperglycemia. So
20 we -- we run that. And we run urine if they can get it.

21 In children we don't do that because it's hard to get
22 the blood even once you've started the autopsy because
23 there's very little blood in the main circulation. And as
24 I told you previously, a lot of it settles down to where it
25 starts leaking out of the tissues and several hours after

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1 death leaks out of the -- out of the blood vessels into the
2 tissues. And so you can't squeeze the blood out of that,
3 or it wouldn't do any good anyway. So I draw those things
4 after -- when I start the autopsy.

5 Q Dr. Wren, you also -- do you collect the brain, liver
6 and kidney samples also?

7 A Yes, yes. SLED protocol in South Carolina for a
8 child -- child deaths require that we sample a hundred -- a
9 hundred grams of brain, a hundred grams of liver.

10 In some cases it's pretty hard because this child's
11 liver only weighed 146, so almost all of it went into a jar
12 rather than being able to -- to bury it with the body. So
13 we had to keep a hundred milligrams of it in case we -- we
14 needed to run toxicology.

15 And then we take kidney and anything else that we
16 think might be significant. But in this case I only took
17 liver, brain and kidney. And usually what I do is I take
18 the anterior cerebrum and the posterior cerebrum, the
19 frontal cortex and occipital cortex, not the midportion of
20 the brain.

21 Q And you secured those things, and they were put in the
22 refrigerator and taken to SLED later, is that right, sir?

23 A Yes. They're locked in a freezer. They're labeled
24 and locked in a freezer. And the only person that has
25 access to that freezer are the morgue attendants where they

1 keep the key with them and the coroner's office, which one
2 of them -- as I understand it, one of them has a key to
3 that freezer.

4 Q Before you go into toxicology I just want to make sure
5 about it. So you saw no evidence of SIDS death and you've
6 seen -- obviously, 4,000 autopsies. I know not all --

7 A Probably a hundred and -- between a hundred and two
8 hundred. We have one or two a year probably.

9 For a while I did -- actually, now I did all of the
10 coroner's cases around in this county and some from
11 neighboring counties. And we do two or three a year
12 probably SIDS -- SIDS death.

13 Q So, but you didn't see any signs of SIDS death in this
14 child.

15 A No, I didn't.

16 Q Did you see any problems through your autopsy,
17 anything physically wrong with the child?

18 A No.

19 Q And the heart, do you also take a close look at it? I
20 know you did a close look. Do you do slides or anything
21 about that to look at?

22 A Yeah. In children, depending on how big the heart is,
23 I take one -- one section of the right ventricle and one of
24 the left ventricle -- usually two -- one of the left
25 ventricle and one of the septum between there. And in this

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1 case I took another one up close to the -- to the outflow
2 tracts, which is near the conduction system. It's called
3 the A.V. node -- atrioventricular node of the heart -- to
4 look in those areas to see if I see any evidence of
5 whatever I see.

6 Q Did you see any evidence that was abnormal on those?

7 A Not to me.

8 Q Yes, sir. I understand.

9 Later on did you receive the toxicology reports in this
10 case?

11 A Yes.

12 Q If you would, tell -- tell us about that if you would,
13 sir.

14 A Well, we have toxicology on the blood which was
15 removed from the aorta, distal aorta, and inferior vena
16 cava.

17 In that case the -- at that time I didn't have the
18 liver and brain results when I signed it out. But this
19 infant had 19 mg per liter of acetaminophen. Acetaminophen
20 can cause liver failure, but a therapeutic level as
21 reported in the report here is 10 to 20 mg per liter.

22 There are other cases where the therapeutic -- do you have
23 my note? Do you have the one that I have written down on?

24 Q Do you want the autopsy one?

25 A You can put that on there.

1 Q would you like for me to put that one on, sir?

2 A well, I have to come down and look at it.

3 Q Yes, sir. If you would, you can step down if that's
4 okay with the Court.

5 THE COURT: Do you have another copy?

6 MR. BARNETTE: well, I think he's got his notes on it,
7 I think is what.

8 A No. I -- I gave this to the coroner. This is a copy
9 of the results.

10 Q Yes, sir.

11 MR. BARNETTE: Can I ask the clerk to run a quick
12 copy, Your Honor?

13 THE COURT: Sure, if y'all don't have one.

14 MR. BARNETTE: I know I've got one in my stuff. I
15 think it would just be as quick to run a copy off.

16 A well, I can go ahead with that part.

17 Ten to 20 is normal. I have seen 5 to 26 as being
18 normal in adults. Once it gets above that level it depends
19 on how long the person is alive as to the amount of toxa --
20 toxic -- toxicity that's present. This was pretty high
21 actually. Usually people that have acetaminophen it's only
22 ten or so. In a lot of cases they don't even measure it.
23 But they did measure this.

24 MR. BARNETTE: May I approach the witness for a
25 second, Your Honor? And, Your Honor, let me show you -- to

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1 show this to the jury do I need to enter it as evidence?

2 I'll be glad to do that.

3 THE COURT: Yes.

4 MR. WISE: Is that the one with his handwritten notes?

5 MR. BARNETTE: Yes, sir.

6 THE WITNESS: It's also dictated here.

7 MR. BARNETTE: Yes, sir.

8 I'd like to enter this into the record, a copy of
9 his -- it's a copy of the forensic report with his notes on
10 it.

11 Your Honor, may I publish this to the jury, State's
12 Exhibit No. 68?

13 THE COURT: No objection?

14 MR. WISE: No objection.

15 (Report of Dr. John David Wren marked State's Exhibit
16 No. 68.)

17 BY MR. BARNETTE

18 A So regardless of -- of when this blood is sampled,
19 toxic is 30 to 300. That means you're having toxicity from
20 the acetaminophen. It can be 300, and a person can be dead
21 if that liver had a level of -- lethal's greater than 160.
22 So if it were 300 at one time and a person lived long
23 enough for it to start decreasing it can still be lethally,
24 even though you only got a toxic range.

25 There was 19 mg per liter of acetaminophen. There was

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1 300ths of a milligram per liter Diphenhydramine, which the
2 therapeutic levels are reported in adults .025 to .112.
3 Another therapeutic level in Basalt, which is another
4 toxicology book -- and I have a forensic book for medical
5 examiners -- is .004 to .260 mg per liter.

6 And then toxic levels are one to five. They call it
7 five from SLED, but in the literature it's one to five.

8 Chlorpheniramine, which is -- was .06 milligrams per
9 liter or 600ths. The therapeutic level's a .01 to .017 as
10 reported by SLED. Therapeutic in the reference book is .01
11 to .04. And toxic is .5.

12 Now, it's not in toxic range, but it's above
13 therapeutic. It has to be taken into account.

14 The Methorphan was three hundredths of a milligram per
15 liter, and the therapeutic is .15 to .40. Lethal is
16 greater than three. And then for Dextromethorphan the
17 therapeutic is .005 to .06, and toxic is -- no data on that
18 one.

19 Now, you have to -- I don't know whether it's Dextro
20 or Levomethorphan, but those were the levels that are
21 there. And it's probably the low therapeutic levels.

22 The Methorphanin -- nan rather -- which is Dextro --
23 Dextrorphan, which is a -- Dextromethorphan metabolite is
24 .04, and the therapeutic level is .007 to .021. That one's
25 elevated also according to the results.

1 Now, we don't have much lethal and toxic data on that
2 one. I could not find any in the literature.

3 Then you come to morphine. The level was .52 mg per
4 liter, therapeutic level was .10 to .30 mg per liter. And
5 from my references therapeutics .001 to .200. Toxic is .3
6 to 2.5. And lethal is .2 to 7.2.

7 Now, you'll notice that some of these overlap. It
8 really depends on how the -- how accustomed the body is to
9 that drug. There's a low -- a window of between
10 therapeutic and toxic in normal people. You can see.

11 Let's just talk about whole numbers. We'll just move
12 every decimal place three places to the right. So
13 therapeutic can be one to 200. Toxic is 300 to 2,500, and
14 lethal's 200 to 7,200.

15 There are reported deaths in people that have a level
16 of 200. So this is actually two and a half times the
17 lethal level at the lowest limits of lethal.

18 Lethal levels from SLED were .05 to 4.0, which
19 actually in the numbers I'm talking about translates to 50
20 to 4,000. And that goes to the lethal over there, 200 to
21 7,200. So their lethal levels are even lower than in some
22 of the literature.

23 And then in peds -- I put this in because I had found
24 this later -- that the levels that produce surgical
25 analgesia in pediatrics is .046 to .083, which is 46 to 83.

1 Once again, the level reported is 520. And then of course
2 there's a caveat there. Lethal levels may be higher in
3 individuals under chronic opioid treatment.

4 If you have a person that's under chronic opioid
5 treatment they're taking in a lot -- a lot often and
6 they're -- over a long period of time they adjust to the --
7 their body physiology adjusts to that, and they can sustain
8 higher levels without it having an effect on them.

9 So you have to take into account where the person has
10 a history of that -- and of course nobody that comes to the
11 morgue is going to tell you they're taking morphine, and
12 sometimes the family don't tell you either. So we have to
13 take it if they don't have a prescription that they're
14 getting it illegal or they're taking something else.

15 So based on all of that all of these drugs essentially
16 lead to respiratory depression. And so I said based on the
17 history and autopsy findings -- and I should have put in
18 including toxicology results -- it was my opinion that this
19 child died as a result of respiratory insufficiency
20 secondary to synergistic drug intoxication. I could just
21 as easily have said morphine intoxication, but lawyers like
22 to split hairs, and so I included them all.

23 Q Yes, sir. And there was also another drug that was
24 involved too, wasn't there?

25 A Oh, I forgot the next page. Excuse me.

1 Q No problem.

2 A There was also Clonazepam, which is Klonopin. The
3 brand name's Klonopin. It was .01 or 100th of a milligram
4 per liter. The therapeutics are listed from the reference
5 in my handwriting from SLED and the other. And they're
6 within therapeutic range for the -- for my reference, as
7 well as for the SLED level.

8 Q Going back to the second page on the morphine then, I
9 think this is the point we talked about before. But,
10 obviously, a six-week-year-old cannot metabolize. I mean,
11 it takes a lot less amount. And, obviously, she only
12 weighed a little over 7 pounds. They're totally different
13 from an adult.

14 A Yes. It's well known that infants and children do
15 react differently to medications than adults, and it takes
16 some -- infants are much more susceptible to any drugs than
17 others. That's why physicians have recommended ranges for
18 giving them antibiotics, as well as other drugs. They
19 don't need as much and they're more susceptible to effects
20 of them.

21 Q Dr. Wren, talking -- you never saw any needle marks or
22 anything on the child, did you?

23 A Pardon?

24 Q Showing anything to be injected in the child or
25 anything?

1 A No.

2 Q Did -- in a six-week-year-old swallowing a pill and
3 things that normally you wouldn't do, I mean, could it
4 even -- could she even do that?

5 A Pardon?

6 Q Pills and stuff like that, trying to give a child that
7 old a pill.

8 A I don't think -- well, it's obvious from -- from what
9 I -- from what I've found, assuming that I'm right, that
10 the only way this child could have gotten that much would
11 be orally, because I saw no injection sites. You don't
12 absorb morphine as far as I know. And there's no other way
13 to get it. The route of administration had to have been
14 orally.

15 You're not supposed to -- there are instances in
16 adults now where people get morphine sulfate, and they'll
17 dissolve that and shoot it up. There's no indication of
18 that. But you're not supposed to break up those tablets
19 because it destroys the -- it leads to irregularities in
20 absorption.

21 So one could take one of those tablets and put it in
22 something and give it to someone. It's not my opinion that
23 it was from milk or anything else. I just know that it was
24 there. It's lethal in the brain; it's lethal in the liver;
25 and it's lethal in the blood.

1 Now, how this child got it is not -- you can postulate
2 anything you want to, but it's there. There's no -- it's
3 indisputable that those are the levels if you trust -- if
4 you trust science, scientific measurement. And they did
5 this by -- I think they did it by spectrophotometry, didn't
6 they? Gas -- gas chromo -- chromatography and mass spec.
7 And those are kind of hard to -- those are kind of hard to
8 mess up to an experienced operator.

9 Q And in the -- three things. Obviously, checked it at
10 three different sites -- the blood and the brain and the
11 liver.

12 A Yes.

13 Q And they were consistent with each other.

14 A Yeah, they were. They were consistent. If you want
15 to argue redistribution, how do you argue? All of these
16 are within the same range.

17 You can't -- kinetics is the rate processes in the
18 body. Now, you can have zero order kinetics; you can have
19 first order kinetics; you can have second order kinetics
20 and third order kinetics.

21 To have any order kinetics other than zero order you
22 have -- there is a concentration gradient that occurs. In
23 other words, it's just like heat. If you have a hot wall
24 and if you have a hundred degrees on the other side of that
25 wall you're sitting against and you have zero over here,

1 you're going to get heat radiating through that wall.

2 The same thing happens with concentrations. It goes
3 from a higher concentration to a lower concentration. And
4 it's dependent on the concentration in some drugs.

5 In some drugs it's not dependent at all, for instance
6 alcohol. I know we're getting off the subject, but alcohol
7 is zero kinetics. And to show you that people are entirely
8 different, if I picked out anyone in this room that had no
9 experience with alcohol and we gave them enough alcohol to
10 get them up to a level of 200 or .20, which everybody
11 knows -- thinks .1 is -- used to be driving under the
12 influence. But if it's up to 200 in a person that's not
13 used to using alcohol it takes -- they can only metabolize
14 15 units an hour. And it doesn't matter whether it's 15 at
15 the start or 15,000 at the start. They can only get rid of
16 15 an hour -- 15 units. So divide a hundred by 15. You
17 get six and two thirds. So, no. Wait a minute. Six times
18 15 -- yes. Six and two thirds. So it takes that person
19 six and two thirds' hours to sober up. They're getting no
20 alcohol after six hours and 45 minutes.

21 If you have somebody that drinks all of the time and
22 theirs is 200, they can metabolize 40 an hour. And so in
23 five hours they can be entirely sober with the 200. With a
24 hundred it only takes two and a half hours. That's
25 zero-order kinetics.

1 Now, most drugs are not zero-order kinetics, but it
2 does depend on concentrations. So you have to have a
3 concentration greater. And if you assume that there's no
4 concentration gradient here, then it's -- then it's
5 equalized. And you can't say it's higher somewhere else
6 than -- than it is in the brain or you can't say it's --
7 that the blood is much lower and it's diffused in there.
8 It just doesn't happen.

9 Q So these three areas are consistent with each other,
10 and that would show the amount in the area that was in
11 Alexis' body, the baby's body.

12 A The morphine in the brain was .04 mg per K.G.

13 Now, when you're going from milligrams per K.G. to
14 milligrams per liter it's a little bit different, but it's
15 pretty close.

16 So in her brain it was point -- it was 40. Let's say
17 it's 40. In her -- her blood, it was 520. In the liver it
18 was 56 mg per K.G. Hers was .52 if I remember correctly --
19 .52 mg per liter. A liter in a K.G. under the same density
20 are equal.

21 If you have water, you have a liter of water, it's
22 going to weigh a kilogram, because its density is one -- in
23 normal circumstances it's -- its density is 1 mg per
24 milliliter. So if you've got a kiloliter, I mean, a liter,
25 you've got a thousand milliliters. A thousand times one is

1 a thousand.

2 So a kilogram of water -- if one milligram per -- I
3 mean one, yeah. One milligram per cc is the same as a
4 kilogram of water in weight. So 540 -- I mean, 520 in the
5 blood, 560 in the liver. Those are pretty close.

6 Q And, Doctor, let me ask you this. Obviously, being a
7 young child, six-and-a-half weeks, her metab -- the ability
8 to metabolize drugs, is it much less than an adult?

9 A That's -- that's correct. It builds up.

10 Q So it will build up over a period of time if it -- if
11 it keeps getting the drugs.

12 A Yeah. If they can't metabolize it'd have to go
13 somewhere. And there's something called intrahepatic
14 circulation. If it's excreted into the bile or whatever,
15 it gets into the GI tract, and it's reabsorbed and goes
16 back in it just recirculates. It's just not eliminated
17 unless she's -- has affluent diarrhea or -- or urinating
18 all of the time.

19 Q So, and the -- the mother was taking morphine in this
20 situation and breastfeeding. Obviously, the baby was
21 getting morphine through the -- taking MS Contin actually.

22 A At least some, yeah.

23 Q Yeah. From there. So the baby would get the morphine
24 from the mother.

25 A That's correct.

1 Q And could then metabolize it as fast as it, you
2 know -- in a fast way or was constantly getting it from the
3 breast milk, could it build up in that body?

4 A That's right. I did a couple of calculations. I'm
5 not as good in my head as I used to be, but I think I might
6 be correct or at least close. I have one reference here if
7 I can find it.

8 Q Yes, sir. Take your time.

9 A It's from toxnet.

10 Q Yes, sir.

11 A It says -- this is a caveat. "Newborn infants tend to
12 be particularly sensitive to the effects of even small
13 doses of analgesics. Once the mother's milk come in --
14 comes in it's best to provide pain control with a
15 nonnarcotic analgesic and limit maternal intake of morphine
16 to a few days at a low dosage with close infant monitoring.
17 And then if the baby shows signs of increased sleepiness
18 more than usual, difficulty breastfeeding, breathing
19 difficulties, a physician should be contacted immediately."

20 It goes further to say there's a study here of one
21 mother who was 21 days postpartum, which is about half this
22 one, received oral morphine, 10 mg every six hours, and for
23 four doses. That's 40 mg. And then five every six hours
24 for two doses. So that's actually 50 mg total she got in a
25 24-hour period.

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1 She had a peak morphine of a hundred micrograms per
2 liter after one hour, and four and a half hours after her
3 first milligram, 5 mg dose.

4 Using the peak level from this study an exclusively
5 best -- breastfed infant would receive 15 micrograms per
6 K.G. daily equal to about three percent of the maternal
7 daily dose assuming a daily maternal oral morphine dose of
8 40 mg.

9 Okay. So I took 40 mg and took three percent of that.
10 That comes out to be 1.2 mg.

11 The baby weighed 3,345 grams, which is 3.345 kg. And
12 I was doing this in my head, so I got -- took three times
13 1.2. That's -- well, actually I didn't even do that. I
14 took 1.2 mg and divided that by the volume of blood in a
15 child that age. The rule of thumb is 75 to 80 milliliters
16 per kilogram.

17 Okay. This child weighed, again, 3.345 kilograms, so
18 3.345 times 75 or 80 comes out to be about .285 liters.
19 285 milliliters is all the blood that child had in her
20 body, and that has to go into the tissues everywhere in the
21 body. So the -- the blood -- you'll have to take my word
22 for it. It is hard to get 10 ccs of blood out of a child,
23 an infant. It is really hard. The younger they are, the
24 harder it is.

25 And we -- a lot of places that do blood toxicology,

1 they want 21 milliliters. They want three 7-milliliter
2 tubes of blood. We can't get that. So we have to send
3 them small amounts.

4 But, at any rate, if you take the 1.2 mg and divide it
5 by two -- .285 you get about 4 mg per liter, which is 4,000
6 micrograms per liter. So that's -- that's a good bit of --
7 when we're talking about micrograms and milligrams, that's
8 a good bit.

9 Then I found another place in the same article where
10 it says that an exclusively breastfed infant receives --
11 tells what it receives. But it also says the peak morphine
12 in -- they did seven women who had preterm deliveries, and
13 they -- they gave them 60 mg of morphine in 24 hours
14 cumulative. And they found out that the peak milk morphine
15 varied, was 48 on the average mic -- micrograms per liter.
16 And the peak six glucuronide metabolite was 1,084 mg or
17 micrograms per liter, which is also secreted in breast
18 milk.

19 And it's thought that that -- that active drug, the
20 six -- the six isomer is actually secreted in the milk too.
21 And in the infant's digestive system it's converted back to
22 morphine, and that is another source of morphine. So --

23 Q Go ahead, sir.

24 A -- doing -- using that I got some calculations which I
25 can put on the board if anyone wants to see it. I got 80

1 micrograms per liter, would be the -- the actual blood
2 concentration if it was just in the blood.

3 Q All right. So over a period of time this could build
4 up if the child didn't get rid of it or metabolize it out.

5 A That's correct. That's a possible explanation.

6 Q Yes, sir.

7 A One of the possible explanations. It's not up to --
8 in my opinion it's not up to me to find out exactly
9 everything that happened because these are not research
10 projects.

11 The -- I have close to 300 autopsies a year plus the
12 regular job I do, and I just don't have time for research.
13 In my opinion -- when I was doing my doctorate level I
14 decided that 95 percent of research reports were worthless
15 because I found out enough about my topic to read the
16 topics that I was trying to review, and I found out they
17 weren't worth a darn. They were just done to get your name
18 on a paper. And so I always resisted doing research after
19 that.

20 Q Like I said, it's hard to have a situation where you
21 have a baby that died from morphine or to put a study on it
22 where you have somebody constantly giving morphine if
23 they're breastfeeding or any other method to do a test on
24 it, it's a dangerous procedure, I assume.

25 A I don't -- I don't think anybody in here would subject

1 that child to an ongoing test like that.

2 Q But obviously this child died from -- well, actually
3 morphine plus the other drugs and synergetic [sic] effect
4 from them.

5 A That's my opinion, yes.

6 Q And from that -- and obviously the morphine could have
7 came from the milk, breast milk, from the -- from the
8 mother.

9 A I don't know how it got there. It's unquestionably
10 there. And you can -- you can argue any mechanism you
11 want, but it's there, period.

12 Q Right. But, like I say, we have no needle punch. We
13 don't have any evidence that there was fed or maybe --
14 obviously, it could have been crushed and put into the milk
15 or whatever.

16 A No.

17 Q But crushing MS Contin would, like you say, release --

18 A Right.

19 Q -- the stuff and even make it more toxic.

20 A Yeah.

21 Q I mean more toxic.

22 A We -- we initially thought -- by the way, when we did
23 the autopsy, when we started this autopsy, this infant was
24 sleeping with the parents according to the history. We
25 thought it could have been a -- actually a positional type

1 asphyxia where a person may trap the infant's face and they
2 can't breathe.

3 That's hard to prove one way or another, and a lot of
4 that is just from circumstantial evidence. We didn't find
5 that.

6 I probably would have -- if I hadn't found out -- if I
7 hadn't found this drug or whatever and with that history I
8 probably would have said respiratory insufficiency of
9 unknown etiology, possibly secondary to overlay.

10 Q But obviously that -- this toxicology showed different
11 evidence than that.

12 A Gave me a different opinion.

13 Q Yes, sir.

14 A And that's why we did the liver and the brain, because
15 when I looked at it I said, gee whiz, this is lethal. And
16 then I told the coroner's office to send the other stuff
17 off because everyone knows about redistribution. So I
18 wanted to find out what it was in the other organs we had.

19 Q Is that why you double or triple check, I guess.

20 A It's triple check, yeah.

21 Q From there. But you saw no evidence. Obviously, you
22 knew she was breastfeeding, and obviously you knew the
23 mother was taking morphine.

24 A Pardon?

25 Q You obviously through the information you received

1 from the coroner's office sharing -- but you're the one I
2 guess actually contacted the coroner's office to tell them
3 about you need to check into this.

4 A Yeah, yeah. I told them it looked like she had a
5 morphine overdose.

6 I'm not -- you know, it's been -- I have done 700
7 autopsies since then, so I can't remember all of the
8 specifics, and I only write down what they tell me in
9 synopsis form, because once you start putting this and that
10 in there you get people wanting to know how'd you find this
11 out and how'd you find that out. So I just put in the most
12 pertinent things that I take from what they tell me.

13 Q But you saw no other -- like I say, no visible signs
14 of where the drug could have came or anything like that.

15 A Pardon?

16 Q You saw no visible signs where the drug came -- I
17 mean, from the outside. No needle marks or nothing like
18 that.

19 A No.

20 Q You saw no injuries to the mouth, I'm assuming.

21 A No. We checked the -- the inside of the mouth, and
22 it's really hard. This is beside the point. But it's hard
23 to -- in even a six-year-old child it's hard to tell when
24 someone has smothered them because there's sometimes -- and
25 most of the time, the infant, the child, does not struggle,

1 and they don't struggle enough to get any signs that --
2 that something has happened like that.

3 So a lot of it is still investigational, I guess,
4 until we find out something that can -- can -- I mean,
5 science is improving every day, and one day we'll find out
6 exactly what has caused SIDS death, but right now we --
7 there's a lot of things that -- that put you at risk
8 including prenatal drug use can put you at -- at a risk of
9 SIDS -- SIDS death.

10 Some of it's illicit, but, nevertheless, everybody
11 knows about -- oh, people my age know about tha --
12 thalidomide which caused people who were giving it to -- to
13 mothers that had anxiety prenatally, and they had a lot of
14 congenital deform -- deformities that occurred where they
15 were missing legs and arms and things like that, so.

16 Q Yes, sir. If I can ask you, talking about Vicoprofen,
17 for example, that's something you shouldn't take in the
18 third trimester of pregnancy, is it?

19 A Well, I don't prescribe drugs, so I can't tell you all
20 about it, but I can look at the -- the P.D.R., and that's a
21 clinician's responsibility. I just take what I -- I'm a
22 pathologist. I'm not a clinical physician.

23 Q So, but talking to the history, and obviously you got
24 access to the coroner's notes and things like that from
25 that standpoint. You realize that this child was lethargic

1 I believe on --

2 MR. WISE: Objection, Your Honor. He's leading the
3 witness.

4 THE COURT: Sustained.

5 Q Did you get a chance to -- to look at the coroner's
6 notes, sir?

7 A Yeah. I have a copy of them. I haven't read them
8 specifically.

9 Q But did you look at when they were looking at -- I
10 guess on the Wednesday before this happened from that
11 standpoint? Did you see the condition of the child?

12 A You can show me.

13 Q Be glad. You don't have the coroner's report with
14 you, do you?

15 A I've got their -- you know, as I said previously
16 when -- yeah. If you take --

17 MR. BARNETTE: May I approach the witness, Your Honor?

18 A This was -- it says, "Stephanie stated that the infant
19 Alexie had a cold on Wednesday, November 10th, and was
20 congested, not eating very well and somewhat lethargic that
21 day. Rectal temperature was 99."

22 Q And being lethargic and having respiratory problems,
23 like you said, you saw mucus in the lungs. Would that be
24 consistent with morphine or a drug that could suppress in
25 those cases?

1 A Lethargic is one of the -- the signs that they're
2 supposed to look at.

3 Now, you know, you can't -- we -- we're looking at one
4 point in time when I get this baby. And I can't tell what
5 happened, meaning the further away from the time that a
6 person dies that symptoms start and may disappear, you
7 don't know what happened in that time.

8 You can take what the person says that might have some
9 information, but then you have to be able to explain. If
10 you take that as the truth, you have to be able to explain
11 what happened in the meantime.

12 So if this child was lethargic and then she got
13 better, then you can either say one of two things. You can
14 either say she wasn't under the influence and something
15 happened in the meantime in those couple of days when she
16 got better. Maybe the mother wasn't taking anything or
17 maybe she had a virus and she got better.

18 But all I'm looking at is the time she died. And the
19 time she died she had a lethal level of morphine in her
20 brain, in her liver and in her blood anyway you look at it.

21 Now, how it got there, you can -- you can -- anybody
22 can postulate. You can make up your own. It's just like
23 this plane crash in the South Pacific. Everybody has an
24 opinion, but eventually we'll find out what happened.

25 Q Yes, sir.

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Direct examination by Mr. Barnette

1 A Maybe.

2 Q Let me ask you this question. Have you got the lab
3 med? I think Mr. Wise had actually asked about -- not you
4 but asked a witness earlier on.

5 During the summary and use for lactation, if you
6 would -- I think you've already part of that to the jury.
7 And, like I said, this is recognized. This comes from the
8 National Library of Medicine.

9 A Yeah. I read that I thought.

10 Q Yes, sir. I think in the middle there talking about
11 opiate use --

12 A Yeah. Maternal use of oral narcotics during
13 breastfeeding can cause infant drowsiness, central nervous
14 system depression and even death. Newborn infant --
15 infants seem to be particularly sensitive to the effects of
16 even small doses of narcotic analgesics and limited
17 maternal intake of morphine to a few -- to a few days at a
18 low dosage with close infant monitoring is best to provide
19 pain control and limited maternal intake to a few days at
20 low dosage."

21 Q And would you agree with that statement, sir, based --
22 based off your experience and so forth? Opiate would be a
23 morphine type substance, is that right, as well as codeine
24 and other things?

25 A Yes, yes. It's an opiate.

Dr. John David Wren
Cross-examination by Mr. Wise

1 Q Yes, sir.

2 MR. BARNETTE: One moment, Your Honor, please.

3 (Pause.)

4 Q Please answer any questions Mr. Wise may have for you,
5 sir. Thank you.

6 CROSS-EXAMINATION

7 BY MR. WISE

8 Q Dr. Wren, I know you don't know how this child got
9 this level of morphine, but in doing research in this case
10 and preparing for it did you ever find any documentations
11 where a child received a toxic dose of morphine from breast
12 milk from the mother?

13 A No. But I might remind you of a case I had in
14 Charleston where I had a suicide that had never been
15 documented that a person was driving along with a shotgun
16 and shot themselves in the head until I found one obscurely
17 in a Texas medical journal. So there's a first time for
18 everything.

19 Q Right. I understand that but --

20 A No. I don't know of any from -- from breast milk, but
21 I've given you a few calculations that can raise some
22 concerns.

23 Q A newborn child is a three-or-four-day-old child?

24 A You know, I'm not a pediatrician, but there's what's
25 called perinatal, and I don't know exactly when they --

1 when they turn from perinatal to neonatal and so forth.

2 But, regardless, six and a half weeks isn't very old.

3 Q I understand it isn't very old, but it doesn't qualify
4 as a newborn medically.

5 A Well, what's the definition of a newborn?

6 Q You know the definition of a newborn.

7 A No. Do you?

8 Q Do you know?

9 A I don't know. I don't remember.

10 Q You went to med school. I didn't.

11 A Well, you did more research than I did too.

12 Q All right. So when you -- do you know at what rate a
13 six-week-old child's liver will metabolize anything or
14 metabolize substances?

15 A Counselor, I tried to explain that at the start.

16 We are chemical factories. Everybody is different. I
17 tried to -- to tell the jury that even with alcohol we
18 don't do the same thing. So I can't tell you the rates.

19 I don't think there's ever been any studies about how
20 well they do, but it's well known. It's -- I tried to
21 explain from the drug levels that they give infants, and
22 children too, that they don't do as well with the same
23 levels we do.

24 Q Children -- or mothers are frequently given morphine
25 and breastfeed the child with no problem.

Dr. John David Wren
Cross-examination by Mr. Wise

- 1 A I don't know.
- 2 Q You don't know.
- 3 A No. I'm not a clinician.
- 4 Q Okay. Or a toxicologist.
- 5 A No, I'm not a toxicologist either.
- 6 Q All right. Then there's an enzyme that breaks down
- 7 morphine in a person.
- 8 A Yes.
- 9 Q Is that correct?
- 10 A Yes.
- 11 Q And there is --
- 12 A P450.
- 13 Q Excuse me?
- 14 A P450.
- 15 Q It's a very specific enzyme.
- 16 A No, it's not specific. It does -- it metabolizes a
- 17 lot of different things.
- 18 Q Okay. Such as?
- 19 A Huh?
- 20 Q Such as?
- 21 A Lots of drugs.
- 22 Q Okay. It metabolizes a lot of drugs.
- 23 A Yeah.
- 24 Q All right.
- 25 A Or helps. It doesn't metabolize them. It's an

1 enzyme, which means it -- it affects the rate of
2 metabolism.

3 Q Okay. Affects the rate. That's probably more
4 accurate.

5 So if that enzyme is not functioning properly because
6 of a genetic reason, then it would not clear out drugs as it
7 would normally.

8 A That's correct.

9 Q All right. Did you order any genetic testing on this
10 child to see if that enzyme was functioning correctly?

11 A I have a limited --

12 Q Budget?

13 A -- budget.

14 Q All right. Let me rephrase the question then.

15 Did you suggest to SLED that they do that?

16 A As I stated previously, in 1982, or three, it was
17 suggested that they would do it on everybody and it was --
18 came to a conclusion that it was -- that it was not worth
19 it.

20 Q Would do what on everybody, test for how --

21 A Test for in-born areas of metabolism mainly.

22 Q Test every newborn or just --

23 A Every newborn.

24 Q All right. And they weren't -- they haven't gotten
25 around to doing -- they don't do that.

1 A No. They test for phenylketonuria, and a couple of
2 others.

3 Q And that is possible to be tested for.

4 A Yeah, I guess. I guess you could.

5 Q Right. Are you familiar --

6 A If you thought that was the problem.

7 Q Have you at all in researching this case looked at the
8 case out of Canada involving codeine?

9 A I think I recall that.

10 Q You think you do recall it?

11 A Yeah. I --

12 Q And that was a -- a woman whose child had an
13 exorbitant amount of morphine in the system who'd been
14 breastfed.

15 A Yes. She was a rapid metabolizer.

16 Q And somebody in Canada ordered that genetic test.

17 A I guess.

18 Q I mean, we found it out, so somebody had to order it.

19 A I guess.

20 Q And we found out that it was a unique flaw in this
21 case as the mother being a rapid metabolizer.

22 A Well, there are rapid metabolizers in lots of drugs.

23 Q But this -- but that was a genetic defect in that
24 case.

25 A In the mother?

- 1 Q Right.
- 2 A Yeah.
- 3 Q Okay. Where did you get the blood from on this baby?
- 4 A I told you inferior vena cava and the inferior aorta.
- 5 Q All right. And exactly where is that?
- 6 A Below the diaphragm.
- 7 Q All right. And that's in the chest area.
- 8 A Chest?
- 9 Q Isn't it?
- 10 A The diaphragm is below the rib cage.
- 11 Q All right. Right in the core --
- 12 A Right at the rib cage.
- 13 Q The preference is to get blood as far from the heart
- 14 as you can?
- 15 A Yeah.
- 16 Q But in a child it's difficult.
- 17 A Yeah. It's like trying to stick a needle in a --
- 18 inside a smaller needle.
- 19 Q And the reason you try to get further away is that
- 20 that blood is generally more reliable.
- 21 A If the drug redistributes from the heart, yes.
- 22 Q Okay. And such -- and you say if the drug
- 23 redistributes from the heart. Does this redistribute from
- 24 the heart?
- 25 A I don't think it affects the heart that much.

1 Q Okay.

2 A I know that Digoxin or Digitalis that people take for
3 heart problems, it concentrates in the heart. They take it
4 for congestive heart failure. So it can be two or three
5 times what it is peripherally. So if we have somebody on
6 Digoxin -- or Lanoxin is the brand name -- we take -- try
7 to take it as far as we can from the heart.

8 Q And you did a calculation and came up with 8 nanograms
9 of morphine?

10 A No.

11 Q What was it? I'm sorry. I missed it then. I was not
12 paying attention.

13 A It said on page two of this --

14 Q Excuse me. What article are you reading from?

15 A Well, actually it's excerpts from toxnet, summary of
16 use of -- during lactation.

17 Q Right.

18 A Says, "Using the reported median milk levels from 60
19 mg cumulative 48 hour maternal morphine dose in this study,
20 an exclusively breastfed infant would receive 2.4 mcg per
21 K.G. daily of morphine and 73 mcg per K.G. daily of
22 6-glucuronide metabolite. Using the peak milk level from
23 this study, an exclusively breastfed infant would receive
24 an estimated maximum of 7.2 mcg per K.G. daily of morphine
25 and 163 mcg per K.G. daily of 6-glucuronide metabolite,"

1 which is 20 something times the morphine. Okay.

2 Q Go ahead.

3 A So I multiplied 3.3, infant's weight, by 7.2, and I
4 got 23.76 micrograms daily --

5 Q All right.

6 A -- from 60 mg cumulative, 48-hour dose, not one day,
7 48 hours.

8 Q Okay. Now --

9 A And I got therefore rounding it off 24 micrograms, and
10 in the blood, which was .3 liters. That concentration is
11 80 micrograms per liter.

12 Q And that comes up to where on that? What number would
13 that be on level with milligrams?

14 A .080.

15 Q .080, is that correct? So that's roughly --

16 A That's a thousand milligrams per microgram.

17 Q All right. So --

18 A I mean, micrograms per milligram. So 80 micrograms
19 time a thousand is 80.

20 Q Right.

21 A Right.

22 Q As far as the last time I did it.

23 A Okay. So that's how much would be in the bloodstream
24 itself if it was all in the bloodstream.

25 Q So you're dealing with --

1 A And -- and wait a minute.

2 Q Go ahead.

3 A Twenty-five times that much of 6-glucuronide
4 metabolite is -- is -- the infant's got -- got it. So you
5 can multiply -- assuming as I stated previously that that
6 infant they think metabolizes that back to morphine, that's
7 another 25 times as much. So 80 times 25 is 2.0.

8 Q Well, what was the M -- M-6-G metabolite in this case?

9 A Morphine is metabolized by the body to the
10 3-glucuronide metabolite, which is inactive, and the six
11 metabolite, which is active.

12 Q That's correct. What was the M-6-G active metabolite
13 in this case? Do you know that figure?

14 A No. It's all -- it's all been converted to morphine.
15 I don't know whether they even -- whether they even measure
16 that.

17 Q As a practical matter, SLED didn't test for that, did
18 they?

19 A I don't know.

20 Q You're using a substance that SLED didn't test for in
21 your analysis.

22 A No, no, no, no, no, no.

23 Q Okay.

24 A I'm saying -- you asked me about breast milk. I said
25 that that patient secreted -- that infant got 7.2 mic --

1 mil -- micrograms per K.G. of morphine and 163 micrograms
2 per K.G. of 6-metabolite.

3 Q Right.

4 A And the infant is thought to metabolize that to
5 morphine.

6 Q Okay.

7 A So if it -- it metabolized all of it, then you would
8 have another 163 micrograms.

9 Q Right. So what would the final reading be in
10 milligrams?

11 A If they were all at once?

12 Q Yes.

13 A Now, we're talking -- we're -- we're talking about 48
14 hours in a less dose. What was the patient taking?

15 Q What would the final reading be in milligrams?

16 A Let's see. Twenty -- 20 times -- four, six -- 1.50 mg
17 per liter.

18 Q 1.50 mg per liter.

19 A Yeah.

20 Q All right. So that would be lethal.

21 A If it were all in the blood, yeah.

22 Q That would be lethal.

23 A Yes.

24 Q And in that study that child did not die.

25 A No. It -- it didn't say that.

1 Q I understand that.

2 A The study doesn't say that. It says how much they
3 would get in 48 hours daily.

4 Q All right. They -- but they use that on testing.
5 They use -- they start out with the mother's milk.

6 A Yeah.

7 Q All right.

8 A And they -- what they did was found out her
9 concentrations, what was in the milk --

10 Q Right.

11 A -- 3.2 hours after a C-section. No. I'm sorry. Oh,
12 I'm sorry. Excuse me. These -- these patients were
13 getting I.V. morphine 7 to 10 mg over 30 to 60 minutes,
14 then 1 mg every ten minutes. And they were taking -- they
15 took Colostrum samples, 12, 24, 36, in 48 hours postpartum.
16 The average cumulative morphine dose was about 60 mg in 48
17 hours.

18 Q And that was taken from the mother.

19 A Yes.

20 Q Okay. What did they take from the child?

21 A The child wasn't -- wasn't sampled. They just take --

22 Q Now --

23 A Wait a minute. Let me answer.

24 Q Well, go ahead.

25 A They took those levels and said that if the child got

1 all of the milk that they needed that that's how much they
2 would get daily of morphine.

3 Q And that would be on how much morphine in 48 hours,
4 again?

5 A One and a half -- no. One and a half milligrams a
6 day.

7 Q One and a half milligrams of --

8 A Morphine a day.

9 Q -- morphine a day.

10 A Right.

11 Q So a very small amount.

12 A A very small dose.

13 Q Very small dose.

14 A To the mother.

15 Q Certainly lower than what a mother would get from a
16 pump, a morphine pump.

17 A This was a pump.

18 Q That was a pump.

19 A Uh-huh.

20 Q Going directly into the system.

21 A I.V. morphine. I don't know whether they gave it to
22 them by pump or whether they gave it to them, just push.

23 Q So what you're -- what you're saying is that if that
24 mother were to breastfeed that the child would receive a
25 lethal dose of breast milk?

- 1 A No. I didn't say that.
- 2 Q Okay. I am --
- 3 A I was -- what I was doing was telling you the
4 concentration in the blood, how much it could be in the
5 blood if it weren't absorbed anywhere else.
- 6 Q Well, if you don't have it in the blood, it's not
7 going to get in the brain, right?
- 8 A Counselor, do you drink beer?
- 9 Q Occasionally.
- 10 A Do you drink a six-pack at one time?
- 11 Q Not often.
- 12 A Huh?
- 13 Q Not often.
- 14 A All right. Well, if you drink a six-pack at one time,
15 it would be pretty high. If you drink a six-pack over six
16 hours, it would go up and then sort of level off. That's
17 what I'm saying here. I'm just saying the total dose that
18 they would be getting in a 24-hour period would be one and
19 a half milligrams.
- 20 Q So in this case you haven't done a calculation on the
21 30 mg time release.
- 22 A No. I haven't.
- 23 Q Because it's difficult to do.
- 24 A Calculations?
- 25 Q Uh-huh.

Dr. John David Wren
Cross-examination by Mr. Wise

1 A Sure.

2 Q Excuse me one second.

3 (Pause.)

4 Q Thank you very much.

5 MR. BARNETTE: No further questions of this witness,
6 Your Honor.

7 THE COURT: All right. You may step down. Thank you.

8 MR. BARNETTE: We would ask for the witness to be
9 excused, Your Honor.

10 THE COURT: He may be.

11 (Whereupon, the witness was excused.)

12 THE COURT: Have you got somebody else?

13 MR. BARNETTE: Your Honor, can we check some items
14 first and check on something and take a break?

15 THE COURT: All right. We'll take a short break.
16 I'll ask the jury to please go to your jury room. Don't
17 yet talk about the case. I'll bring you back shortly.

18 (The following takes place outside the presence of the
19 jury.)

20 THE COURT: Do you have another witness?

21 MR. BARNETTE: Possibly, Your Honor. I wanted to
22 check on -- I want to check the exhibits obviously and see
23 what we have entered in and then check with the -- we may
24 have a possible nother witness.

25 THE COURT: Okay.

Ellen Holmes

Direct examination by Mr. Barnette

1 (Pause.)

2 THE COURT: We'll take ten minutes.

3 (Whereupon, a recess was taken.)

4 THE COURT: Let me see y'all just a second, please.

5 (Bench conference held off the record.)

6 THE COURT: All right. Bring the jury in, please.

7 (The following takes place in the presence of the
8 jury.)

9 THE COURT: All right. Mr. Barnette.

10 MR. BARNETTE: Your Honor, I'd like to call Ms. Holmes
11 back to the stand, please.

12 THE COURT: All right. Ellen Holmes, you've
13 previously been placed under oath.

14 THE WITNESS: Yes, sir.

15 THE COURT: You're still under oath for the purpose of
16 these questions.

17 THE WITNESS: Yes, sir.

18 ELLEN HOLMES, having been
19 previously duly sworn, testified as follows:

20 DIRECT EXAMINATION BY MR. BARNETTE

21 Q Ma'am, I just wanted to -- a couple of things too I
22 just wanted to make sure is clear for the jury on that.

23 A Yes, sir.

24 Q I know Mr. Wise had asked about the breast -- I mean,
25 about not breast, about the milk that was in the

1 refrigerator.

2 A Yes, sir.

3 Q If you would, tell the jury about that.

4 A There were two bottles in the refrigerator. We opted
5 not to take those because they had -- the defendant and her
6 husband had told us that those bottles were freshly made
7 and they were formula, they were not breast milk.

8 Q And the other thing, I know it came up about pills in
9 her purse or whatever. Did she ever tell you about any
10 pills in her purse?

11 A I was never informed of any medications in her
12 pocketbook.

13 Q If you was would y'all try to take pictures of that?

14 A Yes, sir. We would have counted and taken pictures.

15 Q But you never was told about those.

16 A No, sir.

17 Q If you would, please answer any questions Mr. Wise
18 has.

19 CROSS-EXAMINATION

20 BY MR. WISE

21 Q Did you ask about any bottle that she -- the child had
22 been fed out of that day?

23 A Yes, sir.

24 Q And did you find that?

25 A Well, the previous day. It would have been the

Ellen Holmes
Cross-examination by Mr. Wise

1 previous day.

2 Q The previous day. All right.

3 A Yes. And they said they had washed them and refilled
4 them.

5 Q But you didn't know -- you didn't take one of those to
6 check it out anyway. You didn't take one of the bottles in
7 the refrigerator.

8 A They said it had been cleaned and redone.

9 Q But you had two bottles in the refrigerator of fresh
10 made formula.

11 A Of formula, yes, sir.

12 Q Correct.

13 A We took the formula, the actual formula. We did not
14 take the made bottles.

15 Q Did not take the made bottles. All right. Thank you.

16 MR. BARNETTE: That'd be all the questions, Your
17 Honor.

18 THE COURT: Okay. You may step down.

19 MR. BARNETTE: Your Honor, the state would rest at
20 this point.

21 MR. WISE: We do have a matter for the Court.

22 THE COURT: Okay. That's all of the testimony and
23 evidence to be offered by the state, at least in their case
24 in chief.

25 Before we go further I've got one legal matter I'll

1 need to address. It should take only a moment. Then we'll
2 bring you back. But I've got to excuse you one more time.
3 So don't discuss the case. I'll bring you back in just a
4 few minutes.

5 (The following takes place outside the presence of the
6 jury.)

7 MR. BARNETTE: May we approach one second, Your Honor?
8 (Bench conference held off the record.)

9 MR. BARNETTE: Thank you, Your Honor.

10 THE COURT: All right. Mr. Wise.

11 MR. WISE: Your Honor, I would move for a directed
12 verdict on the grounds that taking the light -- the
13 evidence in the light most favorable to the state they've
14 been unable to establish either one of the two theories
15 they have.

16 There's not been anybody who's testified to a
17 reasonable degree of I think certainty or even sufficiently
18 for the jury that the breast milk from the mother killed
19 this child.

20 All of the testimony has been we don't know how it got
21 there, we just know we got a high morphine level.

22 We know -- as Dr. Wren said, we don't know how it got
23 there. I'm not here to tell you that. Their expert from
24 P.C. said I know -- you know, he didn't know. He's not
25 here to say it came from breast milk. So that theory I

1 think from the state has been eliminated.

2 The second theory for the state was that she somehow
3 gave the child a pill. There's been not a scintilla of
4 evidence in this case that she gave her child any -- any
5 morphine.

6 There's been no analysis of stomach contents to show
7 that there's a higher concentration of morphine there to
8 the extent that it would lead one to believe that morphine
9 was, you know, given to the child. There's been no
10 remnants of pills found. There's been no statement by her
11 about giving the child any morphine.

12 If we worked on the assumptions that the child had to
13 get the morphine somehow then, quite frankly, Mr. Greene
14 was also there the whole time the child was there. Why is
15 one more likely than the other? There's no -- not a
16 scintilla of evidence to make it that way.

17 And just, frankly, it just is not there. There's no
18 evidence she gave the child anything and there's no
19 evidence the breast milk caused this child to have an
20 excess amount of morphine.

21 THE COURT: All right. Mr. Barnette.

22 MR. BARNETTE: Thank you, Your Honor.

23 Reading the statute, Your Honor, it talks about
24 omissions as well as -- from the child -- child abuse
25 statute. Obviously, she never told any of her doctors

1 about this, never told all the O.B.G.Y.N. doctors, anybody,
2 about the morphine that she was taking even when she was
3 pregnant and breastfeeding, Your Honor.

4 David Eagerton testified, Your Honor. And he said it
5 was his opinions. And I remember specifically when
6 Mr. Wise was asking him that question and through his
7 testimony his opinion that this baby died from
8 breastfeeding -- from the morphine through the breast milk.

9 He basically said, basically, there's a first time for
10 everything. I know he was asked about studies and
11 everything.

12 Dr. Wren said that he didn't hold much faith in those
13 studies from that standpoint. And if you heard Dr. Wren's
14 testimony, especially on cross, it was interesting. Both
15 of these was on cross, that he basically testified about
16 the amount of blood that would be based off of the studies
17 that Mr. Wise asked him about could be lethal levels from
18 that standpoint.

19 But David Eagerton specifically testified as a
20 pharmacologist he believed based off the evidence that was
21 presented to him and based off the investigation that he
22 looked at the child was showing signs of letharginess
23 [sic]. And Dr. Wren also testified that that's signs of
24 respiratory distress, call for morphine or that type of
25 drug. And it was a syntigentric [sic] effect. It was just

1 not the morphine alone that killed this child from that
2 standpoint and it -- no question morphine passes through
3 the breast milk into the baby.

4 Babies cannot metabolize as nearly as fast. All the
5 warnings -- I know that Mr. Wise argued that this is 2010.
6 But all the 2012 literature -- and we went through it, Your
7 Honor -- saying that use of oral narcotics during
8 breastfeeding can cause infant drowsiness, central nervous
9 system depression and even death.

10 I believe it's a factor for the jury to look at.
11 Looking at in the most light favorable to the state I ask
12 you to deny their motion concerning that.

13 I assume we're talking about homicide by child abuse
14 that the -- I don't know if he's talking about anything
15 else. But I can go into those too if you need to.

16 THE COURT: All right. Well, based upon the evidence
17 that's been presented I do find that considering the
18 evidence in the light most favorable to the state, as I
19 must do on a motion for a directed verdict, I do find that
20 there is sufficient and substantial circumstantial evidence
21 tending to establish each of the essential elements of the
22 crimes that are alleged in the indictment, and therefore
23 your motions for a directed verdict are denied.

24 MR. WISE: Thank you.

25 THE COURT: All right. Are we ready?

William Chad McNeil
Direct examination by Mr. Wise

1 MR. WISE: And that directed-verdict motion would --
2 my argument would apply to all three charges.

3 THE COURT: Each count -- each count of the
4 indictment.

5 MR. WISE: Right.

6 THE COURT: All right. Bring the jury back, please.

7 (The following takes place in the presence of the
8 jury.)

9 THE COURT: As you are aware, the state has rested in
10 their presentation. So we'll now proceed with any to be
11 offered by the defense.

12 MR. WISE: Call Chad McNeil.

13 WILLIAM CHAD MCNEIL, having
14 been first duly sworn, testified as follows:

15 DIRECT EXAMINATION BY MR. WISE

16 Q Please give us your full name.

17 A William Chad McNeil.

18 Q And where are you employed?

19 A I'm employed at the town of Campobello as the police
20 chief in Campobello.

21 Q And how long have you been employed there?

22 A Ten years.

23 Q All right. How long have you been living in
24 Campobello?

25 A All of my life.

William Chad McNeil
Direct examination by Mr. Wise

- 1 Q Do you know Stephanie Greene in this case?
- 2 A I -- I do.
- 3 Q And how long have you known her?
- 4 A Twenty-five or 30 years I guess. Since high school.
- 5 Q Goes back to school.
- 6 A Yes, sir.
- 7 Q Okay. And what about Randy Greene?
- 8 A Ten or 12 years.
- 9 Q All right. Did you receive a call on the early
- 10 morning of November 13th of 2010?
- 11 A I did.
- 12 Q And what was the nature of that call?
- 13 A It was a --
- 14 Q First of all, what capacity did you receive it in?
- 15 A It came in through the fire department. The police
- 16 department and fire department are run together and assist
- 17 each other. That day I was the E.M.T. on the truck working
- 18 that morning, so.
- 19 Q Did you know where you were going when you got the
- 20 call?
- 21 A Not right off, but I did once -- once I turned onto
- 22 the -- the road and realized whose house it was.
- 23 Q You didn't know the house number.
- 24 A No, sir, no, sir.
- 25 Q You knew he -- you knew the Greenes lived on that

1 road.

2 A Yes.

3 Q All right. What did you see when you got there?

4 A We entered through the --

5 Q Now, when you say we, who is we?

6 A Me and I believe it's the fire chief that morning. We
7 entered through the living room and went back to the
8 bedroom where we found a [sic] infant laying on the bed. I
9 believe it was Randy who -- who brought us down the hall to
10 where we found the mother and baby. When we walked in
11 mother was doing C.P.R. on the -- on the child.

12 Q Are you familiar with C.P.R.?

13 A Yes, sir.

14 Q Do you know how to do it?

15 A Yes, sir.

16 Q What was your opinion as to how she was administering
17 C.P.R.?

18 A She -- she was doing it the correct way.

19 Q All right. How long -- did you talk to her at all at
20 that point.

21 A No. If -- if memory serves me correctly, what we did
22 was we asked -- we asked for the child and -- and started
23 to perform C.P.R. We were getting a few things out of our
24 bag and -- and they asked for -- we started asking
25 everybody to leave the room, so.

- 1 Q Okay. Did y'all take over the C.P.R.?
- 2 A Yes, sir.
- 3 Q All right. Obviously, not able to do anything.
- 4 A No, sir.
- 5 Q All right. Later did E.M.S. come?
- 6 A Yes, sir, within two to five minutes, give or take.
- 7 Q What did they do when they got there?
- 8 A They set up their monitors and all of those -- all of
- 9 their stuff and set it up and realized that there was no --
- 10 Q And they took over from there.
- 11 A Yeah, they took over from there.
- 12 Q Did you have a -- and how long did you stay there that
- 13 morning?
- 14 A We were there -- I guess we were there until the
- 15 coroner's office arrived and took over because of --
- 16 Q And that was about 6:15 or 6:30?
- 17 A Yes, sir.
- 18 Q All right. Did you have chance to talk to Stephanie
- 19 that day?
- 20 A I don't know if we -- I mean, we may have spoke, but,
- 21 I mean, it was a shock to everybody.
- 22 Q You didn't have a long conversation.
- 23 A No, sir, no, sir.
- 24 Q Did you see her demeanor and attitude that day?
- 25 A I would say yes, sir.

1 Q Did you -- could you tell whether or not she was under
2 the influence of anything?

3 A I didn't -- I didn't determine that she was. But I
4 wasn't in the -- I guess my capacity was not to be looking
5 for that.

6 Q I guess my question is based upon the time you saw her
7 did she give you any appearance of it.

8 A Not at the time, no.

9 Q Did -- did E.M.S. people ask her to perform services
10 for them, get -- get items in the house?

11 A Yes, sir, they did ask for her to go retrieve some
12 items. I don't really remember exactly what, but they
13 were -- I know cards and things like that, of that nature,
14 and they -- they went to get them.

15 Randy was also asked to go get them and his -- his
16 demeanor was totally -- I guess as a -- me being in law
17 enforcement and E.M.S., his demeanor was as a person who's
18 never dealt with something, a death in the family or
19 anything. He -- you could tell that his -- his was
20 opposite of hers.

21 Q She was -- she was doing the C.P.R. when you got
22 there.

23 A Yes, yes.

24 Q Did she have any trouble walking to get the items you
25 noticed her walking -- noticed her to go get?

- 1 A Not that I remember.
- 2 Q All right. Did you talk to her at all and hear her
3 speak?
- 4 A I did hear her speak, and she gave me the information
5 to tell me what was going on, I mean, where they found the
6 baby, the location, all of that when we arrived, so.
- 7 Q And you've known her for 20 something years.
- 8 A Uh-huh.
- 9 Q Her speech anything out of the ordinary from how she
10 normally talked?
- 11 A Not that I recall.
- 12 Q Maybe a little softer?
- 13 A Well, no. I think she was a little more excited due
14 to the fact of what -- I mean, it wasn't a -- I mean, she
15 wasn't mad or anything at anybody.
- 16 Q Right. I understand.
- 17 A It was -- she was just --
- 18 Q Hyper?
- 19 A Hyper and --
- 20 Q Were you there when the E.M.S. basically told her her
21 child was -- had died?
- 22 A Yes, sir.
- 23 Q And that was about what time?
- 24 A I'm not really sure, about 6:30 or something till
25 7:00, I guess, because they asked her to -- I mean, it was

1 a -- they went in there and talked with them.

2 Q Thank you. Answer any questions Mr. Barnette may
3 have.

4 MR. BARNETTE: Just briefly, Your Honor.

5 CROSS-EXAMINATION

6 BY MR. BARNETTE

7 Q Sir, you said hers was totally different from Randy's.

8 A Yes, sir.

9 Q From there. And you didn't listen to the 9-1-1 call.
10 You didn't hear the 9-1-1 call, did you?

11 A No, sir, no, sir.

12 Q And you weren't there for the interview when the
13 coroner's office interviewed her, were you?

14 A No, sir. Once the coroner's office arrived we -- we
15 were asked to go outside, so.

16 Q Yes, sir. Thank you.

17 MR. BARNETTE: That's all the questions I have.

18 MR. WISE: Hold on one second.

19 (Pause.)

20 MR. WISE: Thank you.

21 THE COURT: You may step down.

22 Do you have another reasonably short witness?

23 MR. WISE: Well, we had one. He had to go pick the
24 child up at 5:00 o'clock.

25 THE COURT: Okay. All right. We'll recess for the

1 afternoon.

2 Let me caution the jury again. No discussions, no
3 research, no investigation, no exposure to any type of
4 media coverage -- television, radio nor newspaper.

5 Have a good evening. Please report to your jury room
6 at 9:30 in the morning. Have a good afternoon.

7 (The following takes place outside the presence of the
8 jury.)

9 THE COURT: Court is in recess until 9:30 in the
10 morning.

11 END OF PROCEEDINGS APRIL 2, 2014

Andrew Homer Havko, Jr.
Direct examination by Mr. Wise:

1 (Proceedings April 3, 2014)

2 (The following takes place outside the presence of the
3 jury.)

4 THE COURT: Are there any matters to address before
5 the jury is brought in?

6 MR. BARNETTE: None from the state, Your Honor.

7 MR. WISE: None from the defense.

8 THE COURT: Bring them in.

9 (The following takes place in the presence of the
10 jury.)

11 THE COURT: Good morning, ladies and gentlemen.

12 As you know, when we recessed yesterday the defense
13 had begun with its presentation of evidence. So we will
14 continue with that presentation this morning.

15 MR. WISE: Call Homer Havko.

16 ANDREW HOMER HAVKO, JR.,
17 having been first duly sworn, testified as follows:

18 DIRECT EXAMINATION BY MR. WISE

19 Q Please give us your full name.

20 A Andrew Homer Havko, Jr.

21 Q And where do you live, Mr. Havko?

22 A 639 Thornbird Circle, Boiling Springs, South Carolina.

23 Q All right. You're employed?

24 A I am retired.

25 Q What did you retire from?

Andrew Homer Havko, Jr.
Direct examination by Mr. Wise

1 A I was a mechanical engineer, switched to systems
2 administration and then ended up at Lowe's.

3 Q All right. Is that here in Spartanburg?

4 A Up at Boiling Springs, yes, sir.

5 Q Boiling Springs. All right. Do you know Stephanie
6 Greene?

7 A Yes, sir, I do.

8 Q And how do you know her?

9 A She's my daughter.

10 Q Going back to November of 2010, did you see Stephanie
11 in the days before November 13th of 2010?

12 A Yes, sir, I did. I was on leave, medical leave, for a
13 hernia. So I got to see her and the baby every day.

14 Q All right. The mother here in the courtroom?

15 A Pardon?

16 Q Is your wife here in the courtroom?

17 A My wife.

18 Q Yes.

19 A Yes, she is, the pretty lady in the purple.

20 Q All right. What did y'all do several days before
21 this?

22 A Well, before this every day --

23 Q Before this meaning November 13th of 2010.

24 A I started picking up my grandson and stopping by every
25 day.

Andrew Homer Havko, Jr.
Direct examination by Mr. Wise

1 Q Your grandson being?

2 A Brandon Greene.

3 Q Okay.

4 A He was at Campobello-Gramling school. I love being
5 around my grandchildren. And I'd stop by the house and
6 visit with Stephanie and the baby for a while. And then
7 on -- well, there were a couple of things. On November
8 11th my granddaughter was in a Veterans Day program at her
9 school.

10 Q That's another granddaughter other than Alexis.

11 A Yes.

12 Q Okay. Go ahead.

13 A So they were having a Veterans Day program. So
14 Stephanie and Alexis and I attended that.

15 Q All right. So you went. And where was that being
16 held?

17 A That was at the elementary school in Boiling Springs.

18 Q That was on Wednesday.

19 A To the best of my recollection.

20 Q What was the condition of Alexis on that Wednesday?

21 A Alexis seemed very normal to me, normal baby.

22 Q Did she have any problem with a cold?

23 A That day she did have a cold. We almost canceled, but
24 then Stephanie called her doctor, and doctor said to get a
25 vaporizer, which we did, and as long as she didn't have a

Andrew Homer Havko, Jr.
Direct examination by Mr. Wise

- 1 fever to --
- 2 Q All right. So y'all went.
- 3 A We went to the thing.
- 4 Q Okay. Did you have any contact with Alexis and
- 5 Stephanie on Friday before the 12th of November?
- 6 A Yes, I did.
- 7 Q What contact did you have then?
- 8 A I guess that was the day that we went to the doctors
- 9 and took Stephanie to the doctors. And then we stopped by
- 10 Lowe's. I'm not sure exactly.
- 11 Q You saw them Friday before.
- 12 A I saw them every day before.
- 13 Q All right. What was the condition of Alexis when you
- 14 saw her on the day before the tragedy?
- 15 A Alexis seemed fine. I've been -- been around a lot of
- 16 babies. I've seen some very active babies and I've seen
- 17 some not-so-active babies. I've seen more active babies
- 18 than Alexis and I've seen less active babies than Alexis.
- 19 She seemed very normal to me.
- 20 Q Did you also come by on the morning of the 13th?
- 21 A Was that -- that was the day?
- 22 Q That's correct.
- 23 A Yes, I did.
- 24 Q Did you see Stephanie that day?
- 25 A I did.

Andrew Homer Havko, Jr.
Cross-examination by Mr. Barnette

1 Q All right. What was her condition that day?

2 A Pardon?

3 Q What was her condition that day?

4 A I'd say pretty much shock.

5 Q Did she appear to be under the influence of anything
6 to you?

7 A She did not appear to be under the influence of
8 anything any of the times that I visited her.

9 Q And what time did you get there on the 13th?

10 A I'm not sure of the exact time. I was sleeping. She
11 called me and told me that they'd called the ambulance and
12 they wanted me to come over and watch my grandson Brandon
13 while they went to the hospital with the ambulance.

14 Q Were the E.M.S. people there when you got there?

15 A The E.M.S. people were there when I got there.

16 Q Thank you. Answer any questions Mr. Barnette may
17 have.

18 CROSS-EXAMINATION

19 BY MR. BARNETTE

20 Q She -- the defendant's your daughter, is that right,
21 sir?

22 A Pardon?

23 Q The defendant's your daughter, is that right, sir?

24 A The defendant is my daughter, yes.

25 Q Yes, sir. And what did you say about the ambulance or

Dr. Steven Bernard Karch
Direct examination by Mr. Wise

1 whatever? I didn't catch that end part there. I just
2 wanted to make sure I understand.

3 A The ambulance was there when I arrived.

4 Q And they -- they went to the ambulance. Or what did
5 you say about that? I didn't quite understand.

6 A Stephanie called me and told me that they were -- that
7 they had called the ambulance to take Lexie to the
8 hospital, that she was unresponsive, and for me to come and
9 keep an eye on my other grandson Brandon.

10 Q Okay. I didn't quite understand. That's all the
11 questions I have. Thank you, sir.

12 MR. WISE: Thank you. You may come down.

13 Like to call Dr. Steve paraphernalias.

14 DR. STEVEN BERNARD KARCH,
15 having been first duly sworn, testified as follows:

16 DIRECT EXAMINATION BY MR. WISE

17 Q Please give us your full name.

18 A Steven Bernard Karch.

19 Q And where do you live presently?

20 A Berkeley, California.

21 Q And how long have you been living out there?

22 A About 40 years.

23 Q All right. Go back. Where were you born?

24 A Providence, Rhode Island.

25 Q All right. And where did you grow up?

Dr. Steven Bernard Karch
Direct examination by Mr. Wise

1 A Partly in Providence and partly in New Orleans, and
2 points in between.

3 Q Okay. Where did you go to undergraduate school?

4 A Brown University.

5 Q Got a degree in what?

6 A Philosophy and logic.

7 Q All right. And you went to school where after that?

8 A After that I went to Stanford University and did
9 molecular biology and biophysics.

10 Q All right. And what degree did you get from there?

11 A I didn't. I decided I wanted to go to medical school.

12 Q So before you got a degree you went to medical school.

13 A Yes, sir.

14 Q Where did you go to med school?

15 A Tulane.

16 Q All right. What degree did you get from there?

17 A M.D.

18 Q All right. After that what did you do?

19 A Then I did an internship back in California, Kiser
20 Foundation. That's when they used to have general
21 internships. I don't believe they have them any more. You
22 do three months of obstetrics, three months of surgery,
23 three months of medicine, three months of electives.

24 Q Okay. What did you -- after you finished that what
25 did you do?

Dr. Steven Bernard Karch
Direct examination by Mr. Wise

1 A From there I went to the Royal London Hospital in
2 London and was a neuropathology fellow for two years.

3 Q What is neuropathology?

4 A Well, you learn the basics of pathology. And I did
5 some autopsies. But mostly you learn how to examine the
6 raw brain, and you learn how to examine the brain under the
7 microscope.

8 Q Okay. Did you have any training after the Royal
9 Academy.

10 A Yes. I worked from the mid 80s to the mid 90s with
11 Professor Margaret Billingham at Stanford. It was the only
12 heart transplant lab in the world at the time, and I both
13 did my research, which was on stress hormones and better
14 ways to resuscitate children, and worked as -- there's no
15 way other to put it except as an apprentice. I followed
16 her around and did what she told me.

17 Q Did you have any training beyond that?

18 A Yes, I did. When she decided to retire the San
19 Francisco Medical Examiner made me assistant medical
20 examiner, and I worked for him one day a week. It was a
21 dollar a week, but it's -- it's a salary. And I looked at
22 every drug-related death that occurred in the city of San
23 Francisco for about 10 or 11 years.

24 Q Did you have any training in toxicology?

25 A Yes. From Dr. Stephens who had a rather advanced lab.

Dr. Steven Bernard Karch
Direct examination by Mr. Wise

1 Q And where was that?

2 A That was in San Francisco in the Hall of Justice in
3 the basement.

4 Q Have you published in the field of toxicology?

5 A Yes.

6 Q And what have you published? well, let me back up
7 first of all. what is a peer review article?

8 A A peer review article can mean different things to
9 different folks.

10 If you have a meeting, like I noticed there's a
11 meeting at my hotel, you can submit an abstract saying I've
12 done this research and it shows this.

13 well, somebody else will have read it. And so some
14 people call that peer review. I don't. And I don't
15 include any of my abstracts in my curriculum vitae.

16 Real peer review is when two, three -- or in the case
17 of a journal that I'm editing now -- four other experts in
18 the field read the paper and criticize parts that they
19 don't like or say, yeah, you got it right and tell the
20 editor whether it should be published or not.

21 Q So people will read the work and basically tear it
22 apart.

23 A That's happened to me.

24 Q Or try to anyway.

25 A Yes.

- 1 Q And that's what you mean by peer review.
- 2 A Yes, sir.
- 3 Q All right. Have you published peer review articles?
- 4 A Yes, sir.
- 5 Q All right. Do you have any idea how many?
- 6 A Probably more than a hundred.
- 7 Q All right. Do you also publish books in the field of
- 8 toxicology and drug abuse?
- 9 A Yes.
- 10 Q All right. Did you publish the "Pathology of Drug
- 11 Abuse, Fourth Edition"?
- 12 A Yes.
- 13 Q Is that peer reviewed or is it self function?
- 14 A They have it reviewed. I don't think they'd spend a
- 15 quarter of a million dollars and put it out there just on
- 16 my word. And the -- the first edition I got back was -- I
- 17 can only describe as bleeding it was covered with so many
- 18 red marks.
- 19 Q And this is the -- the "Pathology of Drug Abuse" is
- 20 the book on what basic topic?
- 21 A It's the changes that you see in the body of drug
- 22 abusers. And if you see enough drug abusers certain
- 23 patterns emerge, like I can look at the heart of a person
- 24 and say either this guy had a very bad doctor who didn't
- 25 treat his high blood pressure or else this is one big-time

1 co-freak. It's pretty easy to tell.

2 I saw Jerry Garcia's heart, and he died, as you know,
3 of combined heroine and cocaine abuse. And even though
4 he'd come out of rehab and was drug free when he died it
5 was still a death due to cocaine and heroine.

6 Q Doctor, is there any other books besides the
7 "Pathology of Drug Abuse"?

8 A Oh, a number of them.

9 Q And generally a couple of titles.

10 A Well, I wrote one on the history of the cocaine
11 industry. I wrote one on the history of the very early
12 cocaine industry in the 1800s. And I'm the editor of a
13 book called the "Drug Abuse Handbook" which is now working
14 on its third edition. The first two editions are used
15 pretty much around the world, as is the textbook.

16 Q And the "Pathology of Drug Abuse," what edition are
17 you on that one?

18 A I'm -- if I could get the proofs done this weekend,
19 the fifth edition.

20 Q Is that book used widely in the profession?

21 A Well, it's not out yet.

22 Q The fourth edition. Excuse me.

23 A The fourth edition is, yes, sir.

24 Q Okay. Have you been qualified as an expert in the
25 affects of drugs on the human body?

1 A Yes, sir.

2 Q In what courts have you been so qualified?

3 A Numerous state courts, federal courts, the Country of
4 Australia, the United Kingdom.

5 Q Do you have any idea how many times you've testified
6 as an expert?

7 A No.

8 Q Okay. More than once or twice?

9 A Yes.

10 Q More than a hundred?

11 A I doubt it.

12 Q Okay. Somewhere in that?

13 A I -- I was surprised when I looked at the list to send
14 you the vitae, but it's between 50 and a hundred probably.

15 Q Okay. All right.

16 MR. WISE: Your Honor, I would offer Dr. Karch as an
17 expert in the effect of drugs on the human body.

18 MR. BARNETTE: Just one or two questions, Your Honor.

19 CROSS-EXAMINATION

20 BY MR. BARNETTE

21 Q Doctor, I mean, sir, when was last time you did an
22 autopsy?

23 A An honest to God whole autopsy --

24 Q Yes, sir.

25 A -- probably 45 years. A heart last week.

Dr. Steven Bernard Karch
Redirect examination by Mr. Wise

1 Q But a full autopsy 45 years ago?

2 A Yes, sir.

3 Q Okay. So how many autopsies have you actually done?

4 A Only about 50.

5 MR. BARNETTE: That's all the questions I have, Your
6 Honor.

7 THE COURT: Do you object to his qualifications?

8 MR. BARNETTE: I'll stipulate to him.

9 THE COURT: All right. He is so qualified.

10 REDIRECT EXAMINATION

11 BY MR. WISE

12 Q Dr. Karch, you've been asked to review this case?

13 A Yes, sir.

14 Q You've reviewed the medical reports?

15 A Yes, sir.

16 Q Much of the discovery?

17 A Much of it.

18 Q All right. Has there ever been a report of a child
19 receiving a toxic level of morphine from breast milk from
20 the mother who's taking morphine?

21 A I don't mean to be cute. Could you classify what you
22 mean by toxic? Do you mean a level to make a child sick?

23 Q Yes, yes, a level to make a child sick.

24 A I think that's happened.

25 Q What about a level that's lethal?

1 A From breast milk?

2 Q Right.

3 A No.

4 Q You think that's happened on a toxic level?

5 A well, I -- I know from the Canadian case that's been
6 referred to several times.

7 Q We'll get to the Canadian case in a minute. If you
8 eliminate the Canadian case what are we dealing with? Are
9 there any cases?

10 A well, then you have -- have the tonsillectomies
11 which -- which are -- the American Medical Association's
12 recommended that you not give codeine to children after
13 tonsillectomies because the codeine gets converted to
14 morphine and maybe too much if they don't have the right
15 genetic component.

16 And then there are maybe half a dozen cases in the
17 world literature where the pharmacist made a mistake and
18 instead of giving 1.0 gave 10.0 solution, concentrated
19 solution, and those children died.

20 Q All right. That would be given directly to a child.

21 A Yes, sir.

22 Q All right. What about through breast milk?

23 A No, sir.

24 Q All right. Now, you've reviewed the -- you've
25 reviewed -- you've reviewed papers published by the

1 American Academy of Pediatrics?

2 A Yes.

3 Q What do they recommend concerning use of morphine from
4 a woman who is breastfeeding?

5 A Well, I think their recommendations are pretty much in
6 conformity with all of the other medical societies in that
7 you don't start with morphine. You start with a
8 nonsteroidal like aspirin or ibuprofen or something of that
9 sort. And you escalate your way up until you get the pain
10 relief you need.

11 Q Do they -- do they rec -- does the American Academy of
12 Pediatrics list morphine as being dangerous for a woman who
13 is breastfeeding?

14 A No.

15 Q You've reviewed several articles on this?

16 A Yes.

17 Q All right. I think the most recent article was in
18 August of last year.

19 A 2013, yes.

20 Q Okay. And does that article have a cautionary comment
21 about codeine?

22 A Yes.

23 Q This is not a codeine case, is it?

24 A No.

25 Q This is regular morphine.

1 A Yes.

2 Q All right. What does the American Academy of
3 Pediatrics recommend to doctors who are prescribing pain
4 medication for breastfeeding mothers in lieu of cocaine --
5 codeine? Excuse me.

6 A I have to look it up. "When narcotic agents are
7 needed to treat pain in the breastfeeding woman, agents
8 other than codeine, i.e., butorphanol, morphine or
9 hydromorphone are preferred."

10 Q So they would prefer morphine over codeine for
11 breastfeeding mothers.

12 A Yes.

13 Q All right. Let me ask you a couple of other
14 questions, go back a second about autopsies in general.

15 All right. You were here yesterday when Dr. Wren
16 testified.

17 A Yes.

18 Q There were stomach contents found.

19 A Yes.

20 Q Should they have been analyzed?

21 A That's a hard question. I would have preferred to
22 analyze them.

23 Q Why is that?

24 A Because if the drug was taken orally, then you'd
25 expect to be a lot in the stomach. For instance, if a pill

1 had been -- if -- kids explore with their mouths, as you
2 know. And if a pill had somehow become available and they
3 had taken it, my recollection is either that oxymorph [sic]
4 is either eletric blue or eletric green. I -- I can
5 remember which. But you could almost see it in the dark.

6 And once you swallow it, or even if you crushed it,
7 you'd have this purple blop [sic], and it would stain the
8 lower part of the esophagus. And it would be -- and when
9 you looked at the stomach contents it would look sort of --
10 it wouldn't look clear and it wouldn't look the normal
11 ratty brown that you see. They -- they'd probably have a
12 color.

13 Q Okay. And you could have done a chemical analysis on
14 the contents.

15 A Yeah, and that would be the important part.

16 Drugs get in the stomachs -- into the stomach two
17 ways. If you take a pill you're going to have a lot in
18 your stomach for a while. But also if you take a pill,
19 medicine, like heroine or morphine intravenously there's a
20 molecular phenomenon called ion trapping. And even though
21 you never put any in your stomach you'll still -- I can
22 still find heroine or morphine in the stomach, smaller
23 amounts though. And it's an easy haul to say this is ion
24 trapping and this is a pill.

25 Q And so that's the test that can be readily run.

1 A It can be done if you've got the facilities and you've
2 got the money.

3 I don't have any intention of criticizing Dr. Wren for
4 not doing it. It's -- it's hard enough. I've never had
5 the honor or the misery of running one of these labs, but I
6 do know that they're all wildly underfunded. And you do
7 the tests you gotta do to get the diagnosis.

8 Q Are these things that can be farmed out, so to speak,
9 these tests?

10 A These tests, they can.

11 Q And farmed out simply means send a sample to a lab
12 that has the equipment.

13 A Sure. Although that one is fairly easy, but that
14 doesn't mean it's free.

15 Q Okay.

16 A It comes out of somebody's budget.

17 Q What do you know about the metabolism rate of livers
18 in small children?

19 A Neonates, little babies -- day one, day two, day
20 three -- clearly have an issue with getting morphine out.
21 It takes them longer.

22 But by a month they're at 80 percent of normal. And
23 to put that into a better picture, you only need 20 percent
24 of your liver to live. So suppose you walked out of here
25 and got in a car accident, got your pelvis broken and your

1 spleen ruptured and a few other things and your liver torn
2 in half, nobody'd think twice about taking out that half of
3 the liver because we know it'll grow back.

4 Q And while it's growing back you could function on half
5 a liver?

6 A Yeah. You might not be a real happy camper, but you
7 could.

8 Q Okay. Is there any merit to the theory of
9 accumulating large amounts of morphine in a 6-week old
10 child?

11 A Some would certainly accumulate. Morphine isn't
12 the -- the -- the most lipophilic drug.

13 Q And what do you mean my lipophilic?

14 A I'm sorry. You can classify drugs in whether they
15 dissolve in water, whether they dissolve in fat. And
16 morphine -- all abused drugs pretty much like to dissolve
17 in fat, which is a real, real problem for places where you
18 have a per se law.

19 So suppose you were a morph -- a marijuana smoker and
20 you had a state that said if you have any morphine
21 metabolite in your body you are D.U.I.

22 Well, that's a good theory. The problem is that
23 marijuana disappears into the fat cells as soon as you
24 smoke it. If you smoke a marijuana cigarette you're prepub
25 [sic] level is one minute after you smoke it. It's while

1 you're smoking it. And when you die as the fat cells fall
2 apart the marijuana falls out of it.

3 Now, marijuana is ultra lipophilic. Morphine is
4 pretty lipa -- lipophilic, a lot more lipophilic than most
5 drugs.

6 Q All right. While we're talking about that, is that
7 based upon the principle of the redistribution of drugs
8 after death?

9 A I -- I think it's the other way around. People
10 observed this and then formulated the theory of
11 redistribution.

12 Q And what basically is that theory?

13 A well --

14 Q well, first of all, is it a theory or is it true?

15 A Oh, of course it's true. And I -- I sort of helped
16 prove it was true years ago.

17 We did autopsies and took the -- the fat layer from
18 the stomachs of known drug users. We tested through urine
19 first to know that they were drug users so we knew which
20 drug to look for. And then we cut the chunk of their belly
21 out and sliced slices of fat and looked to see whether we
22 could find the drugs in the fat. And this was right at the
23 time of the autopsy, right at the time the body came in, no
24 waiting. And, sure enough, it was all there. So we know
25 it's stored in fat. And we know anything that's stored in

1 fat will be released from fat at some point.

2 Q And that's true with morphine.

3 A It's true with morphine. It's true with many drugs.

4 But there -- there are other mechanisms as well. And I

5 know yesterday Dr. Wren talked about digitalis in the

6 heart. And a lot of doctors went to -- lost malpractice

7 suits because high levels of digitalis were taken when they

8 measured heart blood at autopsy. And the doctors hadn't

9 prescribed anything extra. It was just stored there. This

10 was figured out a few years later.

11 The main driving force is that -- you heard yesterday

12 that the liver gets a lot of blood, and it does. But the

13 lungs get tons of blood, and the lungs' blood's got the

14 drug in it.

15 Now, when you die the blood's still there. The blood

16 vessels in the lung are thin, and they're connected back to

17 the heart.

18 So what happens is when you die -- you heard this

19 yesterday too -- things go down obradiant [sic]. So

20 everything in a high concentration can sequalize out so you

21 get the same concentration everywhere.

22 And the drugs will get into the pulmonary blood

23 vessels, and the blood vessel that goes from heart to lungs

24 is very thin, and the drugs just pass right through it and

25 end up in the -- the right side of the -- the left side of

1 the heart, which is why we're taught never, ever, ever,
2 ever, ever, ever, ever, ever to take heart blood or even
3 blood that's close to the heart because you know you're
4 going to get a phony number that's way high.

5 Q Do you know about what percentage it's going to be way
6 high?

7 A No.

8 Q I'm going to hand you. This is the copy of the
9 toxicology report with Dr. Wren's numbers on it.

10 A Yes.

11 Q What about those other drugs? Are they -- do they
12 tend to get into the fat as easily as morphine?

13 A Diphenhydramine probably does. Chlorpheniramine and
14 Dextromethorphan I think are intermediate, but I didn't
15 look them up to be positive.

16 You see them so often in situations where they're
17 clearly irrelevant that I think Dr. Wren does exactly what
18 I do, is I don't pay a whole lot of attention unless I see
19 a very high number. And what I think is a high number is
20 not necessarily the same thing as the high number that you
21 see written in these numbers.

22 I've had a running war with any number of labs begging
23 them to take these numbers off the chart, because all of
24 these numbers that you're looking at where they talk about
25 therapeutic and high are derived from you and me and --

1 Q And that's living human beings?

2 A Living human beings.

3 Q All right.

4 A And whether they apply to dead people is an intuitive
5 leap. And I don't know how to make that leap and I don't
6 know to how justify that that assumption is correct. And
7 nobody's ever proved that it's correct.

8 Q Let me ask you this then. If you look at those
9 reports the lethal level of morphine is within the
10 therapeutic range, is it not?

11 A For a person, yeah.

12 Q Right. For a living being. That's what that report
13 says.

14 A That's correct.

15 Q How is that possible?

16 A Well, tolerance of course.

17 Q Excuse me?

18 A Well, there are two reasons.

19 In the human being -- the human being becomes
20 tolerant. So it makes no sense.

21 I have one paper here they did in Sweden. And I
22 believe they have a free heroine program where they give
23 people that are hardcore addicts -- they give them free
24 heroine in order to minimize the amount of H.I.V. And
25 surprisingly a lot of these people clean their acts up and

1 go back to work on heroine.

2 And they compared them to a bunch of dead folk in the
3 morgue who had died of heroine overdoses, and there was
4 total overlap. You couldn't look at the number and say
5 this one's dead and this one's working at the post office.

6 Q Would it be correct to say that a lethal level of drug
7 is an educated guess?

8 A No, well, yes. But it's not an educated guess.
9 It's -- it's the opposite of an educated guess because you
10 do not know the genetic status of that person. And one of
11 the biggest controlling factors for your blood level and
12 one that's probably operative here is the fact that if this
13 baby didn't have the proper enzyme, which is named U.D.G.P.
14 6, he -- she could not have broken down any morphine,
15 any -- the little bit of morphine that is in normal breast
16 milk of mothers taking morphine.

17 Q Would that be something known to a breastfeeding
18 mother?

19 A Not unless she was a doctor.

20 Q That effect.

21 A Not unless she was a doctor, I don't think so. And
22 even then I wouldn't bet on it.

23 Q Is there a test that can be run for that?

24 A Yes, there is. But the same provisos hold. Prices
25 have come way down, but I can't imagine doing this test for

1 less than \$5,000, which is more than the allocated budget
2 for most complete autopsies.

3 Q Now, in this particular case do you have an opinion
4 about what happened in this case?

5 A If -- if I accept the lab value as reflecting the lab
6 value at the time of death.

7 Q And by accepting the lab value at the time of death
8 you're assuming that that was the amount of morphine in the
9 child at the time she died.

10 A Yes, sir.

11 Q Not due to postmortem redistribution.

12 A No. If I'm accepting this as the real number one
13 minute before the baby died.

14 Q Okay.

15 A If I accept that, then either the baby got an overdose
16 of morphine or the baby has a genetic defect and is unable
17 to metabolize morphine exactly in the same way that the
18 Canadian case could metabolize mor -- codeine.

19 Q Could the baby have ever gotten a morphine level that
20 high from breast milk?

21 A Yes.

22 Q How?

23 A I don't know, but I have one case here where a baby
24 got an 84 nanogram blood level from a mother on morphine.

25 Q And did that baby die?

1 A No.

2 Q All right. Is there any reported case of a baby dying
3 from breast milk from the mother?

4 A No.

5 Q Do you have -- were you here yesterday when Dr. Wren
6 did his little calculation?

7 A Yes, sir. I didn't follow them.

8 Q Do you have any -- is extrapolation backwards a very
9 accurate thing to do?

10 A I've written in my textbook it's something not to be
11 done at all.

12 Q All right. As far as accuracy, is it very accurate?

13 A No. It can be wildly misled.

14 Q All right. Are there any things you can do to give us
15 a rough idea of how much morphine -- well, let me back up.
16 Is there anything you can do to give us a rough idea of how
17 much morphine Ms. Greene would have to be taking to get to
18 these levels in this child?

19 A Well, all I can do is -- is -- is go back to what you
20 introduced yesterday to one of the witnesses. I'm sorry I
21 don't remember which. But you had a patient that the
22 mother was taking 5 mg pills of morphine and the baby had 4
23 nanograms in her blood.

24 Q And how does 4 nanograms compare to this case?

25 A It's -- well, it's roughly a tenth.

1 Q How many nanograms are involved in this case, do you
2 remember?

3 A In this case I think it was a 30 mg tablet.

4 Q Yeah. But that's the tablet. How much nanograms were
5 found in the baby Alexis?

6 A Four -- oh, in the baby Alexis, 51.

7 Q All right. Fifty-one or 52 nanograms?

8 A Yes, sir.

9 Q All right. And four grams would be -- or 52 nanograms
10 would be about 125,000 times greater than four?

11 A Like the man said yesterday, I'll take your word,
12 yeah.

13 Q All right. Roughly that figure. That's a pretty high
14 number.

15 A Yes.

16 Q And the study that you were talking about, that was a
17 mother who had had 5 mg dosage?

18 A Yes.

19 Q And the prescription here was 30 mg?

20 A Yes.

21 Q which is just -- and that's time release.

22 A Yes.

23 Q All right. Time release different from instant
24 release? Is that what it's called?

25 A Different in the fact that the blood levels don't get

1 as high. It's the same net amount of morphine delivered.

2 Q So if -- if you had a pill of 30 mg of morphine that's
3 released instantly how quick would it take you to get 30 mg
4 of morphine in your system?

5 A Probably about 25 minutes to an hour.

6 Q And 30 mg over time release you would get 30 mg total
7 over eight hours?

8 A That's the theory.

9 Q All right. Is that pretty close to accurate?

10 A I think so. It would depend, like, if you were
11 somebody that had gastric surgery and couldn't dissolve the
12 time release as quickly as -- as the average person, or if
13 you were somebody who produced too little stomach acid, but
14 on average I think that's fair.

15 Q And I know comparing one person to another person is
16 not a good idea because of the different metabolism rates
17 and all of that, correct?

18 A Yes, sir.

19 Q All right. But if the woman who took 5 mg to get to 4
20 nanograms and the -- and this was done in a hospital
21 setting --

22 A Yes, sir.

23 Q -- where the mother was receiving morphine in the
24 hospital?

25 A Yes, sir.

- 1 Q And then they were testing the baby.
- 2 A Yes, sir.
- 3 Q All right. To get some idea.
- 4 A Yes, sir.
- 5 Q All right. So that woman would have to take 125 times
- 6 more milligrams to get up to the same level in her child?
- 7 A It appears to be the case.
- 8 Q So that would be about 675 mg of morphine?
- 9 A That's why I don't believe in calculating backwards.
- 10 Q And that's an awfully high number.
- 11 A Yes, sir.
- 12 Q All right. Now, could this child have actually
- 13 swallowed a pill, or would it have been difficult, or what
- 14 do you think?
- 15 A Remember as to, I mean, I don't know what the
- 16 swallowing abilities of a 2-year-old are. Just on general
- 17 principles when I've had to take care of my nieces and
- 18 nephews I've made sure that they weren't around anything
- 19 they could swallow. But I -- I think a 2-month-old might
- 20 have troubles with it, but I can't attest to that.
- 21 Q In people under 40 --
- 22 A Yes.
- 23 Q -- that die unexpectedly --
- 24 A Yes.
- 25 Q -- are there genetic causes?

1 A Oh, yes. This is in the newest information in the
2 last three or four months. This is not information that
3 was known when the case was initiated.

4 If you take everybody from zero to age 40 who die
5 suddenly the No. 1 cause of death of course will be
6 coronary artery disease. But take that group out, and
7 about a third of those people who die suddenly have a
8 genetic defect that caused their death. And there've been
9 three papers on this since December.

10 Q Dr. Wren talked yesterday in doing his calculation
11 about the M-6-G metabolite.

12 A Yes, sir.

13 Q What is that?

14 A Well, if you take morphine -- I have a picture of it,
15 but I don't think they'd help anybody. If you take a
16 morphine molecule you break it down into two components.
17 About 70 percent goes into morphine-3-glucuronide which
18 doesn't do much but take up space. You make about
19 30 percent into something called morphine-6-glucuronide.
20 Morphine-6-glucuronide's a really interesting drug because
21 it's more narcotic than morphine is. And there are drug
22 companies experimenting on producing pure morphine-6 to
23 give to patients instead of morphine.

24 Yesterday Dr. Wren mentioned that in the gut
25 morphine-6-glucuronide is turned back into morphine. And

1 he would have just added the amount in if he'd known what
2 it was. But that wasn't measured.

3 In fact, morphine glucuronide is converted to free
4 morphine in the gut. But as soon as it gets out of the gut
5 it goes to the liver.

6 The first stop for anything that comes out of your
7 intestine is the liver. And once it gets to the liver it
8 gets back turned into morphine-3-glucuronide which is
9 inactive.

10 Q So it basically is --

11 A It's a push.

12 Q -- inactive in the distance between the intestines and
13 the liver.

14 A That's right.

15 Q And does anybody die from the overdose of morphine
16 from the intestines to the liver?

17 A I don't know.

18 Q Basically, because of death morphine would have to get
19 to the brain?

20 A Yes, because the mode of death for morphine is to stop
21 respiration.

22 Q Let me -- let me go back and ask you a question
23 through -- a little bit. You mentioned that there was one
24 study where there was 82 nanograms in a baby.

25 A Yes, sir.

1 Q And the baby was alive.

2 A Yes, sir.

3 Q And did not die of an overdose of morphine.

4 A Yes, sir.

5 Q All right. Yet you said in this case where 52 mg --
6 nanograms of morphine -- you would believe that that could
7 have been a cause of the death if that number is accurate.

8 A If the number is accurate and if the baby was
9 intolerant. I don't -- I have no way of proving what the
10 mother's drug usage was or was not during that period.

11 Q And if the mother had used drugs during pregnancy
12 would the baby have developed an intolerance?

13 A It is written about in the literature. I -- I don't
14 know how good the proof is.

15 Q Well, if you had a baby with 82 nanograms that's alive
16 and a baby with 52 nanograms, which was less, which is
17 dead, how can you attribute death to the morphine?

18 A I don't think one case proves anything.

19 Q Okay. All right. Just maybe an anomaly or something?

20 A Well, we don't know what anybody's genome is.
21 Within -- things are changing so rapidly that you may think
22 I'm exaggerating, but I would say in less than five years
23 when you go to the doctor before he gives you an antibiotic
24 pill he's going to test your blood to see whether your body
25 can metabolize that pill correctly. And that will be

1 within five years we're going so rapidly.

2 Q With genetic type testing?

3 A Yes.

4 Q All right. Now, are there some tests that SLED could
5 have run that could have helped determine whether or not
6 this was an accurate morphine figure?

7 A Well, the one -- subject to what he's got available to
8 him. And we heard yesterday from -- blocking out the
9 woman's name from SLED. There are tests that they don't
10 do. They could send them out, but, again, they'd have to
11 pay for them.

12 If you suspected that somebody was a full-blown addict
13 and you see a number that's high, you think, oh, well,
14 okay, it's high because she's addicted. But then you'd
15 want to confirm it some way.

16 The first thing you do is you'd remeasure it a
17 different way. But then the next thing that would really
18 confirm things is you could measure the amount of M-G-3,
19 the inactive drug. It has a very long half life. It
20 sticks around for about 12 hours.

21 And so if somebody were using morphine on a regular
22 level you'd see a whole lot of M-3-G when you made your
23 blood sample. But if you don't measure the blood sample,
24 then you can't make that inference.

25 On the other hand, if it was real low you'd say, well,

1 there's something else going on here.

2 Now, another thing you can do if you're concerned that
3 that 51 represents tolerance is you could measure hair and
4 see if there's a whole lot of morphine in the hair. But,
5 again, that's too grand. It's the best cheapest price I
6 know where to get it. And I doubt that it's in the budget
7 for -- for the laboratory.

8 Q All right. Is there anything in this case in your
9 review of everything and your knowledge that leads one to
10 believe that breast milk contains some amount of morphine
11 that caused the death of this child?

12 A Only in the sense that we know that there is morphine
13 in breast milk of women that are using morphine. We know
14 it isn't very much. And if you see a whole lot, then
15 either, A, you have a -- a mother that's misleading you,
16 or, B, you don't have the genetic ability to clear it.

17 Q One of the two.

18 A Yes. That's even in one of the papers that SLED put
19 in their discovery folder, and I actually had never had the
20 thought before. And maybe I can get it into the proofs of
21 my -- my new book before I have to send it off.

22 Q All right. Does any -- do you know of any medical
23 group that advises against taking morphine while
24 breastfeeding because of dangers to the child?

25 A No.

1 Q Do you know of any reported case where a child had
2 received a lethal dose of morphine through breast milk?

3 A No.

4 Q I assume with your book your name is out there in the
5 public for people to contact.

6 A Yeah.

7 Q Do you know of any lawsuit against the manufacturer of
8 mor -- any manufacturer of morphine of death or injury
9 caused to a child through the mother taking morphine while
10 breastfeeding?

11 A I know of lawsuits against Perdue, but they don't
12 involve morphine.

13 Q Or breastfeeding mothers.

14 A Or breastfeeding mothers.

15 Q Do you know of any suits against any doctors who
16 prescribed to breastfeeding mothers?

17 A I don't follow that. I don't --

18 Q Has anybody ever contacted you about any?

19 A Most of the ones I've been contacted about have been
20 methamphetamine.

21 Q Okay. No morphine, correct?

22 A Not to my recollection.

23 Q Excuse me one moment.

24 (Pause.)

25 Q There was congestion in the lungs?

1 A Yes, sir.

2 Q Was that consistent with having a cold?

3 A It is consistent with having a cold, but it's a
4 nonspecific finding. There wasn't any pneumonia, and then,
5 again, there wasn't any pulmonary edema, which is what you
6 expect with a morphine overdose. But the lungs were
7 congested.

8 All I think I can conclude from that is the baby's
9 final event was a cardiac arrhythmia. And that puts you
10 under acute heart failure, and blood backs up and fills up
11 spaces in the liver and the lung. And -- and-but that
12 again is nonspecific, and I wouldn't try to draw any
13 conclusion from the mechanism.

14 Q If a baby were slowly building up an amount of
15 morphine in their system -- all right -- what would the
16 physical traits of that baby be?

17 A The baby would start to go south. It wouldn't nurse.
18 It would be lethargic. It's color might not be too good.

19 The best example I know of -- and even though it's
20 codeine and not morphine, or initially, but codeine turned
21 into morphine -- was the baby went off its feed and the
22 mother was concerned that the baby just wouldn't take the
23 breast milk.

24 Q This is a Canadian case.

25 A Yes.

1 Q All right. And in that case it was the mother had a
2 genetic defect that caused her to convert more codeine to
3 morphine than the average person.

4 A That's right. Codeine is an inert drug. You won't
5 get any pain relief from just taking codeine. Codeine is
6 active only to the extent it's converted to morphine.

7 Most of us convert about ten percent. There are
8 people that are called poor metabolizers that maybe only
9 convert one percent, and they don't get much pain relief.
10 And sometimes they come to the doctor and say, hey, these
11 pills are no good. And the tendency is to think, oh, I
12 pulled my leg and want more dope.

13 Q Now --

14 A But it could well be the opposite in that you convert
15 all of the codeine into morphine.

16 Q And the history of that case with the child was what
17 as far as feeding and so forth?

18 A The child was purely breastfed.

19 Q All right. But as far as the child continuing to feed
20 and gain weight, what was the history?

21 A It wasn't gaining, I don't believe. It was taken to
22 the doctors, and the doctors looked at it and had no idea.
23 They just said wait.

24 The only reason we really have an answer for what's
25 going on was that the mother was concerned about the baby

1 and did not want to waste a day's worth of breast milk and
2 used the pump. The baby wouldn't eat, and the mother
3 collected all the milk for 24 hours. And that milk was
4 available when the baby died.

5 Q So the baby would not eat.

6 A No.

7 Q Would a baby become increasingly lethargic over a
8 period of time until up -- the death?

9 A Yes.

10 Q So if a child was lethargic on Wednesday, and Thursday
11 and Friday appeared back to normal, would that be
12 consistent with having taken an increasing amount of
13 morphine?

14 A No.

15 Q Now, you're big in doing research?

16 A I do it. I don't know what big means.

17 Q You believe in research.

18 A I believe in research. I don't think we have anything
19 else to go on, but the buzz word in modern medicine is
20 evidence based, and you don't get evidence unless you do
21 research.

22 Q And peer-review research is the best kind.

23 A Really the only kind. Anything else is anecdote.

24 Q Thank you. Answer any questions Mr. Barnette may
25 have.

1 MR. BARNETTE: May it please the Court, Your Honor.

2 THE COURT: Mr. Barnette.

3 RECROSS-EXAMINATION

4 BY MR. BARNETTE

5 Q Sir, how much are you getting paid an hour for your
6 testimony here?

7 A Nothing, sir.

8 Q You're not getting paid anything?

9 A No. I think Mr. Wise is paying for the hotel.

10 Q Okay. So your testimony is you're not getting paid
11 anything.

12 A No, sir.

13 Q Okay. From there. But obviously you've testified for
14 the defense before, is that right, sir?

15 A In breastfeeding cases, yes, sir.

16 Q Okay. From there wouldn't you agree, Doctor, that a
17 patient should tell their doctor what medications they're
18 on when they're asked?

19 A I can only speak from my own experience, and I know I
20 get lied to and I sometimes forget things. So you take the
21 history as given and hope it's right, but it's often wrong.

22 Q So your testimony is here today the patients -- how
23 many patients do you talk to?

24 A Do I talk to now? All of mine are dead, so I try not
25 to talk to them much.

1 Q When is the last time you actually saw a patient?

2 A In about 2005. In theory I am semiretired.

3 Q I understand. And I believe you said you did your
4 last autopsy 45 years ago?

5 A Full autopsy.

6 Q Full autopsy.

7 A I've seen several thousands of hearts since then.

8 Q I understand. And your testimony was -- I'll tell you
9 what. I'm not going to ask any more questions because I
10 think I got enough to argue from there. But you say the --
11 well, there is one more question I want to ask you. You
12 said that the baby would not gain weight, is that right, if
13 it was under morphine?

14 A If it was on morphine only, I don't think so because
15 it would eat less, but I'm not a pediatrician.

16 Q But you said that.

17 A I did say that. That's my intuitive feeling.

18 Q And that's your opinion, your intuitive feeling.

19 A That's right.

20 MR. BARNETTE: No further questions, Your Honor.

21 MR. WISE: Just one question.

22 REDIRECT EXAMINATION

23 BY MR. WISE

24 Q You commented about the baby not eating. Was that in
25 reference to the study out of Canada?

1 A Yes, sir.

2 Q Thank you.

3 THE COURT: You may step down.

4 MR. WISE: The defense rests, Your Honor.

5 THE COURT: Any reply?

6 MR. BARNETTE: Your Honor, can I check on something
7 real quick before I answer the Court's question on that?

8 (Pause.)

9 THE COURT: Let me ask the jury to please go to your
10 jury room. Don't discuss the case. I'll bring you back
11 shortly.

12 (The following takes place outside the presence of the
13 jury.)

14 (Whereupon, a recess was taken.)

15 MR. BARNETTE: May we approach for a second, Your
16 Honor?

17 (Bench conference held off the record.)

18 THE COURT: Ms. Greene, have you and Mr. Wise
19 discussed your right to testify, as well as not testify,
20 during the course of this trial?

21 THE DEFENDANT: Yes, sir.

22 THE COURT: Do you understand that when you are
23 charged with a crime you have an absolute right to remain
24 silent, which simply means that nobody can ever require
25 that you make any statement, that you answer any questions

1 or that you take the witness stand and testify in order to
2 subject yourself to direct and/or cross-examination?

3 You have an absolute right to remain silent and to
4 rest upon the state's burden to establish your guilt to the
5 satisfaction of this jury beyond a reasonable doubt, and
6 you're never required to assist the state in their efforts
7 to prove your guilt by you answering questions or taking
8 the witness stand and testifying about the allegations made
9 in this case.

10 At the same time, if you wish for this jury to have
11 any additional information from you now is the only
12 opportunity that you will have to testify during the course
13 of this trial.

14 Have you and Mr. Wise discussed your right to testify,
15 as well as not testify?

16 THE DEFENDANT: Yes, Your Honor.

17 THE COURT: Do you understand it?

18 THE DEFENDANT: Yes, sir.

19 THE COURT: Has he also discussed with you the
20 advantages and disadvantages of your testifying, as well as
21 your not testifying?

22 THE DEFENDANT: Yes, sir.

23 THE COURT: And do you appreciate what those
24 advantages and disadvantages are?

25 THE DEFENDANT: I do, Your Honor.

1 THE COURT: And have you had time to reflect upon your
2 decision as to whether or not you will testify?

3 THE DEFENDANT: Yes, sir.

4 THE COURT: And have you reached a decision in that
5 respect?

6 THE DEFENDANT: I -- I would not like to do so. Thank
7 you.

8 THE COURT: All right. So your decision is that you
9 will not take the witness stand?

10 THE DEFENDANT: Yes, sir.

11 THE COURT: And is that a decision that you have
12 reached of your own free will and accord?

13 THE DEFENDANT: Yes, sir.

14 THE COURT: Did you make that decision after careful
15 reflection about all of the factors that go into making
16 such a decision?

17 THE DEFENDANT: Yes, Your Honor.

18 THE COURT: Do you need any -- do you need any
19 additional time to talk with Mr. Wise about that decision?

20 THE DEFENDANT: No, sir.

21 THE COURT: Has anybody suggested to you what you
22 ought to do about testifying or not?

23 THE DEFENDANT: Mr. Wise and I have discussed that.

24 THE COURT: Well, do you understand that while he may
25 have an opinion about that and you may concur in his

1 opinion that whether or not he has an opinion is still your
2 decision as to whether or not you will testify because
3 you're the person who has to suffer any consequence that
4 relates to that decision?

5 THE DEFENDANT: Correct. I understand.

6 THE COURT: And so while Mr. Wise may have an opinion,
7 do you understand that you can't complain later that he's
8 the one that told you not to?

9 You're the person today right now that must make that
10 decision. And you can make that decision based upon your
11 discussions with him or anybody else, but you are the
12 person who has to accept responsibility for the decision,
13 not Mr. Wise. Do you understand?

14 THE DEFENDANT: Yes, sir, I do.

15 THE COURT: Do you still adhere to your decision not
16 to testify?

17 THE DEFENDANT: Yes, Your Honor.

18 THE COURT: Okay. All right. And the state has at
19 least one additional reply witness?

20 MR. BARNETTE: I think it will just be one witness,
21 Your Honor. It depends on how it goes from there.

22 THE COURT: All right. Bring the jury back, please.

23 (The following takes place in the presence of the
24 jury.)

25 THE COURT: Ladies and gentlemen, the state has one

Ellen Holmes

Direct examination by Mr. Barnette

1 witness they intend to call in reply to that which has been
2 presented by the defense.

3 Mr. Barnette.

4 MR. BARNETTE: May it please the Court, Your Honor.
5 I'd like to call Investigator Holmes to the stand, please.

6 THE COURT: All right. Ms. Holmes, you've previously
7 been placed under oath. You're still under oath for the
8 purpose of these questions.

9 ELLEN HOLMES, having been
10 previously duly sworn, testified as follows:

11 DIRECT EXAMINATION BY MR. BARNETTE

12 Q Ms. Holmes, obviously through investigation you
13 collected all of the records, all of the information,
14 concerning this case.

15 A Yes, sir.

16 Q What was the weight of Lexie Greene at the time of
17 birth?

18 A At the time of birth she was 7 pounds, 2 ounces.

19 Q At the second week she was taken for a checkup --

20 A Yes, sir.

21 Q -- at Landrum Family Center.

22 A Yes, sir.

23 Q What was her weight?

24 A They recorded her weight as 7 pounds, 11 ounces.

25 Q What was her weight at death?

Ellen Holmes
Cross-examination by Mr. Wise

1 A Dr. Wren had put it in grams, and we converted it. It
2 was 7 pounds, 5.99, or 7 pounds and 6 ounces.

3 Q It was 7 pounds, 6 ounces, at the time of death.

4 A Correct.

5 Q And at that 2-week checkup, it was 7 pounds and 11
6 ounces.

7 A Correct.

8 Q So it was actually five ounces less two and a half
9 weeks later.

10 A Correct, yes, sir.

11 Q Okay. And when you saw the baby that day what was her
12 color like?

13 A She was extremely pale, very pale, all over.

14 Q Please answer any questions the defense may have for
15 you.

16 CROSS-EXAMINATION

17 BY MR. WISE

18 Q Ms. Holmes, when you saw this baby, the baby was
19 deceased.

20 A Yes, sir.

21 Q People lose color when they're deceased.

22 A They gain a lividity. She had very, very little
23 lividity.

24 Q She had lividity in her back.

25 A Yes, sir.

Ellen Holmes
Cross-examination by Mr. Wise

1 Q And this child had been sick the previous two days for
2 a cold.

3 A The wednesday before is when they say she had had some
4 respiratory issues.

5 Q Thank you.

6 MR. BARNETTE: That'd be all of the questions. We'd
7 asked for the witness to be excused.

8 THE COURT: You may step down.

9 MR. BARNETTE: That's the state's showing, Your Honor.

10 THE COURT: Ladies and gentlemen, that is all of the
11 testimony and other evidence to be offered in the trial of
12 the case.

13 What remains to be done are the lawyers' final
14 summations, after which I'll instruct you on the law. Then
15 you'll begin with your deliberations.

16 I've got a couple of legal matters I'll need to
17 address first. It should take only a few minutes. I'll
18 bring you back to conclude. But do not yet discuss the
19 case. I'll bring you back shortly.

20 (The following takes place outside the presence of the
21 jury.)

22 THE COURT: All right, sir. Motions?

23 MR. WISE: Yes, Your Honor. I'd again move for a
24 directed verdict on the grounds that taking the evidence in
25 the light most favorable to the state -- and this is what I

1 would call definitely a circumstantial-evidence case -- and
2 the standard in a circumstantial case is there must be
3 substantial circumstantial evidence, not just some
4 circumstantial evidence, in order for the case to go to the
5 jury.

6 The state has two theories as I mentioned previously,
7 and I'll discuss each theory separately. And I think on
8 this one theory is that Ms. Greene gave this child,
9 directly gave this child, morphine.

10 There is not a scintilla of evidence in this case that
11 Ms. Greene gave this child any morphine, at least the
12 substantial circumstantial evidence by which you could
13 reach that conclusion. And therefore I don't think that
14 theory should go to the jury at all because there's simply
15 no evidence of it.

16 The second theory is that the morphine came through
17 breast milk. I don't think the state has presented a
18 sufficient scientific basis to conclude that this baby can
19 get that level of morphine from breast milk that's
20 sufficient to get to the jury. And as a result I think the
21 directed verdict should be given on both.

22 THE COURT: Mr. Barnette.

23 MR. BARNETTE: Your Honor, just to follow up my
24 argument from yesterday, obviously we had, I feel like,
25 ample evidence through David Eagerton, through Dr. Wren,

1 through Investigator Kotecha who is testifying as a
2 pharmacist in that situation -- even Wendy Bell -- and
3 including with that, now, we have a situation where even
4 the defense's own expert has testified about a couple of
5 things.

6 One, he testified that the baby had genetic defect,
7 that it could easily not -- not have done this morphine
8 from that standpoint.

9 I understand the argument is there's no way the mother
10 can know that unless she got the testing. However, there's
11 no question that the -- she should have told the doctors.
12 The doctors would have not gave her the morphine or would
13 have definitely talked to the O.B.G.Y.N. to do that.

14 She never told the O.B.G.Y.N. about the morphine. She
15 never told the doctors that was giving her the morphine,
16 the hydrocodone or the Vicoprofen about it either from that
17 standpoint, and that's a major factor in this case.

18 And the other factors that came up here is that the
19 defense's own expert testified about losing weight being
20 exposed to morphine. And obviously the baby had lost
21 weight from the second week it was seen at Landrum Family
22 Practice and four and a half weeks later when it died.

23 So I think there's even more evidence now of that from
24 that standpoint. I ask you to direct a verdict at this
25 point.

1 THE COURT: Well, do I understand --

2 MR. BARNETTE: Deny the directed verdict. I'm sorry.

3 THE COURT: -- that you are -- you're going forward on
4 the theory that the child overdosed morphine through breast
5 milk?

6 MR. BARNETTE: Yes, sir.

7 THE COURT: There's no evidence of any other --

8 MR. BARNETTE: No, sir.

9 THE COURT: -- transference of morphine from the
10 defendant to the child, is there?

11 MR. BARNETTE: No, sir. Just the breastfeed.

12 THE COURT: Okay. So the state would be limited to
13 arguing transference through breast milk.

14 MR. BARNETTE: Yes, sir.

15 THE COURT: All right. To the extent that it's
16 alleged -- and I don't think it is -- but to the extent
17 that it is alleged that she gave the child a pill that the
18 child consumed, that is not being argued, and that motion
19 is granted.

20 MR. WISE: Thank you.

21 THE COURT: I don't think the indictment specifies
22 that particular --

23 MR. WISE: That's one of my pretrial motions but
24 that's --

25 THE COURT: I understand.

1 MR. WISE: Thank you.

2 THE COURT: State's not going to argue it. That's not
3 a ground or a basis for a conviction.

4 what about instruction requests? Does the state have
5 any?

6 MR. BARNETTE: Your Honor, I think your standard
7 charges -- I've been in front of the Court I don't know how
8 many times. I don't have any problems. I assume you'll
9 charge the normal charges plus the three offenses.

10 THE COURT: Okay.

11 MR. WISE: I have a few. The -- you just eliminated
12 one of them.

13 MR. BARNETTE: Your Honor, can I have a copy of those?

14 MR. WISE: Yes, you can.

15 MR. BARNETTE: Thank you.

16 THE COURT: Mr. Wise, is request No. 1, is that a
17 verbatim quote from Logan?

18 MR. WISE: I've had to -- I viewed -- I took this from
19 an old quote. It's pretty close to verbatim, yes. And
20 that's the new case where they came down with
21 circumstantial evidence.

22 MR. BARNETTE: I would disagree because I just did a
23 seminar on this. And I don't think that's exactly what
24 Logan says.

25 THE COURT: Well, pull Logan and let's see.

1 MR. BARNETTE: Yes, sir.

2 MR. WISE: Logan is trying to go back to the old

3 charge. And I may be pushing, pulling a little bit.

4 THE COURT: Well, it's got to be verbatim.

5 MR. WISE: Let me see if I can. I don't think I have

6 it on my computer.

7 (Pause.)

8 MR. BARNETTE: Your Honor, can I e-mail this to you

9 and to Mr. Wise?

10 MR. WISE: You can't e-mail it to me because I'm not

11 on line.

12 MR. BARNETTE: I can e-mail it to myself upstairs and

13 print it if you'd like for me to, Your Honor.

14 THE COURT: Well, let me check.

15 MR. WISE: Just e-mail it to the judge. That's fine.

16 THE COURT: Do you have a South Carolina cite?

17 MR. BARNETTE: Yes, sir, I do.

18 THE COURT: What is it?

19 MR. BARNETTE: The South Carolina cite is 405, SC, 83,

20 Your Honor. It was decided August 15th -- 14th of 2013.

21 THE COURT: 405, 83?

22 MR. BARNETTE: Yes, sir.

23 THE COURT: All right. I'm going to take about ten

24 minutes.

25 (Whereupon, a recess was taken.)

1 THE COURT: All right. Any objections to defense's
2 request?

3 MR. BARNETTE: Your Honor, I think they're entitled to
4 it the way it's written in the case. Obviously, they're
5 entitled to a charge, yes, sir.

6 THE COURT: Well, I'm talking about all of those, not
7 just certain --

8 MR. BARNETTE: Okay. No. 2, Your Honor, we do object
9 to -- I think we had a conference back in the chambers. We
10 spoke about that. I don't know if anything needs to be put
11 on the record about that, about the regulations that was
12 introduced.

13 MR. WISE: My position is it goes to credibility and
14 ought to be charged. I know the Court's position is --

15 THE COURT: I'm going to decline to charge Defendant's
16 Request No. 2.

17 MR. BARNETTE: No. 3, Your Honor, I think is covered
18 in your reasonable-doubt charge that I've heard.

19 MR. WISE: I think actually No. 3 -- that was my
20 mistake. I probably should have put 1 and 1-A. And that's
21 basically a rehash of one.

22 THE COURT: Three is included in one.

23 MR. WISE: Right.

24 THE COURT: Four is withdrawn.

25 MR. WISE: Correct.

1 MR. BARNETTE: Five, Your Honor, I think you basically
2 say that in your charge.

3 THE COURT: Okay.

4 MR. BARNETTE: No. 6, Your Honor.

5 THE COURT: I have an extreme-indifference.

6 MR. BARNETTE: Okay. I started to say I -- I do
7 object to it, but I think you have one in there.

8 THE COURT: I do.

9 Mark that.

10 (Request to charge marked Defendant's Exhibit No. 12.)

11 MR. WISE: If you don't -- if you're not going to
12 charge my six verbatim, what do you charge under extreme
13 indifference?

14 THE COURT: Well, just listen to it.

15 MR. WISE: I kind of wanted to have it ahead of time
16 and discuss it with the jury.

17 THE COURT: Okay. I'll show it to you. Do y'all want
18 to come up here and look at it?

19 (Bench conference held off the record.)

20 MR. WISE: I would also move that the state be
21 required to open fully on the law and the facts, then I
22 respond to their argument, and that they respond only to
23 matters that I brought up in my closing argument. That was
24 the way it was done originally in this state in State vs.
25 Antiberry [sic] which is 129, SC, 464, 129, yeah, 464, 124,

1 S.E., 648. Granted it's a 1924 case.

2 The civil rule changed where the plaintiff in a civil
3 case was not required to open, and the courts in the
4 criminal side kind of followed that rule.

5 Then when the civil rule went back where a plaintiff
6 has to open fully the criminal side has kind of not gone
7 back to that.

8 So the only case that involves criminal law is State
9 vs. Lee. That was under the old criminal rule -- old civil
10 rule where the plaintiff was not required to open fully now
11 that they've remodified the civil rules where the plaintiff
12 is required to open fully. I think the same requirement
13 should have maybe stayed in this case.

14 To allow the state to basically listen to my argument
15 and then give their theory of the case is basically what it
16 boils down to is what they call sandbagging. And I think
17 that violates the due process clause of the 14th Amendment
18 of the Constitution of the United States and due process
19 clause of the state constitution.

20 So I would request that the state open fully on both
21 the law and the facts and be -- and do a reply only to what
22 I do.

23 MR. BARNETTE: Your Honor, the way we've always done
24 business here is basically if I do open it would be just on
25 the law, obviously dealing with the facts from that

1 standpoint. But I'd like to waive my opening.

2 They presented evidence, so I think Mr. Wise knows the
3 traditional way and the rules that's been set in this time.
4 So I would ask to waive opening argument.

5 THE COURT: Well, he's correct on the history. The
6 question now is whether it makes any difference because you
7 get to respond fully anyway. So ordinarily it doesn't cut
8 down on any --

9 MR. WISE: He doesn't get to. Well, he's not allowed
10 if you do it correctly --

11 THE COURT: I'll say this. He wouldn't be able to
12 reply if you don't say anything.

13 MR. WISE: Is that a suggestion?

14 THE COURT: I'm just --

15 MR. WISE: I know.

16 THE COURT: Well, I'm assuming you will.

17 MR. WISE: Right.

18 THE COURT: And I'm assuming if you cover fully, then
19 he has a right to reply to it, so.

20 MR. WISE: I think the real problem is without his
21 going first I don't get his theory of the facts. He gets
22 my theory of the facts. I don't get his. And then he gets
23 to respond to mine and give his, and I have to sit here and
24 be quiet.

25 THE COURT: Have you -- have you not figured that out

1 during the last three days?

2 MR. WISE: I don't know yet.

3 THE COURT: All right. You can open on the law, and
4 then you can reply to his argument.

5 MR. WISE: To -- to adequately preserve the rule, my
6 objection, I'm going to have require that he open on the
7 law.

8 THE COURT: He's going to open on the law.

9 MR. BARNETTE: Give me one second, Your Honor, if you
10 will.

11 MR. WISE: Unless you want to stipulate my objection
12 is preserved if you don't open.

13 (Pause.)

14 MR. BARNETTE: Thank you, Your Honor.

15 I'm prepared to go forward on the law.

16 THE COURT: Okay. Bring the jury in.

17 (The following takes place in the presence of the
18 jury.)

19 THE COURT: All right. Ladies and gentlemen of the
20 jury, as you know, all of the evidence is in. You will
21 hear from the lawyers in their final summations.

22 The state begins first because they have the burden of
23 proof, followed by the defense, and then the state has --
24 can make a reply to the defense's argument.

25 After that I'll instruct you fully on the law. Then

Closing arguments

1 you can begin deliberations.

2 So please give the lawyers your attention now as they
3 give you their final summations.

4 Mr. Barnette.

5 MR. BARNETTE: May it please the Court, Your Honor.

6 Madam forelady, ladies and gentlemen of the jury, what
7 I'm going to do briefly is give you the law in the case.
8 But you follow the law as Your Honor will give it to you at
9 the end of the case, and because he is the judge of the law
10 in this case, but give you a brief idea about that.

11 Then I'm going to sit down and Mr. Wise will get a
12 chance to do his closing. He'll go through the facts and
13 the law as he sees fit. Then I'll come back up and give
14 you the facts and what my perspective is on the case too to
15 you from there.

16 The defendant's charged with three charges. The first
17 one is homicide by child abuse, Your Honor, in this case.
18 It says a person is guilty of homicide by child abuse if
19 the person causes the death of a child under the age of 11
20 while committing child abuse or neglect and the death
21 occurs under circumstances manifesting an extreme to human
22 life.

23 For the purpose of this section child abuse or neglect
24 means an act or omission by any person which causes harm to
25 the child's physical health or well being or welfare. Harm

Closing arguments

1 to a children's health or welfare or to a person goes
2 through there. But the main point that I want to point out
3 to you is obviously omission in this case. It's alleged
4 this.

5 The second law to be given is what we call involuntary
6 manslaughter, and that says that in regard to the crime of
7 involuntary manslaughter criminal negligence is defined as
8 the reckless disregard for the safety of others.
9 Obviously, we're going to be arguing about the safety of
10 others in this situation, obviously, the reckless disregard
11 in this case.

12 The third law or the third crime that's been charged
13 in this case is called unlawful conduct towards a child.

14 It is unlawful for a person who has custody or charge
15 of a child, or who is the parent or guardian of the child,
16 who's responsible for the welfare of a charge [sic] as
17 defined in section 37-7-20 to, one, place the child at
18 unreasonable risk of harm affecting the child's life,
19 physical or mental health or safety.

20 To do so or to cause or to be done unlawfully and
21 maliciously any body part of the child so the health or
22 life of the child is in danger or likely to be in danger in
23 this case -- that'll be the two parts that we're looking at
24 from that standpoint of that charge.

25 And, like I said, take the law as the judge gives it

Closing arguments

1 to you. Like I said, we're going to be talking -- the
2 homicide of child abuse, obviously, the admission in this
3 case. And I'll give you the facts when I come back up.
4 I'm just talking about the law at this point.

5 The reckless disregard of the safety of others. Her
6 actions led to this reckless disregard from that
7 standpoint.

8 And then obviously under -- under the new statute her
9 actions led to that and what happened to the baby in this
10 case -- Alexis.

11 Thank you for listening to me. Like I said, the judge
12 will give you the law at the end. I'll be coming back up
13 to you and arguing the case to you at that point.

14 Thank you, Your Honor.

15 MR. WISE: Madam forelady and ladies and gentlemen of
16 the jury, as you go to the jury room and say to yourself or
17 say among yourselves you know Stephanie Greene is probably
18 guilty, she probably passed enough morphine through her
19 breast milk to go to the child. She probably did it.

20 What should your verdict be? Your verdict should be
21 not guilty, because in this court we don't talk about what
22 probably happened, what possibly happened, what might have
23 happened or what could have happened back on August the
24 10th of 2010. It is the highest standard known to man
25 short of an absolute certainty. And the only way we can

Closing arguments

1 know things of absolute certainty is to actually be there.
2 And that's the standard by which you have to judge this
3 case.

4 Somebody has said that that's for the protection of
5 the defendant. Well, yes, it is. It's also for the
6 protection of a jury, because if you have to go out on the
7 street and ask for volunteers to come in here and sit on
8 cases like this, tragic cases like this, you won't find
9 them.

10 So the state, in essence, has made a deal with you.
11 Your job is easy. We have to prove this case beyond any
12 and all reasonable doubt. And what that means is simply
13 this: If you reach a verdict of guilty you don't go home
14 at night and say is it the right decision. You don't go
15 two days later and say I don't know about that. You don't
16 sit around a month later and say I'm scratching my head,
17 because when it's proof beyond a reasonable doubt it's a
18 decision you can go home and put your head on the pillow
19 and sleep soundly knowing that you did the absolute right
20 thing.

21 Now, against that standard, what is the proof in this
22 case? There is one undisputed fact in this case. There
23 has never been a reported case in the United States of
24 death by a child who is taking -- who is breastfeeding from
25 a mother who is taking morphine. There has never been a

Closing arguments

1 case in the United States of a death by a child
2 whose mother -- who's breastfeeding whose mother was taking
3 the morphine. That fact is undisputed. Their experts
4 agree with that; my experts -- expert agreed with that.
5 The American Academy of Pediatrics agrees with that.

6 That is a fact beyond dispute, period. Anything
7 beyond that is speculation, conjecture and surmise, and
8 you're not allowed to convict on that.

9 Now, the state has one theory in this case, and one
10 theory only. The only theory the state is going to present
11 to you is did Alexis Greene receive morphine through breast
12 milk to the extent it caused her death. That is the only
13 theory.

14 Getting morphine accidentally, getting morphine
15 deliberately from another source is not a theory in this
16 case. It's not a basis for a conviction in this case. The
17 judge will charge you that.

18 That is the only theory. And what is the evidence on
19 that? Let's go to what Dr. Wren said. I don't know how
20 the morphine got there. That was his quote. I just know
21 it's high. I'm not saying how it's got there. If he
22 doesn't know, how can you?

23 Professor from Presbyterian College, he gets up here,
24 cross-examination, are you saying this child died from
25 morphine through breast milk. Did I say that? He didn't

Closing arguments

1 say that.

2 So where is the proof beyond speculation, conjecture
3 and surmise that this child died from morphine through
4 breast milk?

5 Dr. Karch you remember wrote the book quite literally
6 and figuratively. He comes in and says all of his
7 research, all of his years and years of experience he's
8 never seen a death from morphine. He comes in and says to
9 you there is one case out there where there's a very high
10 morphine level. I think it's an anomaly that it's a high
11 reading. He's going to -- I mean, he's not sitting there
12 saying there's no case with morphine levels up there,
13 because there is one, an 82, which is high.

14 Is that representative? He doesn't know. He can only
15 report what is seen in one report. It could be an anomaly.
16 Who knows? It is not a consistent fact that's known in the
17 medical profession. It's not.

18 When people, doctors, regularly give intervenous
19 morphine to pregnant women and to nursing women you cannot
20 sit here and say it is common knowledge that morphine will
21 kill a child when the literature says that morphine given
22 to women who are breastfeeding doesn't kill a child.

23 That's the literature that's out there. There has not
24 been a single article produced that can name by case study
25 one death from morphine. Granted, they've got that report

Closing arguments

1 where they said there have been results. But where is the
2 death in that report? Where is the death that they studied
3 to say that? They don't know.

4 They have a report on one of their exhibits, an insert
5 to a mor -- to MS Contin product. It says do not
6 breastfeed, can harm the baby.

7 I do believe if the manufacturer of that morphine in
8 its entire research, in its entire history, had known of a
9 single suspected -- not proven but suspected -- death from
10 a nursing mother taking that morphine that warning would
11 have read differently, because manufacturers are careful
12 about those things. If they had a single suspected death
13 from overdose of morphine that insert would have read may
14 cause death.

15 They're not looking for the second before they put
16 those warnings in there. They're looking for the first if
17 it can even some way be related.

18 We live in a society, and we all know. Unfortunately,
19 it's part of my profession's fault I have to tell you too.
20 But we litigate everything -- but we litigate everything.

21 Dr. Karch, as I say, wrote the book on the "Pathology
22 of Drug Abuse". The name is out there. If some lawyer
23 somewhere had decided this child's death was caused because
24 the doctor or the drug company didn't give an adequate
25 warning, and if you take this drug you will kill your child

Closing arguments

1 from breast milk, he would have heard about it from a suit.
2 You would have heard about it from newspapers. The
3 prosecutor would have heard about it from research.

4 It does not exist -- it does not exist. And when that
5 suit doesn't exist on a civil side where it's a
6 preponderance of the evidence that's all they have to
7 prove, how can the state come here and tell you we've
8 proven it beyond any and all reasonable doubt? It can't be
9 done.

10 This case is about science, like I told you in
11 opening, and it's what it is. They have never produced any
12 evidence of any child ever dying from an overdose of breast
13 milk in the United States, the only exception being the
14 Canadian case where there was a genetic problem, and
15 whether genetic problems exist in this case, we don't know,
16 unfortunately. It's expensive to find out. But that
17 doesn't lessen the burden on the state. That doesn't mean
18 the state gets a free ride because it's expensive to prove
19 something. It is expensive, but that's not a reason to
20 convict somebody in this case.

21 Now, let's look at some of the evidence in this case.
22 They've made Stephanie Greene out to be a demon,
23 drug-seeking, drug-addict demon, someone who has no concern
24 for her child.

25 Stephanie Greene is a woman in pain, has been since

Closing arguments

1 1998, a woman who's given a lot of serious pain medicine
2 for very legitimate reasons.

3 We stigmatize in this society, unfortunately, people
4 with pain. If you -- unless they're a loved one and you
5 know their situation, we all tend to do this. When we see
6 someone who is taking morphine, taking Oxycontin, any of
7 these substances that we deem to be high powerful
8 medicines, we look at them and say they're a drug addict.
9 No. They're not a drug addict.

10 Rush Limbaugh gets involved in drugs. He's not a drug
11 addict. He was someone seeking relief from pain, and he
12 just happened to take more than the doctor prescribed
13 because he wanted that relief.

14 Pain patients are entitled to that relief. And that's
15 what she is. And, unfortunately, people who take drugs, as
16 the pharmacist testified from the state, people who take
17 drugs realize they're stigmatized. They're not open with
18 their doctors. They're not open with other people, law
19 enforcement in particular, about really what they're
20 taking. And they never will be.

21 She is a woman in pain. That is documented out and
22 out also. No question about that. No one disputed that.
23 And then they make her out to be someone who is sneaking
24 and not telling all of the doctors everything.

25 Dr. Kovacs gave a statement that in April of 2009

Closing arguments

1 Stephanie Greene did not tell -- told her that the
2 hydrocodone was off the list, not being given, and said
3 after that she never went back on the list, I always
4 assumed from that point on that hydrocodone was off her
5 list and I would not have been prescribing this Oxy -- MS
6 Contin had I known that.

7 So we get to ask Ms. Kovacs some questions, and one of
8 them is, you know, didn't you fill out a form in September
9 of 2009 where you filled out that she's getting the
10 hydrocodone. You filled it out in September of 2009 that
11 she's getting hydrocodone. And it says current. Well,
12 current doesn't mean current. Current means in the past.
13 That's the only person I know that defines current as being
14 in the past. She said I really didn't even know.

15 Okay. Everybody's entitled to one mistake. We can do
16 that. That happens. I try to be a forgiving person.

17 Two months later she puts one drug down and tells when
18 it ends. This is the hydrocodone, November of 2009, and
19 says current. She knows how to write when something ends,
20 but she puts the hydrocodone down as current. Two mistakes
21 is a little much, a little much. She was simply, to be
22 polite, incorrect.

23 And then we get Dr. Kooistra on the stand, and Dr.
24 Kooistra knew she was seeing Dr. Kovacs. November of 2010,
25 Dr. Kooistra sends Dr. Kovacs a copy of her office visit

Closing arguments

1 that says cc'd. You can go in the jury room and look at
2 it. It says cc. A copy of her office visit, and says
3 here's what I'm prescribing. And what is she prescribing?
4 Hydrocodone -- hydrocodone.

5 Dr. Kovacs never testified in this courtroom that she
6 didn't receive this. Dr. Kooistra never got a response
7 from Dr. Kovacs saying what are you doing prescribing
8 hydrocodone, I'm prescribing MS Contin, I'm concerned.
9 Never, never.

10 Tell you one other thing about this alleged
11 drug-seeking act. Basic, no concern for her, just want to
12 take these drugs to get high. Of course she does what
13 every drug-seeking addict would do. She goes to doctors
14 locally. The doctors know about each other. Kovacs knows
15 about Kooistra; Kooistra knows about Kovacs.

16 And then she of course goes down to the same pharmacy
17 that prescribed all of her drugs except one day one time.
18 And it's in it. Every single drug she has taken except for
19 that one with Rite Aid was filled at C.V.S. pharmacy.

20 And why does she do that? Because exactly what the
21 pharmacist from Columbia said. It's a smart thing to do if
22 you're taking a lot of medications, because the pharmacist
23 acts as a gatekeeper so that if you don't tell a doctor
24 about something or a doctor prescribes wrong, whatever, it
25 funnels through one point, and that pharmacist can raise

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1 the hand and has the right to say wait a minute, wait a
2 minute, something's wrong, you shouldn't be getting these
3 two medicines, you shouldn't be getting these, something's
4 wrong. And the pharmacist can call the doctor and check
5 it.

6 Did we ever hear any pharmacist or any doctor say they
7 were called by any pharmacist and said these prescriptions
8 are wrong? None, nothing. Never happened. And yet they
9 want to say she is a drug-seeking addict.

10 Well, I tell you what drug-seeking addicts do. They
11 go out of town. They go to one doctor and get the drugs,
12 go to a pharmacist in that town and have it filled. Go to
13 another town, get another drug, same kind, something very
14 similar, get it filled in that town. So the pharmacists
15 never know about each other; the doctors never know about
16 each other. They certainly do not tell the doctors about
17 it.

18 She went to the O.B.G.Y.N. O.B.G.Y.N said we knew she
19 was seeing Kooistra and Kovacs.

20 Now, she may not have been as honest as she should
21 have, and that's the problem with pain medicine, not that
22 it makes you less honest. But you get scared of losing it.
23 You get scared of not getting it, not because you're an
24 addict but because it's actually relieving your pain and
25 making -- enabling you to function in life.

Closing arguments

1 This woman is totally disabled from her pain in an
2 automobile wreck, and other complications. What keeps her
3 going is literally the pain -- the thing about pain
4 medicine is that, one, it works, and, two, if you're in
5 pain you don't get high off of it. It works.

6 So was she scared that some doctor may take her off of
7 it? Maybe so, maybe so. But as she told the policeman
8 when she was interviewed, I researched it on the internet.
9 And if she researched it on the internet, what does she
10 find? She finds the exact same articles that everybody has
11 been referring to in here, these articles from the American
12 Academy of Pediatrics, the articles on the clinical
13 toxicology, the lac -- LactMed website, all of which, whom,
14 say it's okay to take morphine while breastfeeding. All of
15 them say that. There isn't one that doesn't say that. All
16 of them.

17 Yes. She's a former nurse, more reason to do the
18 research, more reason to believe her. But that's what it
19 is. She did the research. That's what she told them. And
20 that's what it showed, because that's what all of the
21 experts here said it shows.

22 Should she have told them? Oh, yeah. There's no
23 question about that. Would they have prescribed them?
24 Doctors do all of the time. That's the testimony too.
25 They prescribe morphine to pregnant women all of the time.

Closing arguments

1 It's a risk benefit relation. Or if you -- you know,
2 if you've got a broken leg and you take a little morphine
3 for a few days, maybe the doctor will take you off it
4 because you know the leg's going to get better in another
5 week and you're not going to be in any pain anyway. She is
6 in chronic, constant pain 24 hours a day and has been for
7 years. There was no way for her to get pain relief without
8 continuing to take it, so the risk benefit's easy to figure
9 out.

10 Now, that's who Stephanie Greene is. That's not a
11 woman who sat down with a reckless or with -- with extreme
12 indifference to her child. And let me tell you. This is
13 interesting too. They have three medicines on that list,
14 three medicines on that list that say do not take when
15 breastfeeding. All of these pictures we have here, three
16 medicines say do not take during breastfeeding.

17 Two of them do not show up in that child at all. Not
18 a minute amount, not a small amount at all. And they
19 tested for it, and they tested for it with such levels that
20 it's so low that it's well below therapeutic, but they
21 don't show up at all. Evidence of reckless indifference.

22 The state's going to get up here and say, oh, she was
23 under the influence that morning, she was under the
24 influence, we can tell.

25 A person who has known her since high school who holds

Closing arguments

1 a reasonably responsible position in the city of
2 Campobello, who knows her when she is, you know, day-to-day
3 activities, comes by and says he didn't notice anything.

4 Granted, he didn't talk to her a lot. But he saw her
5 walk, saw her involved in activities and so forth. And
6 there's nothing wrong with her. Upset, yeah, but nothing
7 wrong with her as far as being under the influence.

8 Hour later during the interview all they say she
9 appeared to us to be under the influence. They never asked
10 for a blood test from her. They could have. They didn't.

11 They filled out a form that took according to the
12 testimony some three hours to do. And I'm going to tell
13 you. I -- I listened to that, and I probably have new
14 respect for people who have to do that job, to sit there
15 with a grieving mother and grieving father and spend three
16 hours asking tedious, important questions of people
17 involving the recent, recent death of their child. It's a
18 tough job. It's not an easy job.

19 But you would think that if someone who is in charge
20 of getting that precise information believed someone to be
21 grossly under the influence they would have said, one,
22 something wrong with you, two, I'm sorry but you appear to
23 be under the influence, let me talk to your spouse.

24 You would not have continuously gotten information
25 that you deem important to fill out these forms, tedious

Closing arguments

1 forms, from someone that you did not believe was an
2 accurate source of information. You wouldn't do it. You
3 simply wouldn't do it.

4 Chad McNeil says when he got there she was performing
5 C.P.R., performing C.P.R. like she's supposed to. I know
6 how it's done. She was doing it right. Something that
7 cannot be done by someone who is grossly under the
8 influence, or at least she would be stumbling doing it and
9 obviously not doing it right.

10 He said Randy Greene was more upset than she was.
11 She's a trained nurse. Nurse mode kicks in, not for Randy
12 because he's not. She's trying to save the child. They're
13 going to say, oh, you were not crying and falling apart and
14 therefore you're guilty.

15 We cannot convict someone in this country based upon
16 our perception of grief. Grief is handled so differently
17 by so many people in so many different ways you cannot
18 convict someone upon your perception of grief. That is not
19 proof at all, much less proof beyond a reasonable doubt.
20 It doesn't exist.

21 I would -- in many cases where you have experts
22 testifying, people like to say, you know, when experts
23 disagree, how can you decide something beyond a reasonable
24 doubt. Unless I missed some testimony, I don't think the
25 experts in this case are in that much disagreement, because

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1 no one has gotten on this stand and said in my professional
2 opinion taking morphine while breastfeeding will cause and
3 easily can cause a child to die. No expert said that.

4 As I mentioned earlier, Dr. Wren says I don't know how
5 it got there, I don't know how it got there.

6 And, by the way, something I forgot to mention about
7 Dr. Karch as he pointed out. You can examine the stomach
8 contents if you're concerned with the death of a child.
9 You examine the stomach contents for poisons, for drugs,
10 whatever. It wasn't done here -- it wasn't done here.

11 If you have a stomach content with appreciably higher
12 level of morphine than is in the blood, then you know where
13 it came from. It came from somebody putting morphine down
14 the child's throat. How? We don't know. But one way or
15 another, that's what happened. We would know that. They
16 didn't do that. They don't do it. So the experts don't
17 disagree.

18 This is tragic. I mean, there is no question about
19 that. November 13th of 2010, a day that Randy and
20 Stephanie Greene will never, ever forget.

21 Eight months later -- eight months later she gets
22 arrested and accused of basically killing the child through
23 breast milk. There is no such crime as homicide by
24 breastfeeding. There never has been and there never will
25 be. There's no such crime.

Closing arguments

1 Now, they're going to say, well, there always has to
2 be a first time. Can anybody seriously believe that the
3 first time since the onset of morphine or the testing of
4 morphine the first case ever recorded originated in
5 Spartanburg County without any real scientific proof to
6 back it up? No, it hasn't. You can an overcount basically
7 if you want to.

8 Dr. Karch testified that there's a report of a woman
9 taking 5 mg, and he said this is not an exact science, so
10 this is not an exact science. But it does give you a
11 general idea, particularly when we're dealing with proof
12 beyond a reasonable doubt. There's a woman who took 5 mg
13 of morphine in a hospital setting. They were testing the
14 baby. The baby got up to .4 -- excuse me -- got to 4
15 nanograms. We're dealing here with 52 nanograms. That is
16 125 times more -- 125.

17 So for that woman to have gotten her child up to 52
18 nanograms she would have to have taken 125 times five,
19 which is 675 mg of morphine, in order for her to get her
20 child up to .56. Even that's not always reliable, but this
21 is going to give you a general idea.

22 In order for that woman if that woman were taking 30
23 mg tablets of morphine, she would have to take to get to --
24 to take 675 mg to get her child up to the level they claim
25 this is, she would have to take 21 tablets of

Closing arguments

1 instant-release morphine.

2 We are dealing here with 30 mg of time-released
3 morphine. The numbers get astronomical if that's the
4 number that came through breast milk, a number that gets so
5 astronomical there's no way you can say logically or --
6 logically that that came through breast milk.

7 As Dr. Karch says, if it's an accurate figure there
8 are things he could have done to make sure it's accurate
9 that weren't done. Didn't have the equipment; didn't send
10 it out. But if that's an accurate figure it's a number
11 that's high enough to cause you concern. Maybe should do
12 more testing.

13 But that number literally means 21 pills for that
14 woman in that study to get to the same level that was in
15 this case. Should have taken 675 mg of morphine, which is
16 21 pills of instant-release morphine -- instant release,
17 not timed release, which releases 30 mg over an 8-hour
18 period.

19 This child did not die from taking breast milk from
20 Stephanie Greene. It simply did not happen. There's no
21 scientific basis for saying it; there's no evidentiary
22 basis for saying it. It's not there.

23 The only theory, the only basis by which you can
24 arrive at a conclusion of guilt, is did this child get this
25 medicine through breast milk. That's the only question

Closing arguments

1 that the state has to prove beyond a reasonable doubt.

2 If you have speculative reasons as to the child
3 getting morphine in any way other way from any other
4 person, that's not relevant to your deliberations in this
5 case today. Your only question is did this child get to
6 this level through breast milk.

7 The literature says it's impossible. The literature
8 says it doesn't happen with children. Our expert clearly
9 said it. David Wren, their expert, says I do not know how
10 the child got the morphine, only that it was done for --
11 find for -- I could find no evidence of punctual. That's
12 all he said.

13 That is not proof beyond a reasonable doubt. We ask
14 you to end this tragedy for the Greenes and come back with
15 a verdict of not guilty. Thank you.

16 THE COURT: Mr. Barnette.

17 MR. BARNETTE: May it please the Court, Your Honor.

18 Madam forelady and ladies and gentlemen of the jury,
19 this case is about a little girl, like Ms. Poulos told you,
20 26 days old and everything.

21 I'll just work backwards. I -- I was shocked. Their
22 own expert said that this morphine points in his opinion,
23 because I went back and asked him that question. He said
24 it would lose weight or would not gain weight. And here
25 this baby weighed 7 pounds, 2 ounces, at birth, went for a

Closing arguments

1 well-check at two weeks, weighed 7 pounds and 11 ounces.

2 When she died she weighed 7 pounds and 6 ounces.

3 Think. I mean, you -- the one that the judge will
4 tell you, you have your own good common sense. That don't
5 happen, ladies and gentlemen, in babies like that. You've
6 seen babies. You know. I mean, common sense tells you
7 babies are not going to lose weight. There's a reason for
8 it, and the reason was the morphine.

9 Also, they keep saying we don't know about the death
10 of a baby. If I heard them -- please remember the
11 testimony as you heard it. And we've heard a lot of it.
12 But the one they talk about the codeine, of course the lady
13 had no idea. Codeine -- it changed the morphine in her
14 body, not in the child's body. So we know morphine can
15 pass through enough to kill a baby because it went from her
16 body into the baby's body through breastfeeding because it
17 was metabolized by the mother, the codeine was, not the
18 child. The child received that overdose.

19 And, unfortunately -- I mean, you don't want to put
20 your children in this situation for a chronic user of
21 morphine from that situation.

22 It all started on March 20th of 2010. The defendant
23 did a home pregnancy test. She finds out she's pregnant,
24 and she goes to her old O.B.G.Y.N., the Piedmont group.

25 And you heard the lady, Ms. Olson, come in and tell

Closing arguments

1 you that on March 25th or 26th of 2010 she called in and
2 said she had a pregnancy test.

3 They set up a meeting for it, but she never comes in.
4 And the reason why is they know about the fennel patches,
5 which is morphine, all of these. So she goes to another
6 O.B.G.Y.N. group because they don't know about it.

7 You have to remember we're talking about a nurse, and
8 she tells people she's a nurse. And you remember the
9 contract, I talk a little bit about, to Dr. Kooistra that
10 she has her patients sign. She signed her name, education
11 and B.S.N., bachelor of science in nursing. So she knows.

12 This is not somebody off the street that doesn't have
13 any kind of education in medicine. She knows, and she's
14 proud of it because she put on that contract where that
15 doctor can see that.

16 And doctors and nurses work together all of the time.
17 And of course you've got some kind of trust there. If you
18 know somebody's a nurse, you assume they can understand
19 everything and they're going to can understand and tell you
20 about that.

21 And Dr. Kooistra and Dr. Kovcas didn't even know she
22 was pregnant. She never told them. Her father -- I mean
23 her husband goes to the doctor. I'll just pick it up and
24 get it mailed.

25 And you remember Mr. Kotecha was talking about the

Closing arguments

1 Last morphine prescription she got she went to Rite Aid
2 because they have a drive-through.

3 The most telling thing to me is that she loved her
4 drugs more than she loved her child, is on June 30th of
5 2010 she goes and sees Dr. Bridges, and Dr. Bridges sat up
6 here and told you they had no record of her ever telling
7 about morphine. If she'd told that, we wouldn't talk about
8 this and, you know, everything, all of these drugs you're
9 taking.

10 She's taking Vicoprofen. She tells her do not take
11 that medicine, it will cause heart defects, there's a
12 potential for it, and it's proven. She tells her not to do
13 it. And what does she do? She goes to Dr. Kooistra and
14 goes and gets two more prescriptions, the July 6th and the
15 August 5th of 2010.

16 She continues getting it. Fortunately, Lexie was born
17 and did not have the defective, but she exposed her to it.
18 She went and got the prescriptions. She keeps saying,
19 well, they locked them up, my husband locked them up.
20 Well, you saw where they were, right beside the bed on the
21 dresser. And you'll have this evidence back there with
22 you.

23 She continues on this raid. And, like I said, the
24 thing about Dr. Kooistra is she knows. Dr. Kooistra told
25 you the first time she met her back in January 5th of 2006

Closing arguments

1 she told her I'm not going to give you any narcotics,
2 because she was pregnant at that time when she went in to
3 see her. And she had her sign this contract, and this is
4 the one I was speaking about earlier. And you'll have this
5 contract with you. You can read it where it tells you I
6 won't -- I won't take any narcotics from another physician.
7 She knows all of this and is even given the law concerning
8 this for them to read. But she had the law available to
9 her concerning the drug prescription. And she signs back
10 here, and she puts college grad, B.S.N., with her name.

11 And you'll have all of the prescriptions back there.
12 I mean, I went through them several times. I could go
13 through each one with you again, but you can see neither
14 doctor knew about it. And I think the most telling factor
15 with that is the one -- and another thing, talking about
16 pharmacists and things. She was given a prescription in
17 two different names -- Stephanie Neet and Stephanie Greene.

18 Dr. Bridges, Dr. Kooistra, Dr. Kovacs told you I would
19 never have given medications to her if I knew she was
20 pregnant or breastfeeding. All three of them told you.

21 The tragedy in this, this should never have happened.
22 It should never have happened. This baby should not have
23 been exposed to any of these drugs from the Vicoprofen, to
24 the morphine, all the way across the board.

25 And you've got to remember Dr. Kooistra knows she's a

Closing arguments

1 nurse, so she's trusting her. When she doesn't come in,
2 they finally said, well, you missed too many appointments,
3 you need to come in. She comes in there and gives her
4 cock-and-bull story that I've been depressed, I've been in
5 my house, you know, after the fact. She don't even tell
6 them that she's had a baby.

7 She saw Kovacs on October the 29th of 2010 to get
8 Klonopin. She goes right around November 4th of 2010 and
9 gets Klonopin filled again by Dr. Kooistra. Klonopin is
10 one of the substances that was found in the breast -- in
11 the baby from the breast milk.

12 The defense makes a big deal out of all of these
13 scientific studies and everything and says, well, if the
14 baby -- if I remember their expert when they testified
15 was -- and please remember it the way you heard it -- that
16 the mother was misleading when the baby had a genetic
17 defect, that it would obviously metabolize the morphine.
18 That's the reason why you need to tell your doctors so they
19 can be aware of this to take action to help protect you
20 from this.

21 All three doctors told you they would have. Dr.
22 Bridges told you she even told her not to take medication
23 she went and got it.

24 She loved her drugs more than she loved her child.
25 She even spoke it to them while she was in neuro, the drugs

Closing arguments

1 you shouldn't be exposing them to.

2 Let me continue that on. And you'll have the
3 interviews, and I know you've heard them. I'm not going to
4 play them again. Obviously, you'll have these back there
5 with you also.

6 And the interesting thing about the 9-1-1 call, I
7 thought, was lady is a trained nurse, right? Why is she
8 patting the back of the child before 9-1-1 calls when her
9 husband's calling 9-1-1 and he says she's patting the back
10 of the child? The child is obviously --

11 (Pause.)

12 THE COURT: No more comments, no more conversation
13 over here, please. Be respectful.

14 MR. BARNETTE: I mean, obviously the child is under
15 duress, respiratory. She ain't breathing. Why would
16 she -- I mean, why is she doing C.P.R. at that time? And
17 he tells her to put her on the floor. That's proper C.P.R.
18 there. She's got her in the middle of the bed, which
19 happened to be -- not on the floor where you have a hard
20 surface, and near the phone.

21 You hear her breathing so hard into the child, a small
22 child weighing 7 pounds, 6 ounces. You get breaths in
23 there. You heard what.

24 He tells her every time you need to count out loud.
25 He has to remind her of that every time. Her count is off

Closing arguments

1 at times.

2 I mean, you know, and you've heard the officer, I
3 mean, both investigators from the coroner's office. You
4 heard the officers testify to what they saw. And they
5 recorded the interview.

6 I mean, something, I mean, in my opinion. Of course
7 y'all are the judge of the facts. There's something really
8 messed up with her. And they keep saying it's shock. They
9 had more than shock. Like I said, you're the judge of the
10 facts in that case.

11 And it was kind of interesting when Mr. Liboker [sic],
12 he didn't talk about David Eagerton, the pharmacologist
13 from P.C., right here in our area. He come and he
14 basically told you, yes, in my opinion you can die from
15 morphine overdose in breastfeeding in these circumstances.

16 On cross-examination being asked by Mr. Wise -- and
17 that's the way I remember it, and I hope that's the way
18 you've heard it from that standpoint. And the thing you've
19 got to remember is -- and like I told you about the case
20 with the codeine switching to morphine, is we know morphine
21 can kill. There's been warnings put out now to make sure.
22 The L.P. has changed their position on that. You've heard
23 it can cause even death, and they know it. And that's the
24 reason why you need to talk.

25 Obviously, these drugs are needed, but obviously you

Closing arguments

1 need to be very safe with them, that the baby has to mark
2 it differ -- it basically takes care of your, you know,
3 breathing and so forth effect from that.

4 You heard from Dr. Wren. Doctor said no question,
5 overdose, not redistribution. That's the reason why -- and
6 SLED tells you about that -- is the reason why they test
7 the blood, the brain and the liver, doing all three to make
8 sure that those results are right.

9 And the one thing, keep saying. Well, why didn't you
10 do something that day. You're not going to accuse. They
11 work baby cases. You don't want to accuse anybody in any
12 circumstances until you have the facts. And once they had
13 the facts, that's when they confronted her and talked about
14 it.

15 They went and got the medical records. They went and
16 got all of that information. That took their time looking
17 to make sure what they had. That's what you're supposed to
18 do as a law enforcement agency, to thoroughly go through
19 and look at the evidence.

20 And the evidence here, ladies and gentlemen, are
21 clear. She never told any doctor, never, about the
22 morphine. She didn't tell the doctors about taking
23 different drugs for different things. They said, well,
24 they sent this note.

25 She's a nurse. She knows that. She knows how to work

Closing arguments

1 the system. She knows to avoid, to send her husband to go
2 pick up the prescription so they can't tell she's pregnant.
3 She knows the missed appointments from there.

4 And an interesting fact to me was you remember when
5 Dr. Kovacs talked to her on April 30th and she was on
6 patches. She was the one that suggested go to MS Contin to
7 control the lead substance of morphine.

8 She told her that she wanted -- and I apologize. I
9 may not pronounce this right -- the I.U.D., which is the
10 Mirena, for conception control. She told her she needed to
11 get that redone on April 30th. She knew she was pregnant
12 then. She'd had the positive test on March 20th of 2010.

13 She knew when she went and saw Dr. Bridges, and Dr.
14 Bridges told her do not take this drug, she went ahead and
15 got the drug anyway.

16 What she wants you to believe is that she stockpiled
17 this stuff, that she did it for insurance purposes. Well,
18 where are they? Where is the drugs?

19 She didn't even tell the coroner's office about the
20 pills that was in her purse because they would've took
21 pictures of it. So we don't know what pills she had in
22 there.

23 Ladies and gentlemen, it's clear to me if this lady
24 had done what she should have done she knew -- what's even
25 worse she knew it was wrong to take these drugs, and she

Closing arguments

1 knew the doctors like Dr. Kooistra would not have gave her
2 the drugs. Dr. Kovacs would not have gave her the drugs.
3 Dr. Bridges wouldn't have gave her any drugs.

4 You've got to remember every nurse that came in here
5 and testified, they asked her. They can say, well, it was
6 a mistake, maybe she didn't understand. She was acting
7 like nurses. Remember the nurses going from -- Vern Anders
8 [sic] when she went into the new Carolina B.G.Y.N., her new
9 one, even the nurse, Emile Horne, before she has Alexis
10 talks to her and asked her what drugs had she was on.

11 The geneticist, Ms. Steen, asked. And she said I
12 asked her several different ways to make sure what drug.
13 She never told any of them about the morphine, not one
14 time.

15 Yes, ladies and gentlemen, it's a tragedy, a tragedy
16 that could definitely, no question, been prevented. We
17 wouldn't have to be here today if it wasn't for her
18 actions.

19 I mean, there's nothing more innocent in this world
20 than a child. A child comes into this world completely
21 dependent upon the mother and the -- and the family to give
22 her support, to take care of her, take care of her
23 well-being in this sense.

24 And you know as parents we make sacrifices ourselves.
25 As a parent you've got to make sacrifices financially,

Closing arguments

1 time-wise. I mean, having a child is a huge
2 responsibility, and it's not to be taken lightly.

3 And your responsibility is to do everything you can to
4 help the well-being of that child, help that child mature,
5 to grow into an adult one day and take our place in this
6 world, and that didn't happen, ladies and gentlemen.

7 And, like I said, she started well, before
8 November 13th of 2010 not taking care of this child. Her
9 actions were so reckless, her omissions were so reckless
10 that it led to the death of this baby.

11 There's only one way this stuff got into her, and
12 that's from her mother. There was no puncture wounds. I
13 mean, a six-and-a-half-week-old can't take medicine --
14 can't take a pill like that. If you had crushed MS Contin
15 it immediately released at that point. There has been
16 documented evidence. There's no question this can cause
17 death, an overdose of pallets.

18 They keep talking about genetic, the effects. One of
19 the genetic effects, you don't get to that point because
20 the morphine shouldn't have been there to start with.

21 She would never have had it if she'd told the doctors.
22 That's her own admission. That's where she didn't tell
23 them the information.

24 She just recklessly disregarded the safety of this
25 child. She also abused this child in the sense. Can you

Closing arguments.

1 imagine? The baby had lost weight from the second week
2 through the 26th and a half weeks, a 46-days-old, and it's
3 only 4 ounces above its birth weight and actually has lost
4 6 ounces from four and a half weeks before that.

5 Dr. Wren told you this is not a SIDS death. He looked
6 at the whole -- I mean, this is something he's looking to
7 see the reason why, because people want answers to those
8 questions. They want to know why this baby died. Well, he
9 found a reason why. It was the morphine that she gave
10 through her breast milk to Alexis.

11 Ladies and gentlemen, I'm going to ask you to do a
12 hard thing. I know it's hard to sit here. I know you
13 listened to this.

14 This child didn't deserve this. No child deserved
15 this, giving poison because of her mom's omissions by her
16 actions being so.

17 I'm going to ask you to return guilty verdicts on all
18 three counts, because she did all three things. Her
19 admissions -- and you'll hear the judge say this just like
20 I read to you on the letter -- her admissions to her
21 doctors -- and, like I said, she's a nurse, she knows
22 this -- led to the death of this child. Her reckless
23 disregard for her safety of this child.

24 Like I say, even before she was born she was doing
25 that with the Vicoprofen and different things, and morphine

Jury charge

1 also obviously.

2 And then obviously unlawful conduct of a child, what
3 she exposed her to.

4 But like I said before, we have a great responsibility
5 as parents. We have to make sacrifices. Our child should
6 not have to make the sacrifice for us. Thank you.

7 Thank you, Your Honor.

8 THE COURT: Madam forelady and ladies and gentlemen of
9 the jury, you of course have heard and seen all of the
10 evidence. You've now heard the final summations of the
11 lawyers, and therefore it becomes my duty and obligation to
12 instruct you on the law that's applicable in the case. And
13 then you'll be asked to go back and begin with your
14 deliberations. And through that process you'll examine all
15 of the evidence, you'll decide the facts, apply the law and
16 arrive at a fair and just decision, whatever that decision
17 may be.

18 It is your exclusive duty to determine what the facts
19 are. You do that through your own common-sense examination
20 and evaluation of all of the testimony and other evidence
21 received during the course of this trial.

22 You 12 jurors alone will decide what weight, value and
23 effect to give to any particular testimony or other
24 evidence in the case. Your sole obligation and duty is to
25 render a fair and impartial verdict based upon the law and

Jury charge

1 the evidence presented during the trial and the facts as
2 you determine them to be based upon your common sense
3 examination and evaluation of the testimony and evidence in
4 the case.

5 Now, as you know, in this case the defendant has been
6 charged with three separate and distinct criminal offenses.
7 They have three separate and distinct elements that make up
8 those separate offenses. But the separate offenses are --
9 in the indictment they're stated one, two and three.

10 The first charge alleged in the indictment in count
11 one is homicide by child abuse; the second count of the
12 indictment alleges a charge of involuntary manslaughter;
13 and the third count of the indictment alleges unlawful
14 conduct towards a child. And I'll be instructing you on
15 the law as it relates to each of those separate criminal
16 offenses during the course of this instruction.

17 But as I told you, the indictment is not evidence in
18 the case. It's not proof of anything in the case. Proof
19 has to be established through evidence presented during the
20 trial. Evidence will be in the jury room with you. The
21 indictment will also.

22 But, as I say, the indictment is not evidence in the
23 case, but it simply will serve as the verdict form, because
24 it is on the back of that indictment, Madam Forelady, that
25 you will be indicating the jury's unanimous decision as it

Jury charge

1 relates to each of the separate counts of the indictment.
2 And your verdicts may be the same; they may be different as
3 it relates to each of those separate charges depending upon
4 your determination of fact, your application of the law and
5 your decision as to the proof in that particular event.

6 But as to each of the charges contained in the
7 indictment the defendant has entered a plea of not guilty.
8 And as I've told you, that plea of not guilty has placed
9 upon the state the burden of proving the allegations that
10 they have set forth in that indictment, the burden of
11 proving each of the essential elements that make up the
12 crime that the state alleges against the defendant; and
13 therefore the burden is upon the state to establish the
14 defendant's guilt as to a particular charge to the
15 satisfaction of you 12 jurors beyond a reasonable doubt
16 before a verdict of guilty could be returned as to a
17 particular charge.

18 The burden is never upon a defendant to prove that he
19 or she is not guilty or to prove that he or she is innocent
20 because in some cases that might not be possible. The
21 burden is always upon the state because they've brought the
22 charge against the defendant to establish her guilt beyond
23 a reasonable doubt.

24 You are further instructed that it is a vital,
25 important and cardinal rule of law that every defendant in

Jury charge

1 a criminal trial -- and it does not matter how serious the
2 offense might be for which that person stands charged -- a
3 defendant is always presumed innocent of a charge. And
4 that presumption of innocence remains with any defendant,
5 as it does with this defendant, from the time that she is
6 placed under arrest and throughout the course of the
7 criminal process and even throughout the course of the
8 actual trial in the case.

9 That presumption of innocence will be with Ms. Greene
10 even as you go back to begin with your deliberations in
11 this case, and that presumption of innocence will be with
12 her in that jury room, and it'll be with her forever unless
13 you 12 jurors determine that she's no longer entitled to
14 that presumption of innocence.

15 In other words, after you've carefully considered all
16 of the evidence in the case and you've deliberated the
17 case, and once you've decided the facts of the matter, you
18 apply the law that I provide you, if you 12 jurors
19 unanimously determine that her guilt as to a particular
20 charge has been proven beyond a reasonable doubt, then she
21 would no longer be entitled to that presumption of
22 innocence as it relates to that particular charge. But it
23 is only if, unless and until you are satisfied of her guilt
24 beyond a reasonable doubt that the presumption of innocence
25 would no longer be applicable.

Jury charge

1 Now, while the state does have the burden of proving a
2 defendant's guilt beyond a reasonable doubt, that does not
3 mean that the state has to prove her guilt beyond all doubt
4 or beyond any possible doubt. But it does require the
5 state to prove her guilt to your satisfaction beyond a
6 reasonable doubt.

7 And the term reasonable doubt should be given its
8 plain and ordinary meaning. A reasonable doubt is the kind
9 of doubt that would cause a reasonable person to hesitate
10 to act upon the information provided. And a defendant is
11 entitled to any reasonable doubt that arises from the
12 evidence or lack of evidence in a case. And if upon any
13 factual issue essential to a finding of a verdict of guilty
14 as it relates to a particular charge -- should you have a
15 reasonable doubt as to how that issue should be resolved,
16 it would be your duty to resolve that reasonable doubt in
17 favor of the defendant.

18 And therefore if upon your consideration of the whole
19 case you have a reasonable doubt as to her guilt you must
20 resolve that doubt in her favor and return a verdict of not
21 guilty.

22 And, at the same time, after you've considered the
23 evidence and decided the facts and applied the law if you
24 have no reasonable doubt as to her guilt as it relates to a
25 particular charge, it would be your corresponding duty to

Jury charge

1 find her guilty of any crime that has been proven beyond a
2 reasonable doubt.

3 Now, the same law that provides that you are the
4 judges of the facts also provides that I am the judge of
5 the law. And that just simply means that nobody is going
6 to tell you how to arrive at your determination of fact in
7 this case.

8 You do that, as I've already stated, through the
9 exercise of good judgment and common sense conscientiously
10 applied to the testimony and evidence received during the
11 course of the trial.

12 You must however under your oath as a juror accept the
13 law as I provide it to you as being the law that you are to
14 apply in this particular case.

15 In other words, you're not to concern yourself with
16 what you thought the law was before you came to serve as a
17 juror this week or what you think the law ought to be.

18 Under your oath as a juror you must simply accept the
19 law as I provide it to you. And then you take that law and
20 you apply it to the facts as you 12 jurors determine those
21 facts to be based upon your examination of the testimony
22 and evidence in the case.

23 Now, while there are various forms of evidence such as
24 testimony, photographs, documents, charts and other types
25 of physical exhibits, there are really only two types of

Jury charge

1 evidence, and either or both of those types of evidence may
2 be used to prove any fact in issue. But the two types of
3 evidence are direct evidence and circumstantial evidence.

4 Direct evidence is the testimony of a person who
5 testifies from actual knowledge of the fact. It is
6 testimony by a person who has perceived the existence of
7 some fact by having used their senses, and then they come
8 into court and they testify as to what they have previously
9 perceived.

10 Circumstantial evidence, on the other hand, is the
11 proof of some other fact or set of facts which taken either
12 singly or collectively may prove the existence of a fact in
13 question as a necessary consequence, that is through an
14 inference.

15 And an inference is simply a deduction of fact that
16 may logically and reasonably be drawn from the proof of
17 some other fact or set of facts.

18 In other words, it's not a fact proven by the direct
19 testimony of a witness based upon that witness' personal
20 perception, but it is a conclusion which might reasonably
21 be drawn from the proof of other facts.

22 In other words, you may infer that a particular event
23 occurred or that a particular fact exists based upon the
24 proof of sufficient factual circumstances which would
25 reasonably warrant your arriving at a particular

Jury charge

1 conclusion.

2 The commission of a crime may be proven by direct
3 evidence or by circumstantial evidence or by a combination
4 of both direct and circumstantial evidence.

5 The law makes no distinction between the weight or
6 value to be given to direct evidence or to circumstantial
7 evidence. However, to the extent that the state relies
8 upon circumstantial evidence to establish the commission of
9 a crime all of the circumstances proven must be consistent
10 with each other and when taken together point conclusively
11 to the guilt of the accused beyond a reasonable doubt.

12 If these circumstances merely portray the defendant's
13 behavior as suspicious the proof is insufficient, and it
14 fails.

15 This burden rests with the state regardless of whether
16 the state relies upon direct evidence or circumstantial
17 evidence or some combination of the two types of evidence.

18 Your verdict may never be based upon speculation,
19 conjecture or surmise but only upon proof proving the
20 defendant guilty beyond a reasonable doubt.

21 Now, as I told you, you are the sole judges of the
22 facts in this case. You are therefore necessarily the
23 sole judges of the credibility and the believability of
24 each witness that has testified during the course of the
25 trial.

Jury charge

1 And you alone will decide what weight, value and
2 effect to give any particular witness' testimony or even
3 portions of it. But there are a number of factors which
4 you should take into consideration in arriving at your
5 assessment or your evaluation as to a particular witness'
6 credibility and believability, and I'm going to list those
7 factors for you.

8 But you should consider the demeanor of the witness,
9 that is how the witness appeared to you as the witness
10 testified from that witness stand. Was the witness
11 straightforward in responding to questions, or was the
12 witness hesitant or evasive in responding to questions that
13 were asked of the witness.

14 Simply put, did the witness appear to you to be
15 telling the truth and to have knowledge of the facts to
16 which that witness has testified.

17 You should also consider whether or not the testimony
18 of a witness is consistent, or is it inconsistent with that
19 witness' own testimony or with other statements made by
20 that witness, whether they be in court or outside of court.
21 And you should consider whether or not the testimony of a
22 witness is consistent, or is it inconsistent with other
23 witnesses' testimony or other evidence received during the
24 course of the trial.

25 You should also consider how the witness came to know

Jury charge

1 the facts to which a particular witness has testified to.
2 In other words, what was that witness' opportunity and
3 ability to perceive the existence of those facts to which
4 that witness has testified, and then what is that witness'
5 ability to be able to come into court and to accurately
6 recollect to you as to what they have previously perceived.

7 You should also consider any bias or prejudice or
8 interest that a witness might have with regard to a case.
9 In other words, do you find some reason that a particular
10 witness would come into court and would testify one way or
11 another to help or hurt one side or the other. And you
12 should consider any interest that a witness might have in
13 the outcome of a case if you determine that a witness does
14 have such an interest and you find that that interest would
15 be -- would influence that particular witness' testimony.

16 You should also consider whether or not the testimony
17 of a witness is strengthened, or is it weakened by other
18 testimony or other evidence received during the course of
19 the trial.

20 During the course of this trial you have heard certain
21 testimony that has been received from a witness or several
22 witnesses that were qualified by the Court as experts in a
23 particular field.

24 Please understand that while I am the person who has
25 to determine whether or not a person can testify as an

Jury charge

1 expert witness, that should not be any indication by me to
2 you that you should consider that witness' testimony any
3 more than you do some other witness' testimony.

4 There's just certain thresholds that have to be met
5 before a person can testify as an expert witness in a
6 particular case, and that's because lay witnesses are
7 generally not permitted to testify in an opinion form.
8 They are simply allowed to testify as to facts within their
9 own knowledge or perception or experience, but they're not
10 permitted to give opinions in regard to a matter.

11 However, where you have witnesses who are qualified as
12 an expert, that is where they have special education or
13 training or experience or skill with respect to a
14 particular field, then those witnesses where they're
15 qualified as experts can give testimony in an opinion form
16 as it relates to the facts of the matter.

17 But the fact, as I say, that a witness has been
18 qualified as an expert should not be taken by you as any
19 indication by me as to how you should evaluate that
20 witness' testimony, that witness' believability or
21 credibility, and that's because you have to evaluate expert
22 testimony just as you do lay-witness testimony.

23 And if you determine that the opinion of an expert
24 witness is not based upon sufficient qualifications or
25 education or training or skill or knowledge or experience,

Jury charge

1 or it was not based upon a proper consideration of the
2 facts that relate to this particular case, then you may
3 disregard that expert's testimony in its entirety, or you
4 may believe some portion of it and reject some other
5 portion of it.

6 Simply put, you have to judge the credibility of an
7 expert witness just as you do any other witness, and it is
8 for you 12 jurors to determine what is the most believable
9 and credible testimony.

10 As a result, you may believe everything that a witness
11 testified to; you may choose to believe none of it. You
12 may believe some portion of a witness' testimony and reject
13 some other portion of that same witness' testimony.

14 You may believe one witness as opposed to several, or
15 several as opposed to one. But whatever your good judgment
16 and common sense tells you is the most believable and
17 credible testimony is the testimony you should accept, and
18 you should reject any testimony or other evidence that you
19 find not to be credible or believable.

20 Now, in this case, as you know, the defendant is
21 charged with three separate and distinct offenses. Those
22 offenses are homicide by child abuse, involuntary
23 manslaughter and unlawful conduct towards a child.

24 I'm going to begin with homicide by child abuse. The
25 order that I instruct you as to the law should not be

Jury charge

1 significant to you. I've got to give it to you in some
2 order, and I'm simply doing it based upon the order it's
3 set forth in the indictment. But you can deliberate the
4 case in what order you wish to.

5 Section 16-3-85 of the South Carolina Code of Laws
6 provides that a person is guilty of homicide by child abuse
7 if the person causes the death of a child under the age of
8 11 years while committing child abuse or neglect and the
9 death occurs under circumstances manifesting an extreme
10 indifference to human life.

11 The term child abuse or neglect within the meaning of
12 the statute refers to an act or an omission by any person
13 which causes harm to the child's physical health or
14 welfare.

15 And the term harm to the child's physical health or
16 welfare in the context of this case refers to the
17 infliction of physical injury or harm to a child resulting
18 from the child's ingestion of a Schedule II controlled
19 substance.

20 The term extreme indifference to human life refers to
21 the deliberate commission of an act with a conscious
22 indifference to the probable consequences of the act which
23 culminates in the death of another human being whether the
24 actual result was intended or not.

25 It may be further described as the commission of an

Jury charge

1 intentional act with a conscious indifference to any risk
2 created thereby which culminates in the death of another
3 person, in this case a child under the age of 11.

4 And therefore before you could find the defendant
5 guilty of a violation of this section, that is before you
6 could find the defendant guilty of the crime of homicide by
7 child abuse, it would be necessary that the evidence in
8 this case establishes to your satisfaction beyond a
9 reasonable doubt four essential elements:

10 No. 1, that the defendant committed a deliberate or
11 intentional act under circumstances revealing an extreme
12 indifference to human life; secondly, that the act caused
13 physical injury or harm to a child; thirdly, the child was
14 under the age of 11 years; and, fourthly, the physical
15 injury or harm culminated in the death of the child.

16 The second count of the indictment charges the
17 defendant with the crime of involuntary manslaughter.

18 Involuntary manslaughter is defined as either the
19 unintentional killing of another person without malice
20 while engaged in the commission of some unlawful act not
21 naturally tending to cause death or result in great bodily
22 harm, or it's the unintentional killing of another without
23 malice while engaged in a lawful activity in a criminally
24 negligent manner.

25 Unintentional means that the defendant did not intend

Jury charge

1 to kill the child nor did the defendant intend to inflict
2 serious bodily harm or injury to the deceased child.

3 A criminally negligent manner refers to the act of
4 criminal negligence. And criminal negligence is defined as
5 a reckless disregard of the safety of others.

6 And in that regard you should understand that simple
7 negligence is a term that refers to a mere carelessness or
8 thoughtlessness in the performance of some act. It refers
9 to a failure to exercise reasonable care required.

10 Criminal negligence is something more than mere
11 carelessness or thoughtlessness. Criminal negligence is a
12 conscious failure to exercise reasonable care.

13 So while a negligent person is acting carelessly or
14 thoughtlessly, a criminally negligent person is not only
15 acting carelessly or thoughtlessly, but they are aware of
16 that fact, and they continue to act anyway.

17 Criminal negligence signifies a conscious disregard
18 for or a conscious indifference to the consequences of
19 one's own conduct and a conscious disregard for and
20 indifference to the safety of some other person.

21 The third count in the indictment charges the
22 defendant with unlawful conduct towards a child, and that's
23 also a statutory offense. It's set forth in section
24 63-5-70 of the South Carolina Code of Laws.

25 And that particular code section provides that it is

Jury charge

1 unlawful for a person who has charge or custody of a child,
2 or who is the parent or guardian of a child, or who is
3 otherwise responsible for the welfare of a child to place
4 the child at unreasonable risk of harm effecting the
5 child's life or safety.

6 The state contends that the defendant did violate this
7 particular provision or this particular statute. And
8 before the defendant could be found guilty of a violation
9 of this section of law it would be necessary that the state
10 has established to your satisfaction beyond a reasonable
11 doubt two essential elements: First, that the defendant
12 was a parent, guardian, custodian or otherwise responsible
13 for the welfare of the child in this case, Alexis Greene;
14 and that the defendant did by some act or omission place
15 the child at an unreasonable risk of harm which affected
16 the life or the physical health or safety of the child.

17 In order to be found guilty of a violation of this
18 particular section or this particular crime it is not
19 required that the state prove the defendant acted knowingly
20 or with a criminal intent. But the state must prove that
21 the defendant did act at least negligently or carelessly
22 and that that negligent conduct on the part of the
23 defendant did place the child at an unreasonable risk of
24 harm which affected the life or physical health or safety
25 of the child.

Jury charge

1 You are further instructed, and I emphasize to you,
2 the fact that a defendant does not take the witness stand
3 and testify during the course of a trial is not a
4 circumstance that may be considered by the jury in any way
5 whatsoever in your deliberations or in your determination
6 as to whether or not her guilt has been proven beyond a
7 reasonable doubt.

8 As I have already told you, the burden is never upon a
9 defendant to prove that he or she is not guilty or to prove
10 that he or she is innocent because in some cases that might
11 not be possible.

12 The burden is always upon the state to prove her guilt
13 beyond a reasonable doubt, and therefore the fact that a
14 defendant does not testify during a trial may not be
15 considered by the jury. You may not allow that to weigh in
16 the slightest degree against a defendant.

17 You are not to consider that fact in any way in your
18 deliberations or in your determination as to whether or not
19 her guilt has been proven, nor are you even to discuss that
20 fact while you are engaged in your deliberations.

21 Now, ladies and gentlemen, I am not in any way
22 concerned with what your decisions are, but you are
23 instructed that any decision that you reach must be
24 unanimous. All 12 of you must be in agreement before a
25 verdict can be rendered as it relates to a particular

Jury charge

1 charge.

2 In this case, as you know, you have three separate
3 charges set forth in the indictment. You'll be called upon
4 to render three separate and distinct verdicts based upon
5 the three charges.

6 As to each of the separate charges you have two
7 potential verdicts. Those verdicts are guilty and not
8 guilty.

9 Madam Forelady, you will have the indictment in the
10 jury room. On the back of the indictment you'll see the
11 word verdict, and it's beneath that word that you will
12 indicate the jury's unanimous decision.

13 I'm going to write on the indictment the numbers one,
14 two and three, which are not there now. But they will
15 correspond to the counts of the indictment. So by count
16 one you'll indicate the verdict, guilty or not guilty.
17 Same with count two; same with count three.

18 Then you'll sign your name as the foreperson. You are
19 the only juror that needs to sign the verdict form.

20 Once you have reached a decision you'll knock on the
21 door, tell the bailiff you've reached a unanimous decision.
22 We'll bring you back to receive the verdicts.

23 You will hold onto the verdict form. The bailiff may
24 take the evidence, but don't give the bailiff the verdict
25 form. You'll hold onto that, Madam Forelady, and I'll

Jury charge

1 receive it from you after you and your fellow jurors are
2 seated back in the courtroom.

3 During the course of your deliberations there may come
4 a time where you have some question about evidence or
5 testimony, or documents for that matter.

6 I am never permitted to answer questions that relate
7 to issues of fact or relate to the evidence in the case.
8 Also, there can be no additional evidence received now that
9 the case is closed and you are getting ready to go back to
10 engage in your deliberations.

11 Once in a while I'll get the jury to send me a
12 question. They want to know if they can have a certain
13 thing -- document or otherwise -- that they don't have. It
14 wasn't introduced into evidence.

15 If you don't have it in the jury room, if it was not
16 introduced into evidence, you cannot have it now. Even if
17 it exists you -- even if it does exist you can't have it
18 because it has not been introduced. So don't ask me about
19 anything that you don't have.

20 However, if you have a question and you think the
21 question can be answered by having a particular witness'
22 testimony replayed in whole or in part, we can bring you
23 back into the jury room [sic] to have a witness' testimony
24 replayed in its entirety or in just some portion if that's
25 all you need.

Jury charge

1 I don't have transcripts of the witnesses' testimony
2 to send back. But if you need to hear a witness'
3 testimony, I will allow you to come back into the courtroom
4 to have that testimony reheard.

5 If you have a question about the law that is
6 applicable, I am permitted to answer those questions. And
7 so if you need to give -- need for me to give you a
8 reinstruction, I'm happy to do that. If you need to get --
9 for me to give you an explanation of some point of law, I'm
10 happy to do that. If you need a clarification of some
11 point of law that I provided, I'll also be happy to do
12 that. You just have to simply let me know.

13 If at any time you need to direct some question or
14 comment to me, Madam Forelady, I'll ask that you write it
15 on a piece of paper, give it to the bailiff. The bailiff
16 will give it to me, and I'll respond to that question or
17 address any issue that you might have.

18 If we have any smokers on the jury, you are permitted
19 to smoke during deliberations, but you can't smoke in the
20 jury room. You have to go outside for that purpose. So if
21 you need to smoke, let the bailiff know. He or she will
22 take you outside to accomplish that purpose.

23 But you are instructed that if a juror is absent for
24 any authorized purpose the deliberations have to stop, and
25 deliberations may only resume and be engaged in when all 12

Jury charge

1 jurors are present so that all 12 may participate.

2 Your lunches have been ordered. I'm not certain
3 whether they're here or not, but if not they'll be here
4 shortly. I'll leave that up to you as to whether you want
5 to stop your deliberations and eat lunch and then resume
6 those after lunch or whether you want to deliberate while
7 you're eating. I'll let the jury make that determination
8 on your own.

9 I think that covers everything that I needed to tell
10 you. But if I neglected something I'm sure these lawyers
11 will be kind enough to remind me that I forgot to tell you
12 something, and I'll bring you back to provide you with
13 additional information.

14 If I do not need to bring you back for any reason I'll
15 send word by way of the bailiff that you may begin with
16 your deliberations. In that event he or she will bring to
17 the jury room all of the exhibits which have been
18 introduced.

19 And to you, Madam Forelady, he or she will also bring
20 the verdict form on which you will indicate the jury's
21 unanimous decisions.

22 I'll ask the two alternate jurors to remain here in
23 the courtroom with me. I'll ask the 12 primary jurors to
24 please retire to your jury room. But do not begin
25 deliberations until I send you word to do so.

Jury charge

1 (Whereupon, the jury retired to the jury room at
2 12:57 p.m.)

3 (Whereupon, the alternate jurors were excused.)

4 THE COURT: Are there any exceptions taken to or
5 requests for additions to the instruction by the state?

6 MR. BARNETTE: None from the state, Your Honor.

7 THE COURT: By the defendant?

8 MR. WISE: Two things, Your Honor.

9 First of all, we would request a jury charge on the
10 state's theory of the case. And I think the charge you
11 made when you referred to ingestion of a controlled
12 substance probably necessitates that because you did not
13 say ingestion of a controlled substance by breast milk.

14 I think the jury should be instructed that the state's
15 theory of the case is that the child died from ingestion
16 of morphine through breast milk, and that has to be proven
17 beyond a reasonable doubt.

18 Secondly, I would object to the charge that the charge
19 of unlawful conduct toward a child does not require
20 criminal intent. I think it requires more than mere
21 negligence.

22 THE COURT: Well, do you have a case that says that
23 because --

24 MR. WISE: No, I don't.

25 THE COURT: -- the Jennings case says it doesn't.

Jury charge

1 MR. WISE: I know. I don't, but I'm just saying --

2 THE COURT: Do you know --

3 MR. WISE: I think -- I think every criminal case
4 ought to have something more than mere negligence.

5 THE COURT: Well, I understand.

6 MR. WISE: Yeah.

7 THE COURT: But you're -- you're not telling me that
8 the Jennings case has been --

9 MR. WISE: No, sir.

10 THE COURT: Been overturned.

11 MR. WISE: No, sir. You can't go up if you don't make
12 an objection.

13 THE COURT: Oh, I understand.

14 MR. WISE: But I do think that the jury should be
15 instructed on the state's theory.

16 MR. BARNETTE: I disagree, Your Honor.

17 I think that -- obviously, I never argued anything but
18 the breastfeeding, and I think that's the evidence that was
19 shown here --

20 MR. WISE: Well, I --

21 MR. BARNETTE: -- from there. And I think Mr. Wise
22 made sure that was very clear too in his closing, so.

23 MR. WISE: But his Honor's charge talked about
24 ingestion of a controlled substance.

25 THE COURT: Ingestion.

Jury charge

1 MR. WISE: Ingestion of a controlled -- Schedule II
2 controlled substance, and that could accomplish one of two
3 ways.

4 THE COURT: Okay. I'll tell them --

5 MR. WISE: All right.

6 THE COURT: -- if you think it's not clear to them.
7 Bring back all 14 of them, please.

8 (Whereupon, the jury returned to the courtroom at
9 12:58 p.m.)

10 THE COURT: I just have one clarification I need to
11 make.

12 When I instructed you on the law as it relates to the
13 criminal offense of homicide by child abuse I told you or
14 instructed you that the term harm to the child's physical
15 health or welfare in the context of this case referred to
16 the infliction of physical injury or harm to a child
17 resulting from the child's ingestion of a Schedule II
18 controlled substance. And that should go on to say
19 ingestion of a Schedule II controlled substance through the
20 consumption of breast milk.

21 MR. WISE: Could we approach, Your Honor?

22 THE COURT: Yes.

23 (Bench conference held off the record in the presence
24 of the jury but out of the hearing of the jury.)

25 THE COURT: well, if it's not clear by now let me make

Jury charge

1 this very clear.

2 The state has the burden of proving these crimes, but
3 it involves the ingestion of controlled substances by the
4 child through the child's mother's breast milk.

5 That's -- that's the state's allegation and theory in
6 the case, that the child died as a result of consumption of
7 a controlled substance through the mother's breast milk.
8 That applies to each of the separate charges.

9 Okay. Please retire to your jury room.

10 (Whereupon, the jury retired to deliberate at
11 1:00 p.m.)

12 THE COURT: Any other exceptions?

13 MR. WISE: Just one thing. We had discussed this in
14 chambers I think like Monday or so, but my objection is
15 that the jury should have been instructed they can only
16 come back with a verdict on one count as the others would
17 violate double jeopardy. And we had discussed that in
18 chambers, I believe.

19 MR. BARNETTE: Yes, sir. I think the State vs. Easler
20 addresses that issue.

21 THE COURT: All right. Y'all verify the exhibits,
22 please.

23 MR. BARNETTE: Yes, sir.

24 (Pause.)

25 THE COURT: All right. The -- the -- there is --

Verdict

1 Mr. Wise, I don't know if you know it or not, but the
2 solicitor has a computer that's clean. There's nothing on
3 it. It's for the benefit of the jury. I've established
4 that precedence sometime ago. So that's all it's used for,
5 is for jury exhibits. And there are two D.V.D.s that if
6 they want to look at, they can.

7 MR. WISE: That's fine. Well, not D.V.D.s.
8 They're --

9 MR. BARNETTE: They're C.D.s.

10 THE COURT: Well, I mean C.D.s. Excuse me.

11 MR. WISE: They can't -- you've got to play them on a
12 computer.

13 MR. BARNETTE: I know.

14 THE COURT: But y'all -- y'all have examined all of
15 the exhibits. They're all present and accounted for.

16 MR. WISE: All present.

17 MR. BARNETTE: Yes, sir.

18 THE COURT: All right. Send them back. Tell the jury
19 to begin deliberations and notify us when they've
20 concluded.

21 We'll be at ease while the jury is deliberating.

22 (Whereupon, a recess was taken.)

23 (Question from the jury and response from the Court
24 marked Court's Exhibit No. 6.)

25 THE COURT: I'm informed that the jury has reached a

Verdict

1 decision. Are we ready to receive it?

2 MR. BARNETTE: The state's ready, Your Honor.

3 MR. WISE: The defense is ready, Your Honor.

4 THE COURT: All right. Bring them in.

5 (Whereupon, the jury returned to the courtroom at
6 4:42 p.m. to report its verdict.)

7 THE COURT: Madam Forelady, have you and your fellow
8 jurors reached a unanimous decision with respect to each of
9 the separate counts of the indictment?

10 THE FOREPERSON: Yes, we have.

11 THE COURT: Have you reflected those decisions on the
12 back of the indictment as requested?

13 THE FOREPERSON: Yes, I have.

14 THE COURT: Did you sign your name as the foreperson?

15 THE FOREPERSON: Yes, I did.

16 THE COURT: I don't think I told you to date it. Did
17 you do so?

18 THE FOREPERSON: I did.

19 THE COURT: Good.

20 If you will, please hand that form up by way of the
21 bailiff.

22 You may publish the verdict.

23 THE CLERK: The General Sessions Court, Case
24 No. 2011-GS-42-5758, the State vs. Stephanie Irene Greene,
25 count one, homicide by child abuse, count two, involuntary

Verdict

1 manslaughter, count three unlawful conduct toward a child.

2 Count one is guilty; count two is guilty; count three
3 is guilty. This is signed by the foreperson and dated
4 today's date.

5 Ladies and gentlemen of the jury, if this is your
6 verdict and still your verdicts, please raise your right
7 hand.

8 (Whereupon, all responded in the affirmative.)

9 THE CLERK: So say you all.

10 THE COURT: Does the defendant wish to have the jury
11 polled?

12 MR. WISE: We do, Your Honor.

13 THE COURT: Please poll the jury.

14 THE CLERK: Yes, sir.

15 Ladies and gentlemen of the jury, I will pose a
16 question to you, after which I will call your name
17 individually. At that time I would ask you to stand and
18 answer my question, question being is this your verdicts
19 and still your verdicts.

20 No. 145, Rider.

21 THE JUROR: Yes, ma'am.

22 THE CLERK: Thank you.

23 88, Horne.

24 THE JUROR: Yes, ma'am.

25 THE CLERK: 181, white.

Verdict

1 THE JUROR: Yes, ma'am.
2 THE CLERK: 73, Harper.
3 THE JUROR: Yes, ma'am.
4 THE CLERK: 106, Lee.
5 THE JUROR: Yes, ma'am.
6 THE CLERK: 135, Porter.
7 THE JUROR: Yes, ma'am.
8 THE CLERK: 83, Hill.
9 THE JUROR: Yes, ma'am.
10 THE CLERK: 99, King.
11 THE JUROR: Yes, ma'am.
12 THE CLERK: 45, Foster.
13 THE JUROR: Yes, ma'am.
14 THE CLERK: 162, Stuard.
15 THE JUROR: Yes, ma'am.
16 THE CLERK: 14, Berry.
17 THE JUROR: Yes, ma'am.
18 THE CLERK: 16, Kirkland.
19 THE JUROR: Yes, ma'am.
20 THE CLERK: Your Honor, the jury has been polled.
21 THE COURT: Are there any other matters that need to
22 be addressed with the jury present?
23 MR. WISE: Not with the jury present.
24 THE COURT: If you will, get me the two alternates,
25 please, sir.

Verdict

1 THE BAILIFF: They're right here, sir, just walked in.

2 THE COURT: Let me just ask y'all to come around and
3 have a seat over here so I can excuse you.

4 This is going to be the last case that's going to
5 require any of your participation this week.

6 So I do want to thank you for your service as jurors
7 this week, and of course for your actual service in the
8 trial of this case.

9 I recognize that your jury service does pose an
10 imposition on you, but we do sincerely appreciate your
11 willingness to serve and the manner in which you carried
12 out your service this week.

13 You will not need to report back any further. You
14 won't need to come back, but you will be receiving a pay
15 voucher that will be mailed to you at the address that
16 appears on your juror summons unless you've given the clerk
17 a different address. So if the address on your summons is
18 not your correct address, be sure that you provide that to
19 the clerk before you leave.

20 So thank you again for your participation. You'll
21 need to go with the bailiffs so they can take your juror
22 badges. And if you need to change an address, let the
23 bailiff know. We'll send the clerk back there to get that
24 address.

25 You'll also be receiving an employer's statement if

1 you need one for an employer to show that you've been
2 serving as jurors this week.

3 Okay. Thank you again for your participation.

4 (Whereupon, the trial jury was excused.)

5 THE COURT: Are y'all prepared to make your sentencing
6 presentation this evening, or do you prefer to do it in the
7 morning?

8 MR. WISE: We would prefer to do it in the morning.

9 THE COURT: In the morning?

10 MR. WISE: Yes, sir.

11 THE COURT: All right. We'll do that at 9:30 in the
12 morning. In the meantime the defendant is in custody.

13 Court is in recess until 9:30 in the morning.

14 END OF PROCEEDINGS APRIL 3, 2014
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1 (Proceedings April 4, 2014)

2 THE COURT: Mr. Wise, have you got any posttrial
3 motions you want to make?

4 MR. WISE: I do, Your Honor.

5 I would first like to make a motion for a new trial on
6 the charge of homicide by child abuse by -- on the grounds
7 that taking the evidence in the light most favorable to the
8 state I don't think the state has proven extreme
9 indifference in this case. Extreme indifference obviously
10 is a pretty -- pretty high standard.

11 This is not a case which I'd call a more typical
12 homicide-by-child-abuse case where someone through their
13 anger or whatever picks a child up and shakes it, throws it
14 down or something like that. All of those actions clearly
15 indicate an act of extreme indifference.

16 Here we have a young lady whose biggest crime may be
17 that a little knowledge is a dangerous thing. She was
18 breastfeeding her child, which is not an act of extreme
19 indifference.

20 She -- the testimony shows that she went out and did
21 some research on the effects of morphine and so forth,
22 which does not show an act of extreme indifference. Bad
23 judgment perhaps in not consulting with physicians, bad
24 judgment perhaps in not doing more research, but certainly
25 does not show extreme indifference because, as the Court's

1 aware from this trial, research clearly would have shown
2 that taking morphine would not have been harmful to the
3 child as it's recommended in many cases. So I don't think
4 there's been an extreme indifference.

5 Secondly, I would move to dismiss the other two
6 charges, the involuntary manslaughter, also on the ground
7 there's been no showing of recklessness on her part. Bad
8 judgment is not recklessness, nor is bad judgment extreme
9 indifference.

10 And then the last one of course being negligence, I
11 don't think there's been any showing of negligence.

12 Also, in -- as I addressed the Court earlier, the
13 double-jeopardy argument, it just seems to me that if the
14 jury found there was simple negligence to convict her of
15 unlawful conduct toward a child, then certainly that is an
16 explicit acquittal of extreme indifference, because
17 they're -- they're not the same.

18 The jury found her guilty of recklessness. That also
19 is an explicit acquittal of extreme indifference. So it's
20 very inconsistent for the jury to have found that, one, she
21 was simply negligent, or, two, grossly negligent, or,
22 three, extreme indifference, because there are different
23 standards requiring different -- different things.

24 So I don't see how you can find on simple negligence
25 to extreme indifference and say that they're compatible

1 with each other.

2 THE COURT: Do you wish to be heard?

3 MR. BARNETTE: Yes, sir, I'd just like to be just
4 heard on this point.

5 Your Honor, one thing Mr. Rauch [sic] keeps saying
6 it's a simple mistake.

7 I have personal experience from this standpoint, what
8 my wife went through. My wife is a nurse. She's a B.S.N.
9 She became pregnant in 1989. I was teaching school then.
10 She had a miscarriage.

11 She went and tried to find out every which reason why
12 she had that. She thought it was her fault. She went and
13 did the research. They went and looked at the lab records.
14 She talked to her doctors about it and found out she had a
15 hormonal imbalance that caused the problem. She could
16 never have carried a child unless she figured that out
17 through her doctors working with them. We was fortunate
18 enough to have two children because of that.

19 And we usually don't talk about cases. She looked at
20 the medical records herself. She's the one that pointed
21 these things out to me off the medical records, about her
22 having a positive pregnancy test, about her going to Dr.
23 Kooistra on April 30th and asking for an I.U.D. and not
24 even telling the doctors that was giving the medication
25 that she was pregnant, that she was breastfeeding.

1 I know you've heard these arguments, but she -- she
2 had the knowledge. She could have corrected the problem
3 and saved this child. She put it in danger when she talked
4 to the O.B.G.Y.N. in this case. And she told her don't
5 take Vicoprofen. What did she do? She goes out and gets
6 two more prescriptions for it.

7 She put her child at risk when she was carrying the
8 child and obviously put it through risk through her life
9 for 46 days. And to me if that's not extreme indifference
10 to life and everything they're talking about -- I mean,
11 this is hard for me to listen, and it's been a hard case
12 for me, period. I know that you shouldn't personally get
13 into it, but, I mean, that's -- that's the facts.

14 She had the knowledge. She knew how to work the
15 system. Like when my wife went and talked to the doctors,
16 doctors are carrying people, for people, but when,
17 especially nurses, people in their profession, they're
18 going to listen to them giving them information.

19 Like Dr. Kooistra, Dr. -- she knew in 2006 when she
20 was pregnant she wasn't going to give her those medications
21 that she got later because she was pregnant. And the
22 defendant knew that.

23 And then go to -- and then she missed her, and then
24 she comes in and gives her this story when she came back
25 November 4th of 2010 basically saying that -- you know, I

1 had the impression and everything. Didn't tell her that
2 she had a baby, telling her -- and the doctor feels sorry
3 for her, giving her medication, changed her medication to
4 try to help her. That's the problem with this case.

5 She could have stopped it at any time, and she has the
6 knowledge just like my wife did with a B.S.N. degree. And
7 the reason I feel I need to put this on the record is to
8 build a record to explain why.

9 And, like I said, the thing was when the coroner's
10 office -- and I've got to thank the Spartanburg County
11 Coroner's Office, Rusty Clevenger and them. They called me
12 when they got the results.

13 We all met -- Rusty Clevenger's office, William Gary
14 with the Spartanburg County Sheriff's Department. We met.
15 The state law enforcement division, Wendy Bell, came. Dr.
16 David Eagerton came and Dr. Wren came. We all met once we
17 got the results and talked about this case, because we knew
18 what kind of case it was. But there was no question once
19 we looked at it what the cause of death was, and what was
20 that cause, which was the defendant.

21 So I'd ask you to deny all of those motions. I wanted
22 to put that on the record because if I don't, because
23 obviously this is going to be looked on appeal. I know
24 that. I wanted to put all on the record so the courts in
25 the future would understand the basis behind that, because

Sentence

1 I can't say enough for the law enforcement, for the
2 coroner's office, for the doctors that talked to us, as
3 well as my staff working on the case. And for me this is
4 the -- it's the toughest case I've ever had personally to
5 see what happened to this child.

6 Thank you, Your Honor.

7 THE COURT: All right. Anything else on the motion
8 for a new trial?

9 MR. WISE: Nothing further on the motion, Your Honor.

10 THE COURT: I think the decision of the jury is amply
11 supported by the record in the case, so your motion for a
12 new trial is denied.

13 what else?

14 MR. WISE: Your Honor, on homicide by child abuse the
15 minimum sentence I think more than adequately vindicates
16 any society, more than adequately sends any message this
17 court wants to send. It -- it more than adequately
18 punishes her.

19 This is the loss obviously to her and to her husband.
20 I don't think this was anything -- to me it's not even -- I
21 don't compare this, frankly, as far as the mental attitude
22 of the defendant to those child abuse cases where the
23 mother or the father shakes that child out of anger because
24 they aren't able to control their anger. I don't think
25 they're equivalent at all and that -- and as far as intent

Sentence

1 is concerned.

2 I think that the decision of the jury shows that she
3 truly used, you know, bad judgment. We don't -- you know,
4 we don't judge intent or we don't judge extreme
5 indifference, I think, by hindsight. We judge it at the
6 time it happened. And I understand the Court's ruling on
7 that.

8 But she's been married ten years to Mr. Greene. They
9 have one other child, as the Court knows from the
10 testimony, who is seven that Mr. Greene will now be raising
11 by himself. With a minimum sentence it'll be until he's a
12 young man, quite frankly.

13 I've gotten to know Stephanie over the two years I've
14 been -- two and a half years in which I've been involved
15 with her. And I will tell you that, you know, in time
16 talking to her and representing her you say how did you
17 ever become a nurse.

18 When this case got scheduled for the 31st of March,
19 and roughly six weeks -- 18 months ago before it started,
20 and we started seeing a whole lot more of each other
21 getting ready, talking a lot more on the phone and asking
22 her to do things for me, I saw somebody then who I
23 understand literally why she became a nurse. She was very
24 focused, very cooperative, very into helping me as much as
25 she can. And I think I saw a side of her that I had not

Sentence

1 seen when I was just meeting with them and trying to gather
2 some basic facts. And it was a side that I began to much
3 appreciate, quite frankly.

4 She is an intelligent woman. I wish she had not
5 fallen apart years ago and lost that nursing degree. I
6 think she had the capability of being a good nurse without
7 any question about it.

8 I think the Court should consider that, you know, I
9 really believe that had she not had that tragic automobile
10 accident years ago we wouldn't be here and she wouldn't
11 have had the need for these type of pain medications.

12 The doctors clearly, clearly stated that in their
13 professional opinion the prescriptions they were filling
14 for her or prescribing for her were truly needed for what
15 was wrong with her.

16 It's not a case of somebody who came in here and
17 decided to go get high and went and lied to a doctor or
18 exaggerated their pain or something like that. All of the
19 doctors said it's real. So we don't have that.

20 And if you look at the drug records, frankly, and on
21 this case -- and I've looked at them carefully -- you
22 don't -- and the medical reports -- there's not a single
23 incident in any of the two or three years of medical, or
24 four years of medical reports, I've seen where there's a
25 notation by the doctor, patient says she lost her meds or

Sentence

1 patient said the meds were stolen or stuff like that,
2 patient says this, because there aren't any.

3 The prescriptions were filled on a pretty timely
4 basis. There were times she would get a prescription for
5 either hydrocodone or the morphine. And it may be two or
6 three days before it's filled after she gets it. So it
7 wasn't someone that I really think exhibited the
8 drug-seeking behavior of someone who's truly an addict.

9 I would also point out to the Court that she did take
10 the good precaution of going to one pharmacy except for one
11 prescription.

12 And from nursing she knew -- and this is conversations
13 we've had -- she knew that the pharmacist is truly the
14 gatekeeper, that if the doctors are prescribing something
15 that -- that together are going to be bad for her, the
16 pharmacist would catch it. And they did go to the same
17 pharmacy every time for all of the drugs except for one.
18 And so I think that's a precaution that perhaps in her mind
19 she was taking that wasn't an -- and maybe thought, well,
20 if the pharmacist doesn't catch it, it's okay.

21 Unfortunately, it turned out not to be true. But I
22 think that's part of her mind-set, that she was at least
23 trying to protect her and her child from harm by going to
24 the same pharmacy.

25 So I think you can consider that, that this is not --

Sentence

1 this is not a -- this is not what I call the typical drug
2 addict who goes out on the street and goes to a doctor here
3 and a doctor there and gets prescriptions, gets pharmacists
4 all over the state to get drugs that are used
5 recreationally or just to stay high. This was something
6 that, as I say, everybody admits she truly needed, truly
7 necessary for her well-being.

8 THE COURT: What about history?

9 MR. BARNETTE: Prior record, Your Honor. She had a
10 D.U.I. conviction in 2003, a D.U.S. conviction, 2003. Your
11 Honor, she had unlawful conduct towards a child. She pled
12 guilty to that October 7th of 2003, Your Honor. She pled
13 to --

14 THE COURT: Do you know what the circumstances of that
15 conviction were?

16 MR. BARNETTE: Yes, sir, I do. You do want the
17 incident report?

18 THE COURT: Yeah. Have you seen it?

19 MR. WISE: I haven't seen it.

20 THE COURT: Show that to Mr. Wise.

21 MR. BARNETTE: Okay. I'll be glad to show it.

22 I do have the sentence -- I have the actual
23 indictments and the sentencing sheets to that, Your Honor.

24 THE COURT: Okay. Have you got the indictments and
25 the sentencing sheet?

Sentence

1 MR. BARNETTE: Yes, sir, I do. Do you want me to
2 finish on those, Your Honor, or wait until --

3 THE COURT: Well, let me see that one first.

4 MR. BARNETTE: Yes, sir, I will.

5 (SLED report marked Court's Exhibit No. 7; copy of
6 Indictment 02-GS-42-755 marked Court's Exhibit No. 8; copy
7 of Indictment 03-GS-42-4180 marked Court's Exhibit No. 9;
8 copy of Indictment 03-GS-42-1967 marked Court's Exhibit No.
9 10; incident report marked Court's Exhibit No. 11.)

10 MR. BARNETTE: It was -- I've marked these as court
11 exhibits, and I believe these have been provided to
12 Mr. Wise. The neglect of a child is Court's Exhibit No. 8,
13 Your Honor. Let me let him see it, Your Honor, if you
14 don't mind before.

15 (Incident report marked Court's Exhibit No. 11.)

16 MR. BARNETTE: Your Honor, the unlawful conduct --
17 conduct indictment is Court's Exhibit No. 11 or No. 8, and
18 the incident report involving that is Court's Exhibit
19 No. 11, Your Honor, I'm passing up to the Court. I've
20 showed both of them to Mr. Wise.

21 THE COURT: Okay. What else?

22 MR. BARNETTE: Your Honor, this is Court's Exhibit
23 No. 9.

24 She pled guilty to obtaining -- attempt to obtain
25 controlled substance by fraud, Your Honor, on

Sentence

1 February 18th of 2006. That's Indictment 03-GS-42-4183.
2 And Court's Exhibit 10, Your Honor, was obtaining
3 controlled substance by fraud conviction, Your Honor,
4 Indictment 03-GS-42-1967. Your Honor, she pled on that
5 August 13th of 2003, Your Honor.

6 Would you like for me to pass these up to Your Honor?
7 I believe Mr. Wise has copies of these.

8 MR. WISE: Right. We've seen those.

9 MR. BARNETTE: And I do have a rap sheet, Your Honor.
10 I've marked that as Court's Exhibit No. 7.

11 MR. WISE: I think I have seen that too.

12 MR. BARNETTE: May I approach the bench, Your Honor?

13 THE COURT: Sure.

14 All right. Anything further from the state?

15 MR. BARNETTE: Your Honor, I forgot one other party to
16 thank. I wanted to thank DHEC for their work in the case,
17 Your Honor.

18 Just to mention, I forgot one other thing I was going
19 to mention in his motion. This -- my wife breastfed both
20 of our children too, and she was very careful what she did
21 being a nurse and everything. And I think, you know,
22 it's -- this is not an indictment on breastfeeding. It's
23 an indictment for what she did and what she caused in this
24 case. Thank you, Your Honor.

25 MR. WISE: I would just point out that -- on the

Sentence

1 record that's set before you, I think virtually everything
2 on there occurred before she and Mr. Greene got married
3 about ten years ago.

4 They've been very good support for each other, and,
5 you know, and pretty well straightened herself up pretty
6 good I think until recently with, you know, this event. So
7 I think we can consider that also.

8 But, as I say, the minimum sentence certainly is going
9 to deter like conduct and the minimum sentence is certainly
10 going to punish her if the Court can actually punish her
11 any more than she's been punished by losing her child. So
12 I think that to me would be an appropriate disposition.

13 THE COURT: All right. Mrs. Greene, do you have
14 anything you'd like to add to what your lawyer has told me?

15 THE DEFENDANT: No, sir.

16 THE COURT: I don't have the sentencing sheets.

17 MR. BARNETTE: I'm sorry. I gave it to Mr. Wise.

18 MR. WISE: And it's in my car. I forgot to bring it
19 in. I just realized that when you said it.

20 THE COURT: Well, we'll need to get them. Should be
21 three of them.

22 MR. WISE: It will take about two minutes. I can run
23 to the car. It's out front.

24 (Whereupon, a recess was taken.)

25 THE COURT: Are you going to sign them?

Sentence

1 MR. WISE: There really isn't anything for her to sign
2 on a guilty plea, is there?

3 THE COURT: It's got both of y'all.

4 MR. WISE: Right. I mean, she doesn't have -- I don't
5 think she has to sign on a guilty -- on a trial.

6 THE COURT: She doesn't have to if she declines to.
7 If she wants to decline, she can feel free to do so.

8 MR. WISE: I just never signed one on a trial.

9 (Bench conference held off the record.)

10 THE COURT: On Indictment 2011-5758, an indictment for
11 homicide by child abuse, involuntary manslaughter and
12 unlawful conduct towards a child, wherein you have been
13 found guilty by the jury for each of those offenses, as to
14 count one, homicide by child abuse, Sentence of the Court
15 is you, Stephanie Irene Greene, be confined to the South
16 Carolina Department of Corrections for a period of 20
17 years.

18 Count two of the indictment, involuntary manslaughter,
19 a sentence of five years concurrent.

20 Indictment 2011-5758, count three, unlawful conduct
21 towards a child, five years concurrent.

22 Ms. Greene, you have a right to appeal the Sentence of
23 the Court and the decision of the jury. You must file any
24 notice of your intent to appeal those decisions within ten
25 days of today's date.

Sentence

1 THE DEFENDANT: Yes, sir.

2 MR. BARNETTE: Thank you, Your Honor.

3 (Defendant's requests to charge marked Court's Exhibit
4 No. 12.)

5 END OF REQUESTED TRANSCRIPT OF RECORD

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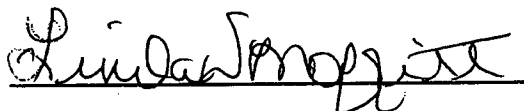
Certificate

CERTIFICATE

I, the undersigned Linda D. Moffitt, Official Court Reporter for the Seventh Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of all the proceedings had and evidence introduced in the trial of the captioned cause, relative to appeal, in the Court of General Sessions for Spartanburg County, South Carolina, on the 31st day of March 2014, 1st through the 4th days of April 2014.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

September 4, 2014



Linda D. Moffitt
Circuit Court Reporter

WITNESSES

Spartanburg County Sheriff's Office



Spartanburg County Sheriff's Office

ARREST WARRANT NUMBER

M127173 & D/I

ACTION OF GRAND JURY

Foreperson of Grand Jury
Date:

SEP 15 2011

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. **11-GS-42-5758**

The State of South Carolina

County of Spartanburg

Barry J. Barnette, Solicitor

COURT OF GENERAL SESSIONS

SEP 15 2011

TERM

THE STATE

v.

STEPHANIE IRENE GREENE

Indictment for

**Count One: Homicide By Child Abuse
Count Two: Involuntary Manslaughter
Count Three: Unlawful Conduct
Towards Child**

SC Code: 16-3-85 (A) (1); 16-3-60; 63-5-70

CDR Code: 2356; 0218; 2481

STATE OF SOUTH CAROLINA)
)
COUNTY OF SPARTANBURG)

INDICTMENT

At a Court of General Sessions, convened on SEP 15 2011 the
Grand Jurors of Spartanburg County present upon their oath:

Count One- HOMICIDE BY CHILD ABUSE

That the defendant, Stephanie Irene Greene, did in Spartanburg County, on or about November 13, 2010, cause the death of Alexis Greene, a child under the age of eleven (11), while committing child abuse or neglect, and the death occurred under circumstances manifesting an extreme indifference to human life, in violation of Section 16-3-85 (A)(1), Code of Laws of South Carolina (1976, as amended).

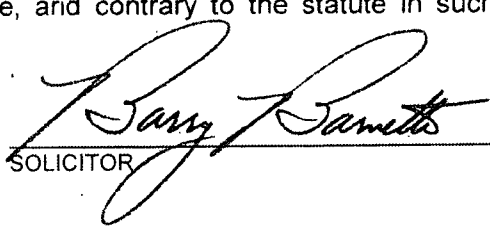
Count Two- INVOLUNTARY MANSLAUGHTER

That the defendant, Stephanie Irene Greene, did in Spartanburg County on or about November 13, 2010, did unintentionally and without malice kill the victim, Alexis Greene, by recklessly disregarding the safety of Alexis Greene, causing her death, in violation of §16-3-60 of *THE CODE OF LAWS OF SOUTH CAROLINA*, (1976), as amended.

Count Three - UNLAWFUL CONDUCT TOWARD A CHILD

That Stephanie Irene Greene, did in Spartanburg County, on or around November 13, 2010, being the parent and/or lawful guardian of Alexis Greene, a minor child, place the child at unreasonable risk of harm affecting the child's life, physical or mental health, or safety and/or willfully abandoning the child, in violation of Section 63-5-70, *THE CODE OF LAWS OF SOUTH CAROLINA*, (1976), as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


SOLICITOR

RECEIVED
JUN 22 2015
SC Court of Appeals

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of General Sessions

Honorable Joseph Derham Cole, Circuit Court Judge

Appellate Case No. 2014-000764

The State, ... Respondent,

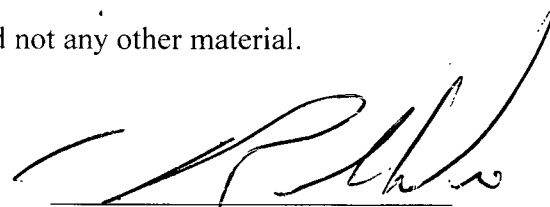
VS

Stephanie Irene Greene, ... Appellant.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

June 19th, 2015



C. RAUCH WISE
Attorney at Law
305 Main Street
Greenwood, SC 29646
(864) 229-5010
S.C. Bar No. 00188

Attorney for Appellant

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of General Sessions

Hon. Joseph Derham Cole, Circuit Court Judge

RECEIVED
JUN 22 2015
SC Court of Appeals

Case No. 2014-000764

The State,.....Respondent,

vs.

Stephanie Irene Greene.....Appellant.

AFFIDAVIT OF SERVICE

PERSONALLY appeared before me Sandy Traynham who, after being duly sworn, deposes and says that she is the receptionist for C. Rauch Wise, Attorney for the Appellant in the above entitled case. That on June 19, 2015, she did deposit in the United States Mail with proper postage affixed thereto, three copies of the Record on Appeal together with a copy of the Certificate of Counsel in the above case addressed to David Spencer, S.C. Attorney General Office, P.O. Box 11549, Columbia, SC 29211.

Sworn to and Subscribed

before me this 19 day

of June, 2015.

Nancy Jane Hunter
Notary Public for South Carolina

My Commission Expires: 6/30/22

Sandy Traynham

LAW OFFICE OF
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Attorney & Counselor at Law
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(864) 229-5010
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(864) 229-2665

RECEIVED

JUN 22 2015
June 19, 2015
SC Court of Appeals

Jenny Abbott Kitchings, Clerk
SC Court of Appeals
P.O. Box 11629
Columbia, SC 29211

Re: State vs. Stephanie Irene Greene, Appellate Case No. 2014-000764

Dear Ms. Kitchings:

I am enclosing herewith the original and fourteen copies of the Record on Appeal together with the original Affidavit of Service and Certificate of Counsel regarding the above matter. However, there will be a total of four different boxes.

With kindest regards, I am

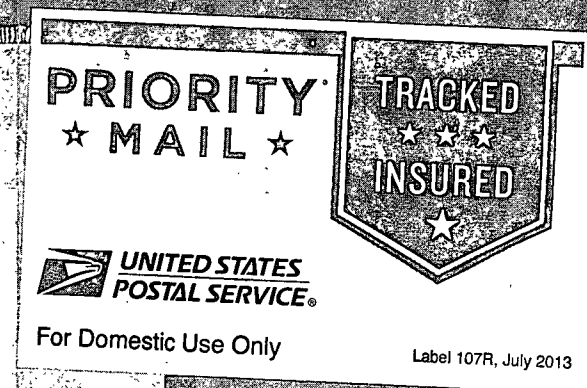
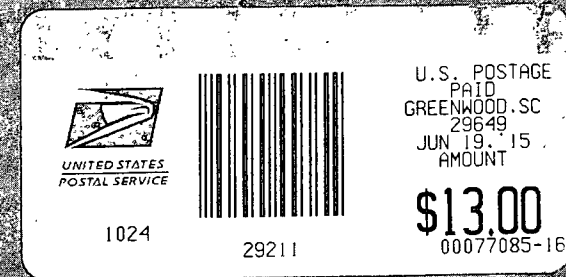
Very truly yours,

C. Rauch Wise

C. Rauch Wise

CRW/slt
Enclosure

cc David A. Spencer



Jenny Abbott-Kitchings, Clerk
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