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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM BEAUFORT COUNTY
Court of Common Pleas

Diane Schafer Goodstein, Circuit Court Judge

Case No. 2012-CP-07-03782

Rebecca Delaney, as Personal Representative of the Estate of Justin Nicholas Miller, Appellant,

v.

CasePro, Inc., Respondent.

Record on Appeal: Volume V
PAGES 2001-2445

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STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Negligence-General)

Negligence can be defined as the failure to do something which a reasonable person would do under the same or similar circumstances. Stated another way, negligence is the failure to use reasonable care.

Hart v. Doe, 261 S.C. 116, 198 S.E.2d 526 (1973); Mickle v. Blackmon, 252 S.C. 202, 166 S.E.2d 173 (1969). Lowrimore v. Fast Fare Stores, Inc., 299 S.C. 418, 385 S.E.2d 218 (Ct.App. 1989).

STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
	)	
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER,	)	**CASE NO. 12-CP-07-3782**
Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Breach of Duty)

A breach of duty exists when it is foreseeable that one's conduct may likely injure the person to whom the duty is owed.

Horne v. Beason, 285 S.C. 518, 331 S.E. 2d 342 (1985).

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PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Corporations)

A CORPORATION CAN ONLY ACT THROUGH ITS AGENTS OR EMPLOYEES. THEREFORE, A CORPORATION IS RESPONSIBLE FOR ANY NEGLIGENT ACTS OR OMISSIONS OF ITS AGENTS OR EMPLOYEES, WHILE ARE ACTING WITHIN THE SCOPE OF THEIR EMPLOYMENT, WHICH PROXIMATELY CAUSE INJURY TO ANOTHER PERSON.

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PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Respondeat Superior)

An employer is liable for the negligent acts or omissions of employees, which are within the scope of their employment and which proximately cause injury to another person.

Generally, the relationship of employer and employee is created by a contract, either express or implied, which provides that the employee will act for the employer, at the employer's request and direction, for the employer's benefit, and under the employer's control.

The most important element of the employer/employee relationship is the right of the employer to control the employee, both as to what work should be done and the way in which the work is to be done. The test is not whether control was actually exercised by the employer over the employee, but whether the employer had the right to exercise control over the employee.

The payment of wages, while usual in an employer/employee relationship, is not required.

Even if the agreement between the parties states that an employer/employee relationship was or was not intended, this is not controlling. It does not matter what the parties call themselves.

If you find that an employer/employee relationship existed, you must then determine whether

the employee was acting within the scope of employment when the negligent act or omission was committed.

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	)	
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER,	)	**CASE NO. 12-CP-07-3782**
Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Negligence-Proof)

It is not necessary that the Plaintiff prove each and every act of negligence charged against the Defendant in order to recover, it is only necessary that he prove at least one.

Parker v. Boswell, 172 S.C. 411, 174 S.E. 234 (1934).

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	)	
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Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Negligence-Comparative)

The Plaintiff in a negligence action may recover damages if his negligence, if any, is not greater than that of the Defendant's.

Nelson v. Concrete Supply Co., 303 S.C. 243, 399 S.E.2d 783 (1991).

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REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER,	)	
Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Negligence-Foreseeability)

It is not necessary that one charged with negligence should have been able to anticipate the precise injury complained of, it is sufficient that he should have reasonably foreseen that his acts or omissions would probably result in injury of some kind to some person.

Young v. Tide Craft, Inc., 270 S.C. 453, 242 S.E.2d 671 (1978), 1 ALR 4th 394.

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Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUESTED JURY INSTRUCTION NO._____
(Negligence-Proximate Cause)

Negligence is deemed to be the proximate cause of an injury when, without such negligence, the injury would not have occurred or could have been avoided.

Proximate cause is not the sole cause. In order to establish negligence, the plaintiff is required only to prove that the negligence on the part of the defendant was at least one of the proximate, concurring causes of his injury. In other words, the plaintiff's particular injuries would not have resulted, except for the acts or omissions of the defendant.

Vinson v. Hartley, 324 S.C. 389, 477 S.E.2d 715 (Ct. App. 1996); Hughes v. Children's Clinic, P.A., 269 S.C. 389, 237 S.E.2d 753 (1977); Willis v. Floyd Brace Company, 279 S.C. 458, 309 S.E.2d 295 (Ct. App. 1983).

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REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER,	)	**CASE NO. 12-CP-07-3782**
Plaintiff,	)	
vs.	)	
CASEPRO, INC.,	)	
Defendant.	)	

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Wrongful Death)

The case on behalf of the Estate of Justin Nicholas Miller is known as a wrongful death action. Such an action is provided for by sections 15-51-10 through 15-51-60 of the Code of Laws of the State of South Carolina.

A wrongful death action must be brought and initiated by the administrator of the decedent's estate; in this case, Mr. Miller's mother, Rebecca Delaney..

In this wrongful death action, the plaintiff, as the Personal Representative of the Estate of Justin Nicholas Miller is contending that the beneficiaries are entitled to damages as a consequence of the wrongful death of Justin Nicholas Miller at the hands of CasePro, Inc.

Initially, I tell you that there are certain matters that are not in dispute and you can accept as being uncontested facts. One of these is that Rebecca Delaney is admitted and duly appointed acting personal representative of the Estate of Justin Nicholas Miller.

There are three essential elements of the Plaintiff's cause of action. They are denied by the Defendant's answer. Since the Plaintiff has made these charges as the foundation of her

claimed right of damages against the Defendant, the burden of proof is upon the Plaintiff to establish all three by the preponderance or greater weight of the evidence.

First, that the Defendant, through its agents, servants, and/or employees, was negligent and/or reckless, willful, or wanton in one or more of those specifications of wrongful conduct as alleged in the complaint.

Second, that the Plaintiff's intestate, Justin Nicholas Miller, came to his untimely death as a consequence of that alleged wrongful conduct.

Third, that through its agents, servants, and/or employees, the Defendant's negligence and/or recklessness, willfulness, and/or wantonness, in one or more of the specifications of wrongful conduct as alleged in the complaint, was a proximate cause of the death of the Plaintiff's intestate.

Vinson v. Hartley, 324 S.C. 389, 477 S.E.2d 715 (Ct. App. 1996); Snow v. City of Columbia, 305 S.C. 544, 409 S.E.2d 797 (Ct. App. 1991); Self v. Goodrich, 300 S.C. 349, 387 S.E.2d 713 (Ct. App. 1989).

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REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Wrongful Death)

IN THIS WRONGFUL DEATH [AND SURVIVAL] ACTION, THE PLAINTIFF, AS PERSONAL REPRESENTATIVE OF THE DECEASED'S ESTATE, CLAIMS THAT THE DECEASED WRONGFULLY DIED AS A RESULT OF THE NEGLIGENT ACTS OR OMISSIONS OF THE DEFENDANT.

WHENEVER THE DEATH OF A PERSON IS PROXIMATELY CAUSED BY THE WRONGFUL ACT OR NEGLECT OF ANOTHER, AND THE ACT OR NEGLECT IS ONE WHICH WOULD HAVE ENTITLED THE DECEASED TO RECOVER DAMAGES IF THE DECEASED HAD NOT DIED, THE PERSONAL REPRESENTATIVE OF THE ESTATE OF THE DECEASED MAY BRING AN ACTION FOR WRONGFUL DEATH. THE PERSONAL REPRESENTATIVE HAS A RIGHT TO RECOVER COMPENSATORY DAMAGES FOR THE WRONGFUL DEATH.[1]

IT IS NOT NECESSARY TO SHOW THE MONEY VALUE OF THE DECEASED'S LIFE SINCE DIRECT PROOF OF THE VALUE OF HUMAN LIFE IS NOT POSSIBLE. WHAT IS REASONABLE COMPENSATION IS LEFT TO YOUR SOUND DISCRETION AND

[1] S.C. Code Ann. §§ 15-51-10 and -20.

JUDGMENT.

THE DAMAGES IN AN ACTION FOR WRONGFUL DEATH INCLUDE:

(1) PECUNIARY LOSS - THAT IS, THE LOSS OF THE DECEASED'S ABILITY TO EARN MONEY IN WHICH THE PLAINTIFF MIGHT LOGICALLY AND REASONABLE HAVE BEEN EXPECTED TO SHARE, SUCH AS MONEY FOR THE CARE AND PROTECTION OF THE DECEASED'S SPOUSE AND CHILDREN AND FOR THE EDUCATION AND TRAINING OF THE DECEASED'S CHILDREN.[2]

WHERE THE RELATIONSHIP OF HUSBAND AND WIFE OR PARENT AND CHILD EXISTS, PECUNIARY LOSS WILL BE PRESUMED.[3]

(2) MENTAL SHOCK AND SUFFERING.

(3) WOUNDED FEELINGS.

(4) GRIEF AND SORROW.

(5) LOSS OF COMPANIONSHIP.

(6) LOSS OF THE USE AND COMFORT OF THE DECEASED'S SOCIETY, INCLUDING THE LOSS OF THE DECEASED'S EXPERIENCE, KNOWLEDGE, AND JUDGMENT IN MANAGING THE AFFAIRS OF THE DECEASED AND HIS [HER] BENEFICIARIES.[4]

(7) MEDICAL[5] AND FUNERAL EXPENSES.[6]

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[2] Brooks v. United States, 273 F.Supp. 619 (D.S.C. 1967).

[3] Ellison v. Simmons, 238 S.C. 364, 120 S.E.2d 209 (1961); Nelson v. Charleston & W.C. Ry. Co., 231 S.C. 351, 98 S.E.2d 798 (1957); Scott v. Porter, 340 S.C. 158, 530 S.E.2d 389 (Ct. App. 2000).

[4] Smith v. Wells, 258 S.C. 316, 188 S.E.2d 470 (1972); Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000).

[5] Baker v. Sanders, 301 S.C. 170, 391 S.E.2d 229 (1990).

[6] Smith v. Wells, 258 S.C. 316, 188 S.E.2d 470 (1972); Gowan v. Thomas, 237 S.C. 223, 116 S.E.2d 761 (1960).

IT IS NOT NECESSARY TO SHOW THE EXACT AMOUNT OF DAMAGES SUFFERED BY THE BENEFICIARIES OR THAT THE BENEFICIARIES SUFFERED A MONETARY LOSS. IN ADDITION, THE PERSON FOR WHOSE BENEFIT THE ACTION IS BROUGHT DOES NOT HAVE TO BE DEPENDENT ON THE DECEASED FOR SUPPORT.[7]

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[7] Johnson v. Charleston & W.C. Ry. Co., 234 S.C. 448, 108 S.E.2d 777 (1959).

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PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Punitive Damages)

IF YOU AWARD ACTUAL DAMAGES, YOU MAY ALSO CONSIDER AN AWARD OF PUNITIVE DAMAGES. PUNITIVE DAMAGES ARE INTENDED TO PUNISH THE DEFENDANT FOR EXTRAORDINARY AND OUTRAGEOUS MISCONDUCT AND TO PREVENT THE DEFENDANT AND OTHERS FROM COMMITTING SIMILAR ACTS IN THE FUTURE. PUNITIVE DAMAGES CAN ONLY BE AWARDED WHEN CONDUCT OF THE DEFENDANT HAS BEEN SOMETHING MORE THAN MERE NEGLIGENCE. THE EVIDENCE MUST ESTABLISH THE DEFENDANT'S ACTS WERE RECKLESS, WILLFUL AND WANTON, MEANING THERE WAS A CONSCIOUS FAILURE TO EXERCISE DUE CARE OR A CONSCIOUS INDIFFERENCE TO THE RIGHTS AND SAFETY OF OTHERS OR A RECKLESS DISREGARD THEREOF.

IF YOU FIND THAT THE DEFENDANT'S CONDUCT WAS WILLFUL, WANTON, OR RECKLESS, YOU MAY AWARD THE PLAINTIFF PUNITIVE DAMAGES. TO SUPPORT AN AWARD OF PUNITIVE DAMAGES, THE PLAINTIFF MUST PROVE BY CLEAR AND CONVINCING EVIDENCE THAT THE CONDUCT COMPLAINED OF INCLUDED A CONSCIOUSNESS OF WRONGDOING AT THE TIME

OF THE CONDUCT.[8]

CLEAR AND CONVINCING IS MORE THAN JUST A PREPONDERANCE, OR GREATER WEIGHT, OF THE EVIDENCE, WHICH REQUIRES ONLY PROOF WHICH PERSUADES YOU THAT A PARTY'S CLAIM IS MORE LIKELY TRUE THAN NOT TRUE. ON THE OTHER HAND, CLEAR AND CONVINCING PROOF IS NOT AS HIGH A STANDARD AS THE BURDEN OF PROOF IN CRIMINAL CASES, WHICH IS PROOF BEYOND A REASONABLE DOUBT.[9] CLEAR AND CONVINCING PROOF LEAVES NO SUBSTANTIAL DOUBT IN YOUR MIND. IT MEANS THAT THE EVIDENCE IS NOT AMBIGUOUS, DOUBTFUL, EQUIVOCAL OR CONTRADICTORY. CONVINCING MEANS PERSUADING BY PROOF OR ARGUMENT, CAUSING ONE TO BELIEVE IN THE TRUTH OF WHAT IS ASSERTED.[10] CLEAR AND CONVINCING PROOF ESTABLISHES IN YOUR MIND, NOT ONLY THAT THE FACT IS PROBABLE, BUT THAT IT IS HIGHLY PROBABLE.[11]

BEFORE AWARDING PUNITIVE DAMAGES, YOU MUST CONSIDER AND WEIGH FOUR ELEMENTS WHICH MAY BE PERTINENT TO THE FACTS OF THIS CASE:[12]

YOU MUST FIRST CONSIDER THE RELATIONSHIP BETWEEN ANY PUNITIVE DAMAGE AWARD AND THE HARM CAUSED. ANY PENALTY IMPOSED SHOULD TAKE INTO ACCOUNT THE REPREHENSIBILITY OF THE CONDUCT, THE HARM CAUSED, THE DEFENDANT'S AWARENESS OF THE CONDUCT'S WRONGFULNESS, THE DURATION OF THE CONDUCT, AND ANY

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[8] Mattison v. Dallas Carrier Corp., 947 F.2d 95 (4th Cir. 1991); Clark v. Cantrell, 339 S.C. 369, 529 S.E.2d 528 (2000); Gamble v. Stevenson, 305 S.C. 104, 406 S.E.2d 350 (1991); S.C. Code Ann. § 15-33-135.

[9] Anonymous v. State Board of Med. Exam'rs, 329 S.C. 371, 496 S.E.2d 17 (1998).

[10] Jimenez v. Diamler Chrysler Corp., 269 F.3d 439 (4th Cir. 2001); Anonymous v. State Board of Med. Exam'rs, 323 S.C. 260, 473 S.E.2d 870 (Ct. App. 1997), overruled on other grounds, 329 S.C. 371, 469 S.E.2d 17 (1998).

[11] Peeler v. Spartan Radiocasting, Inc., 324 S.C. 261, 478 S.E.2d 282 (1996).

[12] Mattison v. Dallas Carrier Corp., 947 F.2d 95 (4th Cir. 1991); Gamble v. Stevenson, 305 S.C. 104, 406 S.E.2d 350 (1991); Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000).

CONCEALMENT. THUS, ANY PENALTY IMPOSED SHOULD BEAR A RELATIONSHIP TO THE NATURE AND EXTENT OF THE CONDUCT AND THE HARM CAUSED, INCLUDING THE COMPENSATORY DAMAGE AWARD MADE BY YOU.

SECONDLY, ANY PENALTY IMPOSED SHOULD TAKE INTO ACCOUNT, AS A MITIGATING FACTOR, ANY OTHER PENALTY THAT MAY HAVE BEEN IMPOSED OR WHICH MAY BE IMPOSED FOR THE CONDUCT INVOLVED, INCLUDING ANY CRIMINAL OR CIVIL PENALTY OR ANY OTHER PUNITIVE DAMAGES AWARD ARISING OUT OF THE SAME CONDUCT.

NEXT, YOU SHOULD CONSIDER WHETHER THE AWARD OF AND THE AMOUNT OF ANY PUNITIVE DAMAGES AWARD MAY DEPRIVE THE DEFENDANT OF ANY PROFITS DERIVED FROM THE IMPROPER CONDUCT AND WHETHER THE ILL-GOTTEN PROFITS SHOULD BE PROPERLY AWARDED TO THE PLAINTIFF.

FINALLY, ANY AWARD OF PUNITIVE DAMAGES MUST BE LIMITED TO PUNISHMENT AND, THUS, MAY NOT EFFECT ECONOMIC BANKRUPTCY. TO THIS END, THE DEFENDANT'S ABILITY TO PAY ANY PUNITIVE DAMAGE AWARD SHOULD BE CONSIDERED. HOWEVER, THE ECONOMIC BANKRUPTCY FACTOR IS NOT AN ABSOLUTE BAR TO AN AWARD OF PUNITIVE DAMAGES.

STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Punitive Damages – Plaintiff's Claim)

THE PLAINTIFF CLAIMS THAT THE DEFENDANT ACTED WITH RECKLESSNESS, WILLFULNESS, AND WANTONNESS AND THAT, THEREFORE, THE PLAINTIFF IS ENTITLED TO PUNITIVE DAMAGES FROM THE DEFENDANT. RECKLESSNESS MEANS A CONSCIOUS FAILURE TO USE REASONABLE CARE. A PERSON WHO IS NEGLIGENT ACTS CARELESSLY. HOWEVER, A PERSON WHO ACTS RECKLESSLY, WILFULLY, AND WANTONLY IS NOT ONLY CARELESS, BUT IS ALSO AWARE THAT HE [SHE] IS BEING CARELESS.[13]

[13] Parker v. Simmons, 163 S.C. 42, 161 S.E. 169 (1931).

STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Negligent Supervision)

An employer may be liable to a third person for its negligence in the training and supervision of its employees. The basis of the employer's liability for negligent supervision is direct liability. To invoke the theory of liability based on negligent supervision, it is necessary to show the employer knew or should have known its employee behaved in a dangerous or otherwise incompetent or unfit manner, and that the employer, armed with this actual or constructive knowledge, failed to adequately supervise the employee.

If an employer is in some way negligent in the hiring, supervising, retaining or assigning of an employee or agent with the knowledge that the employee or agent is in some way unfit, incompetent, or unworthy to perform the work of the employer, or if the employer fails to use the same degree of care that normally would be required to discover this unfitness, such negligent supervision or negligent hiring constitutes an independent basis for liability of the master if it is shown by the greater weight of the evidence.

See Degenhart v. Knights of Columbus, 309 S.C. 114, 420 S.E.2d 495 (1992); *Moore v. Berkeley County Sch. Dist.*, 326 S.C. 584, 486 S.E.2d 9 (Ct. App. 1997); *Brockington v. Pee Dee Mental Health Ctr.*, 315 S.C. 214, 433 S.E.2d 16 (Ct. App. 1993); 30 C.J.S. Employer-Employee §§ 186, 189 (1992); Restatement (Second) of Torts § 317 (1965).

STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Principal Liable for Acts of Agent, Servant or Employee Acting within the Scope of Employment)

A principal or a corporation is liable for the acts of its agent, servant, or employee while the agent, servant or employee is acting within the scope of his authority. This is true even where that agent, servant or employee may be acting against the instructions of the principal or corporation. If an act done by an agent is within the apparent scope of the authority with which he has been "clothed," it does not matter that it is directly contrary to the instructions of the principal.

The principal is bound by, and liable for, the acts which his agent does with or within the actual or apparent authority from the principal, and within the scope of the agent's employment, or which the principal ratifies.

The authorized acts of an agent are, by their nature, the acts of the principal. By operation of law, an agent's exercise of authority is regarded as the execution of the principal's continuing will. An agent conducting business with the authority of the principal binds the principal to the same extent as if the principal personally made the transaction.

When an agent acts against the express instructions of the principal, but within the scope of

the agent's employment, the principal is still liable, unless the person dealing with the agent knew that the agent was exceeding his authority or violating the principal's instructions.

A principal may be liable to third persons for negligence and other malfeasance and omissions of duty of the agent acting within the scope of the agency, although the principal did not authorize, participate in, or know of such misconduct, or even if he forbade the acts or disapproved of them. In every such case, the principal holds out his agent as competent and fit to be trusted, and thereby, in effect, the principal warrants the agent's fidelity and good conduct in all matters within the scope of the agency.

See Rickborn v. Liberty Life Ins. Co., 321 S.C. 291, 468 S.E.2d 292 (1996); *Cook v. Canal Ins. Co.*, 245 S.C. 238, 140 S.E.2d 166; *McPherson v. United American Ins. Co.*, 242 S.C. 28, 129 S.E.2d 842 (1963); *Carver v. Morrow*, 213 S.C. 199, 48 S.E.2d 814 (1948); *Williams v. Commercial Cas. Ins. Co.*, 159 S.C. 301, 156 S.E. 871 (1931); *South Carolina Ins. Co. v. James C. Greene and Co.*, 290 S.C. 171, 348 S.E.2d 617 (Ct. App. 1986)(in true agency situation, principal is liable vice the agent by reason of his consent to be bound; agent contracting with authority of principal binds him to same extent as if principal personally made contract; principal's liability to third party is contractual and direct); *Id.*; 3 Am. Jur. 2d Agency § 270 (1986).

STATE OF SOUTH CAROLINA **COUNTY OF BEAUFORT**	)	**THE COURT OF COMMON PLEAS** **FOURTEENTH JUDICIAL CIRCUIT**
REBECCA DELANEY, as the Personal Representative of the Estate of JUSTIN NICHOLAS MILLER, **Plaintiff,** **vs.** **CASEPRO, INC.,** **Defendant.**	)	**CASE NO. 12-CP-07-3782**

PLAINTIFF'S REQUEST TO CHARGE NO. _____
(Negligence)

A medical provider owes a duty to a foreseeable non patient within a zone of danger that is identical to the duty owed to the patient. *Hardee v. Bio-Medical Applications of S.C., Inc.*, 370 S.C. 511 (S.C. 2006).

DEFENDANT'S REQUEST TO CHARGE NO. 1

(HINDSIGHT)

In considering whether the Defendant has exercised reasonable judgment in a given case, you must consider such judgment in relationship to the facts as they existed at the time the judgment was made, and not in light of what hindsight may later reveal.

Ralph King Anderson, Jr., South Carolina Requests to Charge- Civil, § 27-12

DEFENDANT'S REQUEST TO CHARGE NO. 3

(NEGLIGENCE)

In order to prevail on a negligence claim, Plaintiff must establish three elements by the greater weight or preponderance of the evidence: (1) That the Defendant was negligent; (2) That the Plaintiff was damaged; (3) That the Plaintiff's damages were proximately caused by the Defendant's negligence. If Plaintiff fails to prove any or all of these elements, you must find in favor of the Defendant.

Richardson's Restaurants, Inc. v. National Bank of S.C., 403 S.E.2d 669 (Ct. App. 1991).

DEFENDANT'S REQUEST TO CHARGE NO. 4

(NEGLIGENCE NOT PRESUMED)

Negligence on the part of the Defendants is not presumed, but must be affirmatively proved. The burden of proof is on the Plaintiff to prove the case by the preponderance or the greater weight of the evidence. In the absence of evidence to the contrary, it will be presumed that the Defendant was not negligent.

Ellis v. U.S., 484 F.Supp. 4 (S.C. 1978);

Bessinger v. DeLoach, 230 S.C. 1, 94 S.E.2d. 3 (1956)

Gilland v. Peter's Dry Cleaning Co., 195 S.C. 417, 11 S.E.2d 857 (1941).

DEFENDANT'S REQUEST TO CHARGE NO. 5

(NEGLIGENCE – DUE CARE)

"Negligence" is the failure to use "due care," which is that degree of care which a person of ordinary prudence and reason would exercise under the same circumstances.

Hart v. Doe, 261 S.C. 116, 198 S.E.2d 526 (1973).

DEFENDANT'S REQUEST TO CHARGE NO. 6

DUTY

An essential element in a cause of action for negligence is the existence of a legal duty of care owed by the defendant to the plaintiff. Without a duty, there is no actionable negligence.

Bishop v. S. Carolina Dep't of Mental Health, 331 S.C. 79, 86, 502 S.E.2d 78, 81 (1998)

DEFENDANT'S REQUEST TO CHARGE NO. 7

DUTY

A tortfeasor's duty arises from his relationship to the injured party. It is essential to liability for negligence to attach that the parties shall have sustained a relationship recognized by law as the foundation of a duty of care. Where this relationship is too attenuated a duty will not arise.

18 S.C. Jur. Negligence § 17 (citing *Ravan v. Greenville County*, 315 S.C. 447, 434 S.E.2d 296 (Ct. App. 1993)).

DEFENDANT'S REQUEST TO CHARGE NO. 8

CAUSATION

The Plaintiff must also demonstrate by the preponderance of the evidence, the causal relationship between the alleged negligence of the Defendant and the Plaintiff's damages. If the Plaintiff fails to demonstrate this causal relationship he/she fails to prove his/her cause of action.

Kemmerlin v. Wingate, 274 S.C. 62, 261 S.E.2d 50 (1979)
Armstrong v. Weiland, 267 S.C. 12, 225 S.E.2d 851 (1976)

Defendant's Request to Charge 9

Forseeability

Forseeability of some injury from a negligent act or omission is a requisite to that act or omission being a proximate cause of the injury for which recovery is sought by the Plaintiff. The standard by which forseeability is determined is by looking to the natural and probable consequences of the complained act or omission.

The defendant may be held liable only for those things that appear to have been a natural and probable consequence of the defendant's negligence.

Actual damages include compensation for all injuries which are naturally the proximate result of the alleged wrongful conduct of the defendant.

FENNELL v. FILLER, M.D., 2006 WL 7285671 (2006).

DEFENDANT'S REQUEST TO CHARGE NO. 10

PROXIMATE CAUSE

Proximate cause requires proof of (1) causation in fact and (2) legal cause.

Causation in fact is proved by establishing the injury would not have occurred "but for" the defendant's negligence. Legal cause is proved by establishing foreseeability. Although foreseeability of some injury from an act or omission is a prerequisite to establishing proximate cause, the plaintiff need not prove that the actor should have contemplated the particular event which occurred. The defendant may be held liable for anything which appears to have been a natural and probable consequence of his negligence. A plaintiff therefore proves legal cause only if he establishes that the injury in question occurred as a natural and probable consequence of the defendant's negligence.

Bramlette v. Charter-Med.-Columbia, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990)

DEFENDANT'S REQUEST TO CHARGE NO. 11

REMOTE CAUSE

When the negligence appears merely to have brought about a condition of affairs, or a situation in which another and entirely independent and efficient agency intervenes to cause the injury, the latter is to be deemed the direct or proximate cause, and the former only the indirect or remote cause.

A prior and remote cause cannot be made the basis of an action if an independent negligent act sets into operation the circumstances which result in injury.

Stone v. Bethea, 251 S.C. 157, 162, 161 S.E.2d 171, 173-74 (1968).

Driggers v. City of Florence, 190 S.C. 309, 2 S.E.2d 790, 791 (1939).

DEFENDANT'S REQUEST TO CHARGE NO. 12

SOLE NEGLIGENCE OF THIRD PARTY

The Defendant claims that the Plaintiff's injury was not proximately caused by the Defendant's negligence, but was solely caused by the negligence of another person. The Defendant does not have the burden of proving that the negligence of the other person caused the Plaintiff's injury. Instead, the burden remains on the Plaintiff to prove that the Defendant's negligence was the proximate cause of the Plaintiff's injury.

O'Neal v. Carolina Farm Supply of Johnston, Inc., 279 S.C. 490, 494, 309 S.E.2d 776, 779 (Ct. App. 1983)

DEFENDANT'S REQUEST TO CHARGE NO. 163

EXPERT - "MOST PROBABLY TEST"

When the opinions of medical experts are relied upon to establish causal connection of negligence to injury, the proper test to be applied is that the expert must, with reasonable certainty, state that in his professional opinion, the injuries complained of most probably resulted from the alleged negligence of the defendant. It is not sufficient that the malady in question "possibly" or "could have" or "might have" resulted from the negligence.

Gambrell v. Burleson, 252 S.C. 98, 165 S.E.2d 622 (1969)

Cross v. Concrete Materials, 236 S.C. 440, 114 S.E.2d 828 (1960)

DEFENDANT'S REQUEST TO CHARGE NO. 174

OPINIONS REGARDING TREATMENT

The mere fact that the plaintiff's expert witness may use a different approach in treating a patient is not considered a deviation by the defendant physician from the recognized standard of medical care. Nor is this standard violated because an expert disagrees with the defendant physician as to what is the best or better approach in treating a patient. Medicine is an inexact science, and eminently qualified physicians may differ as to what constitutes a preferable course of treatment. Such differences as to preference do not amount to malpractice.

Todd v. United States, 570 F. Supp. 670, 677 (D.S.C. 1983) (quoting Fitzgerald v. Manning, 679 F.2d 341 (4th Cir. 1982).

DEFENDANT'S REQUEST TO CHARGE NO. 145

OPINIONS REGARDING TREATMENT

There may be more than one school of thought as to the proper treatment of a patient. In cases where there is a difference of opinion between competent medical authorities, a physician or nurse will not be liable if it the exercise of his judgment he followed a course of treatment supported by reputable, respectable, and reasonable medical experts.

Fitzgerald v. Manning, 679 F.2d 341 (4th Cir. 1982).

Furey v. Thomas Jefferson Univ. Hosp., 325 Pa.Super. 212, 472 A.2d 1083 (1984).

Chamber v. McClure, 505 F.2d 489 (6th Cir. 1974).

DEFENDANT'S REQUEST TO CHARGE NO. 186

MEDICAL PROFESSIONAL AT LIBERTY TO FOLLOW RECOGNIZED TREATMENT

The mere fact that the plaintiff's expert may use a different approach is not considered a deviation from the recognized standard of medical care. Nor is the standard violated because the expert disagrees with a defendant as to what is the best or better approach in treating a patient. Medicine is an inexact science, and generally qualified physicians and nurses may differ as to what constitutes a preferable course of treatment. Such differences to preference under our law do not amount to malpractice.

McCourt By and Through McCourt v. Abernathy, 318 S.C. 301, 457 S.E.2d 603 (1995).

DEFENDANT'S REQUEST TO CHARGE NO. 17

MEDICAL PROFESSIONAL NOT LIABLE FOR ERROR IN JUDGMENT

A physician or nurse cannot be held liable for a mere error in judgment except where the error results in a failure to comply with the recognized standard of medical care exercised by physicians or nurses in the same specialty under similar circumstances.

Where, according to standard medical practice, the course of treatment involved are matters to be subjected to the judgment of the medical professional, he or she must be allowed to exercise that judgment based on the conditions existing and facts known at the time of the judgment. The physician or nurse cannot be held liable in the light of knowledge gained through subsequent developments.

Ralph King Anderson, Jr., South Carolina Requests to Charge- Civil, § 27-12

DEFENDANTS' REQUEST TO CHARGE NO. 418

COURSE OF TREATMENT

If you find from the evidence that two or more alternate courses of professional care would be recognized in the Defendant's profession as being proper and the Defendant used his best judgment, based upon information available to them at the time, in selecting one of these proper alternatives, then there is no legal basis for liability and you should find for the Defendant.

Hook v. Rothestein, 281 S.C. 541, 316 S.E.2d 690, 701 n. 3 (Ct. App. 1984).

DEFENDANT'S REQUEST TO CHARGE NO. 12

MALPRACTICE - HINDSIGHT

In South Carolina, the questions of whether a medical professional deviated from the applicable standard of care is to be determined by what an ordinary, careful, and prudent medical professional would have done under the same or similar circumstances. In determining whether the doctor or nurse was negligent in his or her selection of a method of treatment, you should consider the medical professional's judgment in light of all of the attendant circumstances at the time he or she acted. You should not judge the medical professional by after-acquired knowledge or by the results of the treatment.

Ralph King Anderson, Jr., South Carolina Requests to Charge- Civil, § 27-12.

911 Recording Re-cut
Version
PL1
911 Calls
WHR
10-7-15
Redacted
2012-CR-07-
037
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10-7-15
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EXHIBIT
WHR
PL 3-A
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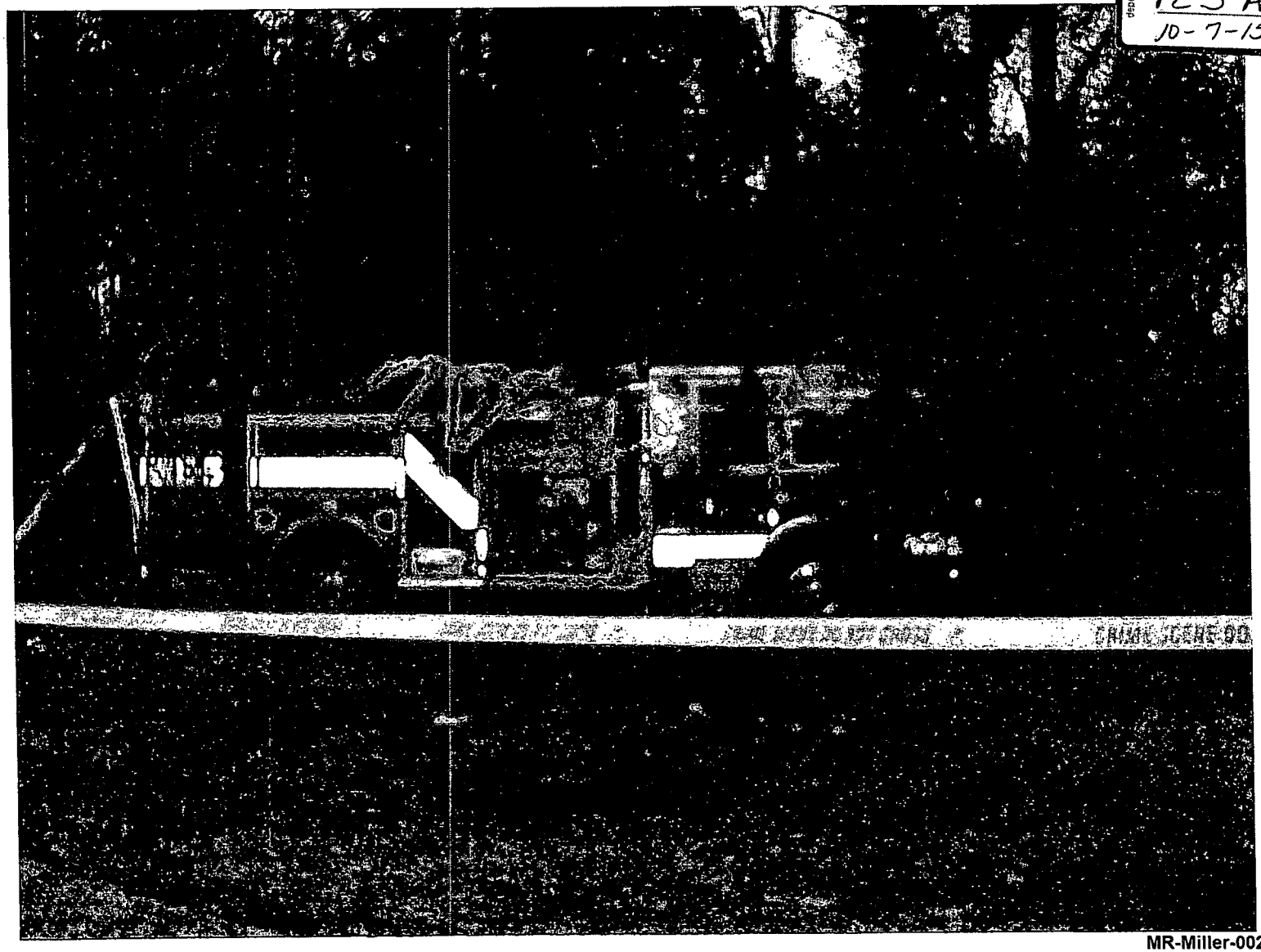
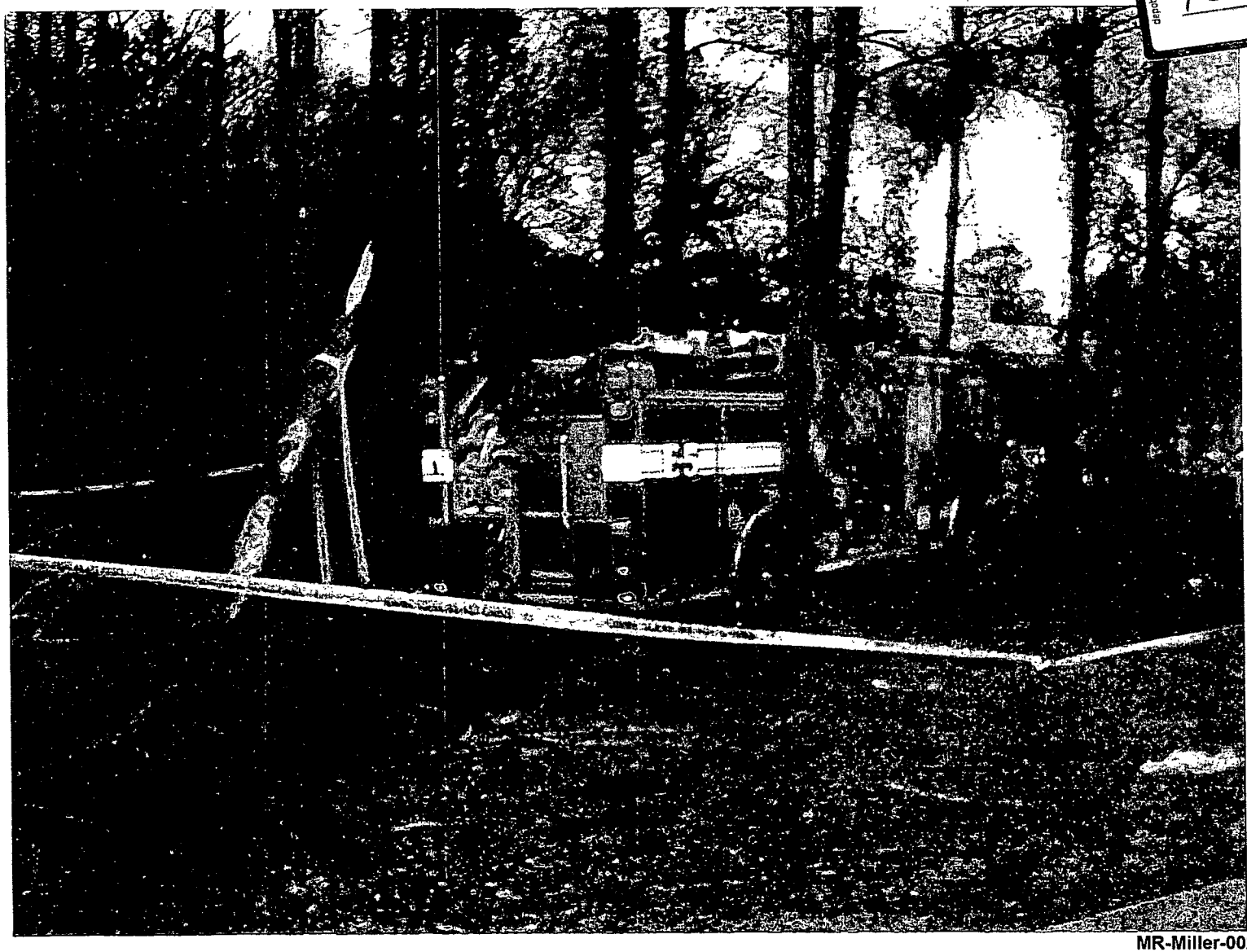


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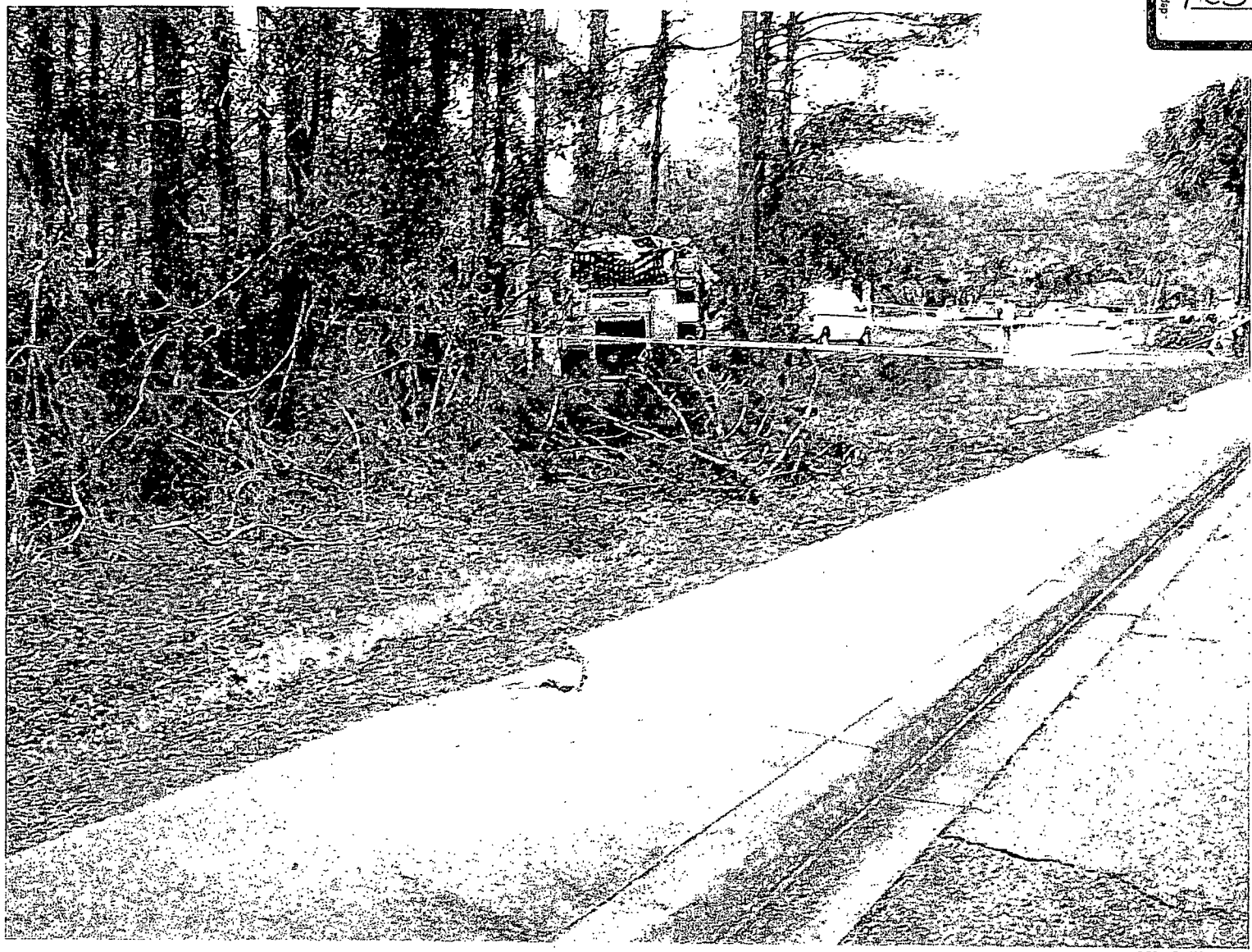


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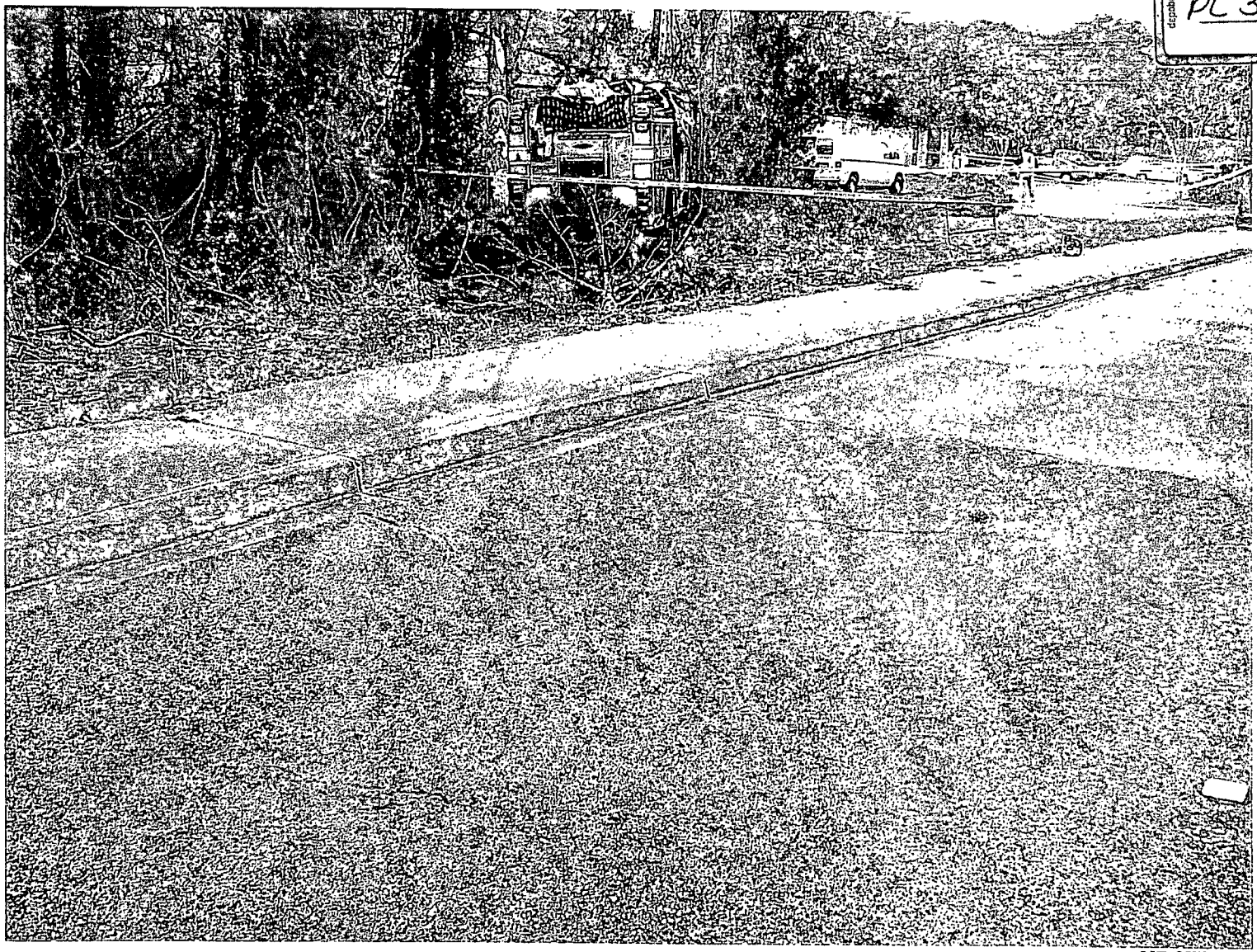


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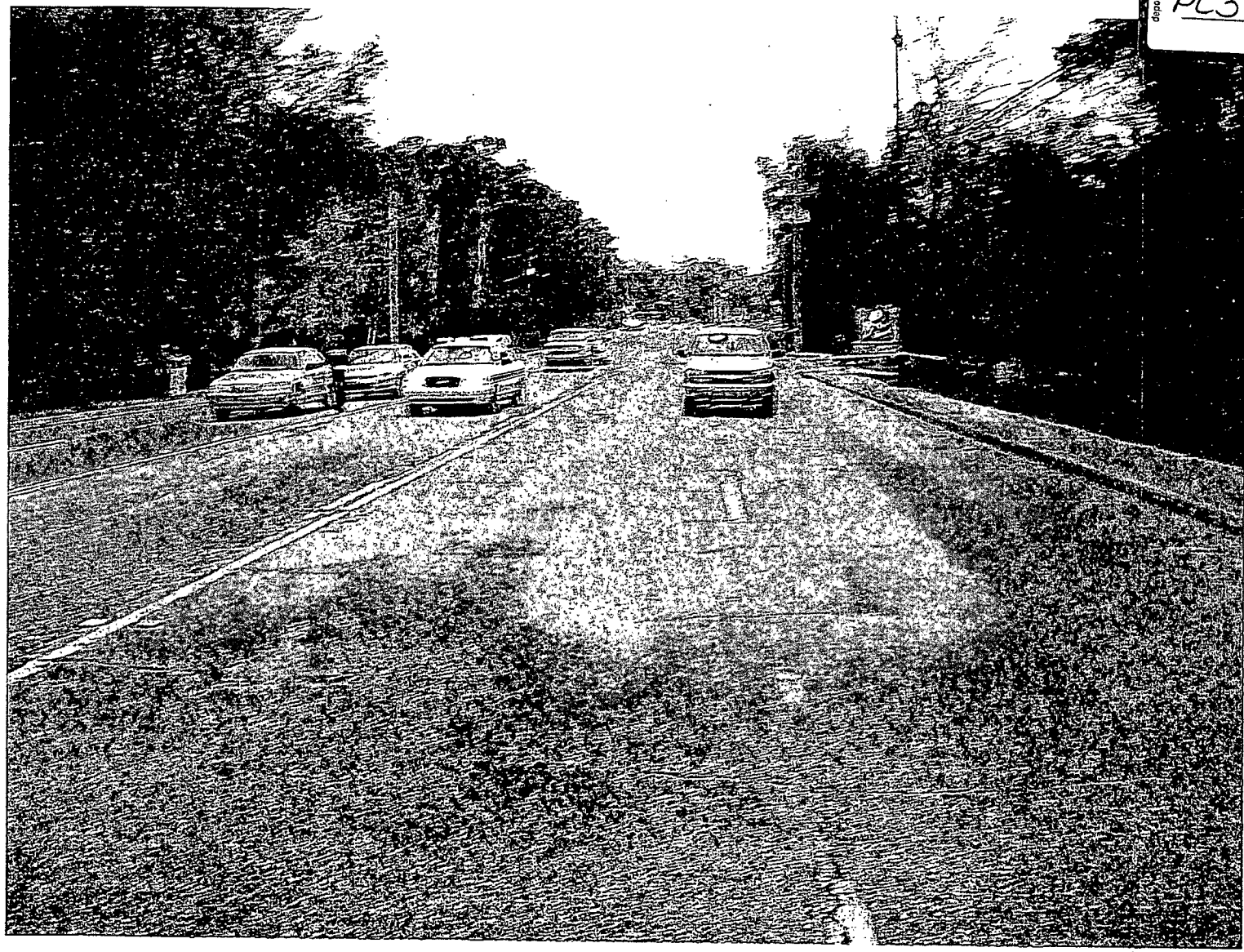


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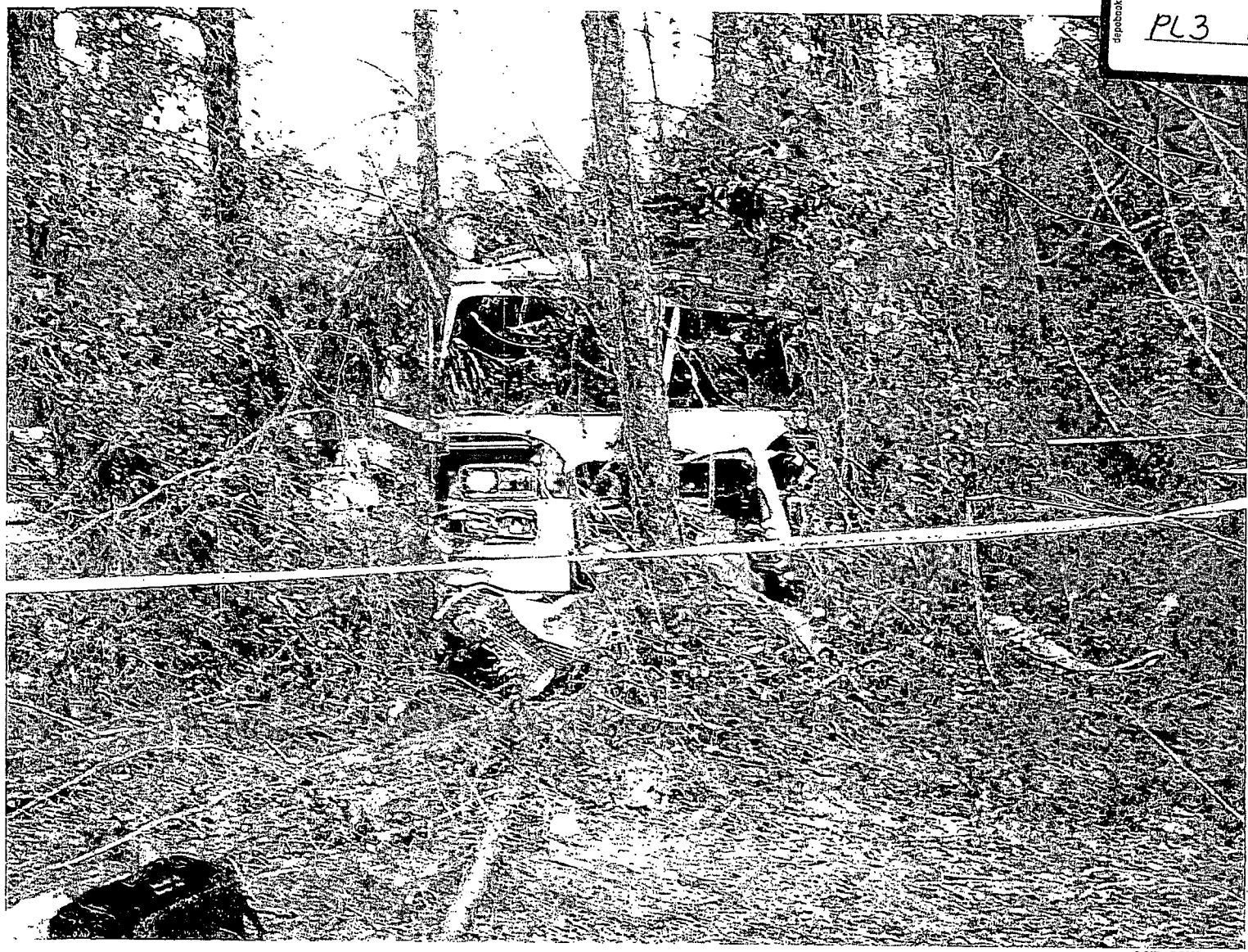


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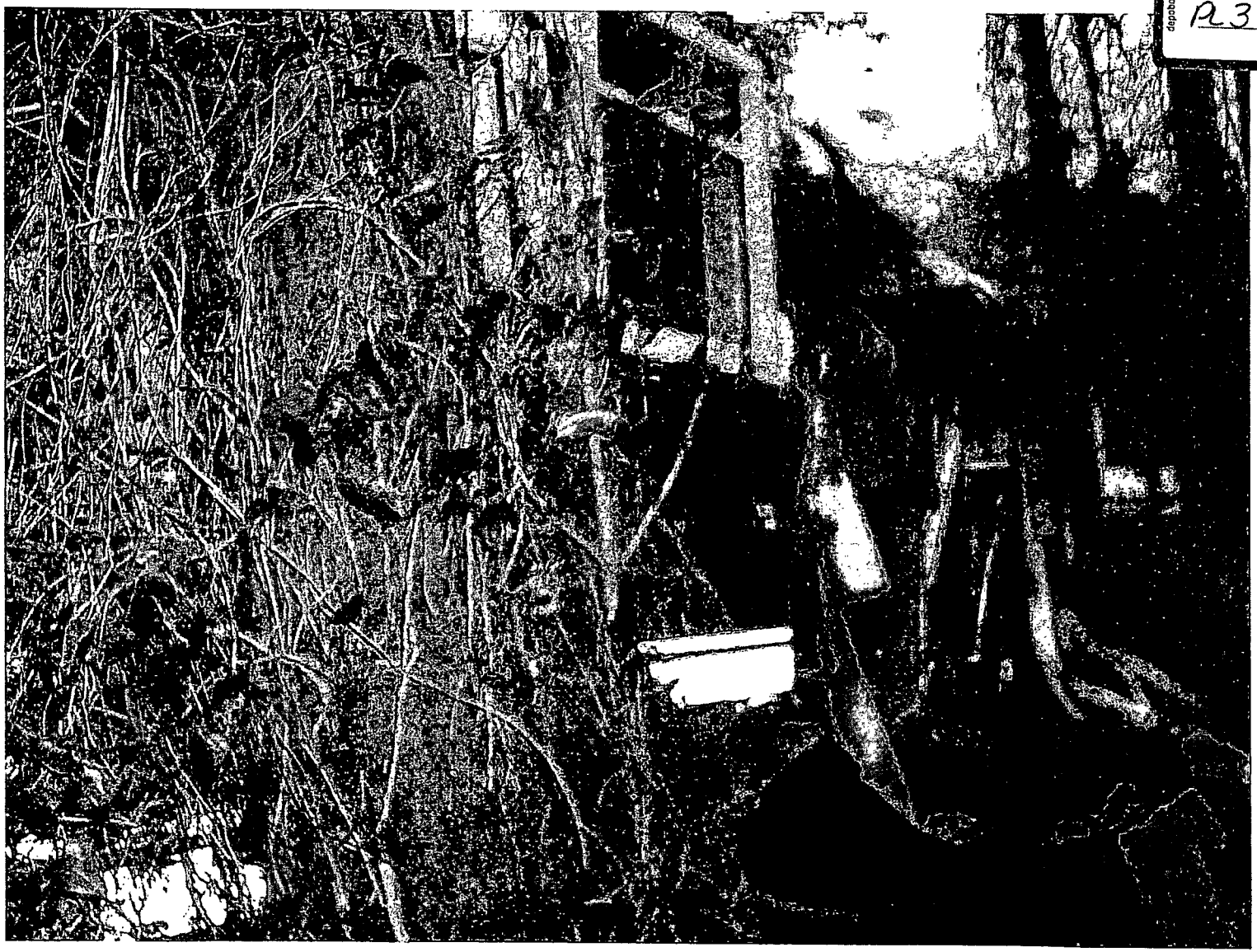


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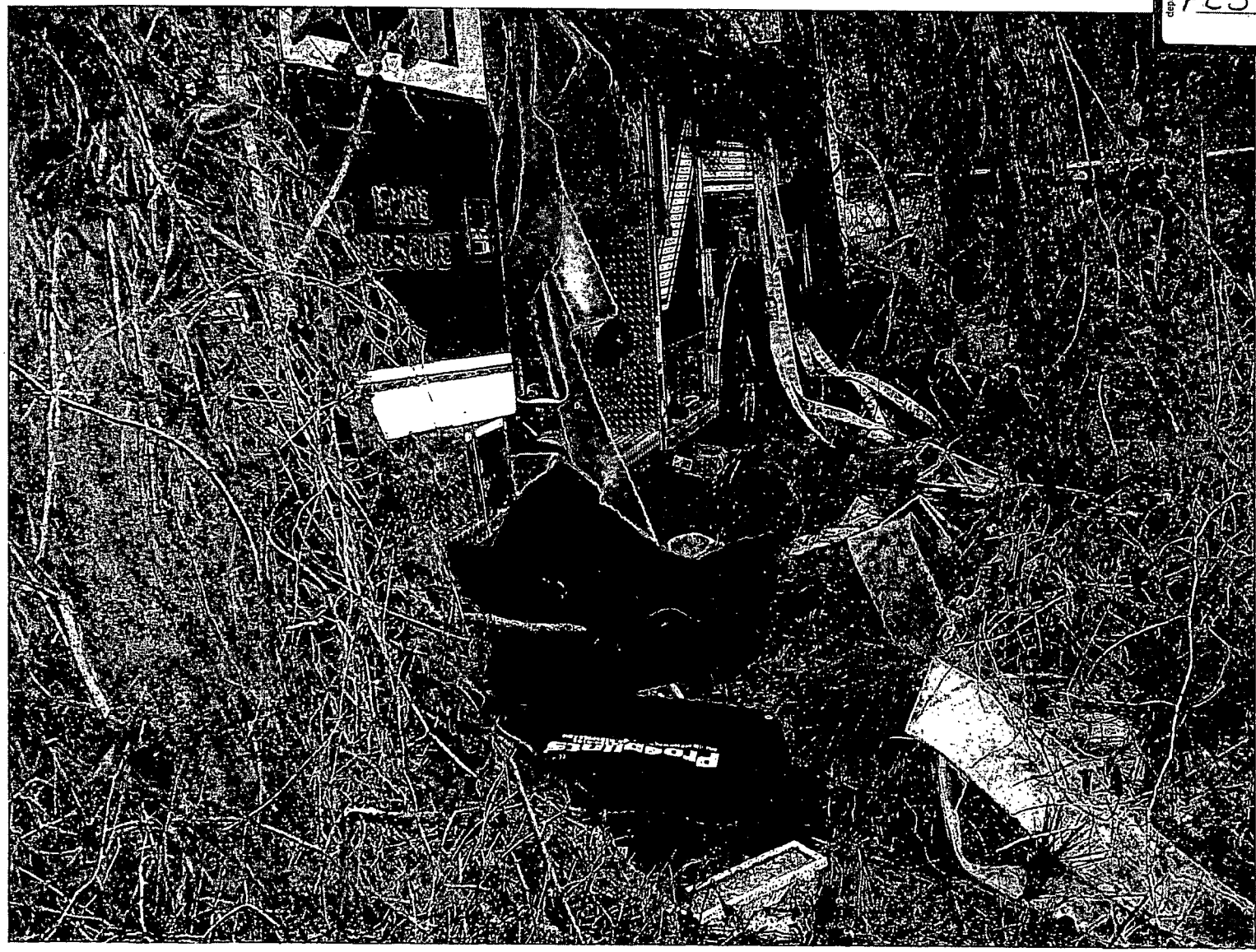


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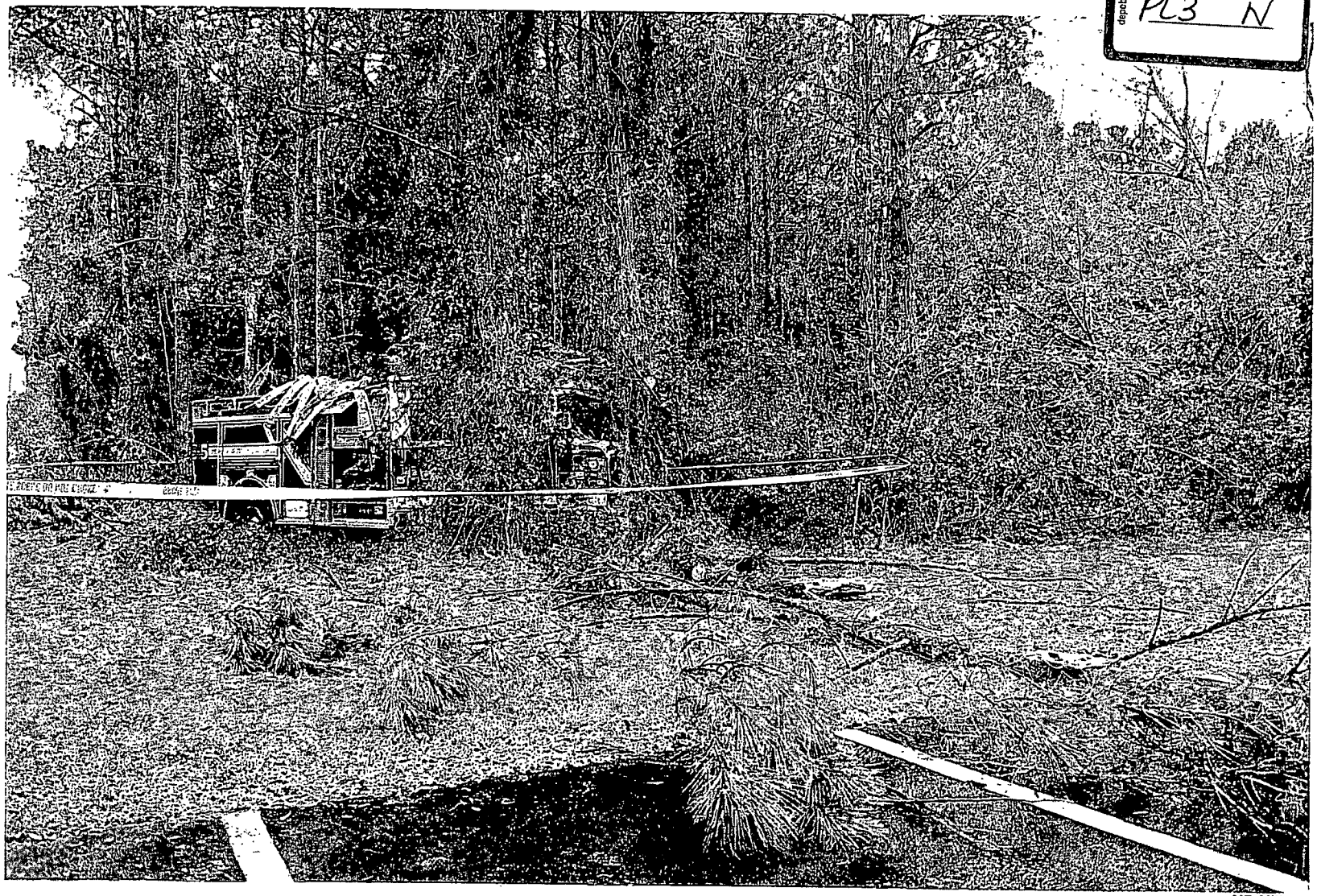


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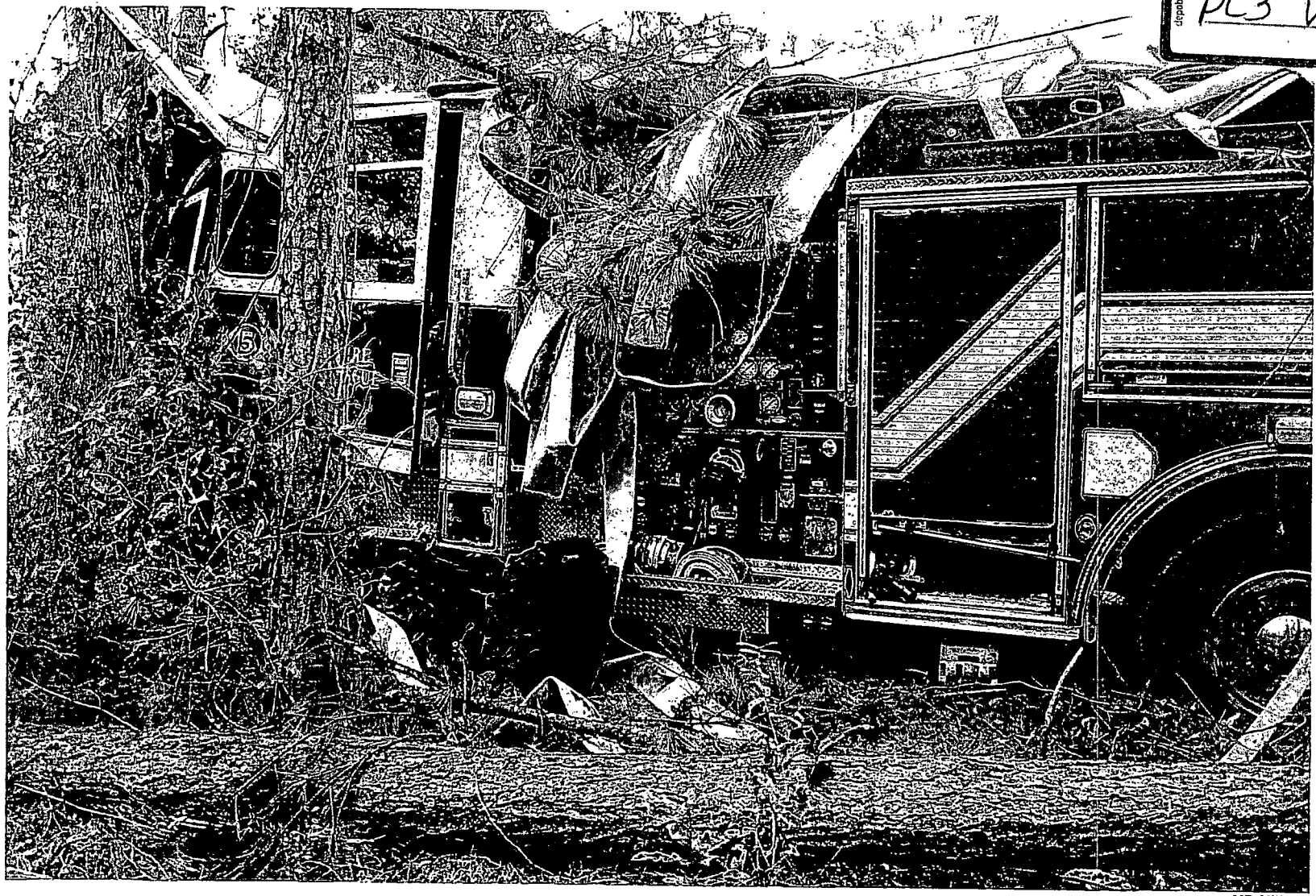


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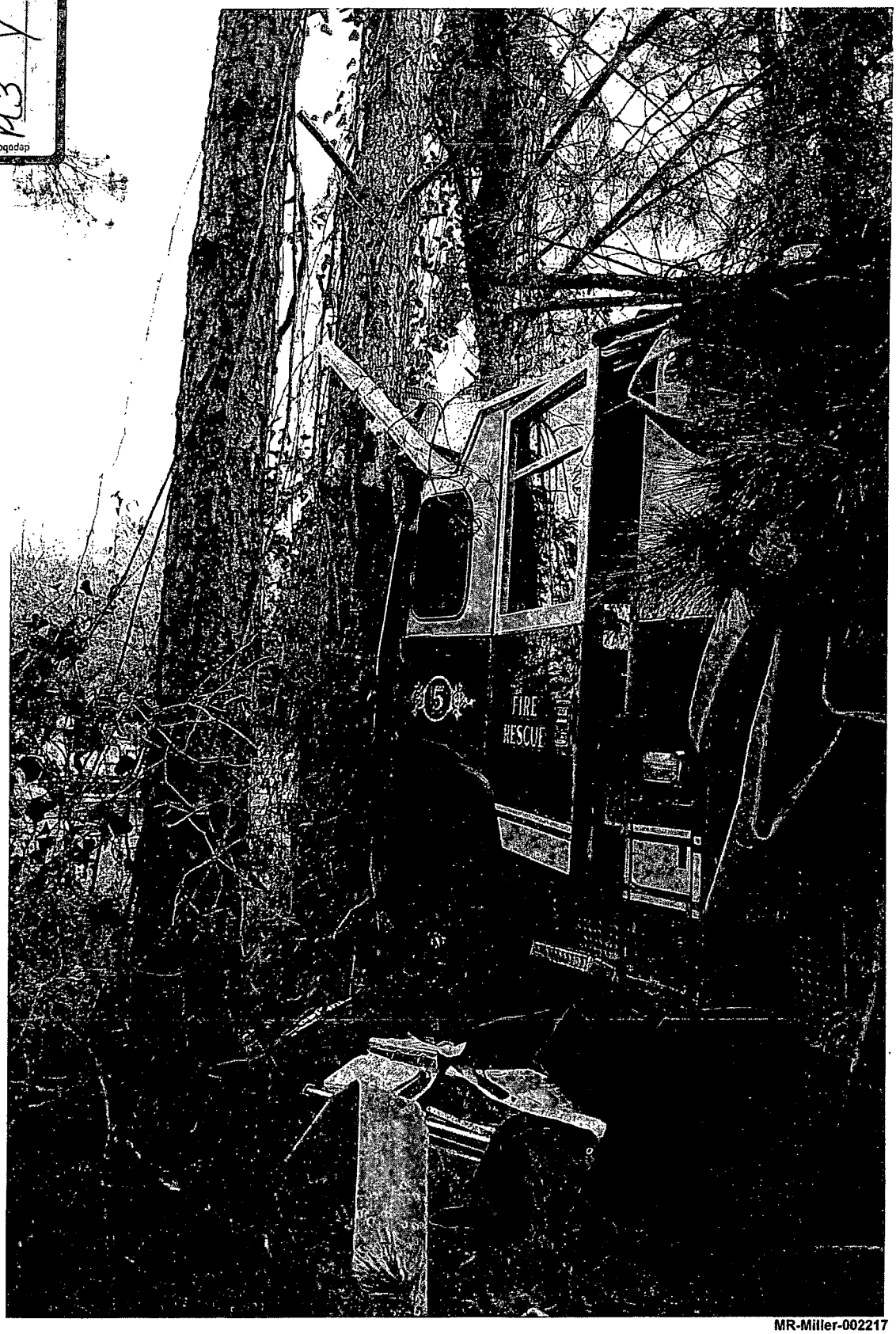


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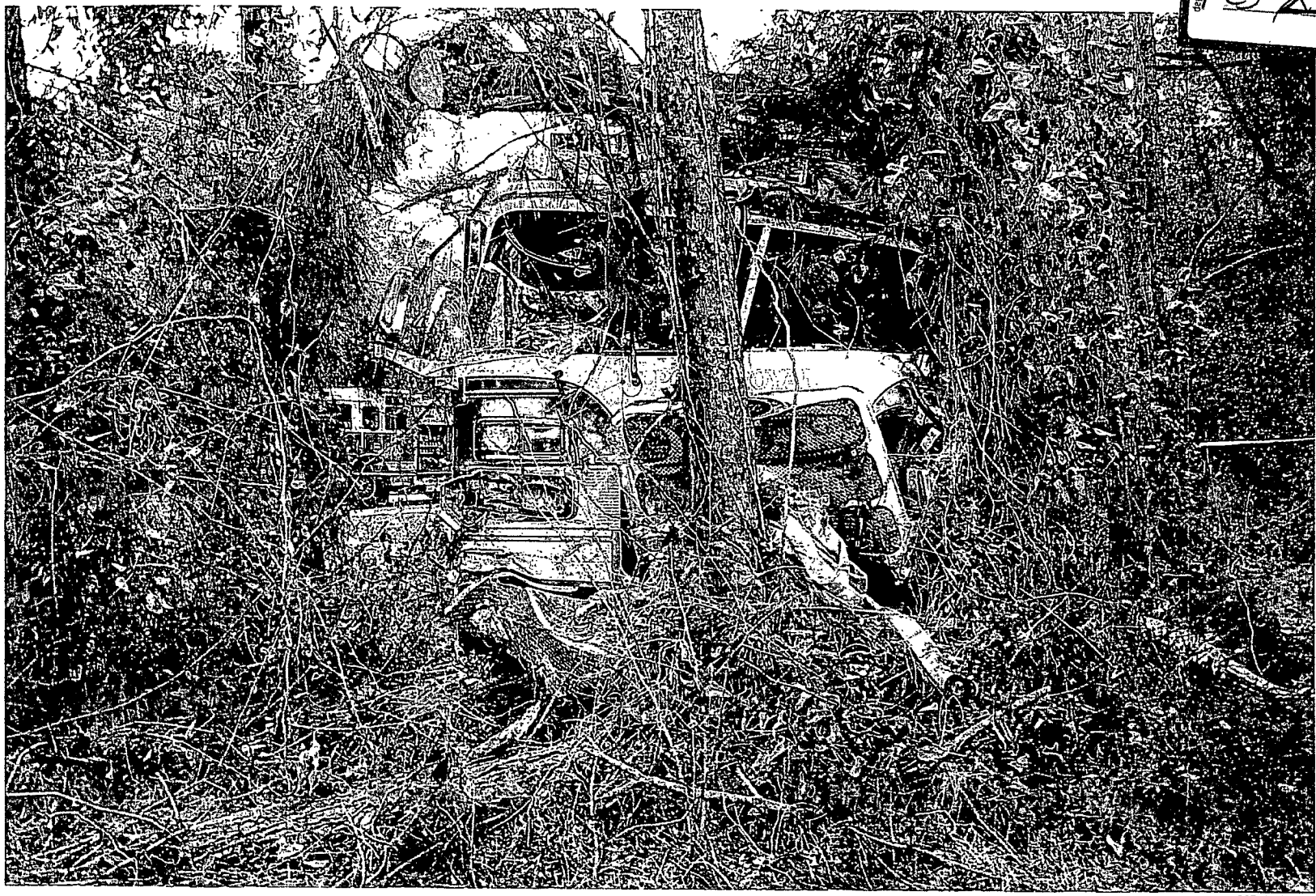
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EXHIBIT
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HEALTH RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: HUNT, KALVIN DONTAY
Treatment Facility: NH Beaufort
Patient Status: Outpatient

Date: 24 Feb 2012 1430 EST
Clinic: BNH PCMH TEAM 2

Appt Type: T-CON
Provider: SMITH,SAUNDRA L
Call Back Phone: (858)-360-0763

AutoCites Refreshed by SMITH,SAUNDRA L @ 24 Feb 2012 1435 EST

Problems
Chronic:
- Pain in the left shoulder joint(s)
- Conditions influencing health status
- Conditions influencing health status
- Cannabis dependence
- Visit for: military services physical for separation
- Hypermetropia
- Regular astigmatism
- Visit for: military services physical
- Adjustment disorder with disturbance of emotions and conduct
- Anxiety
- Prepatellar bursitis
- Patellofemoral dysfunction
- Hemorrhoids
- Bad breath
- Costochondritis (Tietze's syndrome)
- Malingering
- Headache syndromes
- Adjustment insomnia
- Adjustment disorder with anxious mood
- Ataxia
- Visit for: general multisystem exam
- Visit for: examination
- Anxiety disorder NOS
- Alcoholism
- Insomnia
- Sebaceous cyst
- Male erectile disorder
- Delusional disorder
- Personality disorder
- No psychiatric diagnosis or condition on axis I
- Tinea pedis
- Nicotine dependence
- Cannabis abuse
- Adjustment disorder
- Primary snoring
- Visit for: laboratory
- Backache
- Noninfectious gastroenteritis
- Administrative evaluation services
- Psychiatric diagnosis or condition deferred on axis I
- Patient education about a proper diet
- External hemorrhoids
- Depression
- Patient education about medication
- Major depression, single episode
- Knee sprain
- Visit for: screening for pulmonary tuberculosis
- Knee joint pain
- Other physical therapy
- Alcohol abuse

Family History
- Family medical history (General FHx)
- Not family history of legally blind (USA definition) (General FHx)
- Diabetes mellitus (Father)
- Family history [use for free text] (General FHx)
- Family history of mental illness (not retardation) (General FHx)
- Family medical history
- Family history unchanged
- Family history reviewed

Allergies
- No Known Allergies

Trial
EXHIBIT
with PZ 19
10-8-15

PLAINTIFF'S EXHIBIT
7
Smith

Name/SSN: HUNT, KALVIN DONTAY/

	Sex	Sponsor/SSN	HUNT, KALVIN DONTAY
FMP/SSN:	Tel H:	Rank:	PRIVATE
DOB 1986	Tel W:	Unit:	32120 (3D RECRUIT TRN BN)
PCat: MI3 USMC AD RECRUIT	CS	Outpt Rec Run:	RECRUIT HEALTH RECORDS
MC Status:	Status:	PCM:	
Insurance: No		Tel. PCM:	

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STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

- Patellar tendonitis
- Tonsillar hypertrophy
- Acute upper respiratory infection
- Visit for: occupational health/fitness exam
- Acute pharyngitis
- Dermatophytosis
- Swollen glands in the neck

Procedures
- Dr. Supervised Injection (22 Mar 2011)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
MELOXICAM, 15 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY WITH FOOD AS NEEDED FOR PAIN	NR	01 Dec 2011
Mineral Oil + Petrolatum, Hydrophilic, (Aquaphor), Ointment, Topical	Active	AS DIRECTED	2 of 3	01 Dec 2011
VARDENAFIL HCL, 20 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH 30 MINUTES PRIOR TO SEXUAL ACTIVITY OR AS DIRECTED	1 of 3	01 Dec 2011
AZITHROMYCIN (AZITHROMYCIN), 500 MG, TABLET, ORAL, TEVA USA, 30 ea. BOTTLE	Active		NR	10 Mar 2009

Registry Items

Reason for Telephone Consult:Written by SMITH,SAUNDRA L @ 24 Feb 2012 1430 EST
Active duty member elsewhere assigned- requesting medication refill

Questionnaire AutoCites Refreshed by SMITH,SAUNDRA L @ 24 Feb 2012 1435 EST
Questionnaires

SO Note Written by SMITH,SAUNDRA L @ 24 Feb 2012 1554 EST
Subjective
26 y/o male active duty member assigned to base in San Diego presented to front desk of clinic with request for refill of medication. Clerk informing this nurse of request with complaint that patient is not registered in our health care system. Patient traveling with paperwork for military separation and medical eligibility for care.Escorted to clinic by local VA staffer. Patient previous encounter reviewed with last visit in Dec 2011. No current medications on profile. Member called back for further discussion of request. States he does not remember how long he has been in Beaufort. Was previously on medication for sleep and anxiety, but admitted no meds since June 2011. Informed patient he could be scheduled for an appointment and he agreed. While appointment was being scheduled for Monday, 27Feb2012, patient began to moan and rock back and forth. I informed him that he could be seen in the ER if needed, but he declined. As the behavior continued I asked the patient if he felt like hurting himself and he said YES! Patient escorted to ER and turned over to ER nurse following a brief report. Will leave pending appointment in schedule for possible f/u care with a PCM in this area if needed.

A/P Last Updated by SMITH,SAUNDRA L @ 24 Feb 2012 1554 EST
1. Suicidal Ideation

Disposition Written by SMITH,SAUNDRA L @ 24 Feb 2012 1556 EST
Referred for Appointment

Signed By SMITH, SAUNDRA L (Registered Clinical Nurse, NH Beaufort) @ 24 Feb 2012 1556

Personal Data - Privacy Act of 1974 (PL 93-579) Automated Version SF558

EMERGENCY CARE & TREATMENT - BEAUFORT NAVAL HOSPITAL | LOG NUMBER: 120224-00016

Arrival Date/Time: 24 Feb 2012@1417
Trans to Hospital: PRIVATELY OWNED VEHICLE
History Obtained From: PATIENT

3rd Party Payer: NO
Time Seen:
Category: (3) 450

Addr: PARRIS ISLAND, SC
Chief Complaint: WANTS TO CAUSE HARM TO SELF

Phone: PLT
Sex: MALE Age: 26

VITAL SIGNS

Time			1417
BP-SY			
BP-DI			
Pulse			
Resp			
Temp			
WT-Ped			

Orders	Units		Time
			1450

Medications

Tetanus:
Allergies:
NKDA

ASSESSMENT/DIAGNOSIS

depression

====== DISPOSITION =====

__Home __Full Duty
__Quarters
__24hrs __48hrs __72hrs

Modified Duty Until:
Day:____ Mon:____ Yr:____

Referred to:

__Emergency __Today
__72 hours __Routine

Admitted to:

Others:

Condition Upon Release:
__Improved __Unchanged
__Deteriorated

Release Time: 1635

HUNT, KALVIN

1986

Signature of Provider/Stamp:

Instructions to Patient:

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS Janson

HUNT,KALVIN DONTAY M13
1986 MALE W:INDIA CO H:3072 PLT
Loc: BNH EMERGENCY
Spon: HUNT,KALVIN DONTAY Rank: PVT D:INDIA CO
F558 Unit: 3D RECRUIT TRN BN RR: RECRUIT HEALTH RECORDS

EXHIBIT with PL 20 10-8-15

N/A

Page 1

EMERGENCY DEPT
TRIAGE RECORD

Date: 2/24/12
Arrival Time: 1417

Informant: ☑ Pt ☐ Parent
☐ R .ly/SO ☐ Other:____
Primary Care Provider:_____
ESI TRIAGE CATEGORY:
1 2 (3) 4 5

Patient I [illegible]IT,KALVIN DONTAY
FMP/ID (,311 DOB 1986
Birthdat MALE Age: 26
Contact Name/#

ASSESMENT PERFORMED BY RN: Alice McAdoo RN @ 1417

Barriers to communication: ☑ No ☐ Yes Action Taken:

Arrival Via: ☐ POV ☑ Ambulatory ☐ Wheelchair ☐ Ambulance/BVOC ☐ Helicopter ☐ Other_____

PreHospital Care: ☑ None ☐ O2 ☐ Spinal Immobilization ☐ Dressing ☐ IV___gauge NS/LR Lock ☐ Meds ☐ BGL ☐ See EMS Report

CHIEF COMPLAINT: Triage RN:

Nursing Assessment: Suicidal ideation

H/o Alcohol + drug dependence + depression + PTSD

Allergies: ☐ NKDA ☐ Latex

Fall Risk: ☐ No ☐ Yes Interventions: Evaluated in last 72hrs ☐ No ☐ Yes

Immunizations UTD: ☐ Yes ☐ No ☐ UNK Pneumonia vaccine received: ☐ Yes ☐ No ☐ UNK

Influenza vaccine received: ☐ Yes ☐ No ☐ UNK Immunizations UTD: ☐ Yes ☐ No

VITAL SIGNS

Temp	HR	RR	BP	O2Sat	Wt/Kg
99.5 PO PR	103	18	120/64	100	

LMP:
Gravida___ Para___ Ab___
Pregnant ☐ Yes ☐ No ☐ UNK

Visual Acuity: OD:20/___ OS:20/___ OU:20/___
☐ Corrected ☐ Uncorrected

Infants: FLACC Score:

Pain is rated____/10 ☐ Constant ☐ Intermittent
☐ Sharp ☐ Aching
☐ Dull ☐ Pressure ☐ Burning ☐ Throbbing
Onset of Pain:_____
Location:_____
Radiates to:

Circle appropriate category
0 2 4 6 8 10

☐ See attached
Citalopram
Nicotine
Bordezafil
Quetiapine

Past medical history: ☐ None ☐ Unknown ☐ Asthma ☐ COPD ☐ CHF ☑ DM ☑ HTN ☐ CVA ☐ MI ☐ Seizures ☐ Cancer ☐ GI/GU
☐ Back Injury ☐ Migraines ☐ Other: depression
☐ Cigarettes 1 packs per day X 7 years Smokeless tobacco ☐ Yes ☐ No ETOH: 2 day

Surgical History: ☐ None ☐ Other: Cyst removed

Airway: ☑ Patent ☐ Obstructed ☐ Stridor

Breathing: ☑ Effort ☐ Unlabored ☐ Labored Pattern/Rate: ☐ Tachypneic ☐ Shallow ☐ Irregular ☐ Retractions
Breath Sounds: R ☐ Clear ☐ Diminished ☐ Rales ☐ Rhonchi ☐ Wheezes ☐ Absent
L ☐ Clear ☐ Diminished ☐ Rales ☐ Rhonchi ☐ Wheezes ☐ Absent

Circulation: Pulses ☑ Present ☐ Regular ☐ Irregular ☐ Absent Pattern: ☐ Bounding ☐ Weak ☐ Thready Cap Refill ☐ <3sec ☐ >3sec
Skin Color: ☑ WNL for race ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundice ☐ Ashen Temperature: ☐ Hot ☐ Warm ☐ Cool
Moisture: ☐ Diaphoretic ☐ Dry ☐ Clammy
Bleeding: ☐ No ☐ Yes Site:_____

Disability: ☑ Alert ☐ Verbal ☐ Pain ☐ Unresponsive Oriented: ☑ Person ☑ Place ☑ Time ☐ Event

Mechanism of Injury: ☐ N/A ☐ Training ☐ Assault ☐ Animal Bite ☐ Laceration ☐ Other_____ Site of injury:_____
☐ MVC ☐ MCC ☐ MV vs_____ Position in vehicle ☐ Driver ☐ Passenger ☐ Rear Restrained ☐ Lap/shoulder belt ☐ Ejected___ft
Type of collision: ☐ Head on ☐ Side Impact (Driver/passenger) ☐ Rear ☐ Other ☐ Car seat/Booster seat

Triage Interventions: ☐ None ☐ Tylenol___mgPO@___ ☐ Motrin___mgPO@___ ☐ PCM appt with_____@_____
☐ Ice ☐ Dressing ☐ EKG ☐ Splint ☐ C-Collar/spinal immobilization ☐ UA ☐ UHCG ☐ Accucheck___mg/dl@___
☐ Sent to lab@___ ☐ Xray_____ ☐ Other ☐ Escort_____ ☐ Security ☐ Provider notified @___

Reassesment time:_____ By RN_____ Note:_____

HR:_____ Respirations:_____ B/P:_____ SPO2_____ Temp PO/PR_____ Pain: /10

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PL - Exh 20
Page 2

EMERGENCY DEPARTMENT NURSING RECORD

Time in room: 1430 RM# 4
Provider @ bedside: 1430
Provider Name: Sawyer

ESI Triage Category: 1 | 2 | 3 | 4 | 5

HUNT,KALVIN DONTAY
...20/4311 DOB: 1986
ALE Age: 26

NURSING ASSESSMENT PERFORMED BY: (Name & Signature) Janice McDonald RN

NEUROLOGICAL/PSYCHOSOCIAL

Mental Status:
- ☑ Alert/Awake
- ☐ Agitated
- ☐ Combative
- ☐ Stuporous
- ☐ Unconscious
- ☐ Uncooperative
- ☐ ETOH odor

Orientation
- ☑ Person
- ☑ Place
- ☑ Time
- ☐ Event

Speech
- ☑ Clear
- ☐ Coherent
- ☐ Slurred
- ☐ Silent

Paresthesia
- ☐ LUE ☐ RUE
- ☐ LLE ☐ RLE

Other
- ☐ A&Ox___
- ☐ Dizziness
- ☐ H/A___/10
- ☐ Photophobia
- ☐ PERRLA
- ☐ Facial Droop

Strength
- ☐ Equal Bilaterally

L	R	
☐	☐	Weak
☐	☐	Average
☐	☐	Strong

RESPIRATORY/CARDIAC

Quality:
- ☐ Tacypneic
- ☐ Dyspneic
- ☐ Retractions
- ☐ Grunting
- ☐ Cough Prod/unprod
- ☐ Sputum:_____

Effort
- ☑ Unlabored
- ☐ Labored
- ☐ Shallow

Breath Sounds

L	R	
☐	☐	Clear
☐	☐	Crackles
☐	☐	Wheezing
☐	☐	Rhonchi
☐	☐	Diminished
☐	☐	Absent

CARDIOVASCULAR

Chest Discomfort @ this time?
- ☐ No ☐ Yes __/10
- ☐ Location_____
- ☐ Radiating to_____
- ☐ Provoked by_____
- ☐ Unprovoked
- ☐ Previous MI/Angina
- ☐ Edema_____
- ☐ Pacemaker/Defibrillator

Pulses:

Central
- ☐ Present ☐ Strong
- ☐ Absent ☐ Weak

Peripheral
- ☐ Present ☐ Strong
- ☐ Absent ☐ Weak

GASTROINTESTINAL

Abdomen
- ☐ Soft
- ☐ Distended ☐ Guarded

Bowel Sounds
- ☐ Normoactive ☐ Hyperactive
- ☐ Hypoactive ☐ Absent

Tenderness
- ☐ RUQ ☐ LUQ ☐ Suprapubic
- ☐ RLQ ☐ LLQ
- ☐ Epigastric ☐ Diffuse ☐ Rebound
- ☐ Hematemesis ☐ Blood in stool
- ☐ Last BM:_____
- ☐ Last PO Intake:_____
- ☐ Vomiting x___ in___ hrs
- ☐ Diarrhea x_____ in___ hrs

EYES/EARS/NOSE/THROAT

L	R	Visual Acuity
☐	☐	Dilated
☐	☐	Pinpoint
☐	☐	Redness
☐	☐	Itching
☐	☐	Pain
☐	☐	Drainage

OD:20/___
OS:20/___
OU:20/___
- ☐ Corrected
- ☐ Uncorrected

- ☐ Ear Pain ☐ L ☐ R
- ☐ Tonsillar Swelling
  - ☐ L ☐ Exudate
  - ☐ R ☐ Exudate

FACE:
- ☐ Atraumatic
- ☐ Epistaxis

SKIN

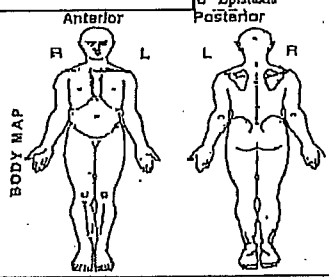
Color
- ☑ Normal for race
- ☐ Pale ☐ Mottled
- ☐ Cyanotic ☐ Flushed
- ☐ Warm ☐ Jaundiced
- ☐ Cool ☐ Erythema
- ☐ Diaphoretic ☐ Hot

- ☐ See body map ☐ Dry

GENITOURINARY

- ☐ Dysuria
- ☐ Frequency ☐ Urgency
- ☐ Hematuria ☐ Incontinence
- ☐ Flank Pain L R
- ☐ Last void____
- ☐ Vaginal/Penile discharge
  Type:_____ Amt____
- ☐ Pads/Tampons___ Q___ Hrs
- ☐ Pregnant: ☐ Denies Yes___ wks
- ☐ FHT's____

A	Abrasions
AB	Abscess
B	Burn
D	Deformity
ED	Edema
GSW	Gunshot
H	Hematoma
L	Laceration
P	Puncture
PN	Pain
R	Rash
SW	Swelling



MUSCULOSKELETAL

Pain:
- ☐ No ☐ Yes __/10

Quality:_____
Radiation:_____
Extremity Pulse:_____
ROM: ☐ Full ☐ Limited
Gait: ☐ Steady ☐ Unsteady
- ☐ Unable to ambulate

Distal Sensation: ☐ WNL ☐ Abn

PSYCHOSOCIAL

- ☐ Escort:_____
- ☐ Security Standby
- ☐ Contract for safety

Eye contact: ☐ Yes ☐ No
Affect: ☐ Broad ☑ Flat ☐ Blunted
Mood: ☑ Depressed ☐ Hyper ☐ Labile
Behavior: ☐ Cooperative
☐ Uncooperative ☐ Agitated
☐ Restless ☑ Withdrawn
Hallucinations:
- ☐ Auditory ☐ Visual

Ideations:
- ☑ Suicidal ☐ Homicidal
- ☐ Previous attempt ☐ Has plan

Support System:
- ☐ Family ☐ Friends ☐ Sig other
- ☐ Lives alone ☐ In training

Diagnostic/Medication/Procedures/Treatments/Follow-up

	☐	O2___L Via___
	☐	Tele Monitoring
	☐	NG Tube___French Foley___Fr
	☐	Straight Catheter french___
	☐	Consultant arrived @_____
	☐	X-Ray: Departed_____ Returned_____
	☐	CT: Departed_____ Returned_____
	☐	U/S: Departed_____ Returned_____
	☐	Labs ☐ ABG
	☐	U/A UHCG
	☐	EKG ☐ MD Notified
	☐	Accu Check(#1)____ (#2)____
	☐	Other_____

PEDIATRIC

Fontanels:
- ☐ Soft ☐ Flat
- ☐ Bulging ☐ Closed

Mucous Membranes:
- ☐ Moist ☐ Dry
- ☐ Tears ☐ No Tears
- ☐ Last wet diaper_____

Fall Risk Evaluation/Safety

- ☐ No Risk ☐ High Risk ☐ Yellow fall risk bracelet applied
- ☐ Side Rails up X1 ☑ Call bell within reach
- ☐ Bed in lowest locked position ☐ Family at bedside

Janice McDonald RN

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Page 3

Vital Signs

Time	BP	HR	RR	Temp	OX	O2 L/min	Pain	GCS	Initials
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	
							10	15	

Start Time	Stop Time	Medication	Dose	Route	Initials

Response Time: Response:

Response Time: Response:

HUNT, KALVIN

1986

Response Time: Response:

Response Time: Response:

T/D/Dilup/DTVIG?	Lot #	Mfg	Exp Date	Route	Initials

Response Time: Response:

Time	Cath	Site	IVF/Blood	Rate	Fluid Time	Total Infused	PRN Q ult

Admission/Transfer

To:_____ Room:___
Dr._____
Report To:_____@___
Phone #_____
Transport w/: ☐ Monitor ☐ O2
☐ IV ☐ HM/RN
☐ See Transfer Sheet
Valuables w/: ☐ Pt ☐ Family
☐ Inventoried
Via: ☐ ACLS ☐ BLS ☐ Air

Disposition

Vitals @ Discharge: Pain /10
B/P___ HR___ R___ T___ O2___
☐ Home ☐ Admit ☐ Transfer ☐ SIQ
☐ Full duty ☐ Light Duty ☐ Morgue
☐ F/U pcm ☐ other___
Mode of release:
☐ Ambulatory ☐ Carried ☐ W/C
☐ Gurney ☐ Crutches ☐ To Drill Instructor
☐ Shadow Watch
Discharge Time:

Time	Nursing Notes
1430	Rec'd report from triage
	MD Eval pending
1500	Rep from Vet Affairs c
	PT - cooperative FR
	MD Eval in progress
1510	TTC to Brnt 2E to inform
	Bed availability - MD Spoke
	c Marilyn
1525	Psych TECH Nancy Eval
	in progress
1612	PT amb to Bathroom, returned
	PTE Vet Affairs Rep Forward Pay ?
	states "we're getting some air"
1625	MR Rep returns to FR
	stating "He took off
	through the gate" Psych
	tech returned 2 10' ago,
	has been looking for PT
	& MR Rep. QRP Desk notified,
	Security @ the Well
	notified
1635	OOP, PMD, FR MD, Nurse FR
	Nurse Director All notified
	of Amn

Name & Signature	Initials

☐ Additional Nursing Notes ☐ ICU Record
☐ Cardiac Arrest Flow Sheet

Intake			Output		
Time	Type	Amt	Time	Type	Amt

Patient Instructions

☐ Verbalizes understanding of discharge instructions.
☐ Instructed not to drive ☐ Driver Present_____
Barriers to learning: ☐ Physical ☐ Reading
☐ Developmental ☐ Visual/Auditory ☐ Language:_____
☐ Discharge instructions given in primary language

Written instructions provided to: 1612 Amn
☐ Patient ☐ Parent Mother/Father ☐ Other

Discharge instructions provided by:_____

Back of 2

S/HUNT, KALVIN DONTAY/PVT
CCN: 27FEB12-CAPJ-0013-7HMA

PL - Ex 20
Page 4

Brought by VA workers from DSS

DATE 8/24/17 TIME 1455 ROOM 1 EMS Arrival

HISTORIAN: patient spouse parame of Mr Ray

HX/ EXAM LIMITED BY:

© 1996 - 2004 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

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EMERGENCY PHYSICIAN RECORD
Psych Disorder, Suicide Attempt, Overdose (5)

HPI

chief complaint:
suicidal thoughts depression agitated hallucinating
suicide attempt self-injury intentional drug overdose
accidental drug ingestion
medication refill

started / timing: several weeks
ago
gone now better continues in ED
sudden/acute
sudden-onset
intermittent
constant

severity:
mild moderate severe

context:
situational problems
related to: spouse / parent / son / daughter / significant other
work / lost job / school / legal problems
pt dishonorably discharged from USMC and is appealing decision. Pending a appointment in Bonnifant Shell called Mr Ray concerned about his daughter

current / associated complaints:
depressed / angry / frustrated / agitated / hostile / paranoid

confused / hallucinating

suicidal thoughts / specific plan / gesture or attempt:
Endorses thoughts of hurting others but no specific plan

Ingestion (see list below)
suicide attempt wanted to escape accidental will not answer

Incised / abraded wrist (R / L)

"RESCUE FACTOR" (if suicide attempt):
How did ingestion / other acts come to attention?

Arrived by private car ambulance (who called?)
police patient spouse

Recently seen / treated by doctor

ROS
CVS / PULMONARY
cough
trouble breathing
chest pain

CONST
fever
chills

NEURO / EYES
headache
visual disturbance

GI / GU
abdominal pain
nausea
vomiting
diarrhea
problems urinating

SKIN / LYMPH / MS
skin rash / swelling
joint pain

☐ all systems neg except as marked

PAST HX negative
prior suicide attempt
psychiatric problems
depression bipolar disorder
schizophrenia other

cardiac disease
high blood pressure
diabetes insulin / oral / diet
lung disease
+HIV / AIDS

other problems: Alcohol / drug abuse
depression
hx suicide gesture

Surgeries:
tonsillectomy appendectomy
cholecystectomy hysterectomy

Medications none see nurses note
Ran out of meds

Allergies NKDA
see nurses note

SOCIAL HX smoker 1 ppd drugs
recent alcohol use / binge drinking alcoholism
marital status: single married children: 1 child
divorced

FAMILY HX mental illness

LIST OF SUBSTANCES INGESTED (if applicable)

name	strength	# taken	when taken
acetaminophen Y/N			
aspirin Y/N			
ethanol Y/N			

HUNT,KALVIN DONTAY
DOB 1986
MALE Age: 26

PL - Ed 20
Pages

(See prior medical notes on Mr. Ray D.)

☑ Nursing Assessment Reviewed ☐ Vitals Reviewed
V/S BP _____ HR 103 RR _____ Temp _____

PHYSICAL EXAM

General Appearance
__no acute distress
__alert
__mild / moderate / severe distress
__anxious / lethargic / obtunded
__uncooperative for exam

ENT
__nml ENT inspection
__pharynx nml
__abnormal TM (R / L)
__dry mucosa
If obtunded:
__nml gag reflex
__gag reflexed diminished / absent

EYES
__PERRL
__EOM's intact
__nystagmus
__disconjugate gaze
__mydriasis / meiosis / anisocoria
R Pupil ___ mm L Pupil ___ mm

NEURO / PSYCH
mental status
__mood / affect nml
__slow / no response to commands
__withdraws to pain / no response to pain
__depressed affect
__tearful / hostile / non-communicative
__suicidal ideation

~~Psychiatric emergency~~ On direct query, patient ADMITS / DENIES continued consideration of suicide as an option.
If denies, why? ____

orientation
__normal x3
__uncooperative / cannot determine
__disoriented to SSN
__to day-of-week day-of-month month year place person

cranial nerves
sensory, motor
__CN's intact as tested
__nml motor response
__nml sensory responses
__nml reflexes
__nml gait
__facial droop / CN abnormality
__motor / sensory deficit
__abnormal gait

NECK / BACK
__normal inspection
__neck supple
__cerv. lymphadenopathy (R / L)
__thyromegaly / meningismus

RESPIRATORY
__no resp. distress
__breath sounds nml
__wheezing
__rales / rhonchi

CVS
__regular rate, rhythm
__heart sounds normal
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__JVD

ABDOMEN
__non-tender
__nml bowel sounds
__no organomegaly
__guarding
__hepatomegaly / splenomegaly

SKIN
__color nml, no rash
__warm, dry
__cyanosis / diaphoresis / pallor
__skin rash

EXTREMITIES
__non-tender
__normal ROM
__no signs of injury
__no pedal edema
__laceration
__pedal edema

PROCEDURES: ☐ Restraints
☐ Intubated by ED physician nasal / oral # ___ ET tube
breath sounds equal tube position confirmed w CXR
☐ Gastric Lavage pill fragments recovered
☐ Charcoal ___ gm given Sorbitol ___ oz given

Psych Disorder; Overdose-52
S/HUNT, KALVIN DONTAV/PVT
CCN: 27FEB12-CAPI-0013-7HMA

LABS, EKG & XR:

CBC (normal except)	Chemistries (normal except)	ABGs (time:)	Toxicology (normal except)
WBC	Na		acetamin.
Hgb	K		aspirin
Hct	Cl	pH	ETOH
Platelets	CO2	pCO2	Triage™ urine drug screen
segs	Gluc	pO2	
bands	BUN	RA	
lymphs	Creat	O2 ___ L	
monos	Ca		

EKG MONITOR STRIP: __NSR __Rate

EKG: __NML ☐ Interp. by me ☐ Reviewed by me Rate ___
__NSR __nml intervals __nml axis __nml QRS __nml ST/T
not / changed from: ____

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discrd w/ radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
not / changed from: ____

Pulse Ox ___% on RA / ___ L / ___% at (time) ____

PROGRESS:

Time ____ unchanged improved re-examined

1520 – called mobile health to be [illegible]
1522 – called mobile health again [illegible]
1540 – Mr. Maxwell passed – [illegible]
1610 – called BMH – Psych [illegible]
[illegible] pt. Marilyn
Discussed with Dr. [illegible] Time 1605
will see patient in: office / ED / hospital

INTERVIEW WITH OTHER RESPONSIBLE ADULT:
Name: ____ Relationship: ____
Considers ongoing suicide risk: high low uncertain
Capable / comfortable with observing patient at home? Yes No N/A

MEDICAL CLEARANCE FOR PSYCHIATRIC REFERRAL (if needed)
Back-stop to indicate that diagnosis is unlikely based on H&P and, when needed, lab testing.
•Toxic (PCP, Amphetamines, Hallucinogens, Acetaminophen, ASA, ETOH, Other)
•Infectious (Meningitis, Encephalitis, Sepsis)
•Metabolic (Thyroid, Hypoglycemia, Drug Withdrawal, Hypocarbia, Electrolytes)
•CNS Vascular and Other (CVA, TIA, Seizure, Trauma)
•Other Unstable Co-morbidities ☐ cleared medically for psych referral

__Counseled patient / family regarding: lab results diagnosis need for follow-up
__Rx given __Admit orders written
__Prior records obtained
CRIT CARE: 30-74 min ___ min 75-104 min ___ min
__Additional history from: family caretaker paramedics

CLINICAL IMPRESSION:

Ethanol Intoxication
Depression major manic
Psychosis Schizophrenia - acute exac.
Drug Overdose (intentional / accidental)
Suicide Attempt / Ideation

pt left ER and escaped [illegible] care Mr. Ray

DISPOSITION: ☐ home ☐ admitted ☐ transfer
Time 1605
CONDITION: ☐ unchanged ☐ improved ☐ stable

CHRIS JANSEN, MD
8869
PHYSICIAN SIGNATURE EMERGENCY ROOM
☐ Template Complete ☒ Addendum ☐ Add On Temp

PL - Exh 20
Page 6

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LABS
TIME

- ____ • CBC
- ____ • CBC & Diff.
- ____ • CMP
- ____ • BMP
- ____ • Lytes
- ____ • Myoglobin
- ____ • CK
- ____ • Mg^{++}
- ____ • UHCG
- ____ • SHCG
- ____ • Strep Screen
- ____ • Amylase
- ____ • Lipase
- ____ • Troponin I
- ____ • PT / PTT
- ____ • Sed Rate
- ____ • H. Pylori
- ____ • UA
  plain path dip (ketones)
- ____ • CSF Protocol
- ____ • Toxin screen:
  urine blood
- ____ • Drug Levels:
  digoxin dilantin ETOH Tylenol ASA

STAND( )PANELS
TIME

- Cardiac
- ____ • Liver
- ____ • Thyroid
- ____ T_4
- ____ T_3
- ____ TSH

X-RAYS

- ____ • CXR *-port PA / LAT*
- ____ • Sonogram
  pelvis abd biliary renal
- ____ • KUB *-flat -upright*
- ____ • CT *head / abdomen*
- ____ • IVP
- ____ • C-Spine 2 view
- ____ • C-Spine 3 view
- ____ • Acute Abdominal Series

CARDIO/RESPIRATORY

- ____ • EKG
- ____ • PPN with ____
- ____ • ABG *RA / O2*

- ____ • Culture
  urine blood x___ stool
- ____ • Stool leukocytes
- ____ • Stool hemoccult

PLEASE CALL DOCTOR

Time Ordered	Doctor	Returned Call
1450	PSYCH TEAM	

DEPARTMENT RECORD
Physician Order Sheet

Initial Nursing Orders

Time	Orders	Noted
	☐ Cardiac Monitor	
	☐ Pulse Oximeter	
	☐ Oxygen ____ L NC titrate to keep SaO_2 greater than 95%	
	☐ Fully Disrobe / Gown	
	☐ Postural Vitals	
	☐ Neuro checks q____	
	☐ IV saline lock ____ mL / hr	
	☐ Phenergan____	
	☐ Toradol____	
	☐ Tylenol____	
	☐ Motrin____	
	☐ Morphine sulfate____	
	☐ Demerol____	
	☐ Nubain____	
	☐ Rocephin____ IM mix w/ 1% Lidocaine plain	
	☐ Rocephin____ IV	

Subsequent Nursing Orders

Time	Orders	Noted
	☐ Please repeat: *BP HR RR Temp*____	
	☐ May be off cardiac monitor for radiology studies or transport.	

Discharge Instructions

Pt LWCC & VA worker. Pls
request before pt brought back
to ER

DISPOSITION

☐ ADMIT ☐ OBS ☐ DISCHARGE

___ med / surg ___ telemetry ___ icu ___ L & D

Dr.____

☐ TRANSFER to:____ Care of Dr.____

Condition: ☐ Improved ☐ stable ☐ other:____

PHYSICIAN SIGNATURES

CHRIS JANICKI, MD
1909
EMERGENCY ROOM

HUNT, KALVIN DONTAY DOB: 1986
MA Age: 26

PL - Exh 20
Page 7

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DEPARTMENT RECORD
Physician Order Sheet

LABS
TIME
- CBC
- CBC & Diff.
- CMP
- BMP
- Lytes
- Myoglobin
- CK
- Mg^{++}
- UHCG
- SHCG
- Strep Screen
- Amylase
- Lipase
- Troponin I
- PT / PTT
- Sed Rate
- H. Pylori
- UA
  clean cath dip (ketones)
- CSF Protocol
- Tox screen: *urine blood*
- Drug Levels: *digoxin dilantin ETOH Tylenol ASA*

STAND[illegible] PANELS
TIME
- Cardiac
- Liver
- Thyroid
  - T_4
  - T_3
  - TSH

X-RAYS
- CXR *-port PA / LAT-*
- Sonogram *pelvic abd biliary renal*
- KUB *-flat -upright-*
- CT *head / abdomen*
- IVP
- C-Spine 2 view
- C-Spine 3 view
- Acute Abdominal Series

CARDIORESPIRATORY
- EKG
- H&N with
- ABG *RA / O2*

- Culture *urine blood x stool*
- Stool leukocytes
- Stool hemoccult

PLEASE CALL DOCTOR

Time Ordered	Doctor	Returned Call
1450	PSYCH TECH	

Initial Nursing Orders

Time	Orders	Noted
	☐ Cardiac Monitor	
	☐ Pulse Oximeter	
	☐ Oxygen ____ L NC titrate to keep SaO_2 greater than 95%	
	☐ Fully Dispobe / Gown	
	☐ Postural Vitals	
	☐ Neuro checks q ____	
	☐ IV saline lock ____ mL / hr	
	☐ Phenergan ____	
	☐ Toradol ____	
	☐ Tylenol ____	
	☐ Motrin ____	
	☐ Morphine sulfate ____	
	☐ Demerol ____	
	☐ Nubain ____	
	☐ Rocephin ____ IM mix w/ 1% Lidocaine plain	
	☐ Rocephin ____ IV ____	

Subsequent Nursing Orders

Time	Orders	Noted
	☐ Please repeat: *BP HR RR Temp* ____	
	☐ May be off cardiac monitor for radiology studies or transport.	

Discharge Instructions
Pt LWCC & VA: worker Hx
Discussed before pt brought back
to ER

DISPOSITION
☐ ADMIT ☐ OBS ☐ DISCHARGE
____ med / surg ____ telemetry ____ icu ____ L & D
Dr. ____
☐ TRANSFER to: ____ Care of Dr. ____
Condition: ☐ improved ☐ stable ☐ other: ____

PHYSICIAN SIGNATURES
CHRIS JANICH MD
1909
EMERGENCY ROOM

HUNT, KALVIN DONTAY
DOB: 1986
Age: 26
MALE

PL - Ex 20
Page 8

Over the LAST 2 WEEKS, have you been bothered by any of the following problems?

- Feeling down, depressed, or hopeless. (YES) NO
- Little interest or pleasure in doing things. (YES) NO

HUNT, KALVIN

1986

PL-Exh 20
Page 9

PDTS Cardholder ID: PDTS Person Code: 24 Feb 2012 14:17
Age: 26y Sex: MALE Profile Length: 180 DAYS

Allergies: NKDA

Pharmacy Comment: NONE

CHCS PROFILE (LAST 180 DAYS)

RX #	DRUG	STATUS	QTY	FILL DATE	REF LEFT
P10556316	CEFTRIAXONE (ROCEPHIN)--INJ 2G E		1	Suspense	NR

PDTS PROFILE (LAST 180 DAYS)

PDTS RX#	DRUG NAME <PHARMACY NAME/PHYSICIAN>	CPD QTY	DAYS SUPPLY	NEW/ REFILL	DATE FILLED
3813092	AQUAPHOR HEALING OINTMENT <SAN DG MIRAMAR PHCY/CARLSON, SCOTT J.>	480	60	0	01 Dec 2011
3633765	LEVITRA 20 MG TABLET <SAN DG MIRAMAR PHCY/1982677746>	6	30	0	01 Dec 2011
1362987	MOBIC 15 MG TABLET <SAN DG MIRAMAR PHCY/MARTENS, JEFFREY STEVEN>	90	90	0	01 Dec 2011
1362992	HYDROCODON-ACETAMINOPHEN 5- <SAN DG MIRAMAR PHCY/MARTENS, JEFFREY STEVEN>	30	7	0	01 Dec 2011

*** END OF REPORT ***

Triage

PL-Exh-20
Page 10

Addendum to Patient : K.D. Hunt

Date: 2/24/2012 Note written at 1640

Patient was brought to BNH ER about 1500 by VA worker Mr Edward Ray who wanted patient assessed after seeing him in his office today at DSS. Patient was well dressed and cooperative but poorly communicative. He did not appear agitated nor psychotic. I was unable to get sufficient history from him except that he wanted to get his medications refilled. His train of thought was delayed and was confused about his social security number. I called Mental Health(about 1520) and asked to have psych evaluate him in the ER. HM Manning (around 1540) came and evaluated Mr Hunt. It was decided that HM Manning would talk to psychiatrist and ask for her assessment. Dr Hendelman called back (around 1605) and told me that patient obviously needed to be admitted. I asked her to see patient but was told that it would not change her opinion.

I went out of ER office to see patient and was told that he and Mr Ray, who appeared to have good rapport with patient ,stepped out to get some fresh air and would be right back. In meantime I contacted BMH Psych Floor and told nurse Marilyn we had a potential admission. I asked nurses and psych tech to look for patient and to notify security and front desk. Around 1620 Mr Ray came back and said patient ran away from him and went out front gate.

Christian Jansen, MD

HUNT, KALVIN

1986

PL - Exh 20
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Edward Rey
Veterans Affairs Officer

BEAUFORT COUNTY
VETERANS AFFAIRS

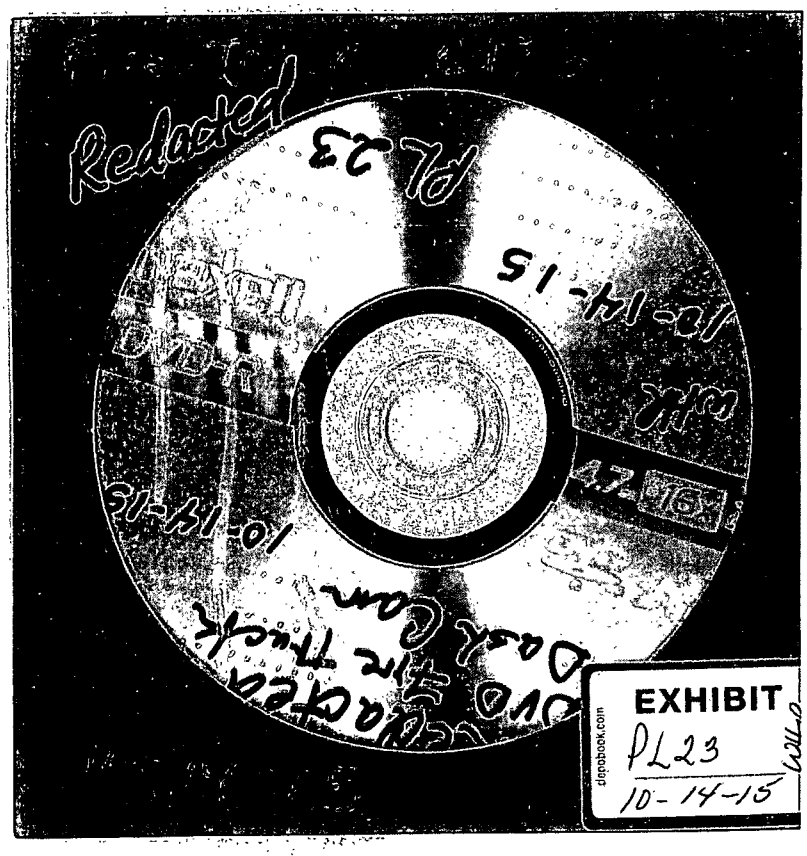
"Putting Veterans First"

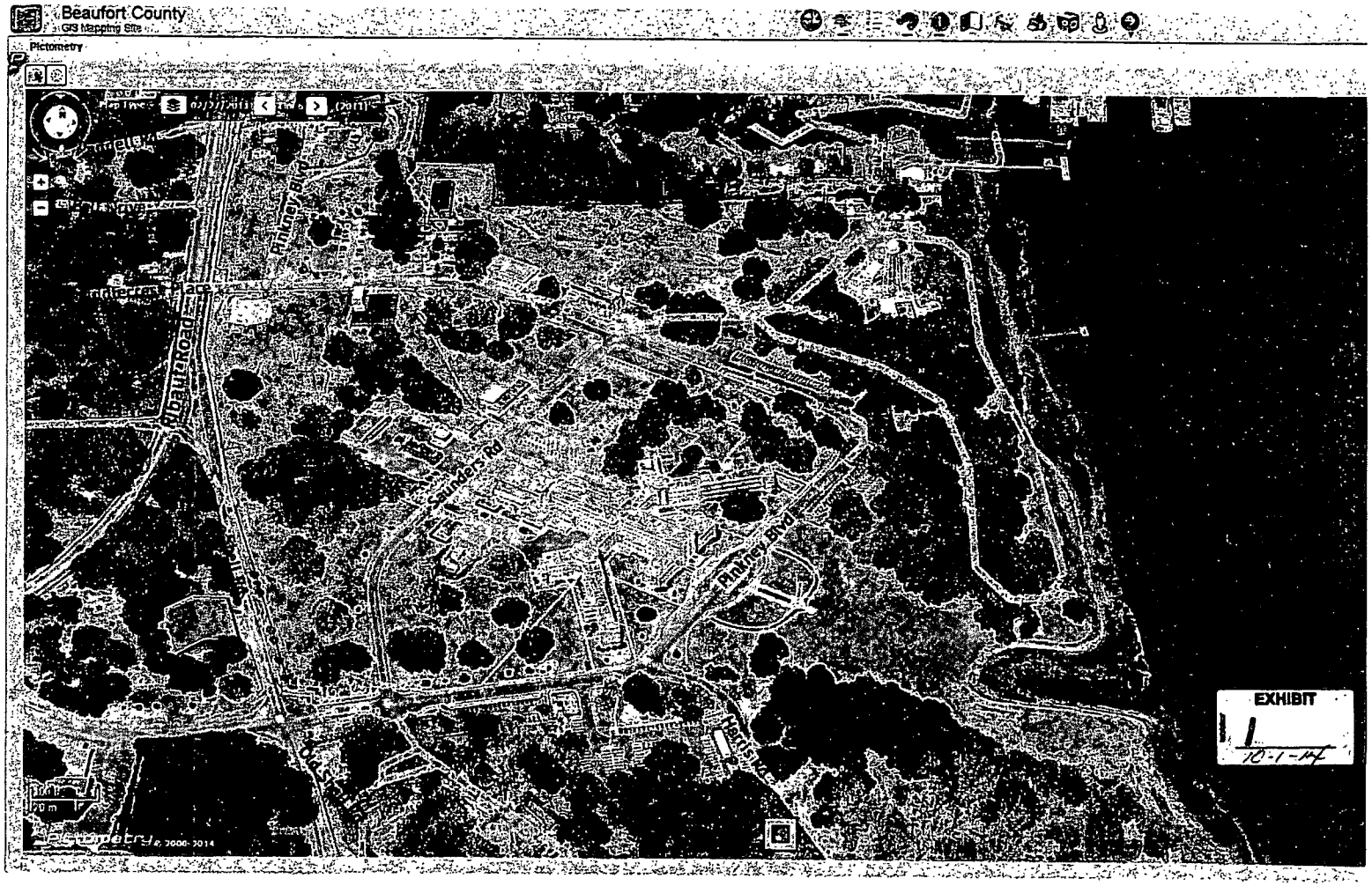
1905 Duke St.
P.O. Drawer 1228
Beaufort, SC 29901

(843) 255-6880
Fax (843) 255-9445

HUNT,KALVIN DONTAY
DOB: 1986
MALE Age: 26

PL - Exh. 20
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Redacted
PL23
10-14-15
EXHIBIT
PL23
10-14-15
depobook.com



Trial

DEFENDANT'S EXHIBIT

2 WHR 10-9-15

DEFENDANT'S EXHIBIT

3 WHR 10-12-15

AWARD/CONTRACT

1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 350)	RATING	PAGE 1	OF PAGES 131
2. CONTRACT (Proc. Inst. Ident.) NO. 62645-07-D-5005	3. EFFECTIVE DATE 28 Sep 2007	4. REQUISITION/PURCHASE REQUEST/PROJECT NO.	

5. ISSUED BY CODE N62645
NAVAL MEDICAL LOGISTICS COMMAND
1681 NELSON STREET
FORT DETRICK MD 21702-9203

6. ADMINISTERED BY (If other than Item 5) CODE
See Item 5

7. NAME AND ADDRESS OF CONTRACTOR (No., street, city, county, state and zip code)
CASEPRO INC
21738 HARDY OAK BLVD
SUITE 105
SAN ANTONIO TX 78258-4864

8. DELIVERY
[ ] FOB ORIGIN [X] OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT
Net 30 Days

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN:
ITEM
Section G

CODE 1RPE3 FACILITY CODE 1RPE3

11. SHIP TO/MARK FOR CODE
See Schedule

12. PAYMENT WILL BE MADE BY CODE N68688
DFAS-SAN DIEGO
DFAS-OPLOC, CODE FPVAD, 4181 RUFFIN ROAD
SAN DIEGO CA 92123-1819

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:
[ ] 10 U.S.C. 2304(c)( ) [ ] 41 U.S.C. 253(c)( )

14. ACCOUNTING AND APPROPRIATION DATA

15A. ITEM NO.	15B. SUPPLIES/ SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	SEE SCHEDULE				

15G. TOTAL AMOUNT OF CONTRACT $0.00

16. TABLE OF CONTENTS

(X)	SEC.	DESCRIPTION	PAGE(S)
		PART I - THE SCHEDULE	
X	A	SOLICITATION/ CONTRACT FORM	1 - 2
X	B	SUPPLIES OR SERVICES AND PRICES/ COSTS	3 - 20
X	C	DESCRIPTION/ SPECS./ WORK STATEMENT	21 - 76
	D	PACKAGING AND MARKING	
X	E	INSPECTION AND ACCEPTANCE	77
X	F	DELIVERIES OR PERFORMANCE	78
X	G	CONTRACT ADMINISTRATION DATA	79
X	H	SPECIAL CONTRACT REQUIREMENTS	80 - 86
		PART II - CONTRACT CLAUSES	
X	I	CONTRACT CLAUSES	87 - 92
		PART III - LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACHMENTS	
X	J	LIST OF ATTACHMENTS	93 - 131
		PART IV - REPRESENTATIONS AND INSTRUCTIONS	
	K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	
	L	INSTRS., CONDS., AND NOTICES TO OFFERORS	
	M	EVALUATION FACTORS FOR AWARD	

CONTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. [X] CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. [ ] AWARD (Contractor is not required to sign this document.) Your offer on Solicitation Number N62645-08-R-1010-0005 including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.

19A. NAME AND TITLE OF SIGNER (Type or print)
Shirley B. Hill, President

20A. NAME AND TITLE OF CONTRACTING OFFICER
TEL: EMAIL:

19B. NAME OF CONTRACTOR	19C. DATE SIGNED	20B. UNITED STATES OF AMERICA	20C. DATE SIGNED
Shirley B. Hill (Signature of person authorized to sign)	7/26/07	BY (Signature of Contracting Officer)	

40-01-152-8069 26-107 STANDARD FORM 26 (REV. 4-85)
PREVIOUS EDITION UNUSABLE GPO 1985 O - 469-794 Prescribed by GSA FAR (48 CFR) 53.214(a)

AWARD/CONTRACT	1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 350)	RATING	PAGE OF PAGES 1 | 131
2. CONTRACT (*Proc. Inst. Ident.*) NO. N62645-07-D-5005	3. EFFECTIVE DATE 28 Sep 2007	4. REQUISITION/PURCHASE REQUEST/PROJECT NO.	

5. ISSUED BY CODE N62645	6. ADMINISTERED BY (*If other than Item 5*) CODE
NAVAL MEDICAL LOGISTICS COMMAND 1681 NELSON STREET FORT DETRICK MD 21702-9203	**See Item 5**

7. NAME AND ADDRESS OF CONTRACTOR (*No., street, city, county, state and zip code*)	8. DELIVERY [ ] FOB ORIGIN [X] OTHER (*See below*)
CASEPRO INC 21738 HARDY OAK BLVD SUITE 105 SAN ANTONIO TX 78258-4864	9. DISCOUNT FOR PROMPT PAYMENT Net 30 Days
	10. SUBMIT INVOICES (*4 copies unless otherwise specified*) TO THE ADDRESS SHOWN IN: ITEM **Section G**
CODE 1RPE3 FACILITY CODE 1RPE3	

11. SHIP TO/MARK FOR CODE	12. PAYMENT WILL BE MADE BY CODE N68688
See Schedule	DFAS-SAN DIEGO DFAS-OPLOC, CODE FPVAD, 4181 RUFFIN ROAD SAN DIEGO CA 92123-1819
13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION: [ ] 10 U.S.C. 2304(c)( ) [ ] 41 U.S.C. 253(c)( )	14. ACCOUNTING AND APPROPRIATION DATA

15A. ITEM NO.	15B. SUPPLIES/ SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	SEE SCHEDULE				

15G. TOTAL AMOUNT OF CONTRACT **$0.00**

16. TABLE OF CONTENTS

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	L	INSTRS., CONDS., AND NOTICES TO OFFERORS	
	M	EVALUATION FACTORS FOR AWARD	

CONTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. [X] CONTRACTOR'S NEGOTIATED AGREEMENT Contractor is required to sign this document and return[ ] copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)	18. [ ] AWARD (Contractor is not required to sign this document.) Your offer on Solicitation Number N62645-06-R-1010-0005 including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.
19A. NAME AND TITLE OF SIGNER (*Type or print*)	20A. NAME AND TITLE OF CONTRACTING OFFICER NANCY L. LAVIGNE / CONTRACTING OFFICER TEL: 301-619-3023 EMAIL: nancy.lavigne@med.navy.mil
19B. NAME OF CONTRACTOR BY _____ (*Signature of person authorized to sign*)	19C. DATE SIGNED
20B. UNITED STATES OF AMERICA BY Nancy L. LaVigne (*Signature of Contracting Officer*)	20C. DATE SIGNED 27-Jul-2007

Def RRFP 00001

2123

Section A - Solicitation/Contract Form

CONTRACTOR IDENTIFICATION
Contractor Identification Codes:

TIN: 742791312

DUNS: 968581348

CAGE: 1RPE3

Navy Marine Corps Acquisition Guide (NMCAG) G5232-9 PROMPT PAYMENT RESPONSIBILITY
For Prompt Payment Act purposes this contract is subject to the 7-calendar day constructive acceptance period.

Section B - Supplies or Services and Prices

SERVICES

B.1. The Contractor shall furnish qualified Health Care Workers in accordance with Section C (Statement of Work), individual Task Orders for these services, and all other terms and conditions set forth herein. Government requirements for contracted health care personnel shall be filled in response to Task Orders issued by the Government against the contract.

B.2. Task Orders will be priced on a firm fixed price basis.

B.3. The following activity is the sole authority to issue Task Orders:

Naval Medical Logistics Command
Code 02
1681 Nelson Street
Fort Detrick MD 21702-9203

B.4. Task Orders will be placed through the use of a DD Form 1155 signed by the Contracting Officer. Task Orders will be executed in writing by the Contracting Officer and transmitted either via facsimile, or electronically via e-mail. The contractor shall acknowledge receipt via e-mail.

B.5. Each Task Order will contain at a minimum the following information:

a. The date of order
b. Contract number and order number
c. Description of services (labor category, position qualifications, place of performance, hours of operation, and quantity required)
d. The unit price
e. The period of performance
f. Accounting and appropriation data
g. Payment office address
h. Invoicing and acceptance instructions
i. Name of the Contracting Officer's Representative (COR)
j. Any other pertinent data

B.6. Location of services. Services shall be performed at locations as follows:

a. Performance of Health Care Worker services at any Department of Defense (DoD), or Coast Guard Military Treatment Facility (MTF) within the States of North Carolina, South Carolina, and Tennessee shall be considered within the scope of this contract.

b. In the event that performance requirements at a particular facility differ slightly from that expressed in Section C, those differences shall be defined in the task order statement of work.

c. Reserved

d. The Government reserves the right to reassign health care workers within a Medical Treatment Facility (MTF) to meet patient demand.

B.7. Reserved

B.8. The estimated ordering period is for 60 months, beginning with the initial start of contract services, or until the time the Government has issued Task Orders totaling the sum of the maximum quantities. Refer to Section F paragraph F.1.

B.9. Instructions and procedures for subsequent Task Order preparation and award are contained in Section H of this contract.

B.10. The period of performance of any Task Order shall be of one year or less in duration.

B.11. Reserved.

B.12. The following minimum Lots and Optional Task Orders (OTO) were awarded to CasePro, Subject to Availability of Funds:

Lot 1					
NAVHOSP Charleston, SC and Branch Medical Clinic Naval Weapons Station Charleston, SC, Case Management. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Lead Case Manager POP: 01 OCT 2007 – 30 SEP 2008	4,192	Hours	$REDACTED	
0004AB	RN Case Manager POP: 01 OCT 2007 – 30 SEP 2008	2,096	Hours	$REDACTED	

Lot 2					
NAVHOSP Charleston, SC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0001	Family Practitioner POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0002	Audiologist POP: 01 OCT 2007 - 30 SEP 2008	840	Hours	$REDACTED	

0003	Pediatric Nurse Practitioner POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0005AA	Mammography Technologist POP: 01 OCT 2007 - 30 SEP 2008	1,048	Hours	$REDACTED	
0005AB	Ultrasound Technologist POP: 01 OCT 2007 - 30 SEP 2008	1,680	Hours	$REDACTED	

Lot 3

NAVHOSP Cherry Point, NC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Lead Case Manager POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0004AB	RN Case Manager POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$$REDACTED	
0008	Travel, RN Case Managers POP: 28 SEP 2007 - 27 SEP 2008	1	Lot	NTE $REDACTED	
0004AC	RN Health Promotion Coordinator POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	

0004AD	RN Breast Care Coordinator POP: 01 OCT 2007 - 30 SEP 2008	1,048	Hours	$REDACTED	
0004AE	RN Perioperative POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0007	Certified Nursing Assistants POP: 01 OCT 2007 - 30 SEP 2008	6,288	Hours	$REDACTED	

Lot 5

NAVHOSP Cherry Point, NC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0002	Chiropractor POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED $REDACTED	
0006	Pharmacy Technicians POP: 01 OCT 2007 - 30 SEP 2008	6,288	Hours	$REDACTED	
0007	Chiropractic Assistant POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	

Lot 6

NAVHOSP Beaufort, SC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0001	Emergency Medicine Physicians	8,928	Hours	$REDACTED	

	POP: 01 OCT 2007 - 30 SEP 2008				
0004AA	RN Emergency Room POP: 01 OCT 2007 - 30 SEP 2008	17,688	Hours	$REDACTED	
0004AB	LPN Emergency Room POP: 01 OCT 2007 - 30 SEP 2008	8,904	Hours	$REDACTED	

Lot 7

NAVHOSP Beaufort, SC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0002	Clinical Social Work Case Manager POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0004AA	RN Lead Case Manager POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0008AA	Travel, Clinical Social Worker POP: 28 SEP 2007 - 27 SEP 2008	1	Lot	$REDACTED	

0004AB	RN Utilization Managers POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	$REDACTED	
0004AC	RN Family Practice POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	$REDACTED $REDACTED	
0004AD	RN Breast Care Coordinator POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0008AB	Travel, RN Breast Care Coordinator POP: 01 OCT 2007 - 30 SEP 2008	1	Lot	NTE $REDACTED	

Lot 9

NAVHOSP Beaufort, SC or MCRD Parris Island, SC or MCAS Beaufort, SC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0004AA	LPNs - NHB Outpatient Clinics (Individuals)	6,304	Hours	$REDACTED	

	POP: 28 SEP 2007 - 30 JUN 2008				
0004AB	LPNs-MCRD Parris Island Outpatient Clinic (Individuals) POP: 28 SEP 2007 - 30 JUN 2008	4,728	Hours	$REDACTED	
0004AC	LPNs - NHB Inpatient (Coverage) POP: 28 SEP 2007 - 30 JUN 2008	9,456	Hours	$REDACTED	
0001	Family Practice Physician POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	

Lot 11

NAVHOSP Camp Lejeune, NC and Henderson Family Medical Clinic. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0001	Family Practitioner Physicians POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	$REDACTED $REDACTED	
0003	Family Nurse Practitioners POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	$REDACTED $REDACTED	
	RN Charge Nurse				

0004AA	POP: 01 OCT 2007 - 30 SEP 2008	2,016	Hours	$REDACTED	
0004AB	RN Family Practice POP: 01 OCT 2007 - 30 SEP 2008	2,016	Hours	$REDACTED $REDACTED	
0004AC	LPN Family Practice POP: 01 OCT 2007 - 30 SEP 2008	2,016	Hours	$REDACTED $REDACTED	
0006AA	Pharmacy Technician POP: 01 OCT 2007 - 30 SEP 2008	2,016	Hours	$REDACTED $REDACTED	
0006AB	Medical Laboratory Technicians POP: 01 OCT 2007 - 30 SEP 2008	4,032	Hours	$REDACTED $REDACTED	
0007	Certified Nursing Assistant POP: 01 OCT 2007 - 30 SEP 2008	8,064	Hours	$REDACTED $REDACTED	

Lot 14

NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.

Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Lead Case Manager POP: 28 SEP 2007 - 30 JUN 2008	1,576	Hours	$REDACTED	
0004AB	LPN Referral Managers POP: 28 SEP 2007 - 30 JUN 2008	3,152	Hours	$REDACTED $REDACTED	
	Travel			NTE	

0008AA	POP: 28 SEP 2007 - 30 JUN 2008	1	Lot	$REDACTED	
0002	Health Educators POP: 28 SEP 2007 - 27 SEP 2008	8,352	Hours	$REDACTED	
0004AC	RN Case Managers POP: 28 SEP 2007 - 27 SEP 2008	6,264	Hours	$REDACTED	
0008AB	Travel, RN Case Manager POP: 28 SEP 2007 - 27 SEP 2008	1	Lot	$REDACTED	

Lot 15					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Outpatient POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0004AB	RN Inpatient POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	$REDACTED	
0004AC	RN Case Manager POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0004AD	LPN POP: 01 OCT 2007 - 30 SEP 2008	6,048	Hours	$REDACTED	
0005	Ultrasound Technologist POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	
0007	Certified Nursing Assistant POP: 01 OCT 2007 - 30 SEP 2008	26,208	Hours	$REDACTED	

0008	Travel, RN Case Manager POP: 01 OCT 2007 - 30 SEP 2008	1	Lot	NTE $REDACTED	

Lot 19					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0002	Pharmacists POP: 01 OCT 2007 - 30 SEP 2008	12,576	Hours	$REDACTED	
0006	Pharmacy Technicians POP: 01 OCT 2007 - 30 SEP 2008	29,344	Hours	$REDACTED	

Lot 20					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Emergency Room POP: 28 SEP 2007 - 27 SEP 2008	6,588	Hours	$REDACTED	
0004AB	RN Critical Care POP: 28 SEP 2007 - 27 SEP 2008	4,176	Hours	$REDACTED	

Lot 23					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line	Description	Quantity	Units	Unit Price	

Item					
0005	Medical Technologist POP: 28 SEP 2007 - 28 DEC 2007	528	Hours	$REDACTED	
0006AA	Phlebotomists POP: 28 SEP 2007 - 28 DEC 2007	2,640	Hours	$REDACTED	
0006AB	Medical Laboratory Technicians POP: 28 SEP 2007 - 28 DEC 2007	2,112	Hours	$REDACTED $REDACTED	
0006AC	Medical Laboratory Technician POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	$REDACTED	

Lot 26 OTO					
NAVHOSP Cherry Point, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0002AA	Pharmacists POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0002AB	Physical Therapist POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0004	RN Labor & Delivery POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	

0005	Radiologic Technologist POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0006AA	Pharmacy Technicians POP: 28 SEP 2007 - 27 SEP 2008	4,176	Hours	$REDACTED $REDACTED	
0006AB	Medical Laboratory Technicians POP: 28 SEP 2007 - 27 SEP 2008	4,176	Hours	$REDACTED $REDACTED	
0006AC	Ophthalmic Technician POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED $REDACTED	
0007AA	Physical Therapy Assistant POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED $REDACTED	
0007AB	Chiropractic Assistant POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	

Lot 30 OTO					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0005	Medical Technologist POP: 29 DEC 2007 - 27 SEP 2008	1,560	Hours	$REDACTED	
	Phlebotomists				

0006AA	POP: 29 DEC 2007 - 27 SEP 2008	7,800	Hours	$REDACTED	
0006AB	Medical Laboratory Technicians POP: 29 DEC 2007 - 27 SEP 2008	6,240	Hours	$REDACTED	

Lot 28 OTO					
NAVHOSP Camp Lejeune, NC. Services are for the period of performance (POP) as stated for each line item.					
Line Item	Description	Quantity	Units	Unit Price	
0004AA	RN Intensive Care POP: 28 SEP 2007 - 23 JUL 2008	3,424	Hours	$REDACTED	
0004AB	RN Emergency Room POP: 28 SEP 2007 - 23 JUL 2008	5,136	Hours	$REDACTED	
0004AC	RN Perioperative POP: 28 SEP 2007 - 23 JUL 2008	3,424	Hours	$REDACTED	
0002	Physician Assistant POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	
0007	Occupational Therapy Assistant POP: 28 SEP 2007 - 27 SEP 2008	2,088	Hours	$REDACTED	

B.13. The following quantities may be ordered by the initial or subsequent task orders awarded per the procedures established in Section H.

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0001		$REDACTED	Hours	UNDEFINED	UNDEFINED

Physician
FFP
Any specialty recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or other Ph.D. positions such as Medical Physicist not included in another labor band.
FOB: Destination

MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0002		$REDACTED	Hours	UNDEFINED	UNDEFINED

Allied Health
FFP
Allied Health Personnel include, but are not limited to, Audiologist, Chiropractor, Clinical Psychologist, Clinical Social Worker, Dietitian, Marriage and Family Therapist, Occupational Therapist, Optometrist, Pharmacist, Physical Therapist, Podiatrist, Speech Pathologist, Genetic Counselor, Physician Assistant.
FOB: Destination

MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0003		$REDACTED	Hours	UNDEFINED	UNDEFINED

Advanced Practice Nurse
FFP
Any specialty recognized by the American Nurses Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP).

FOB: Destination

MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0004		$REDACTED	Hours	UNDEFINED	UNDEFINED

Nursing
FFP
Any Registered Nurse specialty, Licensed Practical Nurse, RN- Health Educator.

FOB: Destination

MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0005		$REDACTED	Hours	UNDEFINED	UNDEFINED

Technologist
FFP
Technologist Personnel include, but are not limited to, Cardiopulmonary Technologist, Cardiovascular Technologist, Dosimetrist, Echocardiograph Technologist, Medical Technologist, Ophthalmic Technologist, Radiologic Technologist (including the various specializations), Laboratory Supervisor, Registered Respiratory Therapist, Certified Athletic Trainer, Perfusionist, Radiation Therapist.

FOB: Destination

MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0006		$REDACTED	Hours	UNDEFINED	UNDEFINED

Technician
FFP
Technician Personnel include, but are not limited to, Cardiac Technician, Central Sterile Supply Technician, Dietetic Technician, Electrocardiograph Technician, Emergency Medical Technician, Medical Laboratory Technician, Optician, Orthopedic Technician, Pharmacy Technician, Phlebotomist, Physical Therapy Technician, Psychiatric Technician, Pulmonary Technician, Certified Respiratory Therapist, and Surgical Technician.
FOB: Destination

MAX NET AMT		UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0007		$REDACTED	Hours	UNDEFINED	UNDEFINED

Assistant
FFP
Assistant Personnel include, but are not limited to, Chiropractic Assistant, Occupational Therapy Assistant, Speech Pathology Assistant.
FOB: Destination

MAX NET AMT		UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0008		$REDACTED	Lot	UNDEFINED	UNDEFINED

Travel /Training
FFP
FFP - Reimbursement of travel expenses in accordance with Section C.11. of this contract and task orders.

FOB: Destination

	MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0009		UNDEFINED		UNDEFINED	UNDEFINED

Incentive Award
FFP

FOB: Destination

	MAX NET AMT	UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0010		$REDACTED	Hours	UNDEFINED	UNDEFINED
	Overtime FFP				
	FOB: Destination				
				MAX NET AMT	UNDEFINED

Section C - Descriptions and Specifications

STATEMENT OF WORK

NOTE 1: The use of Commanding Officer means: Commanding Officer or other activity head, or a designated representative, e.g., Contracting Officer's Representative (COR) or Department Head, of the activity designated in a particular task order.

NOTE 2: The term contractor means the offeror identified in block 15A of Standard Form 33 or block 7 of the Standard Form 26 and its health care workers (HCWs) who are providing services under task orders placed under the contract.

NOTE 3: The term HCW refers to the individual(s) providing services under this contract.

NOTE 4: The term MTF refers to the Military Treatment Facility or other Federal medical treatment facility at which services are performed.

NOTE 5: The term COR refers to the Contracting Officer's Representative, a government employee appointed in writing by the Contracting Officer (KO) to serve as technical liaison between the government and the contractor.

STATEMENT OF WORK

1. This Statement of Work (SOW) applies to all positions encompassed within this contract. Order specific SOWs for Section B, CLINs 0001-0010 will be included with subsequently issued Task Order Proposal Requests (TOPR).

1.1. The contractor shall provide the health care personnel in accordance with the terms and conditions of this contract and each task order issued under this contract.

1.2. Contractor services shall be provided for the treatment of active duty military personnel, their dependents, eligible DoD civilian employees, and other eligible beneficiaries, designated by the Government.

2. SUITS ARISING OUT OF MEDICAL MALPRACTICE

2.1. The HCW(s) is (are) serving at the MTF under a personal services contract entered into under the authority of section 1091 of Title 10, United States Code. Accordingly, section 1089 of Title 10, United States Code shall apply to personal injury lawsuits filed against the HCW(s) based on negligent or wrongful acts or omissions incident to performance within the scope of this contract.

2.2. The HCW(s) is/are not required to maintain medical malpractice liability insurance. In the event of a claim or lawsuit relating to the HCW's performance of duties under this contract, the parties shall follow the procedures established in SECNAVINST 6300.3A, a copy of which can be viewed at http://doni.daps.dla.mil/.

2.3. HCWs providing services under this contract shall be rendering personal services to the Government and shall be subject to day-to-day supervision and control by Government personnel. Supervision and control is the process by which the individual HCW receives technical guidance, direction, and approval with regard to a task(s) within the requirements of this contract.

3. SCHEDULES, ABSENCES, AND LEAVE. Each task order will specify the work schedule of each HCW and shall specify whether the HCW will either: (1) accrue leave as an individual and be subject to approval by the Government for scheduling accrued leave; or (2) not accrue leave under the task order and be subject to replacement coverage by the contractor during all scheduled and unscheduled absences.

3.1. Individuals who accrue leave. Individuals subject to the provisions given in Section C.3.1 and its subparagraphs will be designated in the applicable task order. The Government will administer the leave provisions in this Section.

3.1.1. Individual HCWs who accrue leave shall accrue personal leave (annual leave plus sick leave) at a rate specified in the task order. The specific work schedule for an individual contractor HCW who accrues leave will be scheduled in advance by the supervisor (or designee) specified in the task order. Any changes in the schedule shall be coordinated between the individual HCW and the Government.

3.1.2. Each HCW shall adhere to MTF/supervisor policies and procedures for requesting leave, including requirements for advance notice. Requests by HCWs for taking accrued leave are subject to approval by the supervisor (or designee).

3.1.3. Contractors and HCWs shall ensure that leave requests are requested with sufficient time in advance to allow the supervisor to adequately plan for adequate staffing levels. Unless otherwise specified in a Task Order, all accrued leave shall be used within 90 days following the completion of a 12-month Task Order if a Logical Follow-on Task Order has been issued. If a Logical Follow-on Task Order is not issued, all unused leave shall be either used by the end of the Task Order period or forfeited. If personal leave is carried over beyond the completion date of the Task Order (i.e. to be used in the subsequent 90 days), the Government reserves the right to require the HCW to provide the COR with a schedule for the use of that leave not later than the first workday of the Logical Follow-on Task Order. Healthcare workers shall not presume that their leave schedule has been approved unless notified, in writing, by the COR. The Government will make every effort to accommodate all leave requests; however, the Commanding Officer reserves the right to unilaterally deny these leave requests to meet the demand for patient care.

3.1.4. The Government will compensate the Contractor for periods of authorized absence. The Contractor shall, in turn, compensate the HCW for periods of authorized absence.

3.1.5. If the HCW is absent for three or more consecutive unplanned days, the Commanding Officer may require written documentation from a qualified health care provider that the HCW is free from communicable disease. The Government reserves the right to examine and/or re-examine any HCW who meets this criterion.

3.1.6. At the discretion of the Commanding Officer a HCW shall enter a leave without pay (LWOP) status upon exhaustion of any leave balance. Unless waived by the KO, the Contractor shall replace any HCW who has been on LWOP status for a total of 40 hours per task order. At the discretion of the Commanding Officer, LWOP taken in conjunction with maternity leave is not subject to this limitation.

3.1.7. Upon request, up to 12 weeks of maternity leave, accrued leave plus LWOP, may be granted to the HCW if the circumstances specified in the FMLA, Sec. 102, apply.

3.1.8. Documented military leave for military reservists will be allowed, not to exceed 15 days per fiscal year, in accordance with 5 U.S.C. 6323(a). This leave may be taken intermittently, i.e., one day at a time, and may be carried over into the next fiscal year provided there is a task order in place to allow for this. Military reservists who perform full-time military service as a result of a call or order to active duty in support of a contingency operation may take up to 22 days per calendar year of military leave, in accordance with 5 U.S.C. 6323(b). Documented military leave taken in accordance with 5 U.S.C. 6323(a) and (b) is compensated leave. The contractor shall follow the policy of the MTF with respect to notification of scheduled military duties to the Commanding Officer.

3.1.9. Administrative leave may be granted for HCWs selected to serve jury duty. Requests for administrative jury duty leave shall be submitted to the Commanding Officer in the same manner as planned leave is requested. The HCW is required to provide the Commanding Officer with as much written notice as possible prior to reporting for jury duty, and is responsible for supplying documentation regarding the necessity for and length of absence for jury duty. A HCW whose position is deemed critical by the Commanding Officer may be issued a written request for the court to excuse the HCW from jury duty. The HCW shall be compensated by the contractor for these periods of authorized administrative leave. No individual HCW will be granted more than 15 days of administrative leave for

jury duty per year; in those instances where a contract HCW who accrues leave is anticipated to be in jury duty status in excess of 15 days, the contractor shall provide a replacement worker.

3.1.10. In the event that a task order allows a leave accrual position to be staffed by part-time individuals, no leave will be accrued by any individual who works less than 40 hours during a two week invoice period. This clause does not apply to labor categories covered by the Service Contract Act.

3.1.11. All accrued leave shall be forfeited without compensation or reimbursement at the expiration or termination of a task order or the contract or at the voluntary or involuntary separation of a contract HCW. The only exception to this is in the case of a logical follow-on task order, which includes a provision for carry over from the expiring task order of a specified maximum leave balance for a defined period (see Section C paragraph 3.1.3).

3.2. Positions for which replacement coverage is required. Positions subject to the provisions given in Section C.3.2. and its subparagraphs will be designated in the applicable task order. The Contractor shall be responsible for administering the leave for individuals filling coverage positions.

3.2.1. The Contractor shall have sufficient qualified reserve personnel so that all services are provided in the event a HCW scheduled to work becomes ill, resigns, is terminated, or is otherwise unavailable to work. Contract requirements are not mitigated by inclement weather.

3.2.2. If a HCW becomes ill or is otherwise unable to fulfill his/her obligation to work, they shall notify the contractor who in turn shall notify the COR.

3.2.3. The Contractor is responsible for replacing a HCW who, for any reason, misses more than 2 hours of a shift.

3.2.4. The Contractor shall provide replacement coverage by a HCW who meets the minimum HCW contract qualifications and is approved for work (i.e., has been credentialed and privileged as appropriate and has satisfactorily completed orientation).

3.2.5. The contractor shall prepare the schedule of workers for all positions for which replacement coverage is required. Unless otherwise specified in the task order, the specific schedule for each two week period shall be provided to the DoD Supervisor one month in advance of the two week period. The schedule shall be complete and include the name of the specific individual(s) who will provide the required coverage.

3.3. Provisions for all HCWs.

3.3.1. Administrative Leave. For unusual and compelling circumstances (e.g., weather emergencies) in which the Commanding Officer either excuses all facility personnel from reporting to work or dismisses all personnel early, the Commanding Officer is authorized to grant administrative leave to the HCW. This administrative leave may be compensated leave.

3.3.2. Furlough. Unless otherwise authorized by a defense appropriations bill, contractors shall not be reimbursed by the Government for services not rendered during a Government furlough. In the event of a Government furlough, the Commanding Officer will determine which contract employees are considered critical and therefore must report to work. Contract employees deemed critical shall be compensated for services rendered during a furlough. All other contract employees shall be furloughed until the Government shutdown ends or they are notified by the Contracting Officer's Representative that they have become critical employees.

3.3.3. A HCW with a bona fide medical emergency occurring while on duty, or with an on-the-job injury, will be provided stabilizing medical care according to the procedures of the MTF. The contractor shall reimburse the Government for all medical services provided unless the HCW is otherwise entitled to Government medical services.

3.3.4. In the instance where the Government directs the HCW to remain on duty in excess of their scheduled shift due to an unforeseen emergency or to complete patient treatment where lack of continuity of care would otherwise

jeopardize patient health, the HCW shall remain on duty. The HCW will be given an equal amount of compensatory time to be scheduled upon mutual agreement of the HCW and the Commanding Officer. This provision is not intended to apply to the time required to complete routine tasks (e.g., completion of paperwork or routine administrative tasks at the end of a shift) which are to be completed as part of the shift.

3.3.5. Overtime shall be authorized in advance and scheduled by the government. If approved, the amount of overtime will be defined in the specific task order and the contractor shall be compensated in accordance with Section B, Contract Line Item Number (CLIN) 0010. The contractor shall only be compensated for overtime when the authorized HCW provides services in excess of their regularly scheduled 80 hours per pay period.

3.3.6. HCWs providing services will generally (as specified in the task order) receive uncompensated meal breaks of 30 minutes when assigned an 8-hour shift and 45 minutes when assigned a 12-hour shift. The HCW's shift will be extended 30 minutes or 45 minutes, respectively, to constitute a full 8 or 12 hours of on-site service. This includes extending the work shift beyond the scheduled clinic closing time to complete patient care and administrative duties. No contractor employee shall work beyond 12 ¾ hours per shift.

3.3.7. Contractor employees may receive one compensated work break in the morning and one in the afternoon, work load permitting, at the discretion of the Government. Neither break shall exceed 15 minutes or be taken with the intention of extending the lunch break.

3.3.8. Continuing Education. The Commanding Officer may also grant authorization for planned absences to allow the HCW to attend continuing education courses. This is in addition to the planned and unplanned absences specified above. The Government may compensate the HCW for these periods of authorized absence if the continuing education course(s) are determined to be a necessary expense by the government. This determination will be made on a case by case basis, weighing the costs associated with the training of contractor personnel against the benefit gained by the Government in support of the appropriation that will incur the expense. This compensation will not exceed 40 hours per 12 month Task Order, equivalently apportioned for part-time employees and/or partial year Task Orders. The Commanding Officer may also advance leave for continuing education.

3.3.8.1. Unless authorized in advance, the Government will not reimburse the HCW for the cost of any training and/or other related expenses (travel). If authorized, the contractor shall be compensated for those expenses deemed reasonable using the "Travel/Training CLIN" in Section B, CLIN 0008. The HCW shall provide proof of attendance and successful completion of continuing education to the Commanding Officer upon request.

3.3.8.1.1. The contractor shall submit an invoice in accordance with Wide Area Work Flow instructions itemizing expenses in amounts allowable by the COR.

3.3.8.1.2. All reimbursements will be retrospective, payable only upon presentation of a properly prepared invoice (as specified by the facility) to the COR. The government shall reimburse the contractor only for actual training costs incurred, and any authorized travel expenses deemed reasonable.

3.3.8.1.3. The Government reserves the right to require additional documentation, including memoranda from the HCW obtaining the training.

3.3.8.1.4. Such training shall not be conducted prior to the appropriate funding being applied to CLIN 0008 through a task order.

3.3.9. Training necessary to maintain the professional qualifications required by the contract (e.g. Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), etc.) may be available at the MTF on a space available basis. HCWs participating in such training shall not be in a contract duty status, i.e. training hours are not paid hours of service. Failure of the HCW to obtain training on a space available basis does not release the Contractor from the contract requirement.

4. FAILURE AND/OR INABILITY TO PERFORM.

4.1. Should a HCW who accrues leave in accordance with section C.3.1 be unable to perform duties under any Task Order due to medical or physical disability for more than 13 consecutive days, that individual's performance under the Task Order may be suspended by the KO until such medical or physical disability is resolved. If performance under the Task Order is so suspended, no reimbursement shall be made to the contractor for the affected HCW so long as performance is suspended.

4.2. If clinical privileges of a HCW have been summarily suspended pending an investigation into questions of professional ethics or conduct, performance under the Task Order may be suspended until clinical privileges are reinstated. No reimbursement shall be made to the contractor for the affected HCW so long as performance is suspended. The denial, suspension, limitation, or revocation of clinical privileges based upon practitioner impairment or misconduct will be reported to the appropriate licensing authorities of the state in which the license is held.

4.3. Any HCW demonstrating impaired judgment will be removed from providing health care services. The Government reserves the right to remove any employee who, in the judgment of a licensed physician, is impaired by drugs or alcohol.

4.4. Any HCW with alcohol or drug abuse problems may be allowed to return to work under the terms of this contract only with prior approval from the Commanding Officer.

5. GENERAL PROVISIONS FOR HEALTH CARE WORKERS.

5.1. HCWs shall comply with Executive Order 12731, October 17, 1990, (55 Fed. Reg. 42547), Principles of Ethical Conduct for Government Officers and Employees, and shall also comply with Department of Defense (DOD) and other government regulations implementing this Executive Order.

5.2. HCWs shall become acquainted with and obey all station regulations, shall perform in a manner to preclude the waste of utilities, and shall not use Government resources (i.e. copiers, telephone, and computers, etc.) for personal business. All motor vehicles operated on these installations by HCWs shall be registered with the base security service according to applicable directives. Eating by HCWs is prohibited in patient care areas/clinics and is restricted to designated areas. Smoking is prohibited in all clinic facilities.

5.3. Except as provided in this clause and in section H, HCWs are not prohibited from conducting a private practice of their professions or from engaging in other employment. However, the HCWs shall not, simultaneously with performance under this contract, engage in other employment that creates a conflict of interest, violates federal law (see Section H), or potentially compromises the quality of their work under this contract. Further, such private practice or other employment shall not be conducted during those hours in which the HCW is required to render services under this contract. HCWs shall make no use of the Government facilities or property provided under this contract in connection with other employment. (NAVMED P-117, Chapter 1, Article 1-22 applies (<http://navymedicine.med.navy.mil/default.cfm?selTab=Directives>)).

5.4. While on duty, HCWs shall not advise, recommend, or suggest to individuals authorized to receive services at Government expense that such individuals should receive services from the HCW when they are not on duty, or from a partner or group associated in practice with the contractor, except with the express written consent of the Commanding Officer. The contractor shall not bill individuals entitled to those services rendered pursuant to this contract.

5.5. HCWs shall be neat, clean, well groomed, and in appropriate clothing when in patient care and public areas. All clothing shall be free of visible dirt and stains and shall fit correctly. Fingernails shall be clean and free from dirt, and hair shall be neatly trimmed and combed. HCWs shall display an identification badge, which includes the HCW's full name and professional status (furnished by the Government) on the right breast of the outer clothing. Security badges provided by the Government shall be worn when on duty.

5.6. The Secretary of the Navy has determined that the illegal possession or use of drugs and paraphernalia in a military setting contributes directly to military drug abuse and undermines Command efforts to eliminate drug abuse among military personnel. The policy of the Department of the Navy (including the Marine Corps) is to deter and detect drug offenses on military installations. Measures to be taken to identify drug offenses on military installations, and to prevent introduction of illegal drugs and paraphernalia, include routine random inspection of vehicles while entering or leaving, with drug detection dogs when available, and random inspection of personal possessions on entry or exit. If there is probable cause to believe that a HCW has been engaged in use, possession, or trafficking of drugs, the HCW may be detained for a limited period of time until he/she can be removed from the installation or turned over to local law enforcement personnel having jurisdiction. When illegal drugs are discovered in the course of an inspection or search of a vehicle operated by a HCW, the HCW and vehicle may be detained for a reasonable period of time necessary to surrender the individual and vehicle to appropriate civil law enforcement personnel. Action may be taken to suspend, revoke, or deny clinical privileges as well as installation driving privileges. Implicit with the acceptance of this contract is the agreement by the HCW to comply with all Federal and State laws as well as regulations issued by the Commander of the military installation concerning illegal drugs and paraphernalia.

5.7. All financial, statistical, personnel, and technical data which are furnished, produced, or otherwise available to the contractor during the performance of this contract are considered confidential business information and shall not be used for purposes other than performance of work under this contract. Such data shall not be released by the contractor without prior written consent of the COR. Any presentation of any statistical or analytical materials, or any reports based on information obtained from studies covered by this contract, will be subject to review and approval by the COR before publication or dissemination.

5.8. The Contractor shall comply with all applicable State and local laws and MTF instructions and policies.

5.9. Contractor staff shall participate in executing the Emergency Preparedness Plan (drills and actual emergencies) as scheduled by the MTF (typically semiannually). An MTF personnel re-call list with personal contact information for all military, civil service and contractor staff is required to prepare in advance for an actual emergency. Upon commencement of performance, the contractor shall provide the COR with a list of personal contact information for a designated contractor representative as well as all contractor staff performing services. The contractor shall provide an updated list to the COR bimonthly. Should an emergency occur that will affect the HCWs' shifts, the designated contractor representative and the HCWs will be contacted.

5.10. HCWs providing services under this contract shall arrive for each scheduled shift in a well-rested condition and shall have had at least 6 hours of rest from all other duties as a HCW immediately prior to reporting for the shift.

5.11. Incentive Awards. The Government reserves the right to make incentive awards on behalf of the HCWs in a form of compensation outlined in a specific task order. These awards will be site or position specific based upon the Government's best business practice plans to minimize turnover, maximize the mission of the command and/or reward exemplary work. Incentive plans may be contained in individual task orders for positions within the maximum quantities only. If the task order provides for a time off incentive award and one is actually made the contractor is under no obligation to provide a replacement healthcare worker during the absence.

6. PERSONNEL QUALIFICATIONS. The contractor shall provide personnel having certain minimum levels of training and experience. General qualifications that apply to all HCWs are given in Section C.7. Specific qualifications for various labor categories are given in Section C.8. Additional and/or supplemental qualifications specific to a particular Task Order are contained in the applicable Task Order. Additional/supplemental qualifications may include, but are not be limited to, experience, board certification for physicians, or other professional certifications appropriate to the particular labor category.

7. GENERAL QUALIFICATIONS THAT APPLY TO ALL HEALTH CARE WORKERS.

7.1. HCWs shall read, write, speak, and understand the English language fluently and maintain good communication skills with patients and other health care personnel.

7.2. HCWs shall be physically capable of standing and/or sitting for extended periods of time and capable of normal ambulation.

7.3. Reserved.

7.4. In order to carry out the duties required by the contract, all HCWs will be required to access Navy information technology networks/systems containing sensitive information. Only HCWs who are U.S. citizens can be granted access to Department of Navy (DON) Information Technology networks/systems and sensitive information (see Section H, Information Technology/Sensitive Information Security Requirements and Section J, Attachment AA Citizenship Requirements).

7.5. HCWs shall represent an acceptable malpractice risk to the Government.

7.6. HCWs shall be in good standing, and under no restrictions, with the state licensure board in any state in which a license is held or has been held within the last 10 years.

7.7. HCWs shall maintain current certification in American Heart Association Basic Life Support (BLS) for Healthcare Providers; American Heart Association Healthcare Provider Course; American Red Cross CPR (Cardio Pulmonary Resuscitation) for the Professional Rescuer; or equivalent.

7.8. HCWs shall be current with and have completed all continuing education requirements specified by their professional licensure or certification.

7.9 Occupational Health

7.9.1. Within 60 days prior to performance of services by the HCW, the HCW shall obtain, at contractor expense, documentation of required immunizations and physical testing, and a statement from the HCW 's physician or a report of a physical examination. The physical examination and immunization documentation shall indicate that the HCW is free from mental or physical impairments that would restrict the HCW from providing the services described herein. Section J, Attachment AI details the necessary immunizations and physical examinations required. Attachment AI shall be completed and signed by the HCW's physician. The facility shall identify any incumbent HCWs who are not required to complete this documentation after contract award. Declinations shall only be permitted based on either the HCW's religious convictions or medical contraindications (as documented by a qualified health care provider). The Hepatitis B vaccine declination can be found on the World Wide Web at http://www.osha.gov/SLTC/etools/hospital/hazards/bbp/declination.html.

7.9.2. Except as provided in paragraph 7.9.3, below, no medical tests or procedures required by the contract may be performed in the MTF. Expenses for all required tests and/or procedures shall be borne by the contractor at no additional expense to the Government.

7.9.3. HCWs shall agree to undergo personal health examinations and such other medical and dental examinations at any time during the term of this contract, as the Commanding Officer may deem necessary for preventive medicine, medical surveillance, performance improvement, or privileging purposes. These examinations will be provided by the Government. If the contractor chooses, these examinations may be provided by private physician or dentist, at no expense to the Government.

7.9.4. It is essential that HCWs be vaccinated annually against influenza according to BUMED and CDC guidelines aimed at reducing the impact of influenza disease in health care settings. The Government will provide the influenza vaccine free of charge; if the HCW chooses to be immunized by the Government, they shall sign a waiver in accordance with MTF rules and regulations. Alternately, the HCW may obtain the vaccine at another facility, with the HCW bearing the total cost, and provide proof of vaccination to the Government. If the HCW declines vaccination, a signed declination form shall be provided to the Government in accordance with CDC recommendations and MTF policies.

7.9.5. HCWs who do not show a positive antibody titer after immunization and appear to have a "non-immune" status must report varicella exposure to the COR. In accordance with Centers for Disease Control Recommendations, such HCWs may be removed from patient care duties beginning on the tenth day following exposure and remain away from work for the maximum incubation period of varicella (21 days). In this instance, personnel under this contract who accrue leave will be considered to be in a leave status; all other personnel must be replaced during this period to ensure maintenance of contractually required coverage.

7.9.6. On an annual basis, HCWs must provide a current Purified Protein Derivative (PPD) reading or an evaluation if they are a known PPD reactor. The Contractor is responsible for any expenses incurred for required testing.

7.9.7. BLOODBORNE PATHOGEN ORIENTATION PROGRAM. HCWs shall participate in the Command's Bloodborne Pathogen Orientation Program. The HCW shall also participate in all required annual training and in periodic training for all procedures that have the potential for occupational exposure to bloodborne pathogens.

7.9.8. MANAGEMENT OF HIV POSITIVE HCWs. HIV positive HCWs will be managed in accordance with the current Centers for Disease Control (CDC) guidelines and Section 503 of the Rehabilitation Act (29 U.S. Section 793) and its implementing regulations (41 CFR Part 60-741).

7.9.9. PREVENTION OF THE TRANSMISSION OF THE HIV VIRUS. HCWs shall comply with the CDC's "Universal Precautions" for the prevention of the transmission of the HIV virus.

7.9.10. MANAGING THE CLINICAL RISK IN THE WORK ENVIRONMENT. The work environment inherently involves risks typically associated with the performance of clinical procedures. The HCW may be exposed to contagious disease, infections and flying debris, requiring the wearing of personal protection equipment such as scrub attire, gloves, masks, and eye protection.

7.10. CREDENTIALING REQUIREMENTS

7.10.1 Following award of a task order, the contractor shall submit to the Professional Affairs Department, via the COR, a completed Individual Credentials File (ICF) for each required HCW. The ICF, which will be maintained at the MTF, contains specific information with regard to qualifying degrees and licenses, past professional experience and performance, education and training, health status, and competency as identified in Appendix R of BUMEDINST 6320.66E of 29 August 2006 and subsequent revisions. ICFs for health care practitioners who do not currently have an ICF on file at the facility shall be submitted at least 30 days prior to commencement of services. For those health care providers who currently have an ICF on file, an updated Personal and Professional Information Sheet (PPIS) for Privileged Providers, with notation that a complete up-to-date ICF is on file, shall be submitted no less than 15 days prior to commencement of services.

7.10.2 Following award of a task order, the contractor shall submit to the Professional Affairs Department, via the COR, a completed Individual Professional File (IPF) for each licensed staff member not included in the requirements for ICFs. The IPF, which will be maintained at the MTF, contains specific information with regard to qualifying degrees and licenses, past professional experience and performance, education and training, health status, and competency as identified in Appendix S of BUMEDINST 6320.66E of 29 August 2006 and subsequent revisions. IPFs for personnel who do not currently have an IPF on file at the facility shall be submitted at least 30 days prior to commencement of services. For those personnel who currently have an IPF on file, an updated Personal and Professional Information Sheet (PPIS) for Nonprivileged Providers, with notation that a complete up-to-date IPF is on file, shall be submitted no less than 15 days prior to commencement of services.

7.10.3 Upon receipt of a complete ICF or IPF, the COR will forward it to the Professional Affairs Department for approval and credentialing of the individual health care provider/worker. The Professional Affairs Department will ensure the ICF or IPF is complete in accordance with BUMEDINST 6320.66E of 29 August 2006 and subsequent revisions. The contractor shall not assign an individual to work at the MTF until the HCW's ICF or IPF has been approved and shall discontinue the service of an individual who fails to maintain compliance with qualification and credentialing requirements.

7.10.4 BUMEDINST 6320.66E is available at http://navymedicine.med.navy.mil/default.cfm?selTab=Directives. Click BUMED Directives, select page 4 of the directives, and scroll down to the instruction number. The instruction is now contained in several separate files.

7.10.5 The Contractor shall submit a qualifications package to the COR for each HCW who is not required to submit either an Individual Credentials File (ICF) or an Individual Professional File (IPF), e.g., nursing assistants, medical assistants, laboratory technicians. Prior to Contractor employees providing services under this contract, the COR will verify the compliance of each HCW with the qualification requirements appropriate to their employment category.

7.10.6 Unless otherwise specified in an individual TOPR, the Government reserves the right to transfer to the gaining Contractor the credentials of a HCW who has been granted delineated clinical privileges on a predecessor contract/task order without a new or additional credentialing action. This extension may only occur: a) within the same command; b) when there is no increased clinical competency requirement of the HCW; c) when there is no significant change in the scope of clinical practice of the HCW; d) when there is no gap in performance between the contracts; and e) when the HCW has had acceptable performance evaluations.

7.10.7 Notwithstanding licensure and certification requirements given below in Section 8, each HCW is responsible for complying with all applicable licensure and certification regulations.

7.10.8 The contractor shall continuously maintain a current list of all individuals who have been privileged, credentialed, or approved for service under each task order. The contractor shall provide a copy of the list to the COR monthly, or more often as requested by the COR.

7.11. ORIENTATION

7.11.1. Each HCW providing service under this contract or resultant Task Orders shall undergo an orientation. Orientation may be waived for personnel who have previously provided service at the treatment facility.

7.11.2. Orientation shall consist of Command Orientation and Information Systems Orientation. Command orientation of 8 hours includes annual training requirements for topics such as fire, safety, infection control, and family advocacy. Additional Command Orientation for nurses (local certifications) will comprise an estimated additional 28 hours. Information Systems Orientation of approximately 24 hours includes the Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA), and the Ambulatory Data System (ADS). In addition, HCWs identified as CHCS and/or AHLTA Super-users shall undergo an additional 8 hours of information systems orientation. Any additional or specific requirements for orientation will be provided in the applicable Task Order.

7.11.3. Orientation will be provided to contractor employees, as required, during initial regularly scheduled shifts under the task order or as specified in the task order.

7.11.4. Those contractor employees who are required to be oriented during initial regularly scheduled work shifts shall be scheduled by the contractor for shifts occurring at times when orientation classes are available. The COR will provide a list of training times up to 30 days in advance.

7.11.5. For each task order requiring services of an individual the contractor shall not invoice for orientation, and the government will not reimburse the contractor for orientation, until such time as the individual has provided an amount of clinical services equal to the amount of orientation received. The contractor shall complete all orientation within 60 days after commencement of services by the HCW.

7.12. Turnover of HCWs. The contractor shall recognize the potentially negative impact on continuity of care created by staff turnover and the expense incurred by the Government for orientation and privileging of new workers. Therefore, the contractor shall make every effort to minimize turnover and, notwithstanding contractor employee

probation policies, shall recruit only individuals who indicate interest in a long-term commitment under the task order.

8. SPECIFIC QUALIFICATIONS LABOR CATEGORIES. Each HCW shall meet and maintain the qualifications specified below for their labor category. The following specific labor category qualifications are additional to the general qualifications given in Section C.7 and may be further supplemented by specific qualifications contained in the applicable task order.

8.1. AUDIOLOGIST

8.1.1. Possess a Master's Degree in Audiology from an accredited university.

8.1.2. Possess a Certificate of Clinical Competency in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA).

8.1.3. Possess a current, valid unrestricted license to practice as an Audiologist in any one of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U. S. Virgin Islands and maintenance of same.

8.1.4. Possess post graduate degree experience as a full-time Audiologist of at least 1 year within the preceding 3 years.

8.2. CARDIOVASCULAR TECHNOLOGIST

8.2.1. Possess registration as a Registered Diagnostic Cardiac Sonographer (RDCS) from the American Registry of Diagnostic Medical Sonographers (ARDMS).

8.2.2. Possess full-time experience as a Cardiac Sonographer of at least 18 continuous months within the preceding 36 months.

8.3. CENTRAL STERILE SUPPLY TECHNICIAN

8.3.1. Possess either (a), certification as a sterilization technician as determined by the National Institute for the Certification of Healthcare Sterile Processing and Distribution Personnel or equivalent certifying agency (e.g., the International Association of Healthcare Central Services Materials Management, or the National Institute of Healthcare Sterile Processing and Distribution Personnel), or (b) experience of at least one year within the preceding three years as a sterilization technician.

8.4. CERTIFIED ATHLETIC TRAINER

8.4.1. Possess current certification as an Athletic Trainer through the National Athletic Trainers' Association (NATA) Board of Certification.

8.4.2. Possess experience of at least 12 months within the preceding 36 months as an athletic trainer with collegiate athletes, professional athletes, or military operations personnel.

8.4.3. Possess experience with Windows-based computer systems of at least 12 months within the preceding 36 months.

8.4.4. Possess experience with computerized injury tracking programs of at least 12 months within the preceding 36 months.

8.5. CERTIFIED MEDICAL ASSISTANT

8.5.1. Possess a high school diploma or GED certificate.

8.5.2. Be a graduate from a medical assistant training program accredited by Commission on Accreditation of Allied Health Education Programs (CAAHEP) , the Accrediting Bureau of Health Education Schools (ABHES) of the American Medical Technologists, or a formal medical services training program of the United States Armed Forces.

8.5.3. Possess certification as a medical assistant by the American Association of Medical Assistants or registration by the American Medical Technologists.

8.6. CERTIFIED NURSING ASSISTANT

8.6.1. Possess a high school diploma or GED certificate.

8.6.2. Have completed of a course of education leading to, and possession of, certification as a nursing assistant from a Certified Nursing Assistant program.

8.7. CERTIFIED REGISTERED NURSE ANESTHETIST.

8.7.1. Be a graduate of a CRNA education program accredited by the American Association of Nurse Anesthetists (AANA) Council on Accreditation of Nurse Anesthesia Educational Programs.

8.7.2. Possess a current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.7.3. Possess current certification as a Registered Nurse Anesthetist from the American Association of Nurse Anesthetists (AANA).

8.7.4. Possess experience as a CRNA of at least 24 months within the preceding 48 months.

8.8. CHIROPRACTIC ASSISTANT

8.8.1. Possess a high school diploma or GED certificate.

8.8.2. Have a minimum of one year of full-time experience within the last three years as a chiropractic assistant, nursing assistant, physical therapy assistant, pharmacy technician, operating room technician or other similar medically related support type occupation.

8.9. CHIROPRACTOR

8.9.1. Be a graduate from a Chiropractor training program accredited by the Council on Chiropractic Education.

8.9.2. Possess current, valid, unrestricted license to practice as a Doctor of Chiropractic in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.9.3. Possess minimum of one year of full-time experience as a chiropractor within the last three years in a position in which both diagnostic and treatment services were consistently administered.

8.10. CLINICAL PSYCHOLOGIST

8.10.1. Possess a doctoral degree in clinical or counseling psychology from an accredited university.

8.10.2. Possess and maintain a valid, unrestricted license or certification to practice as a psychologist in any one of the 50 States, the District of Columbia, the Commonwealth or Puerto Rico, Guam or the U.S. Virgin Islands.

8.10.3. Have experience as a Psychologist of at least two years within the preceding 36 months.

8.11. CLINICAL SOCIAL WORKER

8.11.1. Possess a master's degree in social work from a program accredited by the Council on Social Work Education (CSWE).

8.11.2. Have minimum of two years post-masters experience as a clinical social worker within the last three years.

8.11.3. Possess a current, unrestricted license to practice independently as a Clinical Social Worker in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.12. CLINICAL SOCIAL WORKER, CASE MANAGER.

8.12.1. Possess a master's degree in social work from a program accredited by the Council on Social Work Education (CSWE).

8.12.2. Possess a current, unrestricted license to practice independently as a Clinical Social Worker in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.12.3. Be certified as Certified Advanced Social Work Case Manager (C-ASWCM) by the National Association of Social Workers OR possess a minimum of 3 years experience within the preceding 5 years as a social work case manager in a hospital-based setting performing medical crisis counseling and discharge planning.

8.12.4. Possess a valid driver's license and a personal vehicle for use under the contract.

8.13. COMPUTED TOMOGRAPHY (CT) TECHNOLOGIST

8.13.1. Be a graduate from a radiography program accredited by the Joint Review Committee on Education in Radiological Education (JCERT).

8.13.2. Possess current registration as a Radiologic Technologist or a Radiation Therapist by the American Registry of Radiologic Technologists (ARRT).

8.13.3. Possess current post-primary certification as a CT Technologist by the American Registry of Radiologic Technologists (ARRT).

8.13.4. Possess experience as a CT Technologist of at least 12 months within the preceding 36 months.

8.14. CYTOTECHNOLOGIST

8.14.1. Possess a bachelor's degree in biology, chemistry, or a related scientific discipline from an accredited university.

8.14.2. Possess current certification as a Cytotechnologist from the American Society for Clinical Pathology (CT (ASCP)).

8.14.3. Possess experience as a Cytotechnologist of at least 12 months within the preceding 36 months.

8.15. DIETETIC TECHNICIAN

8.15.1. Achieve one of the following:

8.15.1.1. Possess an associates degree from an accredited college or university plus successful completion of a Dietetic Technician program accredited by The Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association, or

8.15.1.2. Possess a bachelor's degree from an accredited college or university including academic requirements for dietetics accredited/approved by CADE plus completion of a supervised practice program accredited/approved by CADE.

8.15.2. Be registered as a Dietetic Technician from the Commission on Dietetic Registration of the American Dietetic Association.

8.16. DIETITIAN

8.16.1. Possess a bachelor's degree in nutrition/dietetics from a school accredited by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA).

8.16.2. Possess registration from the Commission on Dietetic Registration (CDR) of the American Dietetic Association.

8.16.3. Possess a valid, unrestricted license/certification/registration to practice as a dietitian in any one of the 50 States, the District of Columbia, the Commonwealth or Puerto Rico, Guam or the U.S. Virgin Islands.

8.16.4. Possess a minimum of 1 year of full-time experience as a dietitian within the preceding 3 years.

8.17. DOSIMETRIST

8.17.1. Possess certification as a medical dosimetrist by the Medical Dosimetrist Certification Board (MDCB).

8.17.2. Possess post-certification experience of a minimum of 12 months within the preceding three years.

8.18. EMERGENCY MEDICAL TECHNICIAN

8.18.1. Possess a high school diploma or GED certificate.

8.18.2. Possess certification as an EMT by the National Registry of Emergency Medical Technicians or State EMT certification.

8.19. GENETICS COUNSELOR

8.19.1. Possess a master's degree in Genetic Counseling from an accredited university.

8.19.2. Possess certification by the American Board of Genetic Counselors.

8.19.3. Have experience as a genetic counselor of at least one year within the last three years.

8.20. HEALTH EDUCATOR

8.20.1. Possess a bachelor's degree in Health Education, Community/Public Health or Wellness, or a human services related field such as counseling or psychology from an accredited university.

8.20.2. Have at least one year of full-time experience in health promotion programming within the last three years.

8.21. LICENSED PRACTICAL NURSE

8.21.1. Be a graduate from a Licensed Practical Nurse or Licensed Vocational Nurse Program accredited by the National League for Nursing Accrediting Commission (NLNAC).

8.21.2. Possess current, unrestricted license to practice as an LVN/LPN in any one of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.21.3. Prior to commencing service under this contract, Licensed Practical (Vocational) nurses must attend a two hour lecture on IV certification. Contractor nurses must then obtain certifications (e.g., IV, medications and blood administration) in accordance with clinic nursing service and command policy not later than 60 days after commencement of services, including MTF observation of three completed IV sticks.

8.22. MAGNETIC RESONANCE IMAGING (MRI) TECHNOLOGIST

8.22.1. Be a graduate from a radiography program accredited by the Joint Review Committee on Education in Radiological Education (JCERT).

8.22.2. Possess current registration as a Radiologic Technologist, Radiation Therapist, or Nuclear Medicine Technologist by the American Registry of Radiologic Technologists (ARRT).

8.22.3. Possess current post-primary certification as an MRI Technologist by the American Registry of Radiologic Technologists (ARRT).

8.22.4. Possess experience as an MRI Technologist of at least 12 months within the preceding 36 months.

8.23. MAMMOGRAPHY TECHNOLOGIST

8.23.1. Be a graduate from a radiologic technologist education program accredited by the Joint Review Committee on Education in Radiologic Technology (JRCERT).

8.23.2. Possess current registration by the American Registry of Radiologic Technologists (ARRT) as a Registered Technologist (R.T. (ARRT)) and current registration as a Mammography Technologist (R.T. (M)(ARRT)).

8.23.3. Have minimum of one year of full-time experience within the last three years in a setting corresponding to the requirements of the task order.

8.24. MEDICAL LABORATORY TECHNICIAN

8.24.1. Be a graduate from a medical laboratory technician training program accredited by the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) or the Accrediting Bureau of Health Education Schools (ABHES).

8.24.2. Possess certification as a Medical Laboratory Technician by the American Society of Clinical Pathologists (ASCP), National Credentialing Agency for Laboratory Personnel (NCA), or American Medical Technologists (AMT), or state licensure as a medical laboratory technician.

8.25. MEDICAL TECHNOLOGIST

8.25.1. Possess a bachelor's degree in biology, chemistry, or a related scientific discipline from an accredited university.

8.25.2. Possess current certification as a medical technologist from the American Society for Clinical Pathology (ASCP) or the American Medical Technologists (AMT).

8.25.3. Possess experience as a medical technologist of at least 12 months within the preceding 36 months.

8.26. NUCLEAR MEDICINE TECHNOLOGIST

8.26.1. Be a graduate of a program in nuclear medicine technology accredited by the Joint Review Committee on Educational Programs in Nuclear Medicine Technology.

8.26.2. Possess current certification as a nuclear medicine technologist by the Nuclear Medicine Technology Certification Board (NMTCB) or registration as a nuclear medicine technologist by the American Registry of Radiologic Technologists (ARRT).

8.26.3. Have experience as a nuclear medicine technologist of at least 12 months within the preceding 3 years.

8.27. NURSE MIDWIFE

8.27.1. Be a graduate of a Certified Nurse Midwife Education Program accredited by the American Nurses Association and the American College of Nurse-Midwives.

8.27.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.27.3. Possess certification by the American College of Nurse-Midwives Certification Council.

8.27.4. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.27.5. Possess current certification in one of the following: Advanced Cardiac Life Support (ACLS); Advanced Life Support for Obstetrics (ALSO); Pediatric Advanced Life Support (PALS); or Neonatal Resuscitation Program (NRP).

8.28. NURSE PRACTITIONER

8.28.1. Be a graduate of a Masters of Nursing program accredited by the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE).

8.28.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.28.3. Possess current certification (in the specialty corresponding to the specialty required by the task order) as a Nurse Practitioner by the American Nurses Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP) .

8.28.4. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.29. NURSE PRACTITIONER, NEONATAL

8.29.1. Be a graduate of a Masters of Nursing program accredited by the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE).

8.29.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.29.3. Possess certification as a Neonatal Nurse Practitioner from the National Certification Corporation (NCC), OR 3 years of experience within the last 5 years as a Nurse Practitioner in a neonatal unit.

8.30. OPERATING ROOM TECHNICIAN

8.30.1. Have education as follows: Either, (a) possess proof of graduation from a Surgical Technician training program accredited by the Association of Operating Room Technicians or, (b) possess a current, unrestricted license to practice as a licensed practical/vocation nurse (LPN/LVN) in any one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Gram or the U.S. Virgin Islands.

8.30.2. Possess experience as an Operating Room Technician or as an LPN/LVN providing Surgical/Operating Room services of at least 12 months within the preceding 36 months. Scrubbing experience must include competency in multiple surgical specialties, including at least 2 major complex specialties (for example, orthopedics, neurosurgery, laporoscopy, cardio-thoracic).

8.31. OPHTHALMIC TECHNICIAN

8.31.1. Be a graduate from an Ophthalmic Technician training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

8.31.2. Possess current certification as a Certified Ophthalmic Technician (COT) by the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO).

8.32. OPTOMETRIST

8.32.1. Have a doctorate degree in Optometry from an accredited college approved by the Council of Optometric Education of the American Optometric Association.

8.32.2. Possess current, valid, unrestricted license to practice as an optometrist in one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands

8.32.3. Experience as a clinical optometrist of at least 12 months within the preceding 18 months.

8.33. PHARMACIST

8.33.1. Have a bachelor's degree in Pharmacy or Doctor of Pharmacy from a college of pharmacy accredited by the American Council on Pharmaceutical Education (ACPE).

8.33.2. Possess current, valid, unrestricted license to practice Pharmacy in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.33.3. Have working knowledge of pharmacy computer systems such as AHLTA.

8.34. PHARMACY TECHNICIAN

8.34.1. Be a graduate from a Pharmacy Technician program accredited by the American Society of Health-System Pharmacists (ASHP), OR certification by the Pharmacy Technician Certification Board (PTCB), OR successful completion of a formal pharmacy technician training program (i.e., a technical, hospital, or retail-based program).

8.34.2. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.34.3. Have working knowledge of pharmacy computer systems such as AHLTA.

8.35. PHLEBOTOMIST

8.35.1. Possess either a degree or certificate of graduation from an approved/accredited phlebotomy training program – OR - 12 months experience as a Phlebotomist within the past 36 months.

8.35.2. Provide two letters of recommendation written within the last two years attesting to the HCW's clinical skills. A minimum of one letter must be from a supervisor. Reference letters must include name, title, phone number, date of reference, address and signature of the individual providing reference.

8.36. PHYSICAL THERAPIST

8.36.1. Possess bachelors, masters, or doctoral degree in Physical Therapy from an accredited Physical Therapy institution.

8.36.2. Possess current, unrestricted license to practice Physical Therapy in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.37. PHYSICAL THERAPY ASSISTANT

8.37.1. Be a graduate from a physical therapy assistant program accredited by the American Physical Therapy Association (APTA).

8.37.2. Possess current, valid State license as a physician therapy assistant in any one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.38. PHYSICIAN

8.38.1. Be a graduate from a medical school approved by the Liaison Committee on Medical Education of the American Medical Association or the American Osteopathic Association or certification by the Educational Council for Foreign Medical Graduates (ECFMG).

8.38.2. Have successful completion of a residency program (corresponding to the specialty required by the task order) which has been approved by the Accreditation Council for Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association or those Canadian training programs approved by the Royal College of Physicians and Surgeons of Canada or other appropriate Canadian medical authority.

8.38.3. Possess current, valid, unrestricted license in one of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.39. PHYSICIAN ASSISTANT

8.39.1. Be a graduate from a physician assistant training program accredited by the Accreditation Review Commission on Education of the Physician Assistant (ARC-PA).

8.39.2. Possess current certification by the National Commission on Certification of Physician Assistants (NCCPA).

8.39.3. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.40. PODIATRIST

8.40.1. Possess a doctoral degree in Podiatric Medicine from a college accredited by the Council on Podiatric Medical Education (American Podiatric Medical Association).

8.40.2. Possess a current, valid, unrestricted license to practice podiatric medicine in any one of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U.S. Virgin Islands.

8.40.3. Possess experience as a podiatrist of at least 2 years within the preceding 3 years.

8.41. RADIOLOGIC TECHNOLOGIST

8.41.1. Be a graduate from a radiologic technologist education program accredited by the Joint Review Committee on Education in Radiologic Technology (JRCERT).

8.41.2. Possess current registration by the American Registry of Radiologic Technologists (ARRT) as a Registered Technologist (R.T. (ARRT)).

8.41.3. Possess current advanced qualification registration by the American Registry of Radiology Technologists (ARRT) as specified in the task order.

8.41.4. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.42. REGISTERED NURSE

8.42.1. Have education as follows: Either (a), a bachelor's degree in Nursing; or (b) a diploma graduate in Nursing; or (c) an associate degree in Nursing from an accredited university.

8.42.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.42.3. Prior to commencing service under this contract, Contractor nurses must attend a 2-hour lecture on IV certification. Contract nurses must then obtain certifications (e.g., IV, medications and blood administration) in accordance with clinic nursing service and command policy not later than 60 days after commencement of services, including MTF observation of three completed IV sticks during this time.

8.43. REGISTERED NURSE, CASE MANAGER

8.43.1. Possess education as follows: Either (a), a bachelor's degree in Nursing; or (b) a diploma graduate in Nursing; or (c) an associate degree in Nursing from an accredited university.

8.43.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.43.3. Possess at least one of the qualifications given in 8.43.3.1 through C.8.43.3.3:

8.43.3.1. Possess current certification in a minimum of one of the following:

(a) Certified Case Manager (CCM) issued by the Commission for Case Manager Certification
(b) Certified Disability Management Specialist (CDMS) issued by the Certification of Disability Management Specialists Commission
(c) Certified Rehabilitation Registered Nurse (CRRN) issued by the Association of Rehabilitation Nurses
(d) Certified Occupational Health Nurse (COHN) issued by the American Board for Occupational Health Nurses
(e) Advanced Certification in Continuity of Care (ACCC) issued by the National Board for Certification in Continuity of Care
(f) Certified Rehabilitation Counselor (CRC) issued by the Commission on Rehabilitation Counselor Certification
(g) Nurse Case Manager (RN-NCM) issued by the American Nurses Credentialing Center
(h) Care Manager Certified (CMC) issued by the National Academy of Certified Care Managers

- OR -

8.43.3.2. Possess a minimum of 2 years full-time experience within the last 3 years as a registered nurse providing case management and obtain one of the certifications in C.8.43.3.1 within 24 months of commencing service under this contract

- OR -

8.43.3.3. Possess a master's degree in Nurse Case Management and obtain one of the certifications in C.8.43.3.1 within 24 months of commencing service under this contract.

8.43.4. Possess a valid driver's license and a personal vehicle for use under the contract.

8.43.5. Possess the necessary knowledge, skills and computer literacy to interpret and apply medical care criteria such as InterQual.

8.44. REGISTERED NURSE, CHARGE NURSE

8.44.1. Have education as follows: Either (a), a bachelor's degree in Nursing; or (b) a diploma graduate in Nursing; or (c) an associate degree in Nursing from an accredited university.

8.44.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.44.3. Prior to commencing service under this contract, Contractor nurses must attend a 2-hour lecture on IV certification. Contract nurses must then obtain certifications (e.g., IV, medications and blood administration) in accordance with clinic nursing service and command policy not later than 60 days after commencement of services, including MTF observation of three completed IV sticks during this time.

8.44.4. Have minimum of 1 year of full-time experience as a charge nurse within the last 3 years.

8.45. REGISTERED NURSE, PERIOPERATIVE

8.45.1. Have education as follows: Either (a), a bachelor's degree in Nursing; or (b) a diploma graduate in Nursing; or (c) an associate degree in Nursing from an accredited university.

8.45.2. Possess current unrestricted license to practice as a registered nurse in one of the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands.

8.45.3. Possess a minimum of 24 months full-time experience within the last 36 months providing services as a registered nurse in an operating room unit in a setting of comparable size and complexity.

8.45.4. Possess current Advanced Cardiac Life Support (ACLS) certification.

8.45.5. Prior to commencing service under this contract, Contractor nurses must attend a 2-hour lecture on IV certification. Contract nurses must then obtain certifications (e.g., IV, medications and blood administration) in accordance with clinic nursing service and command policy not later than 60 days after commencement of services, including MTF observation of three completed IV sticks during this time.

8.46. RESPIRATORY THERAPIST (CERTIFIED)

8.46.1. Be a graduate from a respiratory therapy education program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Committee on Accreditation for Respiratory Care (CoARC).

8.46.2. Possess certification as a Certified Respiratory Therapist (CRT) by the National Board for Respiratory Care (NBRC).

8.46.3. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.47. RESPIRATORY THERAPIST (REGISTERED)

8.47.1. Be a graduate from a respiratory therapy education program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Committee on Accreditation for Respiratory Care (CoARC).

8.47.2. Be registered as a Registered Respiratory Therapist (RRT) by the National Board for Respiratory Care (NBRC).

8.47.3. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

8.48. SPEECH PATHOLOGIST

8.48.1. Possess a master's degree in Speech Pathology from an accredited university.

8.48.2. Possess a Certificate of Clinical Competency in speech-language pathology (CCC-SLP) from the American Speech-Language-Hearing Association (ASHA).

8.48.3. Possess a current, valid unrestricted license to practice as a speech pathologist in any one of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam or the U. S. Virgin Islands.

8.48.4. Possess post graduate degree experience as a full-time speech pathologist of at least 1 year within the preceding 3 years.

8.49. ULTRASOUND TECHNOLOGIST

8.49.1. Be a graduate from a medical sonography training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

8.49.2. Possess current registration as a Registered Diagnostic Medical Sonographer by the American Registry of Diagnostic Medical Sonographers, Inc. (ARDMS).

8.49.3. Have minimum of 1 year of full-time experience within the last 3 years in a setting corresponding to the requirements of the task order.

9. GENERAL DUTIES. Contractor personnel shall perform a full range of duties consistent with their labor category, education, training, experience, clinical privileges (as applicable), and assigned position. General duties that apply to all personnel or across certain labor categories are given below. Additional and/or supplemental duties which are labor category specific, service area specific, or facility specific, including duties such as on-call or hospital admissions, are contained in Section C.10 and in the specific Task Order. Duties that apply to all contractor personnel are as follows:

9.1. Maintain a level of productivity comparable with that of other individuals performing similar services.

9.2. Comply with the standards of the Joint Commission, applicable provisions of law, and the rules and regulations of any and all governmental authorities pertaining to licensure and regulation of health care personnel and medical treatment facilities, the regulations and standards of medical practice of the MTF and the bylaws of the MTF's

medical staff. Adhere to and comply with all Department of the Navy, Bureau of Medicine and Surgery and local instructions and notices which may be in effect during the term of the contract.

9.3. Participate in peer review and performance improvement activities.

9.4. Participate in the Command's Bloodborne Pathogen Program, including orientation, annual training, and exposure procedures.

9.5. Comply with the CDC's "Universal Precautions" for prevention of the transmission of HIV.

9.6. Practice aseptic techniques as necessary. Comply with infection control guidelines to include the proper handling, storage, and disposal of infectious wastes, the use of universal precautions to prevent the spread of infections.

9.7. Function with an awareness and application of safety procedures.

9.8. Perform efficiently in emergency patient situations following established protocols, remaining calm, informing appropriate persons, and documenting events. Anticipate potential problems/emergencies and make appropriate interventions. Notify supervisor, director, or other designated person regarding problems that the HCW is unable to manage.

9.9. Apply an awareness of legal issues in all aspects of patient care and strive to manage situations in a reduced risk manner.

9.10. Participate in the implementation of the Family Advocacy Program as directed. Participation shall include, but not be limited to, appropriate medical examination, documentation, and reporting.

9.11. Exercise awareness and sensitivity to patient/significant others' rights, as identified within the institution.

9.12. Maintain an awareness of responsibility and accountability for own professional practice.

9.13. Participate in continuing education to meet own professional growth.

9.14. Attend annual renewal of hospital provided annual training such as family advocacy, disaster training, infection control, sexual harassment, and bloodborne pathogens.

9.15. Actively participate in the command's performance improvement program. Participate in meetings to review and evaluate the care provided to patients, identify opportunities to improve the care delivered, and recommend corrective action when problems exist.

9.16. Participate in the provision of in-service training to clinic staff members. Provide training and/or direction as applicable to supporting Government employees (e.g., hospital corpsmen, students, etc.).

9.17. Attend and participate in various meetings as directed.

9.18. Perform timely, accurate, and concise documentation of patient care.

9.19. Use computerized systems such as CHCS, AHLTA, ADS, and Clinical Information System (CIS).

9.20. Operate and manipulate automated systems such as CHCS, AHLTA, participate in clinical staff Performance Improvement (PI) and Risk Management (RM) functions, as prescribed by the Commander.

9.21. Exercise appropriate delegation of tasks and duties in the direction and coordination of health care team members, patient care, and clinic activities.

9.22. HIPAA Compliance. The HCW shall comply with the HIPAA (Health Insurance Portability and Accountability Act) privacy and security policies of the treatment facility. Providers shall obtain/maintain a National Provider Identifier (NPI) in accordance with DOD and MTF policy/instruction as applicable.

10. SPECIFIC DUTIES. The following specific labor category duties are additional to the general duties given in Section C.9 and may be further supplemented by specific duties contained in the applicable task order.

10.1. AUDIOLOGIST

10.1.1. Provide a full range of audiologist services in accordance with privileges granted by the Commanding Officer.

10.1.2. Administer audiological tests to all types of aurally handicapped patients including military personnel and their dependents in varying age groups (newborns to geriatric patients).

10.1.3. Review accompanying consultation forms and records and independently decide on which tests to administer, how many tests are necessary, and adapt test techniques and utilize clinical judgment based on audiological and psychological precepts.

10.1.4. Conduct routine tests, to include air conduction, bone conduction, speech reception thresholds and speech discrimination, including high intensity speech discrimination testing.

10.1.5. Test for non-organicity and determine accuracy and reliability of test results. Administer additional tests to rule out presence of non-organicity such as the Stenger Test. Employ objective test techniques such as Auditory Brainstem Response (ABR) and Otoacoustic Emissions (OAE) to help determine true organic thresholds.

10.1.6. Conduct special Audiological tests as necessary to assist the otologist in the medical diagnosis of site of lesion to differentiate between cochlear and retrocochlear pathology. Independently determine which tests are indicated.

10.1.7. Perform Electrophysiological tests such as Auditory Brainstem Response, Electrocochleography and Otoacoustic Emissions when indicated and appropriate.

10.1.8. Conduct special speech tests for differentiating central auditory pathology when indicated to include filtered and competing message tests, such as Staggered Spondee Words (SSW), Synthetic Sentence Index (SSI) and other dichotic and monotic listening tests.

10.1.9. Conduct Hearing Aid Evaluation. Administer formal objective hearing aid evaluations and informal subjective selection of hearing aids to both children and adults. Select for issue or recommend purchase of the instrument, which is most effectively suited to the patient's needs, orient patient to hearing aid use, and initiate a proper attitude for rehabilitation by means of an appropriate psychological approach.

10.1.10. Maintain area audiometric equipment pool; request required equipment as needed.

10.1.11. Selection of Hearing Aids.

10.1.11.1. Objectively evaluate hearing aids by administering audiological tests to compare the performance of several hearing aids carefully selected by the audiologist as most appropriate for the type and degree of hearing loss; determine on the basis of test results and clinical judgment which aids are most effective.

10.1.11.2. Administer computerized real ear-canal probe microphone measurements providing precision hearing aid fittings.

10.1.11.3. Arrange for issue of selected aid to active and retired personnel, and recommend purchase of aid to dependents.

10.1.11.4. Follow the Audiology Division Standard Operating Procedure (SOP) for processing of referrals to fit hearing aids by commercial hearing aid specialists, and recommendation of purchase of aid after subsequent testing and orientation for all patients not eligible for military issue.

10.1.12. Aural Habilitation. Provide hearing aid orientation, hearing conservation techniques, and individual adjustment counseling.

10.1.13. Immittance Audiometry. Measure acoustic characteristics of ear to assist in the diagnosis of middle ear and sensorineural pathologies. Middle ear acoustic measurements of the eustachian tube function and monitoring of acoustic reflex shall also be performed to aid the otolaryngologist in otological diagnosis. Prepare summary of the measurements and interpretation of results.

10.1.14. Electronystagmography. Evaluate vestibular disorder by objectively measuring and recording the changing electrical activity of the eye during nystagmus. Independently interpret results and prepare report in accordance with the Audiology Division.

10.1.15. Pediatric Testing. Provide testing of pediatric patients to include play audiometry and conditioned orientation reflex audiometry . Utilize knowledge of the development of auditory systems and psychological maturation when administering audiometry to newborns.

10.1.15.1. Recognize and report symptoms of problems in addition to hearing loss in pediatric patients to include mental retardation, emotional disturbances and brain function.

10.1.15.2. Recognize signs of social inadequacy, shyness, withdrawal, depression etc. in order to judge the validity of hearing tests in older children.

10.1.15.3. Counsel parents as required regarding child's problem, interpret results and provide guidance and advice on educational and training needs. Provide narrative summary of each child to referring physician and other interested agencies.

10.1.16. Counseling. Counsel patients regarding hearing problems, implications for or against use of a hearing aid, recommend or arrange for classroom training when indicated.

10.2. CARDIOVASCULAR TECHNOLOGIST

10.2.1. Perform a full range of diagnostic ultrasound examinations.

10.2.2. Operate the equipment such as the following: i)Acuson model 128XP Ultrasound Scanner; ii) ATL model HDI 3000 Ultrasound Scanner; iii) Acuson model Sequios Ultrasound Scanner; iv) ATL model HDI Mark 9 Ultrasound Scanner. Be familiar with and be able to use the linear, sector, and endovaginal probes as well as pulse and color Doppler capabilities of all of the above scanners.

10.2.3. Receive and interpret requests or instructions for diagnostic ultrasound scans; perform daily warm up and assigned quality control checks of the ultrasound scanners.

10.2.4. Receive patients and explain procedures, providing humane and appropriate care and communication to alleviate fear of examination. Correctly position the patient for the examination and make adjustments necessary for the required examination. Determine if any special patient preparation is required.

10.2.5. Key test data and patient information into computer of ultrasound equipment to maintain record of test results.

10.2.6. Identify abnormalities during testing and determine need for additional scans of affected area.

10.2.7. Recognize anatomic variants and determine which other area(s) of the body should be scanned. Use a detailed understanding of diseases of anatomy to accomplish effective ultrasound scanning.

10.2.8. Advise the radiologist of results of the examination and provide a preliminary diagnosis. Notify physician of significant scans requiring immediate attention.

10.2.9. Maintain and clean ultrasound equipment on a regular basis in accordance with Radiology department standards. Stock and maintain an adequate level of supplies required to ultrasound examinations. Recommend necessary monthly repairs when diagnostic quality is degraded.

10.2.10. Make minor adjustments on equipment. Differentiate artifacts from normal or pathological processes and recognize electronic equipment limitations. Program the examination equipment, set up the machine and scanning techniques to be employed.

10.2.11. Review new developments in the field by reading journals and attending meetings when possible and recommend to supervisor those changes which would improve the operation of the ultrasound section. Perform other related duties as assigned.

10.2.12. Recognize the need for and institute the necessary emergency measures for situations where a person requires resuscitation procedures due to cardiac or respiratory arrest.

10.3. CENTRAL STERILE SUPPLY TECHNICIAN

10.3.1. Receive, disassemble and inspect for damage reusable medical devices and surgical instrumentation. Additionally, receive and dispose of regulated medical waste, general waste and soiled linen.

10.3.2. Comply with OSHA regulations governing the wearing of personal protective equipment at all times when working in the decontamination area.

10.3.3. Determine the correct method of decontamination to include the following: removal of blood, tissue fragments, body fluids and other gross contaminants. Decontamination methods shall include wiping, soaking, rinsing, scrubbing and using ultrasonic and washer decontamination/sterilizer equipment.

10.3.4. Follow departmental manuals and procedures as directed.

10.3.5. Examine all items after decontamination/presterilization procedures to ensure that gross contaminants have been removed and that instruments function properly.

10.3.6. Ensure that all Main Operating Room (MOR), Labor and Delivery (L&D) ward and MTF medical devices and surgical instrumentation are properly labeled and identified.

10.3.7. Assemble and prepare the full range of specialty trays and instrument sets for the MOR, wards, and L&D for proper sterilization utilizing inventory sheets. Select correct wrapping or packaging material for medical devices and surgical instrument sets, select sterilization process in accordance with standard MTF procedures to include: Ethylene Oxide (ETO), or Steam Sterilization. Correctly label, seal, wrap or place in rigid containers, items with appropriate chemical indicator tape, and aerate gas sterilized items for the correct period of time.

10.3.8. Periodically monitor operation of Steam and ETO sterilizers using graphs, computer display panels, Bowie Dick, and Spore Challenge tests (biological).

10.3.9. Receive sterilized trays, sets, and equipment from the sterilizer; check for integrity of sterilization, i.e. color changes on indicator tapes, external and internal indicators, dampness of packages; stock and properly store sterile items in sterile storage room in accordance with standard MTF procedures.

10.3.10. Perform physical duties to include, heavy lifting (40 lbs), pushing/pulling wheeled carts weighing an average of 560 lbs.

10.3.11. Take the annual respiratory fit test and have the OSHA mandated physical examination for working with ethylene oxide. Respiratory fit tests shall be provided by the Government.

10.4. CERTIFIED ATHLETIC TRAINER (ATC)

10.4.1. Perform a full range of Certified Athletic Trainer duties. All services performed shall fall within those guidelines established by the National Athletic Trainers Association , American College of Sports Medicine, and American Medical Society for Sports Medicine.

10.4.2. Prevent, recognize, treat and rehabilitate injuries sustained during rigorous military training required to establish/maintain the physical readiness of personnel.

10.4.3. Perform under the clinical supervision of a Physician Supervisor assigned to the HCW by the Commanding Officer. The Physician Supervisor is responsible for the care rendered by the ATC. The following levels of supervision apply:

10.4.3.1. Direct supervision. The Physician Supervisor is involved in the decision making process. This level of supervision is for all ATCs during their initial 30-day evaluation period. Direct supervision includes (1) Verbal, whereby the ATC shall contact the Physician Supervisor by direct conversation or telephone before the ATC implements or changes a regimen of care and (2) Physically present whereby the Physician Supervisor is present through all or a significant portion of care. In the BMC/SMART center, direction supervision is reflected by the physician's co-signature of the patient's record before he/she departs from the facility.

10.4.3.2. Indirect supervision. The Physician Supervisor is not required to be involved in the decision making process at the time decisions are made. This supervision is primarily accomplished through retrospective review of records, evaluation of appropriateness of consultation and referral, and evaluation of events identified through occurrence screens. Retrospective record reviews will assess the adequacy of the history and physical examination, appropriateness of tests, and planned course of treatments and interventions. This type of supervision will be afforded the ATC following successful completion of a 30-day evaluation period and demonstrated knowledge and competency of required functional areas.

10.4.4. Actively consult with physicians at the treatment facility and provide a full range of direct prevention, treatment and rehabilitation as ordered by the Physician Supervisor or other consultant physicians.

10.4.5. Provide evaluation and treatment of musculoskeletal injuries incurred, including, but not limited to, the following: Progressive Resistance Exercise (PRE), Open and Closed Chain Kinetic Exercises, Proprioceptive Neuromuscular Facilitation (PNF), manual therapy and joint mobilization, hydrotherapy, hydrocollator, cryotherapy, ultrasound, phonophoresis, iontophoresis, and all varieties of muscle stimulation. Appropriately apply use of the following equipment: Biodex Isokinetic elevation and stimulation; ski machines; stair machines; treadmill exercisers; gravitron; free weights and universal machines; BAPS board; Back System; Anodyne; aquatic therapeutic devices; and instruction in therapeutic, corrective and rehabilitative exercises using specific equipment and strength training devices.

10.4.6. Provide treatment for soft tissue damage, acute and chronic edema, post-surgical edema, muscle atrophy, pain, overuse injuries, decreased circulation and loss of strength due to injury or biomechanical imbalance.

10.4.7. Provide emergency first aid, evaluation and treatment of injuries, and aid in preliminary diagnosis to include recognition of severity of injury, rendering initial treatment and performing initial examination.

10.4.8. Provide appropriate follow-up evaluation.

10.4.9. Design and fabricate protective pads, equipment and braces for the prevention and treatment of injuries including the use of proper taping techniques.

10.4.10. Technically direct students from various programs and provide instruction in injury assessments and rehabilitation utilization of all indicated modalities, equipment, braces and treatment protocols.

10.4.11. Provide instruction and services in the area of applied anatomy, physiology of exercise, kinesiology and biomechanics.

10.4.12. Provide training and guidance, as necessary, to supporting employees assigned to the HCW by the Physician Supervisor during the performance of rehabilitative procedures. Such direction and interaction shall adhere to government and professional clinical standards and accepted athletic trainer treatment protocols.

10.4.13. Ensure accuracy of all treatment documentation and directed reporting as assessments may be a factor in light duty or limited duty determinations where there is a question of physical ability or potential for injury.

10.4.14. Assist with inventory and maintenance of medical supplies. This includes replenishing exhausted supplies, preventive maintenance, and recommending new rehabilitation equipment purchases.

10.4.15. In cooperation with the Physician Supervisor utilize the following public health model of managing injury risk to assist the Commanding Officer in ongoing efforts to design effective physical readiness programs:

A. Determine existence and size of injury problems.
B. Identify causes of the problem.
C. Determine what prevents the problem.
D. Implement prevention strategies, training and programs.
E. Continue surveillance and monitor effectiveness of prevention efforts.

10.4.16. Document all assessments, treatments and follow-up care rendered through either written reports or through computerized means on a daily basis. Treatment and follow-up records on each individual requiring services shall document cause, contributing factors, duration, diagnosis and follow-up for use in research and analysis to improve treatment and develop methods for injury prevention.

10.4.17. Provide instruction and guidance as directed in courses relating to physical conditioning, injury prevention and recognition, pre-operative and post-operative rehabilitation, stretching, exercise physiology, posture and body mechanics.

10.5. CERTIFIED MEDICAL ASSISTANT

10.5.1. Prepare exam rooms prior to patient's arrival.

10.5.2. Obtain patient's medical record following appropriate procedures.

10.5.3. Check patient's vital signs, to include temperature, respiration, pulse, weight and blood pressure.

10.5.4. Obtain and document patient's current medical history, drug history, chief complaints, allergies and vital signs on the correct Standard Form before patient is in the exam room.

10.5.5. Assist the provider as needed during exams.

10.5.6. Perform diagnostic procedures when ordered, to include EKG's, urine dip sticks, phlebotomy, etc.

10.5.7. Transport patients to other clinical areas as needed.

10.5.8. Check each chart for the provider's signature, stamp, and each patient's diagnosis prior to returning the chart to Health Records.

10.5.9. Administer medication to patients as directed.

10.5.10. Obtain lab and x-ray results.

10.5.11. Maintain exam room stock levels and perform routine maintenance of exam rooms, to include dusting, cleaning wash basins, etc.

10.5.12. Participate in inventory procedures as directed.

10.5.13. Complete lab and x-ray requisitions in accordance with clinic policies.

10.5.14. Enter demographic data into the computer upon patient check-in; enter diagnosis and departing time when patient is released.

10.5.15. Answer telephone and transcribe accurate messages.

10.5.16. Ensure that any broken or unsafe equipment is removed from the clinic in a timely manner and notify appropriate personnel.

10.5.17. Assist with patient flow and give direct patient care as directed.

10.5.18. Operate the following medical equipment, as directed, such as Automatic Blood Pressure Monitor, Hand Held Nebulizer, EKG Machine (12 lead), Electronic Thermometer, IV infusion pump (Set-up only), Typanometer.

10.6. CERTIFIED NURSING ASSISTANT

10.6.1. Prepare exam rooms prior to patient's arrival.

10.6.2. Obtain patient's medical record following appropriate procedures.

10.6.3. Check patient's vital signs, to include temperature, respiration, pulse, weight and blood pressure.

10.6.4. Obtain and document patient's current medical history, drug history, chief complaints, allergies and vital signs on the correct Standard Form before patient is in the exam room.

10.6.5. Assist the provider as needed during exams.

10.6.6. Perform diagnostic procedures when ordered, to include EKG's, urine dip sticks, phlebotomy, etc.

10.6.7. Transport patients to other clinical areas as needed.

10.6.8. Check each chart for the provider's signature, stamp, and each patient's diagnosis prior to returning the chart to Health Records.

10.6.9. Administer medication to patients as directed.

10.6.10. Obtain lab and x-ray results.

10.6.11. Maintain exam room stock levels and perform routine maintenance of exam rooms, to include dusting, cleaning wash basins, etc.

10.6.12. Participate in inventory procedures as directed.

10.6.13. Complete lab and x-ray requisitions in accordance with clinic policies.

10.6.14. Enter demographic data into the computer upon patient check-in; enter diagnosis and departing time when patient is released.

10.6.15. Perform various administrative functions as directed, such as answering telephones and transcribing accurate messages, assisting with patient check-in, assisting with scheduling appointments, properly filing documents including lab chits, consultations, and treatment forms.

10.6.16. Ensure that any broken or unsafe equipment is removed from the clinic in a timely manner and notify appropriate personnel.

10.6.17. Assist with patient flow and give direct patient care as directed.

10.6.18. Operate the following medical equipment, as directed, such as Automatic Blood Pressure Monitor, Hand Held Nebulizer, EKG Machine (12 lead), Electronic Thermometer, IV infusion pump (Set-up only), Typanometer.

10.7 CERTIFIED REGISTERED NURSE ANESTHETIST

10.7.1. Provide a full range of nurse anesthetist services in accordance with privileges granted by the Commanding Officer.

10.7.2. Administer anesthesia to any patient undergoing a surgical procedure, as designated by the attending physician.

10.7.3. Perform a pre-anesthetic assessment and evaluation of the patient. This includes obtaining an informed consent from the patient, requesting consultations and/or diagnostic studies and ordering pre-anesthetic medications.

10.7.4. Develop and implement an anesthetic plan of care.

10.7.5. Perform an assessment immediately prior to induction of anesthesia of the patient. This shall include a review of the medical record with regard to completeness, pertinent laboratory data, time of administration and dosage of pre-anesthesia medication, together with an appraisal of any changes in the patient's condition from that noted on previous visits. This note shall include any previous anesthetic experiences and complications thereof noted in the medical record.

10.7.6. Initiate the anesthetic plan by selecting the type of anesthesia.

10.7.7. Obtain consultations, as appropriate, with a staff anesthesiologist (i.e., patients meeting ASA classification 3 or greater; pediatric patients less than 3 months old).

10.7.8. Maintain the patient's physiologic homeostasis and corrects abnormal responses to the anesthesia and/or surgery.

10.7.9. Collect and interpret patient physiological data by selecting, applying or inserting noninvasive monitoring modalities.

10.7.10. Manage the patient's airway and pulmonary status.

10.7.11. Manage the patient's emergence and recovery from anesthesia by maintaining homeostasis, providing relief from pain and anesthesia side effects and preventing and managing complications through selecting, obtaining, ordering and administrating medications, fluids or ventilatory support.

10.7.12. Remain with the patient as long as required by the patient's condition relative to his/her anesthesia status and until responsibility for proper patient care has been assumed by other qualified individuals. Personnel responsible for post-anesthetic care are to be advised of specific problems presented by the patient's condition.

10.7.13. Record all pertinent events taking place during the introduction of, maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components on all patients that have received anesthesia care.

10.7.14. Record post-anesthetic visits, including at least one note describing the presence or absence of anesthesia related complications within 48 hours of the procedure. While the number of visits will be determined by the status of the patient in relation to the procedure performed and the anesthetic administered, a visit should be made early in the postoperative period.

10.7.15. Discharge or release from PACU according to established criteria. Provide follow-up evaluation and care related to anesthesia complications and/or side effects.

10.7.16. In his/her observation, if the CRNA feels that an anesthetic will put the patient's life in jeopardy, then this condition must be discussed with the operating surgeon or the Head, Anesthesiology Department (or designated representative). The CRNA can rightfully and legally decline to administer an anesthetic to a patient in this category without repercussion. The choice of anesthetic should be discussed with the operating surgeon.

10.7.17. Check all equipment and agents to be used in the administration of the anesthetic to be sure it is in safe working order. Report all malfunctioning equipment to the Head, Anesthesiology Department or Chief Nurse Anesthetist.

10.7.18. Check all resuscitative equipment prior to the beginning of the first surgery of the day. Any malfunctioning or missing equipment shall be reported to the Head, Anesthesiology Department or Chief Nurse Anesthetist immediately.

10.7.19. Provide care appropriate to the age of the patients served. Interpret data about the patient's status in order to identify each patient's age specific needs and provide the care needed by the patient group including neonate, pediatric, adolescent and geriatric patients, such as interpreting nonverbal communication, safety practices and medication dosing of Neonates/Pediatrics; enlisting Adolescent patients in treatment, safety and security practices; and recognizing physical limitations, psychosocial needs, age related conditions, safety and medication precautions for geriatrics.

10.8. CHIROPRACTIC ASSISTANT

10.8.1. Maintain productivity comparable to that of other chiropractic assistants assigned to the same facility. Perform all duties in accordance with the chiropractic guidelines identified as Guidelines for Chiropractic Quality Assurance and Practice Parameters: Proceedings of the Mercy Center Consensus Conference.

10.8.2. Prepare treatment areas for incoming patients. Transport patients to chiropractic department, and prepare patients and equipment for treatment.

10.8.3. Administer complex, specialized supportive physio-therapy treatment in areas such as ultrasound, electrotherapy, therapeutic hot/cold and therapeutic exercise in support of chiropractic treatments in the clinic in a safe and medically accepted manner as directed by the supervisor.

10.8.4. Instruct and supervise patient exercise programs.

10.8.5. Report unusual patient treatment response or hazardous or malfunctioning equipment to the supervisor immediately.

10.8.6. Make recommendations and suggestions about treatment progression, duty limitations and the need for additional assessment and/or treatment.

10.8.7. Provide patient and family education.

10.8.8. Document assessments, tests, treatments and progress in the medical record at each visit. Record alterations of treatment plans and patient's reactions as needed. Document actions taken such as patient history, patient evaluation, treatments/adjustments, unusual occurrences, and morbidity in accordance with the MTF operating procedures. Comply with data collection requirements of the Chiropractic Health Care Demonstration Program (CHCDP) evaluation for each patient.

10.8.9. Assure cleanliness and orderliness in the work area. Assure adequate supply of ice and proper levels of water in hydrocollator. Exchange linen daily, and store clean, folded linen under plinths. Inventory, maintain, and clean equipment. Maintain established levels of supplies including linens, braces, bandages, tape and office supplies. Perform clerical duties such as maintaining statistics, writing patient charges, answering telephone, and other related duties.

10.9. CHIROPRACTOR

10.9.1. Perform a full range of chiropractic procedures within the scope of privileges granted by the Commanding Officer. Utilize the established chiropractic guidelines identified as Guidelines for Chiropractic Quality Assurance and Practice Parameters: Proceedings of the Mercy Center Consensus Conference.

10.9.2. Provide a level of productivity comparable to that of other chiropractors assigned to the same facility and authorized the same scope of practice.

10.9.3. Conduct a patent history and chiropractic physical examination (excluding vaginal examination) as clinically indicated.

10.9.4. Employ and record every measure of observation that will more substantially profile the patient during the initial patient interview and consultation.

10.9.5. Utilize X-ray and standard laboratory tests appropriate to the chiropractic diagnosis, and within the MTF's capabilities as detailed by the standard MTF operating procedures.

10.9.6. Perform standard osseous and soft tissue procedures only, as commonly taught in chiropractic college accredited by the Council on Chiropractic Education.

10.9.7. Utilize modalities of heat, cold, light, electricity, and sound in patient treatment area.

10.9.8. Provide patient instructions and recommendations in all matters pertaining to hygiene, nutrition, exercise and life style changes and ergonomic factors in the activities of daily living.

10.9.9. Refer patients to specialty services available at the MTF.

10.9.10. Orient, instruct, technically direct, and evaluate work activities of clinical support staff.

10.9.11. Plan and conduct lectures and training programs on chiropractic related subjects for staff, students and patients.

10.9.12. Order orthotics, lifts, collars, and lumbar sacral supports if available at the MTF.

10.9.13. Place active duty patients on limited duty or quarters status according to MTF bylaws.

10.9.14. Document actions taken such as patient history, patient evaluation, treatments/adjustments, unusual occurrences, and morbidity in accordance with MTF operating procedures.

10.9.15. Comply with data collection and documentation requirements of the MTF.

10.10. CLINICAL PSYCHOLOGIST

10.10.1. Perform a full range of clinical psychologist procedures in accordance with clinical privileges granted by the commanding officer.

10.1.2. Administer programs of treatment to mentally and emotionally disturbed individual adjustments to life; help medical and surgical patients deal with illnesses or injuries.

10.10.3. Assist in treating rehabilitation patients.

10.10.4. Treat individuals in times of personal crisis such as a divorce or death of a loved one.

10.10.5. Interview patients and study medical and social case histories.

10.10.6. Diagnose and evaluate mental and emotional disorders of individuals and administer programs of treatment.

10.11. CLINICAL SOCIAL WORKER

10.11.1. Perform a full range of clinical social worker procedures in accordance with clinical privileges granted by the commanding officer.

10.11.2. Practice as an interdependent member of the health team and provide important components of primary health care through direct social work services, consultation, collaboration, referral, teaching, and advocacy.

10.11.3. Provide direct and indirect services to both inpatients and outpatients in accordance with social work standards of practice.

10.11.4. Assess and treat outpatients in individual, group, couples, and family modalities exercising mature professional judgment and using a wide range of social work skills to include individual and family counseling to assist patients and their families in dealing with chronic and acute diseases/injuries.

10.11.5. Conduct psychosocial assessments to determine patient needs and resources (both family support and community support). Provide counseling to patient and family in matters directly related to patients' limitation, adjustment to medical condition, and ongoing treatment. Develop and implement discharge plans, follow-up care, and transfers to other health care facilities (e.g., nursing homes, rehabilitation hospitals, and VA facilities).

10.11.6. Plan and maintain referral and coordination services with civilian health and social service agencies to provide optimal patient care.

10.11.7. Provide consultation services to medical, nursing, and ancillary hospital staff regarding psychosocial issues, discharge plans, and follow-up care for patients and families.

10.11.8. Provide crisis intervention services.

10.11.9. Respond independently, and with various media, to appropriate military and community requests for lectures and presentations. Take the initiative in seeking out opportunities to present programs to meet the needs of service members and their families.

10.11.10. Consult with Naval Hospital Command and administration, supplying information and feedback regarding procedures and services provided by the Psychology Division.

10.11.11. Develop and maintain working relationships with community resources. Coordinate with teachers, lawyers, physicians, and representatives of their service disciplines for the benefit of the service member and their families. Take initiative in identifying and assessing the needs of the military community, and organize responses to address those needs.

10.11.12. Act as a human services broker, using clinical judgment and knowledge of area resources to provide information and referrals to patients and other care providers.

10.12. CLINICAL SOCIAL WORKER, CASE MANAGER. In addition to the applicable Clinical Social Worker duties given above:

10.12.1. Interface with the MTF RN Case Manager(s) in the development and implementation of the Case Management Program (CMP).

10.12.2. Integrate social work case management and nurse case management as a team.

10.12.3. Develop local strategies that use the strength and disciplines of both nursing and social work to accomplish case management.

10.13. COMPUTED TOMOGRAPHY (CT) TECHNOLOGIST

10.13.1. Perform a full range of CT Technologist functions and procedures. Operate or direct operations of radiological equipment for computerized tomography. Become proficient with and adhere to the local Standard Operating Procedures (SOP) for the correct conduct of CT procedures.

10.13.2. Receive the patient and explain the procedure to be performed and answer relevant questions. Provide for the physical and emotional comfort of the patient.

10.13.3. Set up patients and perform necessary adjustments and patient position as prescribed by the Diagnostic Radiologist or physician. Position the patient and make exposures necessary to complete the requested exam.

10.13.4. Perform computerized axial tomographic scans. Make independent standard examination, inclusive of arriving/departing patients via automated computer tracking system. Prepare the patient with the required contract agents; position the patients in the scanning unit; make the exposures necessary for the requested examinations and print the film.

10.13.5. Provide direct assistance in the performance of highly sophisticated and complex examinations, requiring dynamic scanning techniques.

10.13.6. Schedule patients for examinations. Evaluate the nature of critical and emergency procedures and determine patient priorities to accommodate them. Maintain records of patients treated, examinations performed, scans taken, etc. Maintain permanent records of scans in tape library.

10.13.7. Provide technical and professional knowledge for diagnostic impressions and findings.

10.13.8. Assist in researching, developing and formulating new techniques for CT procedures required by the Imaging Division.

10.13.9. Perform patient archiving and printing, to include making hardcopy radiographs or required images at the correct window and level settings. Process the images and file in correct file folder, and retrieve file jackets in the film archives as necessary. Archiving responsibilities include: transferring the required image information to the established long term storage device and printing those images for each patient as required by the SOP manual or as directed by the imaging physicians.

10.13.10. Confer with the radiologist to establish requirements of non-standard examinations to determine technical factors, positioning, number and thickness of CT "cuts" necessary to satisfy the requirements of that study.

10.13.11. Notify the radiologist or referring physician of any significant scans requiring immediate attention and visualization while the patient is undergoing examination.

10.13.12. Recognize the need for quality control and maintenance on dry view laser imager.

10.13.13. Review new developments in the field by reading journals and attending meetings when possible and recommend to supervisor those changes that would improve the operation of the department section. Perform other related duties as assigned.

10.13.14. Recognize need for, and institute the necessary emergency measures for situations where a person required resuscitation procedures due to cardiac or respiratory arrest.

10.13.15. Safely and effectively operate equipment used in patient care as specified in the equipment user manuals or other similar documentation. Maintain a safe working environment. This includes general safety procedures, safe practices of emergency procedures, proper handling and storage of hazardous materials, maintaining physical security, and reporting of incidents.

10.14. CYTOTECHNOLOGIST

10.14.1. Perform a full range of cytotechnology procedures.

10.14.2. Examine human body cells to detect evidence of cancer or other diseases.

10.14.3. Draw blood from patients by venipuncture or receive blood specimens sent to laboratory.

10.14.4. Centrifuge blood specimens in test and capillary tubes to separate sediment and cells from blood serum.

10.14.5. Categorize slides, record classification, and compile listings of patients for follow-up analysis.

10.14.6. Report slides with unusual cell structures and findings of analysis on subsequent specimens to pathologist.

10.15. DIETETIC TECHNICIAN

10.15.1. Act as a liaison between the Nutrition Management Department and the patients.

10.15.2. Maintain all required records, reports and statistics in accordance with MTF standard operating procedures. Assist in implementing and evaluating Nutrition Management Department functions.

10.15.3. Assist in care and maintenance of equipment and supplies used in the performance of duties. Document maintenance on equipment. Requisition supplies and educational materials as required.

10.15.4. Collect nutritionally relevant data, e.g., medication, clinical symptoms, laboratory values, dietary history, anthropometrics, etc., from the medical record consistent with screening and assessment guidelines for all age specific groups from infants to geriatrics. Complete nutritional assessment of the nutritional status/needs of the not at risk patients.

10.15.5. Calculate nutrient and energy intake values and assist in evaluating data from patient's dietary history.

10.15.6. Develop and revise nutritional care plan for patients not at nutritional risk, specifying diet, counseling, etc., and document in the medical record.

10.15.7. Monitor, evaluate and document patient's adherence/acceptance/tolerance of nutritional care/food intake and make appropriate recommendations.

10.15.8. Counsel patients not at nutritional risk concerning nutrition concepts and desired change in eating habits. Under direction of the dietitian, instruct patients and their families on prescribed diets including low sodium, weight reduction, prenatal, dental liquid, low fat, low residue, low fiber, high fiber, cardiac, and fat controlled, and document in the medical record.

10.15.9. Provide group classes in basic nutrition and routine modified diets to patients and/or employees. Provide inservice training and orientation for staff employees.

10.15.10. Gather data according to prescribed methods for use in evaluating patient food service. Evaluate patient meal test trays for accuracy in accepted standard levels and give recommendations as necessary. Participate and conduct meal rounds, trayline observation and patient opinion surveys.

10.15.11. Consult the appropriate dietitian concerning unusual nutritional problems of patients and take appropriate action if necessary.

10.15.12. Complete nutrition analysis of menus, recipes, diets, and calorie counts, using the available computer software.

10.16. DIETITIAN

10.16.1. Perform a full range of dietitian services in accordance with clinical privileges granted by the commanding officer.

10.16.2. Perform nutritional assessment, evaluation, and modification of nutrients.

10.16.3. Perform interpretation of laboratory data.

10.16.4. Perform evaluation of diet history, 24-hour recall, and food frequency data.

10.16.5. Perform modifications in fiber, consistency, calories, carbohydrates, fats, proteins, and minerals.

10.16.6. Provide alternate dietary plans to account for food allergy, food intolerance, or for food preferences such as vegetarianism.

10.16.7. Incorporate into dietary plans: nutritional factors associated with obesity, diabetes, cancer, cardiac, gastrointestinal, hepatic, hypertension, metabolic, endocrine, renal, surgery, neurologic, pulmonary, malabsorption, and infection; all life cycle phases (e.g., pregnancy, lactation, infants, children, adolescents, adults, and geriatrics); disease prevention of palliation (e.g., dental caries, oral health, weight control, risk factor intervention, oncology, abnormalities of nutrient metabolism, drug-nutrient, and diet-drug interactions, substance abuse, and feeding problems); and nutritional factors associated with stress, deficiency states, immunologic implication, megavitamin supplementation.

10.16.8. Provide education of patient and family in lifestyle modifications for factors given above.

10.16.9. Provide liaison between physician, nursing care, and nutritional services.

10.17. DOSIMETRIST

10.17.1. Perform a full range of medical dosimetrist duties as assigned by the radiation oncologist or medical physicist.

10.17.2. Perform dosimetric calculations for external beam treatments and brachytherapy.

10.17.3. Utilizing data acquired during the planning process (CT, MRI, and simulation), generate two dimensional or three dimensional isodose plans following the specifications of the radiation oncologist.

10.17.4. Assist with simulations and obtaining patient contours as requested by physicians and radiation therapy technologists.

10.17.5. Coordinate and assist in the performance of cross sectional imaging studies as required in support of treatment planning and dose determination.

10.17.6. Document and communicate all facets of the treatment to the oncology team and assure that a copy of the treatment plan is in the patient's treatment record.

10.17.7. Exercise competence with the clinical treatment requirements for the use of Multileaf Collimation, Dynamic Wedging, and Intensity Modulation.

10.18. EMERGENCY MEDICAL TECHNICIAN

10.18.1. Provide a full range of EMT services within the MTF emergency department.

10.18.2. Upon receipt of an emergency request for an ambulance, accompany the emergency department ambulance.

10.19. GENETICS COUNSELOR

10.19.1. Perform a full range of genetics counseling, both independently and in association with Maternal-Fetal Specialists, for patients at risk of chromosomal, inheritable or acquired birth defects.

10.19.2. Provide genetic counseling services for a variety of indications, including advanced maternal age, abnormal Maternal serum-alpha-fetoprotein (MSAFP) screening, abnormal fetal ultrasound, significant family history of birth defect or inheritable disease, or exposure to known teratogen.

10.19.3. Serve as a resource for health care providers, providing information regarding prenatal testing as well as assessment of need for genetic counseling.

10.19.4. Participate in in-service meetings of OB/GYN staff.

10.19.5. Collaborate and coordinate with other departments such as Pediatrics to maintain continuity of care.

10.20. HEALTH EDUCATOR

10.20.1. Review Health Enrollment Assessment Review (HEAR) reports and PCM reports for high risk and frequent users of health care. Contact these patients to schedule education opportunities in a classroom format, in one on one appointments, or through other appropriate means.

10.20.2. Review HEAR Reports and PCM reports for delinquent preventive services, contact the patient, and schedule an appointment for the clinical preventive service. Ensure that all enrollees receive their clinical preventive services at recommended age intervals.

10.20.3. Use the HEAR group data to determine the health risk of the population and how to improve the overall health of the enrolled population.

10.20.4. Educate the enrolled population about the Healthwise handbook and how to use it for home care.

10.20.5. Use the PPIP Flow Sheet DD2766 medical records form for documenting clinical preventive services.

10.20.6. Provide health promotion and education opportunities including, but not limited to, tobacco awareness; tobacco cessation classes or appointments consistent with the MTF tobacco cessation program; and nutrition education and weight management.

10.21 LICENSED PRACTICAL NURSE

10.21.1. Ensure patient care is carried out in accordance with the Standards of Nursing Care and the policies and procedures of the clinic.

10.21.2. Check patients into the clinic and triage using clinic guidelines. Inform the nurse, physician extender or physician of the patient's condition and potential problems.

10.21.3. Obtain and document patient and pertinent family history.

10.21.4. Perform a full range of diagnostic support duties which include taking vital signs, collecting specimens, obtaining, recording and tracking results of diagnostic tools.

10.21.5. Assist the physician in a variety of diagnostic examinations such as lumber punctures, colposcopies and sigmoidoscopies, by preparing, positioning and monitoring patients, and setting out and handling instruments and equipment.

10.21.6. Perform laboratory tests such as checking urine for sugar and stool for blood. Record and report results.

10.21.7. Perform a range of treatment procedures that include sterile dressing changes, applying compresses, monitoring IV fluids, inserting catheters and suctions, inserting nasogastric tubes, administering medications, giving enemas, setting up and giving treatment that requires auxiliary equipment such as oxygen and suction. Ambulate patients to other areas to include Radiology, various clinics, and physical therapy.

10.21.8. Prepare patients for tests, examinations, treatments, and/or surgery. Collect specimens such as urine, sputum and stool. Label specimens for laboratory examinations and follow up by using CHCS/AHLTA or calling the laboratory for reports. Alert provider to conditions which deviate from expected findings.

10.21.9. Prepare, start, monitor and discontinue intravenous fluids with accuracy and in accordance with established procedures.

10.21.10. Observe, report and document all observed symptoms, reactions, treatments and changes in the patient condition to the registered nurse, physician extender or physician. Make careful observations to assess that nursing procedures and treatment do not cause additional distress.

10.21.11. Perform routine nursing care activities such as taking blood pressures, temperatures, baths and hygiene care, passing and removal of trays, changing of linen, and otherwise assist in the care of the physical needs of the patient.

10.21.12. Operate basic equipment required in delivery of patient care such as pumps, IV pumps, oxygen administration apparatus and incentive spirometers.

10.21.13. Execute physician's orders within the guidelines of standard nursing practice. Ensure accurate medication is administered in correct form and dosage to the proper patient as directed by the physician.

10.21.14. Maintain records of nursing care, dose and time of medication administered, and indicate if the medication was not administered and the reason.

10.21.15. Administer immunizations in a safe and accurate manner with strict adherence to all NAVHOSP, NAVMED and CDC Immunization policies.

10.21.16. Recognize conditions which require isolation. Ensure universal precautions are used in all patient encounters.

10.21.17. Recognize emergency situations and assist with, or institute emergency measures for sudden adverse developments in patients such as cardiac arrests.

10.21.18. Perform preoperative procedures for minor surgery, and fill out pre-op checklist.

10.21.19. Assist patients in admission, transfer, and perform discharge planning follow-up and documentation.

10.21.20. Support the patient and/or family members toward the achievement of treatment plan goals. Provide instructions to the patient on invasive procedures, surgical procedures and post surgical conditions which were previously provided to the patient by a nurse, physician extender or physician.

10.21.21. Instruct patients on how equipment is used such as oxygen, suction, cardiac monitor and pulse oximeter. Instruct patients and family on use of prescribed medications, contraindications of medications, and the necessity of proper follow-up care.

10.21.22. Provide emotional support to patients and families.

10.21.23. Ensure necessary supplies are available and equipment is in functioning order.

10.21.24. Provide an orderly, clean and safe environment for patients and staff.

10.21.25. Handle telephone information requests with courtesy, accuracy and respect for patient confidentiality. Receive information and distribute messages as necessary.

10.21.26. Ensure maintenance and re-supply of pharmaceuticals in the clinic.

10.21.27. Ensure upkeep and perform checks of emergency equipment i.e., oxygen, emergency cart, suction apparatus, etc. and maintain appropriate logs. Inform the Charge Nurse of any discrepancy on daily checks.

10.22. MAGNETIC RESONANCE IMAGING (MRI) TECHNOLOGIST

10.22.1. Perform a full range of MRI technologist functions and procedures.

10.22.2. Explain to the patient the procedure to be performed and answer relevant questions. Provide for the physical and emotional comfort of the patient.

10.22.3 Set up patients and perform necessary adjustments and patient position as prescribed by the Diagnostic Radiologist or senior MRI Technologist.

10.22.4. Perform daily warm up and quality control checks of MRI equipment as per manufacturer's or technical representative's recommendations.

10.22.5. Operate MRI equipment.

10.23 MAMMOGRAPHY TECHNOLOGIST

10.23.1. Perform a full range of mammography technologist duties.

10.23.2. Perform breast imaging procedures.

10.23.3. Corroborate patient's clinical history with procedure, assuring information is documented in accordance with the department's standards.

10.23.4. Prepare patient for procedures; providing instructions to obtain desired results, gain cooperation and minimize anxiety.

10.23.5. Select and operate breast imaging equipment and associated devices to achieve desired results.

10.23.6. Position patient and equipment to best demonstrate anatomic area of interest, respecting patient ability and comfort.

10.23.7. Immobilize patients as required for appropriate examination, explaining the need for breast compression during mammography.

10.23.8. Determine radiographic technique and exposure factors.

10.23.9. Apply principles of radiation protection to minimize exposure to patient, self and others.

10.23.10. Evaluate mammograms or other breast images for technical quality, assuring that proper identification is recorded.

10.23.11. Assume responsibility for provision of physical and psychological needs of patients during procedures.

10.23.12. Provide and assist or physical breast inspection or palpitation.

10.23.13. Provide patient education, including breast self-examination techniques.

10.23.14. Operate mammography equipment.

10.23.15. Perform daily warm up and quality control checks of the Mammography equipment as per manufacturer's recommendations.

10.24. MEDICAL LABORATORY TECHNICIAN

10.24.1. Perform clinical laboratory tests in any one or a combination of areas as described in following sections of the laboratory: Hematology, chemistry, urinalysis, serology, microbiology and blood bank.

10.24.2. Calculate test results and measure prescribed quantities of samples during tests.

10.24.3. Notice pertinent details of specimens under microscopic study.

10.24.4. Perform a wide variety of laboratory tests either manually or using automated instrumentation.

10.24.5. Evaluate information against measurable criteria in the performance of laboratory tests.

10.24.6. Perform precise and accurate laboratory testing according to established laboratory procedures.

10.24.7. Receive written requisitions from health care providers for routine and special laboratory tests.

10.24.8. Set up and adjust laboratory equipment and apparatus.

10.24.9. Obtain laboratory specimens directly from patients by venipuncture.

10.24.10. Add reagents or indicator solutions, and subject specimens to various laboratory operations according to established procedures.

10.24.11. Prepare slides for microscopic analysis as necessary.

10.24.12. Observe test reactions, changes of color, or formation of precipitates; studies or subjects treated specimens to automatic analyzing equipment to make qualitative and quantitative analysis.

10.24.13. Record test results to flat logs and request slips and file reports in the CHCS/AHLTA .

10.24.14. Bring to the attention of the section supervisor, pathologist or general laboratory supervisor any unusual or grossly abnormal test result.

10.24.15. Perform light general cleaning of work areas such as collection of trash, autoclaving of specimens, cleaning of bench tops and light dusting.

10.24.16. Prepare specimens for transport to MTF laboratory or for mail out.

10.24.17. Prepare biological waste for proper disposal.

10.24.18. Participate/perform the prescribed QC/CAP programs.

10.25. MEDICAL TECHNOLOGIST

10.25.1. Perform a full range of automated and nonautomated laboratory procedures in the areas of chemistry, urinalysis, hematology, serology, bacteriology, and immunohematology according to established protocols.

10.25.2. Evaluate requested procedures to determine the suitability of specimens for analysis. Prepare specimens for analysis, ensuring that the physiologic state of the properties is maintained.

10.25.3. Prepare reagents and primary reference materials as necessary. Calibrate, standardize, adjust, and maintain instruments. Verified correct instrument operation using established procedures and quality control checks. Identify the cause of common problems and make simple repairs.

10.25.4. Recognize and react to indicators of malfunction. Locate and implement corrections. Obtain analytical data, convert to prescribed units of reporting as necessary, and correlate data to verify results.

10.25.5. Enter and certify laboratory results into CHCS/AHLTA.

10.25.6. Conduct quality control procedures on equipment, reagents and products and maintain proper records for quality control and quality assurance reports.

10.25.7. Instruct medical laboratory technicians, residents, and others in laboratory policies and procedures.

10.26. NUCLEAR MEDICINE TECHNOLOGIST

10.26.1. Perform a full range of nuclear medicine technologist procedures.

10.26.2. Prepare, measure, and administer radiopharmaceuticals in diagnostic and therapeutic studies, utilizing a variety of equipment and following prescribed procedures.

10.26.3. Operate cameras that detect and map the radioactive drug in the patient's body to create an image on photographic film or a computer monitor.

10.26.4. Administer therapeutic doses of radiopharmaceuticals under direction of physician.

10.26.5. Perform radioimmunoassay studies that assess the behavior of a radioactive substance inside the body, such as adding radioactive substances to blood or serum to determine levels of hormones or therapeutic drug content.

10.26.6. Maintain patient records and record the amount and type of radionuclides received, used, and disposed.

10.27. NURSE MIDWIFE.

10.27.1. Provide a full range of nurse practitioner services in accordance with privileges granted by the Commanding Officer

10.27.2. Adhere to NAVMEDCOMINST 6550.4, Utilization Guidelines for Nurse Practitioners (available from the COR upon request). This instruction includes the following requirements: permits nurse practitioner ordering and administration of an approved list of drugs according to protocol and requires random review of records of patients seen by the nurse practitioner.

10.27.3. Provide comprehensive primary care to a select population of essentially healthy women and their babies in a variety of settings to include prenatal care, intrapartum management, postpartum care, immediate newborn care, and well-woman visits.

10.27.4. Participate in the care of women with medial complications in collaboration with Obstetricians-Gynecologists.

10.27.5. Manage the care of normal antepartum women to include teaching, counseling and support.

10.27.6. Collect, document, and evaluate patient data. Take health history and perform and record the obstetrical physical evaluation.

10.27.7. Assess patient needs and formulate and implement a plan of care for each patient consistent with established guidelines.

10.27.8. Operate support, consultation or collaborative management for those patients and families experiencing critical illness and/or potential death.

10.27.9. Manage labor, including teaching and support.

10.27.10. Perform the following: start intravenous infusions; administer analgesia according to standing orders; manage and control normal spontaneous deliveries; record the labor and delivery.

10.27.11. Perform and record physical evaluation of newborns.

10.27.12. Manage the care of normal newborn including nutrition, elimination and activity.

10.27.13. Maintain all required patient records and reports pertinent information.

10.27.14. Prepare and submit all reports and statistics in a timely manner.

10.27.15. Keep current in nursing practice within the nurse Midwife specialty in accordance with the criteria of the American College of Nurse-Midwives.

10.28. NURSE PRACTITIONER

10.28.1. Provide a full range of nurse practitioner services in accordance with privileges granted by the Commanding Officer (e.g., technically direct and provide general screening and medical care and examinations of patients for routine, acute and chronic conditions involving any and all organ systems; provide immunizations; diagnose, treat, and counsel patients as indicated).

10.28.2. Adhere to NAVMEDCOMINST 6550.4, Utilization Guidelines for Nurse Practitioners (available from the COR upon request). This instruction includes the following requirements: permits nurse practitioner ordering and administration of an approved list of drugs according to protocol and requires random review of records of patients seen by the nurse practitioner.

10.28.3. Treat patients with common acute conditions, illnesses, or minor trauma within accepted protocols, Nurse Practice Acts, and/or in collaboration with a physician.

10.28.4. Collaborate with the physician in the health care of patients with chronic illnesses.

10.28.5. Request consultation or referral with appropriate physicians, clinics, or other health resources as indicated.

10.28.6. Order diagnostic tests as applicable.

10.28.7. Prescribe and dispense medications as delineated by the Pharmacy and Therapeutics Committee.

10.28.8. Promote preventive and health maintenance care, including annual physicals, positive health behaviors, and self-care skills through education and counseling.

10.29. NURSE PRACTITIONER, NEONATAL

10.29.1. Provide a full range of nurse practitioner services in accordance with privileges granted by the Commanding Officer.

10.29.2. Adhere to NAVMEDCOMINST 6550.4, Utilization Guidelines for Nurse Practitioners (available from the COR upon request). This instruction includes the following requirements: permits nurse practitioner ordering and administration of an approved list of drugs according to protocol and requires random review of records of patients seen by the nurse practitioner.

10.29.3. Provide medical management of patients in the newborn nursery under the supervision of a staff pediatrician. This includes attending deliveries, doing admission and discharge assessments, teaching of Birth Product Line staff, and arranging follow-up. Provide well child care for neonates within 28 days of discharge from the nursery.

10.29.4. Provide comprehensive medical assessment, examination, consultation, diagnosis, and treatment plan for neonates, under the direction of a staff Pediatrician.

10.29.5. Provide medical management of neonates in the Nursery and Level II Nursery and other areas to include neonatal resuscitation, conventional ventilation, stabilize and maintain Level III care prior to transport, prescription

of medications (including controlled substances), to treat neonatal medical disorders, under direction of a staff Pediatrician.

10.29.6. Request and interpret laboratory tests, electrocardiograms, and radiographic procedures, and other tests as needed under the direction of staff Pediatricians.

10.29.7. Perform procedures including sedation, endothracheal intubation, routine phlebotomy, arterial phlebotomy, percutaneous central venous line placement, umbilical line placement, lumbar puncture, suprapubic bladder taps, bladder catherization, needle thoracentesis, chest tube placement, circumcision as deemed appropriate under the supervision of the staff Pediatrician.

10.29.8. Attend routine and high-risk deliveries as a member of the Resuscitation Team and perform Neonatal Resuscitation.

10.29.9. Provide medical care to neonates awaiting transport to other facilities and from other higher level of care NICUs, under direction of a staff Pediatrician.

10.29.10. Provide outpatient care for routine well baby appointments, NICU follow-up appointments.

10.29.11. Provide instruction to students and resident physicians rotating through the nursery at Naval Hospital Camp Lejeune.

10.30. OPERATING ROOM TECHNICIAN

10.30.1. Perform a full range of surgical/operating room technician services to include performance as a scrub technician; pass instruments to surgeon and/or surgical assistants; assist circulating nurse to prepare patients for surgery and assists in preparation of patient's operative site; assist the anesthesiologist; adjust lights and other equipment as directed; verify proper identification of patients and scheduled surgical procedure; review to ensure appropriate consent forms are complete; assist in positioning patient in prescribed position for surgery; and assist as directed in moving patient to and from the surgery site.

10.30.2. Count (with the circulating nurse) sponges, needles and instruments used during surgery and assist in clean up of operating room using standard MTF policies.

10.30.3. Prepare operative specimens as directed, label and deliver them to the laboratory and move equipment to and from operating rooms as necessary for scheduled procedures.

10.30.4. Place proper furnishings, equipment, sterile and nonsterile supplies, and instruments in operating room; check equipment for proper functioning and manage case cart system; and provide and place appropriate sterile drapes for surgical procedure. Perform equipment and instrument sanitation; disassemble and sort instruments and transfer to cleaning area.

10.30.5. Provide pick-up and delivery service for such items as blood gasses, supplies, specimens, and materials to support Operating Room needs.

10.30.6. Provide sterile supply service: cleans, washes, decontaminates, and prepares instruments and equipment for sterilization; conducts sterilization by appropriate method; monitor and document sterilizer function; provide pick-up and delivery for Central Sterile Supply (CSS) to activities within the medical facility.

10.30.7. Conduct inventory; determine need; orders, obtains, receives, and stores surgical supplies; and inspect and monitor stocking of Cardiopulmonary Resuscitation (PR) crash cart.

10.30.8. Respond to CPR situations, acute respiratory problems and other emergencies as needed.

10.31. OPHTHALMIC TECHNICIAN

10.31.1. Provide a wide variety of duties to assist the optometrist/ophthalmologist.

10.31.2. Obtain patient histories, perform prescription verification, and maintain patient records.

10.31.3. Assist in testing patients' vision. Test far acuity, near acuity, peripheral vision, depth perception, and color perception.

10.31.4. Examine eye, using slit lamp, for abnormalities of cornea, and anterior and posterior chambers.

10.31.5. Apply drops to anesthetize, dilate, or medicate eyes.

10.31.6. Measure intraocular pressure of eyes (glaucoma test).

10.31.7. Test field of vision, including central and peripheral vision, for defects, and charts test results on graph paper.

10.31.8. Measure axial length of eye, using ultrasound equipment.

10.31.9. Performs other tests and measurements as directed by the physician.

10.31.10. Instruct patients concerning eye care. Instruct patients in contact lens handling.

10.31.11. Administer vision therapy programs prescribed by the optometrist/ophthalmologist.

10.32. OPTOMETRIST

10.32.1. Perform a full range of optometry examinations and procedures in accordance with clinical privileges granted by the commanding officer.

10.32.2. Technically direct, oversee, or instruct other health care professionals seeing patients within the scope of their clinical privileges or responsibilities.

10.32.3. Promote preventive and health maintenance care, including appropriate periodic examinations, positive health behaviors, and self-care skills through education and counseling.

10.32.4. Request consultation or referral with appropriate physicians, clinics, or other health resources as indicated.

10.32.5. Order diagnostic tests as applicable.

10.32.6 Prescribe and dispense medications in accordance with privileges and as delineated by the Pharmacy and Therapeutics Committee.

10.33. PHARMACIST

10.33.1. Perform a full range of pharmacist procedures.

10.33.2. Deliver comprehensive pharmaceutical services within the personnel, supply, and equipment capabilities of the facility.

10.33.3. Counsel patients regarding appropriate use of medications.

10.33.4. Review patient profiles at the time of dispensing in order to closely monitor medication therapy.

10.33.5. Ensure prescription directions for use, dose, medication interactions, therapeutic duplications or overlaps, allergy information, age specific dosage, and other pertinent data are appropriate for individual patients. Intervention with providers shall be made for noted discrepancy of above listed items.

10.33.6. Compound medications as required.

10.33.7. Ensure accuracy of all pharmaceutical products prepared or processed by technical staff.

10.33.8. Work closely with clinical staff in developing patient wellness programs such as smoking cessation programs and asthma classes.

10.33.9. Provide medication information to the clinical staff as required.

10.33.10. Provide medication and health care related in service training to clinical staff on new medications on the market; appropriate use of medications; comparison of current medication therapies; and other topics as deemed appropriate by the department head.

10.33.11. Provide clinical direction of corpsmen and pharmacy technicians and provide input into job performance evaluations.

10.33.12. Maintain inventory control of all pharmaceuticals in the pharmacy, especially scheduled pharmaceuticals, and ensure pharmacy security. Maintain appropriate records and security of all scheduled controlled substances according to applicable regulations.

10.33.13. Consult with other specialty practitioners who have been referred for pharmaceutical services.

10.33.14. Ensure that work areas are clean and safe according to applicable regulations.

10.33.15. Document significant medication interactions, and pharmacy interactions with prescribers.

10.33.16. Execute drug utilization reviews (DURs) as deemed necessary.

10.34. PHARMACY TECHNICIAN

10.34.1. Perform a full range of pharmacy technician procedures.

10.34.2. Perform pharmaceutical dispensing duties including filling new outpatient prescriptions, refilling prescriptions, and entering orders into databases.

10.34.3. Perform information consultation duties including supporting new and refill prescriptions, supporting patient requests, supporting physician's requests, monitoring for drug interactions, and reporting adverse drug reactions.

10.34.4. Perform quality improvement duties including performing drug storage inspection, reviewing expired supplies, and producing error and workload reports and documentation.

10.34.5. Perform supply process duties including assisting with new orders, stocking/restocking shelves, inventory maintenance, producing not in stock reports.

10.34.6. Provide general cleaning of workspaces including removal of trash, breakdown of cardboard boxes, and sweeping or mopping of workspace.

10.35. PHLEBOTOMIST

10.35.1. Perform a full range of phlebotomist duties to include, proper venipuncture, finger-stick and heel-stick procedures using appropriate techniques; and perform set-up and completion of special test-related phlebotomy procedures utilizing appropriate techniques. Ensure that that all aspects of patient accessioning, specimen collection, processing, and distribution are performed properly.

10.35.2. Conduct patient in-processing prior to specimen collection, including review of paperwork accompanying patients and cordial guidance and assistance.

10.35.3. Assemble equipment, such as tourniquet, needles, disposable containers for needles, blood collection devices, gauze, cotton, and alcohol on work tray, according to requirements for specified tests or procedures.

10.35.4. Verify or record identity of patient or donor and converses with patient or donor to allay fear of procedure and conduct interviews, take vital signs, and draw and test blood samples to screen donors at blood bank.

10.35.5. Provide technical oversight and training to ensure that all invasive procedures (venipuncture, capillary puncture, clotting time, etc.) performed in the laboratory are done in the safest, most sanitary, and expeditious manner, with minimal discomfort for the patient. Training may include newly arrived corpsman, nurses, reservists, and American Red Cross volunteers.

10.35.6. Perform phlebotomy-related administrative and clerical procedures of the Front Desk Section of the lab and fully document all samples obtained per the laboratory's standard operating procedures and maintain the supply inventory and cleanliness of the front desk and phlebotomy area.

10.35.7. Provide instruction on patient centered specimen collection (24-hour urine, occult blood testing, semen analysis, etc.) and special requirements necessary for laboratory-collected specimens (fasting requirements, special diets, etc.). Demonstrate knowledge of all aspects of phlebotomy and collection of adequate clinical specimens and utilize "age-specific" techniques to obtain specimens from infants and the elderly.

10.35.8. Possess knowledge of medical terminology, allowing test requests and results to be understood and communicated.

10.35.9. Demonstrate knowledge of the type and severity of patient reactions, including, but not limited to, syncope, vomiting, and unconsciousness and types of procedures in place for such instances. Counsel patients on care of post-phlebotomy complications (i.e. hematomas).

10.35.10. Demonstrate an understanding of Naval Occupational and Safety Office (NAVOSH) guidelines for the use of aseptic and sterile technique, the use of personal protective equipment, the handling of infectious and bio-hazardous materials, and the reporting of any hazards and/or accidents.

10.36. PHYSICAL THERAPIST

10.36.1. Perform a full range of physical therapist services in accordance with the scope of clinical privileges granted by the Commanding Officer.

10.36.2. Provide appropriate therapeutic procedures and provide a full range of therapy services in support of patient referrals from the following specialties: Orthopedics, General Medicine and Surgery, Primary Care Clinic, Rheumatology and other referrals approved by Department Head/Division Officer.

10.36.3. All patient contact and care shall be safe, timely, result in achievement of realistic and documented treatment goals, and comply with or satisfy the intent of the referring medical staff.

10.36.4. Test and measure the patient's strength, motor development, sensory perception, functional capacity, and/or respiratory and circulatory efficiency. Record findings to develop or revise treatment programs.

10.36.5. Plan and prepare written treatment programs based on an evaluation of the patient.

10.36.6. Administer manual exercises to improve and maintain function.

10.36.7. Instruct, motivate, and assist patients in performing various physical activities, such as non-manual exercises, ambulatory functional activities, daily-living activities, and in use of assistive and supportive devices, such as crutches, canes, and prostheses.

10.36.8. Administer treatments involving application of physical agents, using equipment such as a pulsed lavage unit and/or whirlpool bath, moist packs, ultraviolet and infrared lamps, and ultrasound machines. Evaluate effects of treatment at various stages and adjust treatments to achieve maximum benefit.

10.36.9. Administer soft tissue mobilization, applying knowledge of mobilization techniques and body physiology. Administer traction to relieve pain, using traction equipment.

10.36.10. Record treatment, response, and progress in patient's chart and/or automated systems.

10.36.11. Instruct patient and family in treatment procedures to be continued at home. Evaluate, fit, and adjust prosthetic and orthotic devices and recommend modification as required.

10.36.12. Coordinate treatment with physician and other staff members to obtain additional patient information, suggest revisions in treatment program, and integrate physical therapy treatment with other aspects of the patient's health care. Contact referring physicians regarding patient care concerns, as required.

10.36.13. Provide documented treatment and discharge recommendations to members of the staff in routine, emergency, and special cases as needed.

10.36.14. Orient, instruct, and direct work activities of assistants, technicians, aides, students, etc.

10.36.15. Provide input and attend rehabilitation team meetings, seminars, and quality assurance meetings.

10.36.16. Participate in peer review activities.

10.37. PHYSICAL THERAPY ASSISTANT

10.37.1. Provide a full range of physical therapy assistant services, including the services given below, as directed by the supervising physical therapist.

10.37.2. Carry out a program of corrective exercise and treatment for assigned patients, as directed by the head physical therapist. Under supervision, administer such treatment as exercise, gait training, massage, whirlpool, hot packs, diathermy, ultrasound, paraffin, ice packs and traction. Instruct patients on segments of the program including proper use of wheelchairs, crutches, braces, and prosthetic appliances and devices.

10.37.3. Administer traction to relieve neck and back pain, using intermittent and static traction equipment. Instruct, motivate, and assist patients to learn and improve functional activities, such as preambulation, transfer, ambulation, and daily-living activities.

10.37.4. Observe patients during treatments and compile and evaluate data on patients' responses to treatments and progress and report orally or in writing to the physical therapist.

10.37.5. Fit patients for, adjust, and train patients in the use and care of orthopedic braces, prostheses, and supportive devices, such as crutches, canes, walkers, and wheelchairs.

10.37.6. Confer with members of the physical therapy staff and other health team members, individually and in conference, to exchange, discuss, and evaluate patient information for planning, modifying, and coordinating treatment programs. Coordinate with other departments and the clinic staff to provide complete care to patients. Act as a liaison with nursing, medical staff, and other therapists to facilitate problem solving and coordination of services. Act as educational resource.

10.37.7. Give orientation, direction and instruction to new physical therapy assistants and physical therapy aides.

10.37.8. Perform clerical duties, such as taking inventory, ordering supplies, answering telephone, taking messages, filling out forms, scheduling patients, and staffing the reception area. Maintain and care for department equipment and supplies and storage. Maintain department records and files in accordance with facility policies. Perform coding of patient encounters and workload.

10.37.9. Measure patient's range-of-joint motion, length and girth of body parts, and vital signs to determine effects of specific treatments or to assist physical therapist to compile data for patient evaluations.

10.37.10. Monitor treatments administered by physical therapy aides.

10.38. PHYSICIAN

10.38.1. Provide a full range of physician services in accordance with privileges granted by the Commanding Officer.

10.38.2. Technically direct, perform, or assist in the instruction of, other health care professionals seeing patients within the scope of their clinical privileges or responsibilities.

10.38.3. Promote preventive and health maintenance care, including annual physicals, positive health behaviors, and self-care skills through education and counseling.

10.38.4. Request consultation or referral with appropriate physicians, clinics, or other health resources as indicated.

10.38.5. Order diagnostic tests as applicable.

10.38.6. Prescribe and dispense medications as delineated by the Pharmacy and Therapeutics Committee.

10.39. PHYSICIAN ASSISTANT

10.39.1. Provide a full range of physician assistant services in accordance with privileges granted by the Commanding Officer (e.g., technically direct and provide general screening and medical care and examinations of patients for routine, acute and chronic conditions involving any and all organ systems; provide immunizations; diagnose, treat, and counsel patients as indicated).

10.39.2. Adhere to NAVMEDCOMINST 6550.5, Utilization Guidelines for Physician Assistants (available from the COR upon request). This instruction includes the following requirements: permits physician assistant ordering and administration of an approved list of drugs according to protocol and requires random review of records of patients seen by the physician assistant.

10.39.3. Request consultation or referral with appropriate physicians, clinics, or other health resources as indicated.

10.39.4. Order diagnostic tests as applicable.

10.39.5. Prescribe and dispense medications as delineated by the Pharmacy and Therapeutics Committee.

10.39.6. Promote preventive and health maintenance care, including annual physicals, positive health behaviors, and self-care skills through education and counseling.

10.40. PODIATRIST

10.40.1. Provide a full range of podiatry services in accordance with privileges granted by the Commanding Officer (e.g., medical and surgical treatment of disorders of the foot and ankle with comprehensive and complete podiatric medical examination for consultation, diagnosis, and treatment planning).

10.40.2. Perform biomedical examination with fabrication or prescribing of orthotic and shoe appliances of devices, including design of special shoes.

10.40.3. Provide comprehensive joint and gait analysis as related to foot and ankle.

10.40.4. Provide diagnosis and treatment of a wide range of podiatric conditions including but not limited to: dermatological diseases of the foot and ankle; circulatory disorders affecting the foot and ankle; neurological disorders affecting the foot; arthritis and other inflammatory diseases affecting the foot and ankle; toenail disorders; skin and soft tissues tumors and cysts of the foot; soft tissue surgery of the foot (including the skin and nails); digital osseous and soft tissue surgery, including the great toe; foot and ankle trauma (strains, sprains, contusions); skin and soft tissue biopsy of the foot and ankle; and closed extremity dislocations or simple fractures of foot and ankle.

10.40.5. Order x-rays of foot and ankle.

10.40.6. Order and interpret all appropriate laboratory studies in the practice of podiatric medicine and surgery.

10.40.7. Order and prescribe treatment by physical medicine and therapy.

10.40.8. Admit podiatric patients to the hospital for further treatment or surgery with co-signature by attending physician.

10.41. RADIOLOGIC TECHNOLOGIST

10.41.1. Perform a full range of radiologic technology duties associated with the radiologic technologist position required by the task order.

10.41.2. Perform diagnostic studies and procedures. These studies shall include all variances of extremities, chest, abdomen and head.

10.41.3. Operate or direct operations of radiological equipment provided for routine radiographic examinations.

10.41.4. Receive and position patients so the anatomy/pathology is correctly visualized on the radiograph.

10.41.5. Prepare the patient and adjust equipment for taking X-rays. Position and instruct patient regarding procedures. Administer contrast medium when ordered.

10.41.6. Explain procedure to the patient and provide humane and appropriate care and communication to alleviate the patient's fear of examination and correctly position the patient for the examination.

10.41.7. Determine proper voltage and current and desired exposure time. Set equipment. Arrange attach or adjust immobilization and support devices, e.g. sandbags, binders, etc. to obtain precise positions, prevent patient from moving and lessen discomfort.

10.41.8. Perform correct film identification, ensuring that the patient's name, date of examination, anatomical positioning markers are provided.

10.41.9. Observe and report any symptoms which have direct bearing on the patient's condition as a result of adverse reaction to contrast media and inform the Radiologist of any condition requiring his/her attention.

10.41.10. Recognize the need for and institute the necessary emergency measures for situations where a person requires resuscitation procedures due to cardiac or respiratory arrest.

10.41.11. Process films and prepare them for reading by radiologist.

10.41.12. Operate and maintain radiological equipment designed for primary care services. Maintenance of equipment shall include daily film processor cleaning.

10.41.13. Perform unscheduled procedures as declared by the requesting physician "no matter what the indication" as directed. The study is to be performed, developed and all required administrative processing completed (labels, jackets, CHCS/AHLTA schedule/arrive depart).

10.42. REGISTERED NURSE

10.42.1. Perform a full range of RN duties in accordance with assignment under the task order, including: triage; patient assessment and monitoring; use of patient monitoring and treatment equipment; appropriate nursing care, procedures, and treatments; execution of physicians' orders within the guidelines of standard nursing practice; documentation of patient care and observations; and patient education and emotional support.

10.42.2. Provide professional nursing care in a knowledgeable, skillful, consistent, and continuous manner.

10.42.3. Assess each patient and perform triage duties as assigned.

10.42.4. Formulate and carry out a goal directed plan of care which based on determined nursing diagnosis and patient outcomes and which is prioritized according to patient needs and available resources including time, personnel, equipment, and supplies.

10.42.5. Evaluate effectiveness of self care given by all health team members, and contribution of systems, environment, and instrumentation in progressing patient toward outcomes.

10.42.6. Provide treatment and discharge instructions upon patient release.

10.42.7. Perform assessment/data collection in an ongoing and systematic manner, focusing on physiological, psychological, and cognitive status.

10.42.8. Provide a safe and clean environment for each patient.

10.42.9. Ensure areas are stocked and properly equipped.

10.42.10. Identify patient/significant other learning needs and implement appropriate measures to meet identified needs.

10.42.11. Assist in planning, supervising and instructing LPNs/LVNs, nursing assistants and ancillary personnel.

10.43. REGISTERED NURSE, CASE MANAGER

10.43.1. Participate in all phases of the Case Management Program (CMP) and ensure that the CMP meets established case management (CM) standards of care. Assist in coordinating a multidisciplinary team to meet the health care needs, including medical and/or psychosocial management, of specified patients.

10.43.2. Serve as consultant to all disciplines regarding CM issues. Provide nursing expertise about the CM process, including assessment, planning, implementation, coordination, and monitoring. Identify opportunities for CM and identify and integrate local CM processes.

10.43.3. Develop and implement local strategies using inpatient, outpatient, onsite and telephonic CM; develop and implement policies and protocols for home health assessments and outcome measures.

10.43.4. Develop and implement tools to support case management, such as those used for patient identification and patient assessment, clinical practice guidelines, algorithms, CM software, databases for community resources, etc.

10.43.5. Integrate CM and utilization management (UM) and integrate nursing case management with social work case management. Prepare routine reports and conduct analyses.

10.43.6. Assist in establishing and maintaining liaison with appropriate community agencies and organizations, the TRICARE Lead Agent office, and the Managed Care Support Contractor.

10.43.7. Maintain adherence to JCAHO, URAC, CMSA and other regulatory requirements. Apply medical care criteria (e.g., InterQual).

10.43.8. Ensure accurate collection and input of patient care data and ensure basic CM budgetary management.

10.43.9. Oversee MTF CM resources and make recommendations to the Command as to how those resources can best be utilized.

10.43.10. Collaborate with the multidisciplinary team members to set patient-specific goals. Develop treatment plans including preventive, therapeutic, rehabilitative, psychosocial, and clinical interventions to ensure continuity of care toward the goal of optimal wellness.

10.43.11. Establish and implement mechanisms to ensure proper implementation of patient treatment plan and follow-up post discharge in ambulatory and community health care settings.

10.43.12. Provide nursing advice and consultation in person and via telephone.

10.43.13. Ensure appropriate health care instruction to patient and/or caregivers based on identified learning needs.

10.43.14. Alert physicians to significant changes or abnormalities in patients and provide information concerning their relevant condition, medical history and specialized treatment plan or protocol.

10.43.15. Facilitate multidisciplinary discharge planning and other professional staff meetings as indicated for complex patient cases and develop a database and knowledge of local community resources.

10.43.16. Develop and implement mechanisms to evaluate the patient, family and provider satisfaction and use of resources and services in a quality-conscious, cost-effective manner.

10.43.17. Implement strategies to ensure smooth transition and continued health care treatment for patients when the military member transfers out of the area. Develop a policy for, and assist with, region-to-region transfers.

10.43.18. Facilitate screening and assist with transfers of Exceptional Family Member Program (EFMP) families.

10.43.19. Plan for professional growth and development as related to the case manager position and maintenance of CM certification. Actively participate in professional organizations including participation in at least one annual national CM conference to be funded by the Government to be scheduled at the convenience of the government and the HCW.

10.43.20. Establish cost containment/cost avoidance strategies for case management and develop mechanisms to measure its cost effectiveness.

10.43.21. Assist with the CHCS/AHLTA CM interface or other database designed to support CM.

10.43.22. Participate in video teleconferences (VTCs) and other meetings as required.

10.44. REGISTERED NURSE, CHARGE NURSE.

10.44.1. Provide clinical oversight of the nursing staff within the clinic.

10.44.2. Coordinate nursing staff operations with the medical staff.

10.44.3. Provide registered nurse services.

10.45. REGISTERED NURSE, PERIOPERATIVE.

10.45.1. Perform a full range of RN duties in accordance with assignment under the task order.

10.45.2. Provide professional nursing care in a knowledgeable, skillful, consistent, and continuous manner.

10.45.3. Plan, implement, deliver, direct, and coordinate Perioperative, Post Anesthesia Care Unit (PACU), and Ambulatory Procedure Unit (APU) nursing care using scientific and professional principles as a basis for all techniques and procedures.

10.45.4. Pre-admission: Confirm scheduled surgery date and procedure with the Main Operating Room, check procedure on consult against written consent form, ensure surgical checklist is completed. Make pre-op telephone call to client to confirm arrival time and re-enforces physician/anesthesia instructions. Provide any pre-op teaching, post procedure transportation arrangements or significant other teaching.

10.45.5. Day of surgery: Greet client, properly identify client with placement of identification and/or allergy band(s). Orient client to Unit. Verify post procedure transportation arrangement.

10.45.6. Conduct and document pre-op nursing assessment. Verify client compliance with instructions. Prepare client for procedure, may need to obtain additional labs. Arrange transport to OR (if necessary).

10.45.7. Develop an individualized plan of care that prescribes nursing action to achieve desired patient outcomes.

10.45.8. Confer with surgeon on procedures concerning instruments, sutures, and equipment, assuring all prescribed equipment is present and functional.

10.45.9. Provide equipment and supplies based on patient need. Select equipment in an organized, timely and cost effective manner.

10.45.10. Assure emergency equipment is functional before use. Report defective equipment.

10.45.11. Monitor patients under local infiltration and block anesthesia.

10.45.12. Perform duties as circulatory for surgical procedures, assuming responsibilities for coordinating patient care activities. Assume responsibilities for aseptic technique maintenance during procedures, accuracy of sponge counts and adequacy of supplies.

10.45.13. Perform as a scrub nurse.

10.45.14. Monitor and control environment. Regulate temperature and humidity as indicated. Adhere to OR sanitation policy/procedures.

10.45.15. Post-op: Receive, assess, monitor and document findings on client. Provide education. Ambulate. Verify post-op voiding. Discharge patient after re-enforcement of teaching. Complete nursing care document, reorganize chart and sign out patient. Make follow up clinic appointment for patient.

10.45.16. Set up, operate, maintain, and discontinue medical equipment. Administer prescribed medications. Provide emergency medical/surgical treatment. Provide nutrition and nourishment. Assist with transporting patient(s). Maintain nursing record(s) and plans. Provide patient and family teaching. Provide consultative services.

10.45.17. Perform telephone follow up assessment of patient and provide instruction reinforcement.

10.45.18. Assume responsibility when assigned for inservice programs and training activities relative to surgical procedures and maintenance of aseptic technique and basic aseptic principles. Orient and train new staff member or OR tech/nursing students in scrubbing and circulating duties.

10.45.19. Demonstrate a working knowledge of the supply procurement system

10.45.20. Adhere to Clinical Sterile Resupply (CSR) policies, procedures and regulations.

10.45.21. Monitor economic use of supplies and equipment.

10.45.22. Investigate new developments and trends in perioperative, PACU, and APU nursing practice and analyze impact on improved patient care equipment.

10.45.23. Assist in maintaining suite readiness and structural safety/integrity by reporting discrepancies to Division Officer.

10.45.24. Demonstrate knowledge of the special needs (Perioperative, PACU, and APU) nursing considerations for high-risk age group: infant, pediatric, adolescents, and geriatrics.

10.45.25. Responsible for completion of weekly field day of assigned operating room suite. Ensure field day sheet is signed off.

10.45.26. Monitor patient emergence from a variety of anesthetic agents; uses the nursing process in rendering this care.

10.45.27. Use the Alderete scoring system to Guide PACU care.

10.46. RESPIRATORY THERAPIST (CERTIFIED).

10.46.1. Efficiently administer all types of respiratory care, and efficiently draw blood, in accordance with professional qualifications, and as directed by the Respiratory Therapist (Advanced) or physician.

10.46.2. Operate and troubleshoot all types of respiratory equipment to include proper disassembly, cleaning, sterilization, and packaging of all respiratory therapy equipment to ensure safe patient care.

10.46.3. Maintain equipment, to include performing examinations to detect worn tubes, loose connections or other indications of disrepair and notify supervisor of need for maintenance. Start equipment and observe gauges measuring pressure, rate of flow and continuity of test equipment. Notify supervisor of malfunctions.

10.46.4. Be familiar with the functions and modes of equipment, ensuring equipment is cleaned, reassembled, and returned to storage.

10.46.5. Receive, set-up, operate, and maintain various devices and systems such as ventilators; nebulizers, oxygen therapy systems, humidity and aerosol therapy, sterilizers, and aeration chambers.

10.46.6. Administer prescribed doses of medical gases and aerosolized drugs intermittently and continuously. Perform airway management and hygiene including chest percussion postural drainage. Obtain arterial blood gas specimens.

10.46.7. Perform patient assessments and monitoring and provide patient instructions including breathing exercises. Make therapeutic recommendations. Examine patient records and report and identify changes in the clinical status of patients. Identify contraindications and report adverse responses/reactions.

10.46.8. Change nebulizers on nursing wards and reset 0^2 flow as prescribed by physician.

10.46.9. Stock shelves in department and other departments of the MTF as needed for the provision of respiratory therapy.

10.46.10. Deliver oxygen tanks and other equipment and supplies to specified MTF locations.

10.47. RESPIRATORY THERAPIST (REGISTERED).

10.47.1 Efficiently administer all types of respiratory care, including drawing blood, in accordance with professional qualifications and as directed by the Respiratory Therapist (Advanced) or physician.

10.47.2 Operate and troubleshoot all types of respiratory equipment to include proper disassembly, cleaning, sterilization, and packaging of all respiratory therapy equipment to ensure safe patient care.

10.47.3 Maintain equipment, to include performing examinations to detect worn tubes, loose connections or other indications of disrepair and notify supervisor of need for maintenance. Start equipment and observe gauges measuring pressure, rate of flow and continuity of test equipment. Notify supervisor of malfunctions.

10.47.4 Be familiar with the functions and modes of equipment, ensuring equipment is cleaned, reassembled, and returned to storage.

10.47.5 Receive, set-up, operate, and maintain various devices and systems such as ventilators; nebulizers, oxygen therapy systems, humidity and aerosol therapy, sterilizers, and aeration chambers.

10.47.6 Administer prescribed doses of medical gases and aerosolized drugs intermittently and continuously. Perform airway management and hygiene including chest percussion postural drainage. Obtain arterial blood gas specimens.

10.47.7 Perform patient assessments and monitoring and provide patient instructions including breathing exercises. Make therapeutic recommendations. Examine patient records and report and identify changes in the clinical status of patients. Identify contraindications and report adverse responses/reactions.

10.47.8 Change nebulizers on nursing wards and reset 0^2 flow as prescribed by physician.

10.47.9 Stock shelves in department and other departments of the MTF as needed for the provision of respiratory therapy.

10.47.10 Deliver oxygen tanks and other equipment and supplies to specified MTF locations.

10.48. SPEECH PATHOLOGIST

10.48.1. Provide a full range of speech pathology services in accordance with privileges granted by the Commanding Officer (e.g., evaluation, remediation, counseling, appropriate referral and management of all cases of speech, language, and voice disorders per current ASHA and applicable MTF guidelines).

10.48.2. Provide, upon physician referral, evaluation, and treatment programs for basic and more complicated communication disorders including: articulation, language, fluency, resonance phonatory, and neuromuscular problems.

10.48.3. Select, administer, and interpret commonly used diagnostic tests including vocabulary, articulation, and language batteries for adults and children.

10.48.4. Refer patients to physicians, audiologists, or other health care providers as appropriate.

10.48.5. Select appropriate laryngeal (non-vocal) communication devices.

10.49. ULTRASOUND TECHNOLOGIST

10.49.1. Receive patients and explain procedures, providing humane and appropriate care and communication to alleviate fear of examination. Correctly position the patient for the examination and make adjustments necessary for the required examination. Determine if any special patient preparation is required.

10.49.2. Operate facility provided ultrasound scanners. Operate the linear, sector, and endovaginal probes as well as pulse and color Doppler capabilities of provided scanners.

10.49.3. Receive and interpret requests or instructions for diagnostic ultrasound scans; perform daily warm up and assigned quality control checks of the ultrasound scanners.

10.49.4. Perform a full range of diagnostic ultrasonic examinations including but not limited to:
fetal echo; placental Doppler studies; obstetrical sonography, including imaging of all fetal anatomy in order to obtain accurate dating and growth parameters and evaluate for fetal abnormalities and problems with the pregnancy; pelvic sonography, including imaging of all pelvic anatomy to attain accurate assessment of suspected pathology; and endovaginal sonography exams to obtain accurate assessment of suspected pelvic pathology.

10.49.5. Identify abnormalities during testing and determine need for additional scans of affected area.

10.49.6. Recognize anatomic variants and determine which other area(s) of the body should be scanned.

10.49.7. Use a detailed understanding of diseases of anatomy to accomplish effective ultrasound scanning.

10.49.8. Advise the physician of results of the examination and provide them with a preliminary diagnosis.

10.49.9. Notify physician of significant scans requiring immediate attention.

10.49.10. Maintain and clean ultrasound equipment on a regular basis in accordance with Radiology department standards. Stock and maintain an adequate level of supplies required to ultrasound examinations. Recommend necessary monthly repairs when diagnostic quality is degraded.

10.49.11. Make minor adjustments on equipment. Differentiate artifacts from normal or pathological processes and recognize electronic equipment limitations. Program the examination equipment, set up the machine and scanning techniques to be employed.

10.49.12. Review new developments in the field by reading journals and attending meeting when possible and recommend to supervisor those changes which would improve the operation of the ultrasound section. Perform other related duties as assigned.

10.49.13. Recognize the need for and institute the necessary emergency measures for situations where a person requires resuscitation procedures due to cardiac or respiratory arrest.

11. TRAVEL. The Commanding Officer may request that the HCW travel to provide services, attend training and/or attend Government specified conferences when in the best interest of the Government and patient care. The COR will determine the reasonableness of all costs incurred. When questions arise, the Government's Joint Travel Regulations (JTR) shall always be followed. The contractor shall be compensated for travel per Contract Line Item 0008 in Section B of the contract.

11.1. When using a personal vehicle for official duties, the HCW will be compensated for mileage at the prevailing rate. The HCW shall not transport the patient or the patient's family in his/her personal or Government vehicle without prior approval from the supervisor.

11.2. The Government will not issue Government Travel Orders to the HCW.

11.3. Government contract air carriers and the Government's contract airfares are not available to the HCW. Airfare will be paid at the coach rate with 7 days advance purchase, non-refundable ticket price; unless the Government grants prior written approval. The Government shall reimburse the fee charges to reschedule the non-refundable ticket only if the Government reschedules the trip.

11.4. The JTR shall serve as the basis for the cost limits for lodging, per diem, miscellaneous expenses and mileage reimbursement if use of privately owned vehicle is authorized. The contractor shall utilize discount hotel/motel and car rental practices. Per diem rates can be found on the World Wide Web at: http://www.dtic.mil/perdiem/trvlregs.html.

11.5. Costs for transportation, lodging, meals and incidental expenses incurred by the HCW are allowable subject to Federal Acquisition Regulations 31-205-46 and Federal Travel Regulations prescribed by the General Services Administration or deemed reasonable by the COR.

11.6. When possible, the HCW shall use government-provided quarters (BOQ/BEQ) and transportation. If not available, the Government will provide the HCW with an identification letter for presentation to transportation and lodging firms (see Attachment AC). The Government retains the right to direct the mode of travel including the availability and size of rental cars. It should be noted that vendors are not obligated to extend discounted Government rates to contractors working on behalf of the Federal Government.

11.7. The contractor shall submit an invoice in accordance with WAWF instructions itemizing expenses in amounts allowable by the COR.

11.8. The COR will specify the MTF's procedure to document that the travel was completed and that the expenses were actually incurred.

11.9. All reimbursements will be retrospective, payable only upon presentation of a properly prepared invoice (as specified by the facility) to the COR.

11.10. The Government reserves the right to require additional documentation, including memoranda from the HCW performing the travel.

11.11. The travel shall not be conducted prior to the appropriate funding being added to Contract Line Item 0008 in Section B of the appropriate task order by modification.

12. MIGRATION OF CONTRACT HEALTH CARE WORKERS TO CIVIL SERVICE POSITIONS

12.1 If a contract HCW is selected by the Government for a civil service position and commences work as a civil servant, the contractor may be entitled to compensation towards recruitment costs of the contract position. Upon the contractor's written submittal of a request for compensation, the KO will consider all circumstances relative to the request and make a determination to grant or deny compensation in accordance with the subparagraphs below on a case by case basis.

12.1.2. In order for the contractor to be eligible for compensation, all of the following criteria must be met:

12.1.2.1. The civil service position must require the same qualifications and be located at the same MTF (which includes any location which receives credentials review services from the MTF) as required by the task order, and

12.1.2.2. The HCW must have occupied a position subject to credentials review in accordance with BUMED Instruction 6320.66E (or current version), and must have performed at least one shift of service, and

12.1.2.3. The HCW commences work as a civil servant not later than 180 days following initial commencement of work under the task order or prior to the expiration date of the current task order, whichever occurs first.

12.1.3. If compensation is determined appropriate by the KO, this one-time payment will be calculated by multiplying the current hourly rate for the contract position times the number of contract service hours scheduled for the HCW in a typical two-week payment period. For example, if the contract hourly rate is $40.00 per hour, and the HCW is typically scheduled for 80 hours of service in one payment period, the total compensation paid to the contractor is $3,200.00.

12.1.4. At such time as the KO determines compensation towards recruiting costs is appropriate, a task order modification will be executed. The task order modification will define the total amount of compensation for which the contractor may invoice, the CLIN under which the compensation is to be invoiced, the appropriate adjustment to the period of performance for task order services, and include a contractor release statement barring the contractor from seeking additional compensation.

C.13. FILL RATE REPORTING.

13.1. On the Wednesday following each invoice period after award, Not Later Than (NLT) 1600 hours local time for the COR, the contractor shall submit to the COR a completed Fill Rate Worksheet (Attachment AJ) in an Excel spreadsheet format via email.

13.2. Within 24 hours of receipt, the COR will inspect the worksheet to ensure that it accurately reflects the number of HCWs provided by the contractor. The COR will notify the contractor and the KO that the report is verified or of any discrepancies. If discrepancies are noted, the contractor shall prepare a corrected copy and resubmit as required in paragraph (13.1) above. Once a report is approved, the COR will forward a verified copy to the KO.

13.3. The Fill Rate Report is not a substitute for the Contractor Discrepancy Report (CDR), which must be prepared in accordance with the Contract Administration Plan (CAP).

Section E - Inspection and Acceptance

COR

(a) The Contracting Officer's duly authorized representative, the Contracting Officer's Representative (COR), will perform inspection and acceptance of services to be provided.

(b) For the purpose of this clause, the COR is the authorized representative of the Contracting Officer. The COR for any awarded Task Order(s) resulting from this contract shall be appointed in the specific task order(s).

(c) Inspection and acceptance will be performed at the locations listed in Individual Task Order(s) written as a result of this contract.

INSPECTION AND ACCEPTANCE TERMS

Supplies/services will be inspected/accepted at:

CLIN	INSPECT AT	INSPECT BY	ACCEPT AT	ACCEPT BY
0001	N/A	N/A	N/A	Government
0002	N/A	N/A	N/A	Government
0003	N/A	N/A	N/A	Government
0004	N/A	N/A	N/A	Government
0005	N/A	N/A	N/A	Government
0006	N/A	N/A	N/A	Government
0007	N/A	N/A	N/A	Government
0008	N/A	N/A	N/A	Government
0009	N/A	N/A	N/A	Government
0010	N/A	N/A	N/A	Government

CLAUSES INCORPORATED BY REFERENCE

52.246-4	Inspection Of Services--Fixed Price	AUG 1996
252.246-7000	Material Inspection And Receiving Report	MAR 2003

Section F - Deliveries or Performance

DELIVERIES
F.1 PERIOD OF PERFORMANCE

Periods of Performance shall be detailed in the individual Task Order(s) written under this contract.

Task Order(s) awarded as a result of this contract will have effective dates starting on 28 Sep 2007. The Contracting Officer reserves the right to adjust the start date of service based on the actual award date. No single Task Order shall exceed 12 months in duration. The contract length shall not exceed 60 months.

F.2 PLACE OF PERFORMANCE

Places of performance shall be detailed in the individual Task Order(s) written under this contract.

DELIVERY INFORMATION

CLIN	DELIVERY DATE	QUANTITY	SHIP TO ADDRESS	UIC
0001	N/A	N/A	N/A	N/A
0002	N/A	N/A	N/A	N/A
0003	N/A	N/A	N/A	N/A
0004	N/A	N/A	N/A	N/A
0005	N/A	N/A	N/A	N/A
0006	N/A	N/A	N/A	N/A
0007	N/A	N/A	N/A	N/A
0008	N/A	N/A	N/A	N/A
0009	N/A	N/A	N/A	N/A
0010	N/A	N/A	N/A	N/A

CLAUSES INCORPORATED BY REFERENCE

52.242-15	Stop-Work Order	AUG 1989
52.242-17	Government Delay Of Work	APR 1984
52.247-34	F.O.B. Destination	NOV 1991

Section G - Contract Administration Data

WAWF
CONTRACT ADMIN DATA
In order to expedite administration of this contract/order, delineation of duties is provided at Attachment AB, Contract Administration Plan, Enclosure 1, Contract Administration and Duties.

INVOICING INSTRUCTIONS AND PAYMENT FOR SERVICES
Invoices for services rendered under this Contract shall be submitted electronically through Wide Area Work Flow – Receipt and Acceptance (WAWF):

The vendor shall self-register at the web site https://wawf.eb.mil. Vendor training is available on the Internet at http://wawftraining.com.

A separate invoice will be prepared for every pay period. Do not combine the payment claims for services provided under this contract.

Select the 2-in-1 Invoice within WAWF as the invoice type. The 2-in-1 Invoice prepares the Material Inspection and Receiving Report, DD Form 250, and invoice in one document.
Back up documentation (such as timesheets, etc.) can be included and attached to the invoice in WAWF.

Attachments created in any Microsoft Office product are attachable to the invoice in WAWF.

EXAMPLE: The following information regarding Naval Hospital, Camp Lejeune, NC is provided as an example for completion of the invoice in WAWF:

Issuing Office DODAAC: N62645
Admin DODAAC: N62645
Acceptor DODAAC: N68093
LPO DODAAC: N68093
Pay DODAAC: N68688

The contractor shall submit bi-weekly invoices for payment per contract terms.
The Government shall process invoices for payment per contract terms.

For training materials, instructions for setting up WAWF, and step-by-step instructions for the (Invoice 2-in-1 Services Only) Invoice, please visit the following web site:
http://www.acquisition.navy.mil/navyaos/content/view/full/99/

For any other questions, please contact the WAWF helpdesk at 1-866-618-5988 or cscassig@ogden.disa.mil or the WAWF Implementation Team at wawf@nmlc.med.navy.mil.

NOTE: WAWF INSTRUCTIONS SHALL BE INCLUDED IN INDIVIDUAL TASK ORDER(S) ISSUED UNDER THIS CONTRACT.

Section H - Special Contract Requirements

SPECIAL INSTRUCTIONS
1. TASK ORDER CONTRACT.

1.1. Services will be procured via the award of Task Orders issued against the basic contract. There are two procedures to be followed for the submission of offers for award of Task Orders.

1.2. Initial Task Orders. The Government intends to award a minimum of one initial Task Order to each firm selected for contract award. Initial Task Orders will order the contract minimum quantity of services required from each contract awardee. The quantity and type of services to be procured, as well as position specific duty descriptions for these initial Task Orders, are provided in sections B, C, and the applicable Task Order.

1.3. Subsequent Task Orders. The Government intends to order additional services, up to the stated contract maximum quantities, throughout the life of the contract. Special procedures and regulations apply to the award of subsequently awarded Task Orders. These procedures are provided in H.2. below.

2. TASK ORDER PROCEDURES (Subsequent Task Orders).

2.1. Fair Opportunity For Consideration.

2.1.1. One or more Task Orders may be issued during the performance period of the contract. The Government will provide all awardees a fair opportunity for consideration. Fair opportunity is not the same evaluation process used to make the initial award of the IDIQ contract. In accordance with FAR 16.505(b), the KO will give each awardee a "fair opportunity" to be considered for each order in excess of $2,500 unless one of the conditions in paragraph 2.1.2 below applies.

2.1.2. Exceptions to Fair Opportunity for Consideration. Awardees will not be given a fair opportunity to be considered for Task Orders which are expected to exceed $2,500 when the KO determines one of the following conditions apply:

2.1.2.1. The agency need for services is of such urgency that providing such an opportunity would result in unacceptable delays;

2.1.2.2. Only one awardee is capable of providing the services required at the level of quality required because the services ordered are unique or highly specialized;

2.1.2.3. The order should be issued on a sole-source basis in the interest of economy and efficiency as a logical follow-on to a Task Order already issued under this contract, provided that all awardees were given fair opportunity to be considered for the original order. For the purposes of this contract the KO may negotiate a sole source logical follow-on Task Order with the current contractor providing previously competed services. In the event an increase in the amount of previously competed services is required by the Government, the KO may negotiate a sole source logical follow-on Task Order with the current contractor provided the required additional services do not represent more than one full time equivalent position or 20% of the total competed labor hours on the entire task order, whichever is greater. When deciding whether to negotiate a sole source logical follow-on Task Order with the current contractor, consideration will be given to the contractor's past performance, continuity of HCW services, and price.

2.2. The KO has broad discretion in determining which awardee should receive a Task Order. Each task order award decision will consider the first three of the following six factors (i.e., H.2.2.1., H.2.2.2., and H.2.2.3.). Factors four, five, and six (i.e., H.2.2.4., H.2.2.5., and H.2.2.6.) may be considered as described in the TOPR.

2.2.1. The price of the Task Order. The factors to be considered in evaluating prices proposed are:

2.2.1.1. COMPLETENESS. All price information required by the TOPR has been submitted including completed supplemental pricing worksheets.

2.2.1.2. REASONABLENESS. The degree to which the proposed prices compare to the prices a reasonable prudent person would expect to incur for the same or similar services.

2.2.1.3. REALISM. The offeror's CLIN prices and the Supplemental Pricing Worksheets will be examined to identify unusually low price estimates, understatements of costs, inconsistent pricing patterns, potential misunderstandings of the contract requirements, and the risk of personnel recruitment and retention problems during Task Order performance.

2.2.2. Timeliness of submission of Task Order proposal. Task Order proposals which are submitted late (see H.2 for submission instructions) may not be considered for award.

2.2.3. The past performance and management record of the awardee in previous task orders and task order proposals under this contract will be evaluated. Performance within the past 5 years on other contracts for the facilities covered by this contract may also be considered if requested. This past performance evaluation will include a review of all aspects of contract performance, both positive and negative, including but not limited to performance enhancements or problems, management enhancements or problems, timeliness of proposal submission, continuity of HCWs, shift fill rates, and quality of HCWs provided.

2.2.4. Quality of the HCW(s) proposed under the task order. General ranking factors of HCWs will be detailed in each TOPR.

2.2.4.1. The quality and characteristics of the proposed personnel mix in relationship to the labor mix requirements specified in the Task Order.

2.2.4.2. Quality and quantity of qualifications, including education, training, and experience, as they relate to the duties in the Task Order. Prior experience in a military medical setting may enhance the candidate's ranking.

2.2.4.3. Letters of Recommendation.

2.2.4.4. Additional certifications and licensure, as applicable.

2.2.4.5. Total continuing education within the 3 years immediately preceding the task order.

2.2.5. Management plan for accomplishment of the task order requirements.

2.2.6. Certificate of availability.

2.3. When placing orders, the KO is not required to prepare formal evaluation plans, score offers, post notice on the Federal Business Opportunities (FedBizOpps) web site or hold discussions or negotiations with each awardee. Even though the KO does not have to comply with the competition rules in Part 6 of the Federal Acquisition Regulations and does not have to conduct discussions before issuing an order, there will be an internal record of why a particular offeror provided the best value based on the particular requirements of each Task Order.

2.4. Issues arising from the placement of orders are not protestable to the Government Accountability Office (GAO) unless the protest alleges that the order exceeded the value, scope, or period of the contract.

2.5. TOPR, Proposal Submission, and Task Order Award. The process for requesting Task Order proposals, evaluating the proposals, selecting an awardee for each Task Order, issuing the Task Order, and the commencement of services under each Task Order is shown below.

2.5.1. Task Order Proposal Request.

2.5.1.1. The KO will issue a written TOPR and will forward it to all awardees unless one of the exceptions to the fair opportunity for consideration listed above in 2.1 applies.

2.5.1.2. The TOPR will include as a minimum the following information:

* The due date for proposal submission (generally between 14 and 30 days following the date of the TOPR).
* A description of the services, including minimum qualification requirements and specific ranking factors.
* The place of performance.
* The period of performance including the quantity required.
* Any additional instructions for proposal submission not contained in this section.
* Any other information deemed appropriate by the KO.

2.6. Proposal Submission.

2.6.1. If an awardee is unable to submit a proposal, they must notify the KO in writing as soon as practicable. A brief written statement as to why the awardee is unable to submit a proposal is required. Failure to submit a Task Order proposal without sufficient justification may be considered as negative past performance information which may jeopardize the award of future Task Orders.

2.6.2. The contractor's Task Order proposal shall always be required to contain a price section and may be required to include a technical section. The price section shall include a completed Supplemental Pricing Worksheet for each proposed HCW. The original and one copy of the price section shall be forwarded to the Naval Medical Logistics Command. Certified cost or pricing data is not required for individual Task Orders. Direct labor rates must be consistent with that currently being paid in the geographic location where services are to be performed. If required, the technical section shall include the personnel and past performance information required by the TOPR.

2.7. Task Order Award.

2.7.1. Upon completion of the evaluation of the technical and price sections, the KO will issue a Task Order to the contractor whose proposal is most advantageous to the Government considering the evaluation factors specified in 2.2 above.

2.7.2. In the event issues pertaining to a proposed Task Order cannot be resolved to the satisfaction of the KO, the KO reserves the right to withdraw or cancel the proposed Task Order. In such event, the contractor will be notified, via letter or email, of the KO's decision and this decision shall be final and conclusive and shall not be subject to the "Disputes" clause or the "Contract Disputes Act".

2.8. Commencement of Performance.

2.8.1. Upon award, a Task Order will be transmitted to the contractor on a DD Form 1155. Approved HCWs will generally be required to begin performance no later than 30 days after execution of the Task Order by the KO for services ordered under CLINs 0005, 0006 and 0007, and will generally be required to begin performance no later than 60 days for services ordered under CLINs 0001, 0002, 0003 and 0004 unless otherwise required in the Task Order. For example, urgent requirements may require expedited processing and a shortened performance start up period. Conversely, some difficult to fill positions may require a longer performance start up period. If a HCW who was proposed in response to the TOPR is not available to begin performance on the Task Order, the contractor must notify the KO immediately.

2.8.2. Failure to begin performance with the approved HCW may result in termination of the Task Order and reconsideration of the other Task Order proposals received in response to the TOPR. The contractor may or may not be given the opportunity to propose a new HCW. The Government reserves the right to terminate the contract for default if the contractor fails to begin performance.

3. OMBUDSMAN.

3.1. The Ombudsman will review complaints from contractors regarding the award of Task Orders and ensure that all contractors are afforded a fair opportunity to be considered, consistent with the procedures in the contract. The Task Order contract Ombudsman for this contract is the Navy Competition Advocate General. Contractors are encouraged to settle their complaints through the Competition Advocate chain of command, seeking review by the Command Competition Advocate at the Naval Medical Logistics Command before taking their complaints to the Navy Competition Advocate General. The Naval Medical Logistics Command's Competition Advocate can be reached at (301) 619-2158 or at the following address:

Naval Medical Logistics Command
ATTN: Executive Officer
1681 Nelson St.
Fort Detrick, MD 21702-9203

4. PRIOR WRITTEN PERMISSION REQUIRED FOR SUBCONTRACTS.

4.1. None of the services required by this contract shall be subcontracted to or performed by persons other than the contractor or the contractor's employees without the prior written consent of the KO.

5. RESTRICTION ON THE USE OF NAVY-AFFILIATED PERSONNEL.

5.1. Restrictions on the use of Government-affiliated personnel. Except in very limited cases, the federal criminal statutes at 18 USC 203 and 18 USC 205 bar Government personnel; both active duty and civil service, from working as a contractor employee in a Government workplace, including a medical treatment facility, either as a second job ("moonlighting") or while on terminal leave. The contractor agrees that, before making an employment offer to an active duty member or a civil servant, it shall inform the individual of the potential applicability of these statutes and further agrees to encourage that individual to seek an advisory opinion from his/her local ethics counsel before accepting an employment offer. In addition, without the prior written approval of the KO, the contractor shall not use in the performance of this contract any persons currently performing medical or dental services under other Navy contracts.

6. SUBSTITUTION OF PERSONNEL FOR HEALTH CARE WORKERS WHO ACCRUE LEAVE.

6.1. The contractor agrees to initiate performance of the contract requirements using only the HCW(s) whose professional qualifications have been determined technically acceptable by the Government as part of the source selection process.

6.2. During Task Order performance, no personnel substitutions shall be made by the contractor without the express consent of the KO or in accordance with a procedure specified by the KO. All substitution requests will be processed in accordance with this clause.

6.3. No personnel substitutions shall be permitted during the first 60 days of Task Order performance, unless they are necessitated by a HCW's unexpected illness, injury, death or termination of employment. Should one of these events occur, the contractor shall promptly notify the KO and provide the information required in paragraph 6.4 below. After the initial 60 day period, all substitution requests shall be submitted, in writing, at least 30 days prior to the planned change of personnel. All such requests must provide the information required by paragraph 6.4 below.

6.4. All substitution requests must provide a detailed explanation of the circumstances necessitating the proposed replacement of personnel. The contractor shall also demonstrate that the substitute HCW(s) possess professional qualifications that are equal to or higher than the qualifications in Section C.6. In addition, all substitution requests shall include a certificate of availability signed and dated by each proposed HCW, and any other information identified by the COR. The COR will evaluate such requests and promptly notify the contractor of the approval or disapproval thereof.

7. HEALTH CARE WORKER BACKGROUND INVESTIGATION REQUIREMENTS.

7.1. CRIME CONTROL ACT OF 1990 REQUIREMENT.

7.1.1. Section 21 of the Crime Control Act of 1990, 42 U.S.C. 13041, as amended by section 1094 of Public Law 1-02-190, requires every facility operated by the Federal Government (or operated under contract with the Federal Government) that hires (or contracts to hire) individuals involved in the provision of child care services to assure that all existing and newly-hired employees undergo a criminal background check. The term "child care services" is defined to include health and mental health care.

7.1.2. CONTRACTOR REQUIREMENTS.

7.1.2.1. It is the contractor's responsibility to ensure its employees undergo proper criminal history background checks by providing the Government support, cooperation, and active assistance throughout the process.

7.1.2.2. In accordance with 42 U.S.C. 13041(d) the contractor shall ensure that employment applications for potential HCWs contain a question asking whether the individual has ever been arrested for or charged with a crime involving a child, and if so, requiring a description of the disposition of the arrest or charge. The application shall further state that it is being signed under penalty of perjury, with the applicable Federal punishment for perjury stated on the application.

7.1.2.3. Within 30 days after contract award, the contractor and all contractor employees shall provide all reasonable and necessary assistance to the Government to facilitate and complete the background investigation.

7.1.2.4. To initiate the process for a background investigation, the Contractor shall ensure each HCW reports to the COR for specific MTF processing instructions, completes the appropriate portion of the SF 85 P, and obtains fingerprints for submittal to the Office of Personnel Management.

7.1.2.5. Contractor employees who have previously received a background check must provide proof of the check or obtain a new one.

7.1.2.6. Upon receipt of the results of a background check, the contractor agrees to undertake a personnel action in accordance with 42 U.S.C. 13041(c), when appropriate.

7.1.3 GOVERNMENT RESPONSIBILITIES.

7.1.3.1. The Government will conduct criminal background checks on all HCWs providing child care services under this contract based on fingerprints obtained by a Government law enforcement office (e.g., local, state, federal, etc.) and a completed SF 85P form (Questionnaire for Public Trust Positions).

7.1.3.2. The COR will identify the appropriate DoD Component for billing purposes and the appropriate security point of contact and/or installation commander who will receive the background results.

7.1.4. MISCELLANEOUS PROVISIONS.

7.1.4.1. Contractor employees shall have the right to obtain a copy of any background check pertaining to them and to challenge the accuracy and completeness of the information contained in the report.

7.1.4.2. With written recommendation from the Commanding Officer, and the approval of the KO, a contractor employee with a background investigation pending completion may be permitted to perform work under this contract prior to the completion of the background check, provided the employee is within sight and continuous supervision of an individual with a successful background check.

7.2. INFORMATION TECHNOLOGY/SENSITIVE INFORMATION SECURITY REQUIREMENTS

7.2.1. Contractor personnel shall meet the personnel security requirements for Sensitive and Information Technology (IT) positions outlined in Secretary of Navy (SECNAV) Manual M-5510.30 and SECNAV Instruction 5510.30 (most current version). Department of Navy (DON) IT positions include any position in which the incumbent has access to DON IT systems and/or performs IT-related duties with varying degrees of independence, privilege and/or ability to access and/or impact sensitive data and information. Use of CHCS and/or AHLTA is illustrative examples of such systems where security requirements apply.

7.2.2. The same level of trustworthiness is required for contractor personnel as is required for Government personnel requiring similar access to and/or processing of proprietary data, information requiring protection under the Privacy Act of 1974, sensitive information, and Government-developed privileged information involving award of contracts; including user level access to DON or DOD networks and information systems, system security and network defense systems, or to system resources providing visual access and/or ability to input, delete or otherwise manipulate sensitive information without controls to identify and deny sensitive information. As such positions filled under this contract are designated as Non-Critical Sensitive (NCS), and IT-II.

7.2.3. U.S. citizenship is a basic condition for assignment to a designated sensitive IT position. U.S. citizens who are also dual citizens are not specifically excluded from occupying either sensitive or designated IT positions, however, a dual citizenship status raises foreign influence and foreign preference concerns that will most likely prohibit interim assignment pending favorable investigation and adjudication of these issues. Eligibility will not be established for persons who hold a foreign passport. The U.S. citizen reference in the aforementioned regulation(s) make no distinction between those who are U.S. citizens by birth, those who are U.S. nationals, and those who have derived U.S. citizenship or those who acquired it through naturalization. Additional information on U.S. citizenship requirements is contained within SECNAV Manual M-5110.30 and SECNAV Instruction 5510.30. MTF security personnel must validate citizenship of individuals before submitting initial personnel security investigation requests.

7.2.4. The investigative basis for assignment to a designated NCS/IT-II position is a favorably completed and adjudicated National Agency Check with Local Agency and Credit Checks (NACLC) for contractor employees.

7.2.5. Personnel background investigations and training must be initiated and interim approval/temporary access be granted before access to DOD and DON IT systems/networks or DOD and DON sensitive information is allowed.

7.2.6. Contractor personnel shall report to the COR to receive MTF specific processing instructions to complete the appropriate personnel security questionnaire, complete and submit the appropriate paperwork for the background investigation or provide proof of a favorable adjudication, and receive requisite training. A copy of the temporary access approval shall be provided to the COR upon receipt by the contract employee.

7.2.7. The Navy manual and instruction referenced in paragraph 7.2.1 leave open the possibility of a waiver to the policies described herein. See M-5510.30, Chapter 1-10. However, neither the KO nor the Commanding Officer of the MTF is authorized to grant such a waiver. All waiver requests must be forwarded to, and approved by, the Chief of Naval Operations (N09N2). In the event that the contractor wishes to pursue this course of action, it shall contact the COR of the MTF for the proper administrative procedures. The Commanding Officer of the MTF, or designee, shall decide if an individual waiver request will be submitted to the CNO. The mutual understanding of the parties is that waiver requests are rarely, if ever, granted, and further that delays in the processing of, or the failure of the Navy to act favorably on, such a request does not excuse the contractor from performance under this contract.

7.3. LOCAL INSTALLATION REQUIREMENTS

7.3.1. In accordance with installation regulations establishing protocol to gain access to the installation or it's facilities, contract employees must provide, among other documentation, a criminal records check from the state or county level covering the period of time specified in the installation regulations.

7.3.2. Contractor personnel shall contact the COR immediately after contract award to receive MTF/installation specific instructions for documentation and background investigation requirements to gain access to the installation/facility for contract performance.

8. LIABILITY INSURANCE.

8.1. Before commencing work under a contract, the contractor shall certify to the KO in writing that the required insurance has been obtained. The following insurance as referenced in FAR 28.307, is the minimum insurance required:

8.1.1. General liability - Bodily injury liability insurance coverage written on the comprehensive form of policy of at least $500,000 per occurrence.

8.1.2. Automobile liability - Automobile liability insurance written on the comprehensive form of policy. The policy shall provide for bodily injury and property damage liability covering the operation of all automobiles used in connection with performing the contract. Policies covering automobiles operated in the United States shall provide coverage of at least $200,000 per person and $500,000 per occurrence for bodily injury and $20,000 per occurrence for property damage. The amount of liability coverage on other policies shall be commensurate with any legal requirements of the locality and sufficient to meet normal and customary claims.

8.1.3. Workers' compensation and employer's liability - Contractors are required to comply with applicable Federal and State workers' compensation and occupational disease statutes. If occupational diseases are not compensable under those statutes, they shall be covered under the employer's liability section of the insurance policy, except when contract operations are so commingled with a contractor's commercial operations that it would not be practical to require this coverage. Employer's liability coverage of at least $100,000 shall be required, except in States with exclusive or monopolistic funds that do not permit workers' compensation to be written by private carriers.

9. NON-COMPETE CLAUSES.

9.1. The use of non-compete agreements (including non-compete clauses within employment agreements) that are aimed at preventing the loss of contract providers are acceptable only if the non-competition is limited to the current performance period specified in the contract/task order. The use of non-compete agreements or clauses that prevent employees of an incumbent contractor from accepting future employment with either the Government or with another contractor is not acceptable. Awardees (including sub-contractors) may not include conditions in employment agreements that hinder the Government's ability to accomplish the current or future mission of providing health and medical care to beneficiaries.

9.2. The Government reserves the right to query each offeror or contractor regarding the use and purpose of these clauses or agreements and to use this information in award or logical follow-on decisions. If such conditions are included in employment agreements, the Government further reserves the right to reject an offeror's proposal or to terminate existing contracts or task orders.

10. LIMITATION OF PAYMENT FOR PERSONAL SERVICES. Under the provisions of 10 U.S.C. 1091 and DODI 6025.5, "Personal Services Contracting", implemented 6 January 1995, the total amount of compensation paid to an individual direct health care provider in any year cannot exceed the full time equivalent annual rate specified in 10 U.S.C. 1091. Effective 21 January 2000, the maximum amount the Government is allowed to pay for these personal services is $400,000 per year for this contract.

Section I - Contract Clauses

CLAUSES INCORPORATED BY REFERENCE

52.202-1	Definitions	JUL 2004
52.203-3	Gratuities	APR 1984
52.203-5	Covenant Against Contingent Fees	APR 1984
52.203-6	Restrictions On Subcontractor Sales To The Government	JUL 1995
52.203-7	Anti-Kickback Procedures	JUL 1995
52.203-8	Cancellation, Rescission, and Recovery of Funds for Illegal or Improper Activity	JAN 1997
52.203-10	Price Or Fee Adjustment For Illegal Or Improper Activity	JAN 1997
52.203-12	Limitation On Payments To Influence Certain Federal Transactions	SEP 2005
52.204-4	Printed or Copied Double-Sided on Recycled Paper	AUG 2000
52.204-9	Personal Identity Verification of Contractor Personnel	NOV 2006
52.204-9	Personal Identity Verification of Contractor Personnel	NOV 2006
52.209-6	Protecting the Government's Interest When Subcontracting With Contractors Debarred, Suspended, or Proposed for Debarment	JAN 2005
52.215-2	Audit and Records--Negotiation	JUN 1999
52.215-8	Order of Precedence--Uniform Contract Format	OCT 1997
52.217-7	Option For Increased Quantity-Separately Priced Line Item	MAR 1989
52.219-28	Post-Award Small Business Program Rerepresentation	JUN 2007
52.222-3	Convict Labor	JUN 2003
52.222-21	Prohibition Of Segregated Facilities	FEB 1999
52.222-26	Equal Opportunity	APR 2002
52.222-35	Equal Opportunity For Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans	DEC 2001
52.222-36	Affirmative Action For Workers With Disabilities	JUN 1998
52.222-39	Notification of Employee Rights Concerning Payment of Union Dues or Fees	DEC 2004
52.222-41	Service Contract Act Of 1965, As Amended	JUL 2005
52.223-5	Pollution Prevention and Right-to-Know Information	AUG 2003
52.223-6	Drug-Free Workplace	MAY 2001
52.223-14	Toxic Chemical Release Reporting	AUG 2003
52.224-1	Privacy Act Notification	APR 1984
52.224-2	Privacy Act	APR 1984
52.225-13	Restrictions on Certain Foreign Purchases	FEB 2006
52.227-1	Authorization and Consent	JUL 1995
52.228-5	Insurance - Work On A Government Installation	JAN 1997
52.229-3	Federal, State And Local Taxes	APR 2003
52.232-8	Discounts For Prompt Payment	FEB 2002
52.232-11	Extras	APR 1984
52.232-17	Interest	JUN 1996
52.232-23	Assignment Of Claims	JAN 1986
52.232-25	Prompt Payment	OCT 2003
52.232-33	Payment by Electronic Funds Transfer--Central Contractor Registration	OCT 2003
52.233-1	Disputes	JUL 2002
52.233-1 Alt I	Disputes (Jul 2002) - Alternate I	DEC 1991
52.233-3	Protest After Award	AUG 1996
52.233-4	Applicable Law for Breach of Contract Claim	OCT 2004

52.237-2	Protection Of Government Buildings, Equipment, And Vegetation	APR 1984
52.237-3	Continuity Of Services	JAN 1991
52.242-13	Bankruptcy	JUL 1995
52.243-1 Alt I	Changes--Fixed Price (Aug 1987) - Alternate I	APR 1984
52.245-2 Alt I	Government Property (Fixed-Price Contracts) (May 2004) - Alternate I	APR 1984
52.246-25	Limitation Of Liability--Services	FEB 1997
52.249-8	Default (Fixed-Price Supply & Service)	APR 1984
52.253-1	Computer Generated Forms	JAN 1991
252.203-7001	Prohibition On Persons Convicted of Fraud or Other Defense-Contract-Related Felonies	DEC 2004
252.203-7002	Display Of DOD Hotline Poster	DEC 1991
252.204-7003	Control Of Government Personnel Work Product	APR 1992
252.204-7004 Alt A	Central Contractor Registration (52.204-7) Alternate A	NOV 2003
252.209-7004	Subcontracting With Firms That Are Owned or Controlled By The Government of a Terrorist Country	MAR 1998
252.223-7004	Drug Free Work Force	SEP 1988
252.223-7006	Prohibition On Storage And Disposal Of Toxic And Hazardous Materials	APR 1993
252.225-7004	Reporting of Contract Performance Outside the United States and Canada--Submission after Award	JUN 2005
252.225-7012	Preference For Certain Domestic Commodities	JUN 2004
252.232-7010	Levies on Contract Payments	SEP 2005
252.243-7001	Pricing Of Contract Modifications	DEC 1991
252.243-7002	Requests for Equitable Adjustment	MAR 1998
252.247-7023	Transportation of Supplies by Sea	MAY 2002

CLAUSES INCORPORATED BY FULL TEXT

52.216-18 ORDERING. (OCT 1995)

(a) Any supplies and services to be furnished under this contract shall be ordered by issuance of delivery orders or task orders by the individuals or activities designated in the Schedule. Such orders may be issued from time of contract award for a period of 60 months.

(b) All delivery orders or task orders are subject to the terms and conditions of this contract. In the event of conflict between a delivery order or task order and this contract, the contract shall control.

(c) If mailed, a delivery order or task order is considered "issued" when the Government deposits the order in the mail. Orders may be issued orally, by facsimile, or by electronic commerce methods only if authorized in the Schedule.

(End of clause)

52.216-19 ORDER LIMITATIONS. (OCT 1995)

(a) Minimum order. When the Government requires supplies or services covered by this contract in an amount of less than $1,000.00, the Government is not obligated to purchase, nor is the Contractor obligated to furnish, those supplies or services under the contract.

(b) Maximum order. The Contractor is not obligated to honor:

(1) Any order for a single item in excess of 100,000 hours;

(2) Any order for a combination of items in excess of the maximum total requirements of the contract; or

(3) A series of orders from the same ordering office within 14 days that together call for quantities exceeding the limitation in subparagraph (1) or (2) above.

(c) If this is a requirements contract (i.e., includes the Requirements clause at subsection 52.216-21 of the Federal Acquisition Regulation (FAR)), the Government is not required to order a part of any one requirement from the Contractor if that requirement exceeds the maximum-order limitations in paragraph (b) above.

(d) Notwithstanding paragraphs (b) and (c) above, the Contractor shall honor any order exceeding the maximum order limitations in paragraph (b), unless that order (or orders) is returned to the ordering office within 14 days after issuance, with written notice stating the Contractor's intent not to ship the item (or items) called for and the reasons. Upon receiving this notice, the Government may acquire the supplies or services from another source.

(End of clause)

52.216-22 INDEFINITE QUANTITY. (OCT 1995)

(a) This is an indefinite-quantity contract for the supplies or services specified, and effective for the period stated, in the Schedule. The quantities of supplies and services specified in the Schedule are estimates only and are not purchased by this contract.

(b) Delivery or performance shall be made only as authorized by orders issued in accordance with the Ordering clause. The Contractor shall furnish to the Government, when and if ordered, the supplies or services specified in the Schedule up to and including the quantity designated in the Schedule as the "maximum". The Government shall order at least the quantity of supplies or services designated in the Schedule as the "minimum".

(c) Except for any limitations on quantities in the Order Limitations clause or in the Schedule, there is no limit on the number of orders that may be issued. The Government may issue orders requiring delivery to multiple destinations or performance at multiple locations.

(d) Any order issued during the effective period of this contract and not completed within that period shall be completed by the Contractor within the time specified in the order. The contract shall govern the Contractor's and Government's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period; provided, that the Contractor shall not be required to make any deliveries under this contract after 27 Sep 12.

(End of clause)

52.219-6 NOTICE OF TOTAL SMALL BUSINESS SET-ASIDE (JUN 2003)

(a) Definition.

"Small business concern," as used in this clause, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and

qualified as a small business under the size standards in this solicitation.

(b) General. (1) Offers are solicited only from small business concerns. Offers received from concerns that are not small business concerns shall be considered nonresponsive and will be rejected.

(2) Any award resulting from this solicitation will be made to a small business concern.

(c) Agreement. A small business concern submitting an offer in its own name shall furnish, in performing the contract, only end items manufactured or produced by small business concerns in the United States or its outlying areas. If this procurement is processed under simplified **acquisition** procedures and the total amount of this contract does not exceed $25,000, a small business concern may furnish the product of any domestic firm. This paragraph does not apply to construction or service contracts.

(End of clause)

52.219-14 LIMITATIONS ON SUBCONTRACTING (DEC 1996)

(a) This clause does not apply to the unrestricted portion of a partial set-aside.

(b) By submission of an offer and execution of a contract, the Offeror/Contractor agrees that in performance of the contract in the case of a contract for--

(1) Services (except construction). At least 50 percent of the cost of contract performance incurred for personnel shall be expended for employees of the concern.

(2) Supplies (other than procurement from a nonmanufacturer of such supplies). The concern shall perform work for at least 50 percent of the cost of manufacturing the supplies, not including the cost of materials.

(3) General construction. The concern will perform at least 15 percent of the cost of the contract, not including the cost of materials, with its own employees.

(4) Construction by special trade contractors. The concern will perform at least 25 percent of the cost of the contract, not including the cost of materials, with its own employees.

52.222-37 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001)

(a) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on--

(1) The number of disabled veterans and the number of veterans of the Vietnam era in the workforce of the contractor by job category and hiring location; and

(2) The total number of new employees hired during the period covered by the report, and of that total, the number of disabled veterans, and the number of veterans of the Vietnam era.

(b) The above items shall be reported by completing the form entitled "Federal Contractor Veterans' Employment Report VETS-100."

(c) Reports shall be submitted no later than September 30 of each year beginning September 30, 1988.

(d) The employment activity report required by paragraph (a)(2) of this clause shall reflect total hires during the most recent 12-month period as of the ending date selected for the employment profile report required by paragraph (a)(1) of this clause. Contractors may select an ending date: (1) As of the end of any pay period during the period January through March 1st of the year the report is due, or (2) as of December 31, if the contractor has previous written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(e) The count of veterans reported according to paragraph (a) of this clause shall be based on voluntary disclosure. Each Contractor subject to the reporting requirements at 38 U.S.C. 4212 shall invite all disabled veterans and veterans of the Vietnam era who wish to benefit under the affirmative action program at 38 U.S.C. 4212 to identify themselves to the Contractor. The invitation shall state that the information is voluntarily provided; that the information will be kept confidential; that disclosure or refusal to provide the information will not subject the applicant or employee to any adverse treatment; and that the information will be used only in accordance with the regulations promulgated under 38 U.S.C. 4212.

(f) Subcontracts. The Contractor shall include the terms of this clause in every subcontract or purchase order of $10,000 or more unless exempted by rules, regulations, or orders of the Secretary.

(End of clause)

52.222-42 STATEMENT OF EQUIVALENT RATES FOR FEDERAL HIRES (MAY 1989)

In compliance with the Service Contract Act of 1965, as amended, and the regulations of the Secretary of Labor (29 CFR Part 4), this clause identifies the classes of service employees expected to be employed under the contract and states the wages and fringe benefits payable to each if they were employed by the contracting agency subject to the provisions of 5 U.S.C. 5341 or 5332.

THIS STATEMENT IS FOR INFORMATION ONLY: IT IS NOT A WAGE DETERMINATION
Employee Class Monetary Wage-Fringe Benefits

Employee Class	GS Equivalent
Certified Medical Assistant	GS/5
Certified Nursing Assistant II	GS/3
Licensed Practical Nurse II	GS/7
Medical Laboratory Technician	GS/7
Nurse Practitioner	GS/12
Occupational Therapy Assistant	GS/11
Optical Technician	GS/7
Pharmacy Technician	GS/7
Physical Therapy Assistant	GS/11
Radiologic Technologist	GS/10
Registered Nurse II	GS/12

(End of clause)

52.232-3 PAYMENTS UNDER PERSONAL SERVICES CONTRACTS (APR 1984)

The Government shall pay the Contractor for the services performed by the Contractor, as set forth in the Schedule of this contract, at the rates prescribed, upon the submission by the Contractor of proper invoices or time statements

to the office or officer designated and at the time provided for in this contract. The Government shall also pay the Contractor:

(a) a per diem rate in lieu of subsistence for each day the Contractor is in a travel status away from home or regular place of employment in accordance with Federal Travel Regulations (41 CFR 101-7) as authorized in appropriate Travel Orders; and

(b) any other transportation expenses if provided for in the Schedule.

52.232-18 AVAILABILITY OF FUNDS (APR 1984)

Funds are not presently available for this contract. The Government's obligation under this contract is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal liability on the part of the Government for any payment may arise until funds are made available to the Contracting Officer for this contract and until the Contractor receives notice of such availability, to be confirmed in writing by the Contracting Officer.

(End of clause)

52.249-12 TERMINATION (PERSONAL SERVICES) (APR 1984)

The Government may terminate this contract at any time upon at least 15 days' written notice by the Contracting Officer to the Contractor. The Contractor, with the written consent of the Contracting Officer, may terminate this contract upon at least 15 days' written notice to the Contracting Officer.

(End of clause)

52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es):

http://farsite.hill.af.mil

(End of clause)

Section J - List of Documents, Exhibits and Other Attachments

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Document Type	Description
Attachment AA	LISTS OF ACCEPTABLE DOCUMENTS to establish U.S. Citizenship
Attachment AB	Contract Administration Plan (CAP) with 3 Enclosures
Attachment AC	Letter of Identification – Travel (EXAMPLE)
Attachment AD	HEALTH CARE WORKER CERTIFICATE OF AVAILABILITY
Attachment AE	Offeror's Technical Proposal (Reserved)
Attachment AF	Wage Determination – Beaufort, SC and Charleston, SC
Attachment AG	Wage Determination – Camp Lejeune, NC and Cherry Point, NC
Attachment AH	Supplemental Pricing Worksheet sample
Attachment AI	Health Examination and Immunization/Screening Requirements Form
Attachment AJ	Format for contractor's bi-weekly Fill Rate Report to NMLC

ATTACHMENT AA
Citizenship Requirements

Excerpt from SECNAV M-5510.30 of June 2006, Appendix F

4. All documents submitted as evidence of U. S. citizenship must be original documents or certified copies. Uncertified copies are not acceptable. The following documents are acceptable proof of citizenship:

a. The original U. S. birth certificate with a raised seal issued at the time of birth from one of the 50 states, or outlying territories or possessions.

b. A hospital birth certification (clinic and commercial birth center certification is not permitted) with an authenticating raised seal or signature provided all vital information is given.

c. A delayed birth certificate provided it shows the birth record was filed within one year after birth, it bears the registrar's seal and signature, and cites secondary evidence such as a baptismal certificate, certificate of circumcision, affidavits of persons having personal knowledge of the facts of the birth or other official records such as early census, school or insurance.

d. U.S. Passport (current or expired) or U.S. passport issued to individual's parent in which the individual is included.

e. FS-240 Report of Birth Abroad of a Citizen of the United States of America/Consular Report of Birth.

f. FS-545 Certification of Birth issued by a U.S. Consulate or DS-1350 the Department of State Certification.

g. INS N-550/570 U.S. Immigration and Naturalization Service Naturalization Certificate.

h. INS N-560/561 U.S. Immigration and Naturalization Service Certificate of Citizenship. If the individual does not have a Certificate of Citizenship, the original Certificate of Naturalization of the parent(s) may be accepted if the naturalization occurred while the individual was under 18 years of age (or under 16 years of age before 5 October 1978) and residing permanently in the U.S.

i. Certificate of birth issued by the Canal Zone government indicating U.S citizenship is only acceptable if verified by direct government inquiry to: Vital Records Section, Passport Services, 1111 19th Street NW, Suite 510, Washington, D.C. 20522-1705.

j. DD 372, Verification of Birth is acceptable for military members (officer and enlisted) provided the birth data is listed and verified by the Department of Vital Statistics.

k. DD 1966, Application for Enlistment into the Armed Forces of the United States are acceptable provided the documents sighted are listed and attested to by a recruiting official.

5. If none of the above forms of evidence are obtainable, a notice from the registrar issued by the state with the individual's name, date of birth, which years were searched for a birth record and that there is no birth certificate on file for the applicant should be presented. *The registrar's notice must be accompanied by the best combination of the following secondary evidence:

a. Baptismal certificate

b. Census record

c. Certificate of circumcision

d. Early school record

e. Family Bible record

f. Doctor's record of post-natal care

g. Newspaper files and insurance papers

* NOTE: These documents must be early public records showing the date and place of birth, created within the first five years of life. The individual may also submit an Affidavit of Birth, Form DSP-10A, from an older blood relative, i.e., a parent, aunt, uncle, sibling, who has personal knowledge of the birth. It must be notarized or have the seal and signature of the acceptance agent.

ATTACHMENT AB
CONTRACT ADMINISTRATION PLAN (CAP)

1. Definitions.

1.1 Administrative Contracting Officer (ACO). To the extent that the Procuring Contracting Officer (PCO) has delegated contract administration, the Government official responsible for administering the contract. For the purposes of these contracts, the PCO has retained contract administration responsibilities. Therefore, the terms PCO and ACO refer to different functions performed by the same individual.

1.2 Alternate Contracting Officer's Representative (ACOR). In the absence of the Contracting Officer's Representative (COR), the Government official appointed in writing by the PCO who functions as the technical representative of the PCO for a specific contract, for a specified period of time.

1.3 Bureau of Medicine and Surgery (BUMED). The Department of the Navy command responsible for all Navy health and dental contracting initiatives.

1.4 Commanding Officer. The medical department officer that has ultimate responsibility for the operation of a Dental Treatment Facility (DTF) or Medical Treatment Facility (MTF).

1.5 Contracting Officer's Representative (COR). The Government official appointed in writing by the PCO who functions as the technical representative of the PCO.

1.6 Contractor. The offeror identified in block 15A of the Standard Form 33 or block 7 of the Standard Form 26 and its health care workers who are providing services under the contract.

1.7. Dental Treatment Facility (DTF). The DoD clinic or dental center requiring services under these contracts. The abbreviation, "DTF" includes all the Branch Dental Clinics, Dental Administrative Units, Branch Dental Annexes and other subordinate clinical activities specified in these contracts. The abbreviation, "DTF" also refers to any military treatment facility within the scope of these contracts.

1.8 Health Care Program Analyst. The Naval Medical Logistics Command (NAVMEDLOGCOM) contract administration advisory resource for the COR/Technical Liaison (TL)/Technical Assistant (TA)/supervisor.

1.9 Medical Treatment Facility (MTF). A Department of Defense (DoD) hospital or medical center that may require services under these contracts. The abbreviation, "MTF" includes all the Branch Medical Clinics, Medical Administrative Units, Branch Medical Annexes and other subordinate clinical activities specified in these contracts. The abbreviation, "MTF" also refers to any military treatment facility within the scope of these contracts.

1.10 Naval Medical Logistics Command (NAVMEDLOGCOM). The Department of the Navy command responsible for implementation of the Bureau of Medicine and Surgery health care contracting initiatives.

1.11 Procuring Contracting Officer (PCO). The Government official within NAVMEDLOGCOM authorized by warrant to enter into these contracts for the Government.

1.12 Supervisor. The Government official whose duty it is to provide day-to-day direction to, and oversight of, contractor personnel, including supervisory functions such as time and attendance.

1.13 Technical Assistant (TA). The DTF/MTF representative who may be assigned by the COR to provide technical or administrative assistance to the COR. TAs may be assigned to assist and support the COR but shall not be given the authority to provide any technical direction or clarification directly to the Contractor.

2. Responsibilities.

2.1 The Navy's ASSISTANT CHIEF FOR HEALTH CARE OPERATIONS, BUREAU OF MEDICINE AND SURGERY (BUMED Code M3) as Program Manager shall:

2.1.1 Establish dental/medical contract policy guidance.

2.1.2 Provide overall direction for the planning, development, and operation of all Navy DTFs/MTFs.

2.1.3 Monitor the progress and achievement of dental and medical contracts within the Navy's health care delivery system.

2.1.4 Serve as subject matter expert for all technical aspects of medical and dental contracting efforts.

2.2 The PCO, ACQUISITION MANAGEMENT DIRECTORATE (Code 02), Naval Medical Logistics Command shall:

2.2.1 Perform all required pre-award actions including providing information or answering questions that arise during the solicitation period and as a result of Freedom of Information Act (FOIA) inquiries.

2.2.2 Review the Contract Administration Plan (CAP). The PCO shall furnish sample COR and TA nomination letters to the DTF/MTF in accordance with NAVSUPINST 4205.3C.

2.2.3 Verify that the individual(s) nominated to act as COR have had the required training and the necessary experience. If the PCO determines that a nominee does not meet experience and training requirements, the PCO shall request that the DTF/MTF nominate another individual.

2.2.4 Review the CAP prior to incorporation into the solicitation. This review shall ensure that all contract administration functions are assigned, suit the specific circumstances of the contract and give due consideration to the type of contract, the place of performance, period of performance, and inspection and acceptance criteria stated in the solicitation/contract.

2.2.5 Include the COR duties contained in this master CAP in the resultant solicitation/contract. Additional duties shall be separately delineated within the contract, as appropriate.

2.2.6 Designate the paying office in the contract.

2.2.7 Appoint the COR and ACOR.

2.2.8 Perform all contract administration duties of a Contracting Officer. Regular meetings between the PCO, the COR or the DTF/MTF Commanding Officer (or representative) will be held to discuss the status of and the performance under individual contracts. The format and frequency of these meetings will depend upon the size and complexity of the contract.

NOTE: All parties are specifically reminded that only the Contracting Officer has the authority to modify the terms of the contract. Therefore, in no event will any understanding, agreement, modification, change order, or other matter deviating from the terms of the basic contract between the Contractor and any other person be effective or binding on the Government. When/if, in the opinion of the Contractor, any direction affecting the terms of the basic contract has been given by the COR or any other person, the Contractor shall promptly notify the PCO.

2.2.9 Evaluate reports of Contractor non-compliance and take appropriate action within 30 days of receipt. Copies of any correspondence regarding the results of such analyses shall be provided to the DTF/MTF and the COR simultaneously with the action taken.

2.2.10 Arrange the post-award conference, if required. Invite necessary attendees. Ensure that the requirements of the contract and the COR's duties are thoroughly discussed and understood. Ensure that all personnel involved understand current DoD Standards of Conduct policies.

2.2.11 Oversee the performance of CORs under the contract. Prompt action shall be taken when COR (or alternate) is not performing properly.

2.2.12 Maintain the official contract file including modifications (and all back-up documentation).

2.2.13 Maintain the accuracy of this Master CAP throughout the life of these contracts.

2.2.14 Maintain a list of all CORs under their authority. Periodically review the files and performance of these CORs in accordance with NAVSUPINST 4205.3C and local policies.

2.2.15 Review the existing annual Contractor performance reports prior to negotiating any task orders under these contracts. Enter data into the Contractor Performance Assessment Reporting System (CPARS).

2.2.16 Maintain a log of total hours ordered under these contracts by Contract Line Item Number (CLIN)/Sub Contract Line Item Number (SLIN) to guarantee that maximum order quantities are not exceeded. Notify the Health Care Program Analyst (NAVMEDLOGCOM Code 07) and the DTF/MTF when 75% of the maximum order quantity of any CLIN/SLIN has been reached.

2.3 The HEALTH CARE PROGRAM ANALYST, HEALTH CARE SERVICES SUPPORT DIRECTORATE (Code 07), Naval Medical Logistics Command shall:

2.3.1 Submit a completed and signed CAP Documentation Form with answers to questions that pertain to this acquisition.

2.3.2 As appropriate, submit the Contract Data Requirements List (DD Form 1423 or CDRL) providing a description of all reports/outputs required from the Contractor.

2.3.3 Act as the health care contracting technical manager for BUMED. Ensure consistency among health care contracts, providing coordination and technical liaison between DTFs, MTFs, BUMED, CORs, and the PCO.

2.3.4 Coordinate/develop the procurement technical requirements including a performance work statement (Section C); draft input to Sections B, H, L and M; a draft Source Selection Plan; a draft CAP; potential sources for the procurement; draft quality assurance plan; surveillance plan and other related documents required for the acquisition.

2.3.5 Monitor and manage reports of Contractor non-compliance, evaluate reports submitted by the individual CORs, and recommend PCO disposition on all noted discrepancies.

2.3.6 Perform health care trend analyses and provide feedback to the PCO and CORs.

2.3.7 Provide any other technical assistance to the DTF, MTF, PCO/ACO, CORs, and other customers.

2.3.8 Through coordination with the PCO, participate in periodic COR meetings and inspections to discuss status and performance under the contract emphasizing problem identification, problem solving and contract familiarity.

2.3.9 Ensure that the DTF, MTF, PCO/ACO, CORs, and BUMED are appropriately informed of related dental and health care issues.

2.3.10 Provide periodic statistical and financial reports to BUMED.

2.3.11 Apprise customers of any anticipated impact that new task orders will have on availability of overall contract hours due to plans for changes (expansion/reductions) of services.

2.4. The COMMANDING OFFICER OF THE DTF OR MTF shall:

2.4.1 Budget and provide funding for the contracts.

2.4.2 Nominate (to the PCO) individual(s) to be appointed as COR (by name, title, organizational code and telephone number). This individual(s) shall also be the contract quality assurance monitor and lead technical advisor to the ACO and shall be responsible for the technical interface needed during contract performance. An ACOR can be nominated to act in the absence of the COR, when needed, or to provide additional expertise.

NOTE: COR duties cannot be delegated. The COR shall be accountable for the actions of ACORS or TAs.

NOTE: Nomination of new CORs as a result of reassignment, termination of employment, etc., shall be made in accordance with the procedures outlined herein.

2.4.3 Ensure all individuals nominated as COR or ACOR have the necessary qualifications to satisfactorily perform the required duties and hold a position of responsibility commensurate with the complexity of the contract. All CORs shall have graduated from a Naval Supply System Command (NAVSUP) approved/BUMED provided medical/dental COR training course prior to their appointment.

2.4.4 Upon receipt of the contract from the PCO, forward copies of documents to staff having administrative responsibilities for these contracts.

2.4.5 Support and supervise the COR in the performance of their duties. If the Commanding Officer determines that assigned duties are not being performed in a satisfactory manner, immediate corrective action shall be taken (including the recommendation to replace the COR if required). The PCO shall be promptly notified of all actions taken. The DTF/MTF should consider COR performance in rating all individuals assigned COR functions.

2.4.6 Notify the PCO in writing of any organizational or personnel changes affecting the CAP.

2.4.7 Ensure that appropriate timely action is taken on all contract related correspondence received from either the PCO or COR. This includes the timely submission (to the PCO) of any requests for changes to the performance work statement, deviations or waivers. An Independent Government Cost Estimate of the impact on contract price and the availability of additional funding (if required) must accompany all requests for changes to the performance work statement/contract. The Contractor's price quote and the rationale for requesting the change shall accompany any changes proposed by the Contractor. The Contractor's price quote serves as a budgetary estimate of the cost impact. The DTF/MTF shall also provide input as to technical acceptability of proposed contract language changes.

2.4.8 The DTF/MTF Commanding Officer may appoint a TA to assist the COR in executing routine contract administration, monitoring and, surveillance duties. The appointment of all TAs must be in writing and must include the TA's responsibilities and limitations. A copy of this appointment letter shall be provided to the PCO. Before appointment, the DTF/MTF shall assure that all TAs have the appropriate training and experience.

2.5 The CONTRACTING OFFICER'S REPRESENTATIVE (COR) shall:

2.5.1 Attend both the pre-proposal and post-award conferences, if held.

2.5.2 Attend periodic meetings (as necessary) among the PCO, DTF/MTF and Contractor(s) to discuss the status of and performance under the contracts.

2.5.3 Avoid issuing any instructions that would constitute a change to the contract. The COR and Contractor shall not enter into any understanding, agreement, modification, or change order deviating from the terms of the basic

contracts which shall be effective or binding on the Government. If in the opinion of the Contractor, an effort outside the scope of the contract is requested, the Contractor shall promptly notify the PCO in writing. The Contractor shall not act unless the PCO or ACO has issued a written change to the contract. The COR will include, on all correspondence to the Contractor, a declination of authority statement as follows:

"I have neither the authority nor the intent to change the terms or conditions of this contract. This contract can only be changed by a written modification issued by the Contracting Officer. If you believe that I am requesting an effort outside the scope of this contract, promptly notify the Contracting Officer. Additionally, this shall not be construed as an authorization for new work or additional work not already contained in the contract."

2.5.4 Perform as the technical interface between the Government and the Contractor(s) for these contracts. The COR shall provide technical advice or clarification regarding the performance work statement; milestones to be met within the general terms of the contract or specific subtasks of the contract. The COR is the point of contact through whom the Contractor can relay technical questions and problems to the Contracting Officer. The Contractor may also contact the Contracting Officer directly.

2.5.5 Coordinate/facilitate complete and timely credentials submissions between the DTF/MTF and the Contractor using the applicable Professional Affairs Coordinator (PAC) staff at the DTF/MTF. The COR shall provide technical advice or clarification regarding the performance work statement, milestones to be met within the general terms of the contract or specific subtasks of the contract, maintain a method for tracking expiring credentials, and maintain shift schedules. The COR shall inspect the credentials of each contract employee prior to submission to the PAC.

2.5.6 Monitor Contractor performance and progress under the contract. If potentially inefficient or wasteful methods are being used, the COR shall take reasonable and timely action to alert the Contractor and the PCO. Furthermore, the COR shall promptly advise the PCO of any observed continuous and/or substantial deficiencies in the Contractor's performance or other noncompliance with the terms or conditions of the contract. Enclosure (1) is the surveillance plan to be used by the COR to monitor Contractor performance. Deviation from this surveillance plan is only permitted with the prospective approval of the PCO.

2.5.7 In accordance with procedures given in Enclosure 1, Surveillance Plan, promptly issue Contract Discrepancy Reports (CDRs) (Enclosure (2)) to the Contractor to document discrepant performance. The COR shall always obtain the Contractor's response/rebuttal to the CDR, evaluate the acceptability of the response and promptly forward the CDR, Contractor response/rebuttal, and their recommendation to the NAVMEDLOGCOM PCO and Health Care Program Analyst.

2.5.8 Monitor and verify services provided in accordance with Section B of the contract. Keep accurate records of Contractor performance and compare these records with the Wide Area Work Flow (WAWF) invoice or time sheet submitted by the Contractor. The COR shall always use this information as a tool when evaluating Contractor invoices.

2.5.9 Inspect and/or accept the services as the official Government representative.

2.5.10 Use appropriate, contract-specific sampling methods for contract surveillance.

2.5.11 Completely understand contract invoicing requirements. The COR shall process all WAWF Invoices in a timely manner to ensure that prompt payment due dates are met.

2.5.12 Immediately alert the PCO and the ACO of any unusual performance problems. If a corrective action plan is approved by the Contracting Officer, the COR shall monitor the implementation and effectiveness of that corrective action plan. In uncertain situations, the COR shall always seek advice from the PCO and/or ACO, as prudent, before acting.

2.5.13 Continually monitor the quantity of services provided under each CLIN/SLIN and/or task order. Advise the PCO if it appears that service quantities may be exhausted before the end of the performance period, or if quantities of unused hours for services have been ordered but will not be received by the end of the performance period.

2.5.14 Perform administrative duties including all files which support the actions performed as a COR. The COR shall respond to all contract correspondence in a timely manner. Contract files shall include a conforming copy of the contract, all modifications, a conforming copy of the Contractor's Technical Proposal, all surveillance reports, each CDR (including the Contractor's response/rebuttal), any contract-related correspondence, a contract log or COR diary, all telephone conversation and email records, meeting minutes, reports from Government subject matter experts, and Independent Government Cost Estimates.

2.5.15 Take the necessary steps to ensure that Government property furnished to the Contractor is provided in a timely manner and in proper condition for use. The COR shall maintain both inventory and disposition records for all Government furnished property. This inventory/disposition file is coordinated with the ACO. The COR shall ensure that the Contractor returns all Government furnished property or that Government furnished material has been reasonably consumed in the performance of work.

2.5.16 Read and comply with all applicable Standards of Conduct and Conflict of Interest instructions and procedures including annual financial interest filings.

2.5.17 Ensure that the Contractor receives copies of all regulations and/or directives considered appropriate to the services being provided.

2.5.18 Submit information detailing the Contractor's performance to the PCO. A statement indicating performance has been satisfactory along with your request to continue performance would be required prior to the issuance of any Logical Follow On. An annual report on the Contractor's performance will be required 30 days after the end of each performance period. A final report shall be sent to the PCO within 60 days after completion of the contract. The final report shall contain a conclusive statement describing the Contractor's overall performance and an evaluation on the accountability of Government property furnished to the Contractor. Enclosure (3) contains the format for the reports.

2.5.19 Perform other duties, particular to the contract, as may be incorporated into the contract document or as required by the Contracting Officer.

2.6. TECHNICAL ASSISTANT (TA). All requirements for TA duties are reported directly to the COR. At the direction of the COR, the TA shall:

2.6.1 Perform surveillance and identify Contractor deficiencies.

2.6.2 Review contract deliverables, recommending acceptance/rejection, and providing the COR with the documentation to support all recommendations.

2.6.3 Assist the COR in the preparation of the final Contractor performance report using the format and procedures prescribed by the Contracting Officer.

2.6.4 Identify Contractor non-compliance with reporting requirements.

2.6.5 Evaluate Contractor proposals, identifying potential problem areas.

2.6.6 Provide (a) timely input for technical clarifications to the performance work statement, (b) technical direction for the Contractor, and (c) recommendations for CAPs.

2.6.7 Provide detailed written reports of any trip, meeting, correspondence, telephone conversation, email or, anecdotal conversation after any contact between the TA and the Contractor.

Enclosures:
Enclosure 1 - Surveillance Plan
Enclosure 2 - Contractor Discrepancy Report
Enclosure 3 - Report on Contract Performance

Enclosure 1
SURVEILLANCE PLAN

1. INTRODUCTION

1.1 Purpose. This surveillance plan has been developed to aid the Contracting Officer's Representative (COR) in providing effective and systematic surveillance of all aspects of this contract.

1.2 Objective. To ensure that the Contractor is complying with the specifications of the contract by providing quality health care services to eligible beneficiaries.

1.3 Scope. This plan applies to the Dental and Medical contract services. This is a personal services contract. Contract performance will be monitored chiefly through prospective supervision by Navy personnel. Some elements of performance will be monitored by the COR through retrospective surveillance.

2. RESPONSIBILITIES

2.1 The Contracting Officer (KO) at NAVMEDLOGCOM is responsible for negotiating all modifications to contract terms, conditions or amounts.

2.2 The Health Care Program Analyst at NAVMEDLOGCOM serves as the technical agent for coordinating issues among the KO, the DTF/MTF and the COR. The Health Care Program Analyst reviews the COR's contract surveillance and provides feedback to the COR and recommendations to the KO. The Health Care Program Analyst provides technical support to the COR and the KO in preparing modifications. The Health Care Program Analyst also tabulates statistical data.

2.3 The DTF/MTF commanding officer is responsible for establishing and maintaining a system for reviewing and approving correspondence submitted by the COR to NAVMEDLOGCOM.

2.4 The COR is responsible for assuring Contractor performance through audit, documentation and liaison with the KO. The COR shall ensure that copies of all Contractor correspondence and DTF/MTF/COR responses are provided to the KO. The COR must observe the following cautions and limitations:

2.4.1 Do not request or direct the Contractor to do anything that is not expressly stated in the contract.

2.4.2 Do not attempt to control Contractor efforts except as specifically authorized in the contract.

2.4.3 Do not make suggestions or comments that the Contractor could construe as authority to proceed on work not specified in the contract.

2.4.4 Do not request changes that add work or objectives not within the scope of the contract. Seek the advice of the KO.

2.4.5 Do not accidentally generate a basis for a Contractor claim. Communicate with the Contractor in a timely manner.

2.4.6 Exercise diligence in monitoring and documenting the Contractor's performance. When in doubt about any aspect of the contract specifications or the Contractor's performance, seek the advice of the KO or the NAVMEDLOGCOM Health Care Program Analyst.

2.4.7 Bring to the attention of the KO any extraordinary action on the part of the Contractor, i.e., any performance outside the scope of the contract.

2.5 The Government supervisory personnel specified in the Task Order are responsible for providing day-to-day supervision and control of contract personnel. This includes provision of technical guidance, direction, and approval of tasks performed to satisfy requirements of the contract/task order.

3. INSPECTION METHODS. Several methods serve as means for inspecting Contractor performance. Some methods are more appropriate than others are. The COR may use any or all of these inspection methods. Inspection, along with documentation, is vital to ensuring Contractor compliance with contract requirements.

3.1 100% Inspection. This method of surveillance is time consuming, expensive and unrealistic for services performed frequently. However, it is appropriate in critical areas where health and safety are involved and each occurrence of a particular requirement must be examined to determine compliance.

3.2 Surveillance Checklists. Checklists are used for services performed on an infrequent but predictable schedule (e.g., monthly, quarterly, annually, etc.) Any scheduled service that is provided on less than a daily basis can be considered for inclusion on a checklist.

3.3 Random Sampling. Sampling can be an unbiased, comprehensive evaluation of the Contractor's performance while efficiently using limited inspection time. The basis for doing random sampling is MIL-STD-105D, "Sampling Procedures and Tables for Inspection by Attributes". It is based on the statistical concept that an evaluation of randomly chosen occurrences may allow the evaluator to draw conclusions (acceptable/not acceptable) about the universe of occurrences.

3.4 Validated Customer Complaints. Validated customer complaints are the customer's method of documenting problems. The COR will coordinate efforts to acquire, document and validate these complaints. Customer complaints are not used to reject a service, but can be used as further evidence of unsatisfactory performance (e.g. if random sampling shows the specific service is unsatisfactory). When other surveillance continues to show unsatisfactory performance, validated customer complaints can indicate a need to increase surveillance. The COR must have a written validation process for all customer complaints (much like the CDR process). Only validated customer complaints should be forwarded to the Contracting Officer for action. Customer complaints cannot be used in conjunction with other surveillance methods (i.e., partial random sampling plus certain customer complaints) because their occurrences are not truly random.

4. TIME FRAMES FOR MONITORING PERFORMANCE REQUIREMENTS. There are several different time frames for monitoring performance requirements of the contract. Depending upon the specific performance requirement, the COR will monitor activities on a one-time basis, a per occurrence basis, or an ongoing basis.

4.1 One-time Activities. This performance requirement is generally monitored for initial or start-up activities, such as submission and verification of the credentials files.

4.2 Per Occurrence Activities. This activity is one that is monitored at each occurrence. It is often an activity could place a patient at unnecessary risk for which the COR will investigate. Examples of these would include medication errors, impaired providers, or any incidents that resulted in disciplinary action against a Contractor employee.

4.3 Ongoing Activities. This performance requirement is one that must be continually monitored throughout the life of the contract because the requirement itself is ongoing. Examples include a requirement for shift coverage, schedule submissions, meeting attendance, maintenance of personnel qualifications and, documentation of annual training.

5. DOCUMENTATION.

5.1 The need to document each contact between the COR and the Contractor cannot be overemphasized. CORs should understand the procedures that are described in FAR Part 33.2. CORs should remember that the documentation prepared by the COR will be the primary evidence presented by the Government in any litigation, with the Government bearing the burden of proof. This documentation must be thorough, accurate and complete.

5.2 It is important to maintain a record of all other contacts between the COR and the Contractor which reflect normal clinic operations or the services required in the contract. Examples may include schedule submissions, feedback on Contractor credentialing actions, substitution procedures for dental/health care workers, etc. These examples may or may not be a part of routine surveillance, but the COR's ability to reconstruct events will be important if the Government rejects the quality or timeliness of contract services.

5.3 Documentation may include Contract Discrepancy Reports (CDRs), meeting minutes, annotations on surveillance checklists, letters, email, telephone conversation records, memoranda, etc. Results of inspections identifying unsatisfactory Contractor performance must be given to the Contractor for review, comment, and corrective action as appropriate.

5.4 All performance related inspection documentation is an integral part of the contract file and must be stored and maintained accordingly. The COR should maintain a reading file of all correspondence and pertinent documentation.

6. INVOICING PROCEDURES

6.1 At the end of each bi-weekly period of contract performance, the contractor will present the COR with an invoice via Wide Area Work Flow. The COR will inspect the invoice to ensure that it accurately reflects the amount of service provided by the contractor, but will not accept (sign) the invoice if there are any substantial inaccuracies.

6.2 The COR shall coordinate with the supervisor of each clinical area represented on the invoice to determine the accuracy of the service totals included on the invoice. Additional tools which may be available to the COR to confirm invoice amounts are contract employee time clock cards and sign-in/sign-out sheets. Time which is not in some way confirmed through coordination with the applicable supervisor, documented by time clock, documented by time sheet, or confirmed through some other appropriate method available to the COR will not be considered to have been provided.

6.3 If the COR disagrees with the invoiced quantities, the COR shall attempt to promptly resolve the discrepancy with the designated contractor representative. The COR shall return the invoice with a memorandum to the key person, rejecting the invoice as "improper". The memorandum shall state the quantity which the COR considers to be correct (the COR can attach a copy of the government time sheet or other documentation as appropriate). A copy of the invoice and the memorandum shall be retained by the COR. The COR shall encourage the contractor to re-invoice for the correct quantity so that it can be certified correctly.

6.4 CORs may NOT note changes directly on the contractor's invoice, as it will be rejected by DFAS as improper.

6.5 Failure of the contractor to submit invoices in a timely manner, significant or recurring quantity discrepancies on submitted invoices, or failure of the contractor to submit a revised invoice for a billing period, shall be brought to the attention of the KO and the NAVMEDLOGCOM Health Care Program Analyst.

7. CONTRACT DISCREPANCY REPORTS (CDRs)

7.1 The COR shall recognize that CDRs become official records within the contract file and that they have serious implications for overall contract management and relationships. CDRs shall not be the first and only choice for communicating contract issues with the contractor and shall be implemented in accordance with the procedures given below within this Surveillance Plan.

7.2 For serious contract performance deficiencies, or when less formal communications fail to resolve minor performance deficiencies, the COR will issue a CDR to the Contractor.

7.3 The COR shall ensure that all inspection data is attached to the CDR. The Contractor cannot be expected to respond to performance deficiencies that are not clearly and specifically identified. A cover memorandum on the

CDR should specify that the Contractor has three working days, or other appropriate deadline, to respond in writing to the COR. At the time the CDR is issued to the Contractor, the COR shall provide a copy of the CDR to the Contracting Officer and to the Health Care Program Analyst.

7.4 Upon return of the CDR package from the Contractor, the COR shall review the Contractor's comments and give careful, objective consideration to the facts and mitigating circumstances documented in the response. The COR shall then make a final written determination and recommendation to the Contracting Officer on the acceptability of Contractor performance and note it on the CDR. The COR shall state why the Contractor's response does or does not have merit. The COR shall prepare the determination, recommendation, and other statements as appropriate along with actions being requested of the Contracting Officer and as much additional documentation as required to support their conclusions and recommendations.

7.5 The COR shall provide the above documentation along with actions being requested of the Contracting Officer and as much additional documentation as required to support their conclusions and recommendations to (1) the Contractor, (2) the PCO, and (3) the Health Care Program Analyst.

7.6 The PCO and Health Care Program Analyst will review CDRs and will advise the COR of the need for any further documentation.

8. COR SURVEILLANCE REQUIREMENTS

8.1 Submission of Credentials. The COR shall inspect the credentials of each contract employee.

8.1.1 The contractor shall submit Individual Credentials Files (ICFs), Individual Professional Files (IPFs), and qualifications packages (for non-credentialed/non-licensed personnel) in accordance with requirements of the contract and BUMEDINST 6320.66 (latest revision).

8.1.2 ICFs and IPFs. The COR will inspect each ICF/IPF for completeness and compliance with contract qualification requirements. Incomplete/incorrect packages will be returned to the contractor under a memo documenting the deficiencies. Complete/correct packages will be forwarded to the Professional Affairs Coordinator (PAC) for formal credentialing action. The PAC will inform the contractor by letter or email upon approval of a package.

8.1.3 Non-credentialed/non-licensed personnel. The contractor shall submit to the COR a package of documents demonstrating the individual's compliance with contract requirements. The COR will review each package and return to the contractor under a memo stating approval or reason(s) for disapproval.

8.2 Orientation. In coordination with the supervisors for whom services are being provided, the COR shall coordinate the availability of appropriate orientation sessions and shall track and maintain records of orientation completed by contractor personnel. The COR shall ensure that all orientation is completed within the timeframes specified in the contract and notify the contractor of deficiencies.

8.3 Background checks for childcare workers. The COR shall ensure the completion by contractor personnel of background check forms, coordinate with appropriate security service to obtain requisite fingerprinting and forwarding of forms to the required law enforcement agencies, and shall maintain a file of completed background checks. The COR shall notify the DTF/MTF chain of command and the contracting officer immediately upon the receipt of an unfavorable background check.

8.4 Maintenance of Credentials.

8.4.1 The COR shall maintain a method for tracking expiring credentials, such as a database or spreadsheet. The method chosen should include at least the guidelines in this paragraph, as best implemented in accordance with DTF/MTF policy. Not less than once per month, the COR shall review the tracking file and identify any credentials due to expire within 2 months. The COR shall notify the contractor of those expiring credentials and shall advise the

contractor that the affected individual will not be permitted on the staffing schedule or to provide service under the contract following expiration of credentials.

8.4.2 The COR shall maintain a record of contractor personnel compliance with health certification requirements of the contract. The COR shall notify the contractor of expired health certifications.

8.5 Contractor Shift Schedules for Personnel For Which Replacement Coverage is Required. The COR will inspect the Contractor submitted schedule for those positions for which coverage is required. The COR shall compare the schedule to the contract requirements, note deficiencies, and inform the contractor of those deficiencies. The contractor shall be required to submit an updated schedule.

8.6 Full-time versus part-time staff. The COR shall ensure that the contractor utilizes only full-time individuals when required by the contract. The COR shall also ensure that the contractor does not utilize part-time personnel in excess of any restrictions imposed thereon by a particular task order. The COR shall coordinate with the respective supervisors to monitor these requirements.

8.7 Personnel substitution. The COR shall monitor contractor compliance with Section H restricting substitution of approved personnel within 30 days following the start of task order services.

8.8 Contract Discrepancy Reports (CDRs). The COR's responsibilities for documentation of contractor performance problems using the CDR (provided by Enclosure 2) are given in paragraph 2.5.7 of this Surveillance Plan. The COR shall maintain close communication with the supervisor(s) of contractor personnel as they will be most aware of day-to-day performance issues which may arise. CDRs shall be completed by the COR, not the supervisor. A CDR shall be completed by the COR in accordance with the Contract Administration Plan whenever there exist unresolved COR surveillance deficiencies or unresolved supervisory issues. Remember that the CDR is presented to the contractor firm's designated representative, not the contractor employee who failed to perform in accordance with the contract. That is not to say that a CDR must be completed every time there is a deviation from contract requirements. The COR or supervisor is better served by attempting to solve performance problems at the lowest level possible and in the least threatening manner possible., not by producing a CDR for every minor infraction. It is best to seek cooperative resolution, and then resort to formal documentation via a CDR if resolution cannot be reached. This approach is not intended as a license to avoid documentation of performance problems; if a problem cannot be expeditiously resolved cooperatively, the CDR process should be invoked. The CDR form is designed to produce a record of both Government and contractor positions. There is no requirement that this form be reduced to hard copy; an electronic copy attached to emails transmitted between representatives is acceptable.

9. SUPERVISOR RESPONSIBILITES

9.1 The supervisor is the individual Government employee who is responsible for providing the day-to-day direction and control of the activities of the personal services health care worker. The supervisor(s) of contract personnel shall read and retain a copy of the contract and the specific task order under which the supervisor is receiving services. The supervisor shall recognize that the contract/task order protects the interests of both the Government and the contractor/contract personnel and that the contract prescribes duties and responsibilities for both parties.

9.2 This is a personal services contract and provides the supervisor with the ability to direct and control the day-to-day activities of the contract personnel. However, the supervisor shall be cognizant of the overall scope of the contract and the particular duties defined by the contract as being within that scope. The supervisor shall ensure that duties assigned to contract personnel are consistent with the duties prescribed by the contract.

9.3 The supervisor shall be cognizant of their responsibilities for supervision of contract personnel which may differ from their responsibilities regarding supervision of government personnel. This includes assignment of specific work hours; the task order may impose this responsibility on the supervisor or it may reserve work scheduling as a function for the contractor. The same may apply to the administration of leave for contract personnel. The task order will provide specific information regarding these functions and the supervisor shall become familiar with these provisions.

9.4 Under those task orders where the supervisor is responsible for administering leave, it must be noted that contract personnel do not fall under the government personnel system and that their leave balances will not be maintained by a third party. Leave balances must be maintained by the supervisor. It is recommended that the supervisor coordinate with the COR to develop and maintain an effective system (likely a spreadsheet file) to track contractor leave. Further, it is essential that a system be developed between the supervisor and the contract personnel to ensure each is aware of the current balance so to avoid disputes regarding leave amounts accrued and used.

9.5 Regardless of whether the supervisor is responsible for administering leave for contract personnel, it is essential that the supervisor track the amount (hours) of service received from contract personnel. Coordination with the COR on this point is essential. The COR is responsible for certifying contractor invoices as being correct, i.e., representing the actual services received by the government. As the COR will not have day-to-day visibility on each contract site, contract individual, shifts worked, etc., it is absolutely essential that supervisors keep meticulous records of services received and establish a convenient means to transmit accurate, complete records to the COR for use in certifying invoices.

9.6 In general, and always keeping in mind the specific requirements and limitations prescribed by the contract, the supervisor is best served by supervising the contract personnel in the same manner as they supervise the government personnel on their staff. That is, the supervisor should not impose on contractor personnel burdens or privileges which are contrary to those imposed on other staff performing the same function, always, again, keeping in mind the requirements of the contract. When in the slightest doubt regarding this general guidance, the supervisor shall contact the COR for specific guidance and interpretation.

9.7 The supervisor's responsibility for supervision of contractor personnel extends to the normal feedback that should be provided to any employee regarding the quality of their performance. Contractor employees should be informed when they have performed well, or performed poorly (failed to meet contract requirements). Counseling sessions regarding both good performance and poor performance must be documented by the supervisor; this documentation, both positive and negative, creates a critical trail that will be used for future task order award decisions. When counseling sessions for poor performance do not have a positive effect on contractor employee performance, the supervisor must contact the COR. A copy of all counseling sessions must be provided to the COR.

9.8 The supervisor should schedule regular meetings with the COR to discuss contract progress and performance. Performance problems are always most easily handled with early recognition and a consistent corrective action system. Between regularly scheduled meetings, the supervisor should contact the COR immediately upon recognition of contract performance issues. The supervisor should attempt to handle normal day-to-day individual duty performance issues through the normal supervisory methods, but contact the COR when these individual performance issues continue without resolution or when there is a pattern of non-performance across the contract personnel.

Enclosure 2

CONTRACT DISCREPANCY REPORT		
Contract Number:	Contract Clause:	Date:
COR Findings:		
COR (sign and date):		
Contractor Response:		
Contractor Project Manager (sign and date):		
COR Determination/Recommendation:		
COR (sign and date):		

Enclosure 3
REPORT ON CONTRACT PERFORMANCE

Company or Individual's Name: _____
(IF CONTRACT IS WITH INDIVIDUAL STATE THEIR NAME)
(IF CONTRACT IS WITH A COMPANY STATE THE COMPANIES NAME)

Contract number: _____

Type of service: _____

Reporting period: _____

COR/technical liaison: _____
telephone no: _____

Supervisor of HCW: _____
telephone no: _____

Report prepared by: _____
telephone no: _____

Definitions:
"Contractor" means the entity (business or individual) that has the legal duty to perform the contract.
"HCW" means the "Health Care Worker" who is providing the service.
Note: In contracts with individuals, the Contractor is also the HCW.

	QUALITY OF SERVICE	YES	NO	N/A
1.	Was any HCW the subject of a validated patient complaint? If yes explain:			
2.	Was any HCW the subject of an occurrence report? If yes explain:			
3.	Did the HCW(s) interact and take direction in accordance with the contract, clinical standards, and protocol? If no, explain:			
4.	Did the HCW maintain productivity and quality comparable to that of other HCWs assigned the same scope of services? If no, explain:			
5.	Were all services provided as dictated by the terms of the contract? If no,			

	explain:			
6.	Were there any other documented problems with the quality of the services provided by an HCW? If yes, explain:			
7.	Have any HCWs been cited for commendable performance? If yes, explain:			
8.	Have any contract HCWs performed in an exemplary manner? If yes, explain:			
9.	Additional comments on Quality of Service provided:			

	SCHEDULE	YES	NO	N/A
10.	Did the Contractor submit complete credentials file/professional file information on time? If no, explain:			
11.	Did the health care workers begin performance on the date and time scheduled? If no, explain:			
12.	Did any HCW miss a shift without approved leave? If yes, explain, including number of shifts missed:			
13.	Did the Contractor submit invoices on time and in accordance with the contract? If no, explain:			

14.	Did any HCW request excessive unplanned absences during the contract year? If yes, explain. Did the absences affect work accomplishment? How many unplanned absences were there?			
15.	Did any HCW request leave without pay (LWOP) during the performance period? If yes, what were the circumstances? Did the LWOP affect work accomplishment?			
16.	Was leave requested and used in accordance with the contract? If no, explain:			
17.	Was any HCW habitually late to work? If so, how many times?			
18.	Additional comments on the Schedule of services:			

	MANAGEMENT OF KEY PERSONNEL	YES	NO	N/A
19.	Did the HCWs meet the minimum qualifications in the contract? If no, explain:			
20.	Did any of the HCWs exceed the minimum qualifications stated in the contract in a way that was beneficial to the Navy? If yes, explain:			
21.	Did the Contractor experience turnover of HCWs during the period? Was it excessive? If yes, describe the circumstances. What was the ratio of HCW turnover to total HCWs on the contract (e.g., 2 replacement hires out of a staff of 20= 2/20 = 10%)?			

22.	If yes to 21 above, state the average amount of time taken for substitution of personnel from the date that one HCW left contract? Number of days:			
23.	Did the Contractor submit complete qualification packages for substitutions? If no, explain:			
24.	Were all HCW maintenance requirements (licensure, BLS, etc.) kept current during the reporting period? If no, explain:			
25.	Did any HCW experience problems obtaining pay or benefits from the Contractor during the reporting period? If no, explain:			
26.	Additional comments on the Management of Key Personnel:			

	BUSINESS RELATIONSHIPS	YES	NO	N/A
27.	Is the Contractor responsive to your questions and concerns? If no, explain:			
28.	Does the Contractor conduct business in a professional and courteous manner? If no, explain:			
29.	Additional comments on Business Relationships:			

ATTACHMENT AC
Letter of Identification – Travel (EXAMPLE)

[Date]

From: Contracting Officer, Naval Medical Logistics Command (NMLC)
To: [Name of Military Treatment Facility]

Subj: CONTRACTOR LETTER OF PROFESSIONAL IDENTIFY (COPI) AND OFFICIAL GOVERNMENT TRAVEL – [NAME AND SSN OF CONTRACT EMPLOYEE]

1. This letter certifies [contract employee's name] is an employee of [contractor's name], under contract number [contract number] providing services with the Department of the Navy (DON) Medical Records Coding services for the period [task order period of performance].

2. The employee must have access to military installations and temporary housing areas in order to fulfill the requirements of the contract. While on a military installation, the identified employee is subject to all the rules and regulations governing civilian personnel conduct. The employee must carry an identification card or badge at all times identifying him/her has a DON contract employee.

3. The primary duty location is in [city, state or country]. During the period of employment, the named individual may be required to travel on government business to other locations. The purpose of the travel may be to provide direct services to the Military Treatment Facility staff as medical records coders, trainers and/or auditors. This letter, accompanied by a memorandum from the supervising agency, will serve as notification of official government travel.

4. When traveling the employee must use a mode of transportation that is the most economical to accomplish the mission. Travel may be by private automobile or public conveyance such as bus, trains, or commercial airlines. The contractor will be reimbursed in accordance with the task order.

5. As a contract employee traveling on government business, the named individual may use temporary government lodging facilities, when available. The government will reimburse for the actual cost of lodging and the government established daily rate for meals at the temporary duty location. These rates are published on the world wide web at http://dtic.mil/perdiem/pdrates.html.

6. The undersigned is the point of contact for this matter and may be reached at DSN 343-0287 or commercial (301) 619-0287.

NMLC, Code 02, 24S
Contracting Officer

Copy to:
Contractor
Contract employee

ATTACHMENT AD
HEALTH CARE WORKER CERTIFICATE OF AVAILABILITY

I, _____ [NAME OF HEALTH CARE

WORKER/PROVIDER] hereby certify that I have agreed to provide

services as a _____ under this contract

at (fill in the location)_____

as a subcontractor/employee (CIRCLE ONE) for

_____ [NAME OF PRIME CONTRACTOR]

for salary of $_____ per hour ($_____ per annum).

I am available to begin providing these services from

_____, should the above named prime

contractor be awarded this position.

_____ _____
Health Care Worker Signature Date

HEALTH CARE WORKER MUST CIRCLE EITHER SUBCONTRACTOR OR EMPLOYEE ABOVE.

TO BE COMPLETED BY THE OFFEROR

If my company is awarded a Task Order, I verify that the above health care worker will be:

my employee, or

a subcontractor

Check one of the above.

_____ _____
Signature and title Date

ATTACHMENT AE
Attachment AE
Offeror's Technical Proposal (Reserved)

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ATTACHMENT AF
WD 05-2473 (Rev.-5) was first posted on www.wdol.gov on 06/05/2007
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****
REGISTER OF WAGE DETERMINATIONS UNDER | U.S. DEPARTMENT OF LABOR
THE SERVICE CONTRACT ACT | EMPLOYMENT STANDARDS ADMINISTRATION
By direction of the Secretary of Labor | WAGE AND HOUR DIVISION
| WASHINGTON D.C. 20210
|
|
|
| Wage Determination No.: 2005-2473
William W.Gross Division of | Revision No.: 5
Director Wage Determinations| Date Of Revision: 05/29/2007

State: South Carolina

Area: South Carolina Counties of Beaufort, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Williamsburg

Fringe Benefits Required Follow the Occupational Listing

OCCUPATION CODE - TITLE	MINIMUM WAGE RATE
12000 - Health Occupations	
12010 - Ambulance Driver	12.96
12011 - Breath Alcohol Technician	15.64
12012 - Certified Occupational Therapist Assistant	20.47
12015 - Certified Physical Therapist Assistant	20.13
12020 - Dental Assistant	14.07
12025 - Dental Hygienist	23.07
12030 - EKG Technician	19.32
12035 - Electroneurodiagnostic Technologist	19.42
12040 - Emergency Medical Technician	12.96
12071 - Licensed Practical Nurse I	14.92
12072 - Licensed Practical Nurse II	16.70
12073 - Licensed Practical Nurse III	18.62
12100 - Medical Assistant	11.69
12130 - Medical Laboratory Technician	16.31
12160 - Medical Record Clerk	13.18
12190 - Medical Record Technician	13.47
12195 - Medical Transcriptionist	15.56
12210 - Nuclear Medicine Technologist	23.07
12221 - Nursing Assistant I	7.91
12222 - Nursing Assistant II	8.82
12223 - Nursing Assistant III	9.62
12224 - Nursing Assistant IV	10.80
12235 - Optical Dispenser	15.64
12236 - Optical Technician	14.92

12250 - Pharmacy Technician	12.11
12280 - Phlebotomist	12.09
12305 - Radiologic Technologist	21.56
12311 - Registered Nurse I	23.05
12312 - Registered Nurse II	28.19
12313 - Registered Nurse II, Specialist	28.19
12314 - Registered Nurse III	34.11
12315 - Registered Nurse III, Anesthetist	34.11
12316 - Registered Nurse IV	40.89
12317 - Scheduler (Drug and Alcohol Testing)	20.68

ALL OCCUPATIONS LISTED ABOVE RECEIVE THE FOLLOWING BENEFITS:

HEALTH & WELFARE: $3.16 per hour or $126.40 per week or $547.73 per month

VACATION: 2 weeks paid vacation after 1 year of service with a contractor or successor; 3 weeks after 8 years, and 4 weeks after 15 years. Length of service includes the whole span of continuous service with the present contractor or successor, wherever employed, and with the predecessor contractors in the performance of similar work at the same Federal facility. (Reg. 29 CFR 4.173)

HOLIDAYS: A minimum of ten paid holidays per year, New Year's Day, Martin Luther King Jr's Birthday, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day. (A contractor may substitute for any of the named holidays another day off with pay in accordance with a plan communicated to the employees involved.) (See 29 CFR 4174)

THE OCCUPATIONS WHICH HAVE PARENTHESES AFTER THEM RECEIVE THE FOLLOWING BENEFITS (as numbered):

1) Does not apply to employees employed in a bona fide executive, administrative, or professional capacity as defined and delineated in 29 CFR 541. (See CFR 4.156)

2) APPLICABLE TO AIR TRAFFIC CONTROLLERS ONLY - NIGHT DIFFERENTIAL: An employee is entitled to pay for all work performed between the hours of 6:00 P.M. and 6:00 A.M. at the rate of basic pay plus a night pay differential amounting to 10 percent of the rate of basic pay.

3) AIR TRAFFIC CONTROLLERS AND WEATHER OBSERVERS - NIGHT PAY & SUNDAY PAY: If you work at night as part of a regular tour of duty, you will earn a night differential and receive an additional 10% of basic pay for any hours worked between 6pm and 6am. If you are a full-time employed (40 hours a week) and Sunday is part of your regularly scheduled workweek, you are paid at your rate of basic pay plus a Sunday premium of 25% of your basic rate for each hour of Sunday work which is not overtime (i.e. occasional work on Sunday outside the normal tour of duty is considered overtime work).

HAZARDOUS PAY DIFFERENTIAL: An 8 percent differential is applicable to employees employed in a position that represents a high degree of hazard when working with or

in close proximity to ordinance, explosives, and incendiary materials. This includes work such as screening, blending, dying, mixing, and pressing of sensitive ordance, explosives, and pyrotechnic compositions such as lead azide, black powder and photoflash powder. All dry-house activities involving propellants or explosives. Demilitarization, modification, renovation, demolition, and maintenance operations on sensitive ordnance, explosives and incendiary materials. All operations involving regrading and cleaning of artillery ranges.

A 4 percent differential is applicable to employees employed in a position that represents a low degree of hazard when working with, or in close proximity to ordance, (or employees possibly adjacent to) explosives and incendiary materials which involves potential injury such as laceration of hands, face, or arms of the employee engaged in the operation, irritation of the skin, minor burns and the like; minimal damage to immediate or adjacent work area or equipment being used. All operations involving, unloading, storage, and hauling of ordance, explosive, and incendiary ordnance material other than small arms ammunition. These differentials are only applicable to work that has been specifically designated by the agency for ordance, explosives, and incendiary material differential pay.

** UNIFORM ALLOWANCE **

If employees are required to wear uniforms in the performance of this contract (either by the terms of the Government contract, by the employer, by the state or local law, etc.), the cost of furnishing such uniforms and maintaining (by laundering or dry cleaning) such uniforms is an expense that may not be borne by an employee where such cost reduces the hourly rate below that required by the wage determination. The Department of Labor will accept payment in accordance with the following standards as compliance:

The contractor or subcontractor is required to furnish all employees with an adequate number of uniforms without cost or to reimburse employees for the actual cost of the uniforms. In addition, where uniform cleaning and maintenance is made the responsibility of the employee, all contractors and subcontractors subject to this wage determination shall (in the absence of a bona fide collective bargaining agreement providing for a different amount, or the furnishing of contrary affirmative proof as to the actual cost), reimburse all employees for such cleaning and maintenance at a rate of $3.35 per week (or $.67 cents per day). However, in those instances where the uniforms furnished are made of "wash and wear" materials, may be routinely washed and dried with other personal garments, and do not require any special treatment such as dry cleaning, daily washing, or commercial laundering in order to meet the cleanliness or appearance standards set by the terms of the Government contract, by the contractor, by law, or by the nature of the work, there is no requirement that employees be reimbursed for uniform maintenance costs.

The duties of employees under job titles listed are those described in the "Service Contract Act Directory of Occupations", Fifth Edition, April 2006, unless otherwise indicated. Copies of the Directory are available on the Internet. A links to the Directory may be found on the WHD home page at http://www.dol.gov/esa/whd/ or through the Wage Determinations On-Line (WDOL) Web site at http://wdol.gov/.

REQUEST FOR AUTHORIZATION OF ADDITIONAL CLASSIFICATION AND WAGE RATE {Standard Form 1444 (SF 1444)}

Conformance Process:

The contracting officer shall require that any class of service employee which is not listed herein and which is to be employed under the contract (i.e., the work to be performed is not performed by any classification listed in the wage determination), be classified by the contractor so as to provide a reasonable relationship (i.e., appropriate level of skill comparison) between such unlisted classifications and the classifications listed in the wage determination. Such conformed classes of employees shall be paid the monetary wages and furnished the fringe benefits as are determined. Such conforming process shall be initiated by the contractor prior to the performance of contract work by such unlisted class(es) of employees. The conformed classification, wage rate, and/or fringe benefits shall be retroactive to the commencement date of the contract. {See Section 4.6 (C)(vi)} When multiple wage determinations are included in a contract, a separate SF 1444 should be prepared for each wage determination to which a class(es) is to be conformed.

The process for preparing a conformance request is as follows:

1) When preparing the bid, the contractor identifies the need for a conformed occupation) and computes a proposed rate).

2) After contract award, the contractor prepares a written report listing in order proposed classification title), a Federal grade equivalency (FGE) for each proposed classification), job description), and rationale for proposed wage rate), including information regarding the agreement or disagreement of the authorized representative of the employees involved, or where there is no authorized representative, the employees themselves. This report should be submitted to the contracting officer no later than 30 days after such unlisted class(es) of employees performs any contract work.

3) The contracting officer reviews the proposed action and promptly submits a report of the action, together with the agency's recommendations and pertinent information including the position of the contractor and the employees, to the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor, for review. (See section 4.6(b)(2) of Regulations 29 CFR Part 4).

4) Within 30 days of receipt, the Wage and Hour Division approves, modifies, or disapproves the action via transmittal to the agency contracting officer, or notifies the contracting officer that additional time will be required to process the request.

5) The contracting officer transmits the Wage and Hour decision to the contractor.

6) The contractor informs the affected employees.

Information required by the Regulations must be submitted on SF 1444 or bond paper.

When preparing a conformance request, the "Service Contract Act Directory of Occupations" (the Directory) should be used to compare job definitions to insure that duties requested are not performed by a classification already listed in the wage determination. Remember, it is not the job title, but the required tasks that determine whether a class is included in an established wage determination. Conformances may not be used to artificially split, combine, or subdivide

classifications listed in the wage determination.

ATTACHMENT AG
WD 05-2393 (Rev.-4) was first posted on www.wdol.gov on 06/05/2007
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REGISTER OF WAGE DETERMINATIONS UNDER | U.S. DEPARTMENT OF LABOR
THE SERVICE CONTRACT ACT | EMPLOYMENT STANDARDS ADMINISTRATION
By direction of the Secretary of Labor | WAGE AND HOUR DIVISION
| WASHINGTON D.C. 20210
|
|
|
| Wage Determination No.: 2005-2393
William W.Gross Division of | Revision No.: 4
Director Wage Determinations| Date Of Revision: 05/29/2007

States: North Carolina, South Carolina

Area: North Carolina Counties of Beaufort, Bladen, Brunswick, Carteret, Columbus, Craven, Cumberland, Dare, Duplin, Greene, Harnett, Hoke, Hyde, Johnston, Jones, Lee, Lenoir, Martin, Moore, New Hanover, Onslow, Pamlico, Pender, Pitt, Richmond, Robeson, Sampson, Scotland, Tyrrell, Washington, Wayne, Wilson
South Carolina Counties of Dillon, Horry, Marion, Marlboro

Fringe Benefits Required Follow the Occupational Listing

OCCUPATION CODE - TITLE	MINIMUM WAGE RATE
12000 - Health Occupations	
12010 - Ambulance Driver	14.01
12011 - Breath Alcohol Technician	13.58
12012 - Certified Occupational Therapist Assistant	19.59
12015 - Certified Physical Therapist Assistant	19.59
12020 - Dental Assistant	13.15
12025 - Dental Hygienist	24.51
12030 - EKG Technician	18.15
12035 - Electroneurodiagnostic Technologist	18.15
12040 - Emergency Medical Technician	14.01
12071 - Licensed Practical Nurse I	12.21
12072 - Licensed Practical Nurse II	13.72
12073 - Licensed Practical Nurse III	15.34
12100 - Medical Assistant	10.79
12130 - Medical Laboratory Technician	14.40
12160 - Medical Record Clerk	11.26
12190 - Medical Record Technician	14.22
12195 - Medical Transcriptionist	11.01
12210 - Nuclear Medicine Technologist	30.24
12221 - Nursing Assistant I	8.63
12222 - Nursing Assistant II	9.70
12223 - Nursing Assistant III	10.58

12224 - Nursing Assistant IV	11.90
12235 - Optical Dispenser	12.02
12236 - Optical Technician	12.30
12250 - Pharmacy Technician	12.79
12280 - Phlebotomist	11.90
12305 - Radiologic Technologist	20.45
12311 - Registered Nurse I	19.44
12312 - Registered Nurse II	23.79
12313 - Registered Nurse II, Specialist	23.79
12314 - Registered Nurse III	28.78
12315 - Registered Nurse III, Anesthetist	28.78
12316 - Registered Nurse IV	34.50
12317 - Scheduler (Drug and Alcohol Testing)	17.05

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HOLIDAYS: HOLIDAYS: A minimum of ten paid holidays per year, New Year's Day, Martin Luther King Jr's Birthday, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day. (A contractor may substitute for any of the named holidays another day off with pay in accordance with a plan communicated to the employees involved.) (See 29 CFR 4174)

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2) After contract award, the contractor prepares a written report listing in order proposed classification title), a Federal grade equivalency (FGE) for each proposed classification), job description), and rationale for proposed wage rate), including information regarding the agreement or disagreement of the authorized representative of the employees involved, or where there is no authorized representative, the employees themselves. This report should be submitted to the contracting officer no later than 30 days after such unlisted class(es) of employees performs any contract work.

3) The contracting officer reviews the proposed action and promptly submits a report of the action, together with the agency's recommendations and pertinent information including the position of the contractor and the employees, to the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor, for review. (See section 4.6(b)(2) of Regulations 29 CFR Part 4).

4) Within 30 days of receipt, the Wage and Hour Division approves, modifies, or disapproves the action via transmittal to the agency contracting officer, or notifies the contracting officer that additional time will be required to process the request.

5) The contracting officer transmits the Wage and Hour decision to the contractor.

6) The contractor informs the affected employees.

Information required by the Regulations must be submitted on SF 1444 or bond paper.

When preparing a conformance request, the "Service Contract Act Directory of Occupations" (the Directory) should be used to compare job definitions to insure

that duties requested are not performed by a classification already listed in the wage determination. Remember, it is not the job title, but the required tasks that determine whether a class is included in an established wage determination. Conformances may not be used to artificially split, combine, or subdivide classifications listed in the wage determination.

ATTACHMENT AH
EXAMPLE: Supplemental Pricing Worksheet

This supplemental pricing worksheet shall be completed in accordance with Section H, paragraph H.2.2.1.3. This worksheet requires two sets of data: 1) information regarding the minimum compensation rates to be paid by the offeror to any health care worker in this labor category/CLIN; and 2) information regarding the average compensation rate for the labor category, considering all health care workers to be utilized and all hours of service to be performed. The Contracting Officer will use the minimum compensation information to determine the price realism of the proposed compensation. The Contracting Officer will use the average compensation information for best value determinations. A separate supplemental pricing worksheet for each of the labor categories/CLINs shall be completed.

SLIN 06-0006AA Central Sterile Technician at NH Camp Lejeune, NC	Minimum compensation for HCWs in this labor category.	Average compensation for HCWs in this labor category
i. Hourly Rate (direct compensation to the HCW) (expressed in dollars and cents)	$0.00	$0.00
ii. *Fringe Benefits (expressed in dollars and cents)	$0.00	$0.00
Total Health Care Worker Compensation Per Hour	$0.00	$0.00

*Fringe Benefits include non-cash compensation provided to employees (including that necessary to comply with Department of Labor compensation requirements), such as 401(k), Insurance (Medical/Dental/Life), Continuing Education Expenses, Bonuses, Incentives, and Uniform Allowances.

The offeror shall describe other fringe benefits offered but NOT included in the fringe benefit rate above (please specify and describe the value of the benefit):

SOURCE INFORMATION NOTES:

ATTACHMENT AI
HEALTH EXAMINATION AND IMMUNIZATION/SCREENING REQUIREMENT FORM

AFTER contract award, but prior to performing services, the contract health care worker shall have this form completed by a licensed medical practitioner.
All health care workers providing services under this contract must meet all the requirements specified under the "Required Documentation" column of this form.*

COPIES OF TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (to be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX)	Reliable history of chickenpox disease, OR	Hx:	
	2-dose vaccine series, OR	Dates of Shots: 1. 2.	
	Positive titer	Titer/Date:	
MEASLES/ MUMPS/ RUBELLA (MMR)	MMR live virus 2-dose vaccine series (1-dose vaccine if born before 1957), OR	Dates of Shots: 1. 2.	
	Positive titers	Titers/Date:	
HEPATITIS B	HBV 3-dose vaccine series AND positive titer, OR HBV 3-dose vaccine series with negative titer AND repeat 3-dose HBV series with repeat titer AND in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response	Dates of Shots: 1. 2. 3. Titer/Date:	Dates of Repeat Shots: 1. 2. 3. Titer/Date: Counseling provided:
TETANUS/ DIPHTHERIA	Tetanus/Diphtheria (TD) booster, OR	Date of TD booster:	
	Tetanus/Diphtheria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS	Two-step Tuberculin Skin Test (TST), OR One Blood Assay for Mycobacterium Tuberculosis (BAMT), OR An annual evaluation if known TST reactor, including chest x-ray within 1 year if new hire	2-Step TST dates: 1st test: 1st result: 2nd test: 2nd result: CXR Date: Pos: Neg:	BAMT date: Result: Date/result of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing	Date of test: Results:	

_____ [Name of Contract Health Care Worker] has presented for a physical examination. He/She is applying for the position of _____[Please enter job title].

He/She was examined on _____ [date] and found to be in good health, meeting the immunization/ screening required above, and is free of any medical condition or infectious disease that may prevent his/her ability to perform services for the position described above. YES NO [Please circle either YES or NO.]

Provider's Signature: _____ Provider's Name: _____

Facility/Address: _____

Phone Number: _____ Date: _____

*The facility shall identify any incumbent HCWs who are not required to complete this documentation.

ATTACHMENT AJ
Format for contractor's weekly Fill Rate Report to NMLC

Contractor Name: _____
Dates of Invoice Period for which the report applies:
_____

Contract Number	Task Order Number	MTF	CLIN	Labor Category	Individual / Coverage	Quantity Required (Positions/ Hours)	Quantity Filled	Percent Filled	Comment:
06-D-1234	0012	NH Beaufort	0001AA	Family Practitioner	Individual	4	2	50%	2 credenti packages submitted 1/2/07
06-D-1234	0013	NH Charleston	0003AA	Family NP	Individual	1	1	100%	
06-D-1234	0013	NH Charleston	0004AA	RN, Outpatient	Coverage	224	208	93%	Currently recruiting increase coverage pool

Contract Number. FY-Type-Number, e.g., 06-D-1234

Task Order Number. The contractor must keep the reported positions grouped by Task Order Number.

CLIN. Contract Line Item Number from the task order

Labor Category. Position Title as specified in the Task Order. The contractor must list each position type separately, by CLIN, as it is shown in the Task Order.

Individual/Coverage. Indicate whether the task order is for a specified number of individuals or whether the contractor is required to fill a specifed schedule

Quantity Required (Positions/Hours). For CLINs shown as "Individual", enter the number of individuals required by the task order. For CLINs shown as "Coverage", enter the number of hours service required by the task order for the applicable invoice period.

Quantity Filled. For CLINs shown as "Individual", enter the number of individuals who were both approved for service and provided service during the invoice period. For CLINs shown as "Coverage", enter the number of hours service provided during the applicable invoice period.

Percent Filled. Quantity Filled divided by Quantity Required expressed as a percentage. The formula is already entered for your use.

Comments. If an "Individual" position is not filled or all required hours of "Coverage" have not been provided, describe the actions being taken by the contractor to meet the requirement.

SUBMISSION REQUIREMENTS. The data shall be submitted electronically as a Microsoft Excel spreadsheet with the following file name convention: [name of contractor] [contract number] [last date of invoice period].xls, e.g., ABC Corp 06-D-1234 1-12-07. xls. The contractor shall submit a separate Excel file for each contract held.

DEFINITIONS

1. Abeyance. The temporary removal of a health care provider from clinical duties while an inquiry into allegations of provider impairment or misconduct is conducted. Periods of abeyance provide privileging authorities the opportunity to review allegations while ensuring patient safety and protecting providers from unwarranted adverse privileging action. An abeyance terminates upon referral to a peer review hearing or at the end of 28 days, whichever occurs sooner. An abeyance is not an adverse action and is non-punitive.

2. Adverse Privileging Action. The denial, suspension, reduction, or revocation of clinical privileges based upon provider impairment or misconduct. Termination of a professional staff appointment based upon conduct incompatible with continued professional staff membership is also an adverse privileging action. The voluntary relinquishment of privileges by providers in administrative positions who are unable to maintain current competency is not an adverse privileging action.

3. Clinical Privileges. Clinical privileges define the scope and limits of practice for individual providers based upon the assets and capability of the medical or dental treatment facility, peer and departmental recommendations, and the provider's licensure, relevant training and experience, current competence, ability to perform, and judgment. Clinical privileges include both core and supplemental privileges.

4. Clinical Support Staff. Personnel required to be licensed, but who are not privileged providers. This category includes pharmacists, dental hygienists, and non-privileged nurses.

5. Denial of Privileges (Denial). An adverse privileging action that denies privileges requested by a practitioner when those privileges are of a nature that would normally be granted at the facility to a practitioner of similar education, training, and experience in the same specialty. A privileging authority may only deny privileges after affording the practitioner the opportunity for a peer review hearing. Denial of a request for reinstatement of privileges previously suspended or reduced within the prior year or revoked within the prior 2 years is not a denial of privileges within the meaning of this definition and will not require a peer review hearing.

6. Health Care Provider (Provider). Military (active duty or drilling Reserve) or DON civilian health care professional (Federal civil service, foreign national hire, contract, managed care support contract (MCSC) provider working within a Navy medical treatment facility (MTF) or partnership) required by references (a) and (b) to be granted clinical privileges to independently diagnose, initiate, alter, or terminate health care

DEFENDANT'S EXHIBIT
WHR
10-13-15
23

Terrance L. Baker, M.D.

Kingsville, MD

Phone: 410-592-9889
Fax: 410-592-8464

September 24, 2015

T. David Hoyle
Attorney at Law
Motley Rice
28 Bridgeside Blvd
Mt. Pleasant, SC 29464

Re: Justin Nicholas Miller

Dear Mr. Hoyle:

I, Terrance L. Baker, M.D., M.S. am a licensed physician Board Certified in emergency medicine, family practice, geriatrics and forensic medicine. I am a physician licensed to practice medicine in all of its branches. I currently practice or teach in the areas of medicine applicable in this case. This case involves a wrongful death and survival action brought by the mother and personal representative of Justin Nicholas Miller who lost his life after being run over by a fire truck stolen by Kelvin Hunt who walked out the front gate of the Beaufort Naval Hospital. Despite the knowledge of employees of CasePro, Inc. and the Beaufort County Veterans Affairs officer, Edward Ray, that Kelvin Hunt intended to hurt others and himself. These documented events form the basis of negligence; negligence undertaking of duty; and wrongful death.

I am familiar with the issues in this case by virtue of my training, education and experience of over 25 years in the same field and/or related healthcare field as they physicians and treatment team practiced when treating Kelvin Hunt a former United States Marine Corps Corporal. The boards of emergency medicine, family medicine, geriatrics, and internal medicine share the same knowledge, training, education and experience when treating patients such as Kelvin Hunt. Attached is a copy of my current curriculum vitae.

During the course of my career, I have routinely provided care and treatment to patients in emergency department settings similar to the Naval Hospital Beaufort. This report is furnished in connection with care provided to Kelvin Hunt by various agents, servants and/or employees of Naval Hospital Beaufort and Veterans Affairs Officer, Edward Ray, a Beaufort County employee and/or other licensed professionals as identified herein to extent possible on February 24, 2012.

I have reviewed the records pertaining to medical care and treatment rendered to Kelvin Hunt including records from his admission to the Naval Hospital Beaufort as well as deposition testimony and supporting exhibits and documentation. Documents also reviewed include but are not limited to:

AA(1)

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DEFENDANT'S EXHIBIT
29 WHR 10-14-15

1. Deposition of Deborah J. Meaut taken September 16, 2015 along with exhibits.
2. Deposition of Erik D. Oberg, MD, FACEP taken September 17, 2015
3. Deposition of Michael Allen McCabe taken August 5, 2015, along with exhibits.
4. Deposition of Christian Jansen with exhibits.
5. Deposition of Craig Martin.
6. Deposition of Janice McDonald with exhibits.
7. Deposition of Joseph McDonald with exhibits.
8. Deposition of Karen Pope.
9. Deposition of Sandra Smith.
10. Defendant/Third-Party Plaintiff CasePro, Inc.'s Answers to Plaintiff's First Set of Interrogatories.
11. Defendant/Third-Party Plaintiff CasePro, Inc.'s Responses to Plaintiff's First Set of Requests for Production.
12. Defendant/Third-Party Plaintiff CasePro, Inc.'s Supplemental Answers to Plaintiff's First Set of Interrogatories and Request for Production.
13. Defendant/third-Party Plaintiff CasePro, Inc.'s Responses to Plaintiff's Second Set of Request for Production.
14. Defendant CasePro, Inc.'s Answers to Plaintiff's Second Set of Interrogatories and Third Set of Requests for Production.
15. Defendant Case Pro, Inc.'s Response to Plaintiff's Fourth Request for Production.
16. Defendants Second Supplemental Responses to Plaintiff's First Set of Request for Production.
17. Defendant CasePro, Inc.'s Third Supplemental Response to Plaintiff's First Set of Requests for Production.
18. Plaintiff's Supplemental Discovery Response.
19. News Articles.
20. Complaint.

I have the expertise to evaluate the reliability of these records. These records are of the type usually relied upon by reviewers such as myself. As healthcare becomes increasingly complex it is important for reviewers like myself to keep the documented interaction between a patient, healthcare institution and healthcare providers including physicians at the heart of the review process. This report is based upon my own personal knowledge and expertise in the fields of emergency medicine, family practice and forensic medicine; my professional experience in practice and working in these areas of medicine; my understanding of the facts; and circumstances surrounding the care and treatment provided to Mr. Kalvin Hunt and my review of the relevant medical records of Kalvin Hunt.

While it is true to some extent all patient interactions are unique, however, there are specific medical practices that the Naval Hospital Beaufort emergency department including the treating physician, Dr. Janson, and Beaufort County employee and Veterans Affair Officer Edward Ray would be expected to provide to meet the applicable standards of care and the duty to provide care to patients such as Kalvin Hunt. I specifically reviewed these records to determine whether within a reasonable degree of medical certainty that the duty to provide care was met.

EXECUTIVE SUMMARY

Based upon my review of the above medical records and also my education, training, experience and expertise in the fields of emergency medicine, family practice and forensic medicine; it is my opinion within a reasonable degree of medical probability that the care rendered to Kalvin Hunt by employees of CasePro, Inc. and Beaufort County Affair Officer, Edward Ray, departed from the duty of care required of

practitioners under the same or similar circumstances. It is my further opinion within a reasonable degree of medical certainty that the departures from national standards of care and the duty to provide care as further described below, directly and proximately caused Justin Nicholas Miller to lose his life after being run over by a fire truck stolen by Kelvin Hunt, a patient at the Beaufort Naval Hospital, known by employees of CasePro, Inc. and Beaufort County Veterans Affair Officer, that Mr. Hunt was a danger to himself and the community at large.

HISTORICAL SUMMARY

The above records disclose the following facts in summary:

On 2/24/2012, Kelvin Hunt was a former United States Marine Corps Corporal who was court marshalled in April 2011 for charges of assault, communicating a threat, resisting arrest. Mr. Hunt was subsequently discharged from the Marine Corps. Mr. Hunt at the time of discharge was believed to have suffered with post-traumatic stress disorder as a result of his military service.

On 2/24/2012, Beaufort County employee and Veterans Affairs Officer Edward Ray received a telephone call from Kelvin Hunt's grandmother, Claretha Hunt, regarding erratic behavior demonstrated by Mr. Hunt.

On 2/24/2012, 10:30, Veterans Affair Officer Edward Ray met Kelvin Hunt. During this meeting, Kelvin Hunt disclosed to Edward Ray that he wanted to hurt himself and others. Edward Ray serving as a Beaufort County employee and Veterans Affair Officer had knowledge that Kelvin Hunt posed a specific threat of harm to himself and others. Mr. Edward Ray voluntarily undertook a duty to monitor, supervise and control Kelvin Hunt's conduct. As part of this duty Edward Ray arranged for Kelvin Hunt to be examined at Naval Hospital Beaufort (NHB) at 13:30 hrs.

On 2/24/2012, at 13:30 hrs., Edward Ray escorted Kelvin Hunt through the front gate of NHB and took Mr. Hunt to Managed Care Intake where he was first seen by Koren Pope, Medical Support Assistant and Sandra Smith, RN.

Notably, CasePro, Inc. by contract with the Naval Medical Logistics Command provided personnel to Managed Care Intake at NHB. Kelvin Hunt was subsequently interviewed by the staff of NHB while in the presence of Edward Ray. During interviews with the staff of NHB, Kelvin Hunt stated in the presence of Edward Ray that he did want to hurt himself or others. As a result, personnel employed by CasePro staffing the NHB were aware that Kelvin Hunt presented a serious danger of violence to himself and others.

Beginning at approximately 13:30 hrs. the personnel of NHB had the ability to monitor, supervise and control Kelvin Hunt's conduct. The staff of NHB undertook a duty to insure that Kelvin Hunt was appropriately admitted and kept under close supervision. The emergency department staff included Janice McDonald, RN; Joseph McDonald, RN; Christopher Jannnsen, MD; and Gwen Gutter, LPN.

Subsequently, Mr. Kelvin Hunt was taken to the emergency room of NHB for medical treatment. Law enforcement, department of mental health and other public officials were not notified under the circumstances to ensure that Kelvin Hunt did not hurt himself or others. By 15:20 hrs. Dr. Jannsen attending emergency department physician was concerned about Mr. Hunt's psychiatric symptoms and altered mental status. Mental health was consulted. Shortly thereafter, Mr. Hunt was examined by

psychiatric tech Arthur Manning who confirmed the presence of psychiatric symptoms requiring further evaluation. Arthur Manning discussed Mr. Hunt with Dr. Hendelman who recommended that the patient be sent in-patient either to BMH or Fort Stewart.

Subsequently, Mr. Hunt was examined in the emergency department at NHB. No measures were taken to secure Mr. Hunt to protect himself and to prevent Mr. Hunt from harming others.

Subsequently, psychiatric tech Arthur Manning accompanied by psychiatric tech Clifton returned to the emergency room to further evaluate Mr. Hunt. Mr. Manning at all times was not comfortable with the patient's mental state and his somewhat unpredictable behavior. However, when Mr. Manning returned to the emergency room accompanied by psychiatric tech Clifton the ER staff reported that he had left the emergency department with Veterans Administration Office for a walk but no one had seen them return. Mr. Manning reported possible patient elopement from the emergency department. The quarterdeck subsequently called Code and searched outside the hospital and grounds for Mr. Hunt. While searching the immediate area the Veterans Administration Officer Edward Ray returned to the emergency room and reported that Mr. Hunt had run away from him when they were outside and he could not keep up. The situation was reported to the facility Commander Bristol and Chief Geter. Additionally, the incident was reported to Captain Simmer.

In fact, Mr. Hunt was allowed by the emergency department staff and Edward Ray to leave the emergency department. Specifically, Kalvin Hunt asked to get a quick breath of fresh air and with the permission of the emergency department staff as well as Edward Ray, existed the emergency department.

After existing the facility, Kalvin Hunt reportedly removed all of his clothing and left the NHB property on foot.

At about the same time, the town of Port Royal Fire Department was responding to a non-fire emergency call at the Laurel Hill Apartment complex located near the NHB.

Apparently, a naked Kalvin Hunt jumped into the unoccupied fire truck and entered the highway from the apartment complex parking lot.

Subsequently, Kalvin Hunt struck Justin Nicholas Miller with the fire truck as he was crossing the road on foot. Justin Nicholas Miller subsequently died from his injuries related to this accident.

It is my professional opinion based upon my own personal knowledge and expertise in the fields of emergency medicine, family practice and forensic medicine; my review of the records associated with this case that CasePro, Inc. through their agents, servants and or employees of the Managed Care intake, the emergency department and urgent care clinic at NHB deviated from the national standards of care committing specific negligent acts/omissions which directly caused the death of Justin Miller. My opinions do not allege acts of medical negligence. Instead, my opinions are expressed to demonstrate negligent acts/omissions of CasePro, Inc. employees and agents through their actions and/or failures to act that lead to the death of Justin Miller.

Specifically, CasePro, Inc. through its agents, apparent agents, employees, and staff had:

- Specific knowledge that Kalvin Hunt opposed a threat of harm to himself and others.

- Entered into a special relationship with Kalvin Hunt to provide necessary care and safety.
- Had the ability to monitor, supervise and control Kalvin Hunt's suicidal and/or homicidal thoughts.
- Undertook a duty to ensure that Kalvin Hunt was safe and secure during his medical treatment and throughout his entire visit to NHB. At all times Kalvin Hunt was required to be kept under close supervised observation.

CasePro, Inc. breached its duty and was negligent, grossly negligent, careless and reckless in the following ways:

- Failure to adequately screen potential patients for psychiatric and behavioral disturbance.
- Failure to prevent certain situations that place patients, staff and the community at large in danger due to suicide, homicide or elopement.
- Failure to adequately restrain individuals who indicate that they intend to harm themselves or others.
- Failing to recognize that Mr. Hunt required immediate psychological treatment.
- Failed individually and collectively as healthcare administrators to recognize that Mr. Hunt required immediate psychological treatment given his current signs and symptoms in combination with a significant past medical history of substance abuse, previous suicide attempts, and psychotic episodes, threats of bodily harm to others and to himself.
- Failed to ensure the safety of Mr. Hunt in the emergency department and to ensure that qualified psychiatric intervention was provided to him on a timely basis.
- Failure to institute precautionary measures to prevent injuries and/or death of Mr. Hunt, the treating medical staff and the community at large.
- Failure to prevent Mr. Hunt's elopement.

As a direct and proximal result of the actions or failure to act by the CasePro staff, agents, apparent agents, Justin Miller died.

Additionally, it is my professional opinion that Beaufort County through the Beaufort County Office of Veterans Affair and Edward Ray acting as a Veterans Affairs Officer and employee of Beaufort County failed to exercise reasonable care in performing its duties so as to prevent injury and death to Justin Nicholas Miller.

At all times Beaufort County employee, Edward Ray, had a non-delegable responsibility after he undertook a duty to monitor, supervise and/or control Kalvin Hunt and to ensure that he obtained medical care so as to prevent Kalvin Hunt from harming himself or others.

Beaufort County, Beaufort County Office of Veteran Affairs and Edward Ray as the Veterans Affair Officer neglected its duties and was grossly negligent, careless and reckless as follows:

- Failure to follow policies and procedures in order to ensure the safety of Kalvin Hunt and the community at large.
- Failing to ensure that employees/agents of the County and the Office of Veterans Affairs had or received adequate, experienced, training and supervision in the care and treatment of patients with underlying psychological diagnosis.
- Failure to exercise adequate care in performing the duties required by Mr. Hunt.

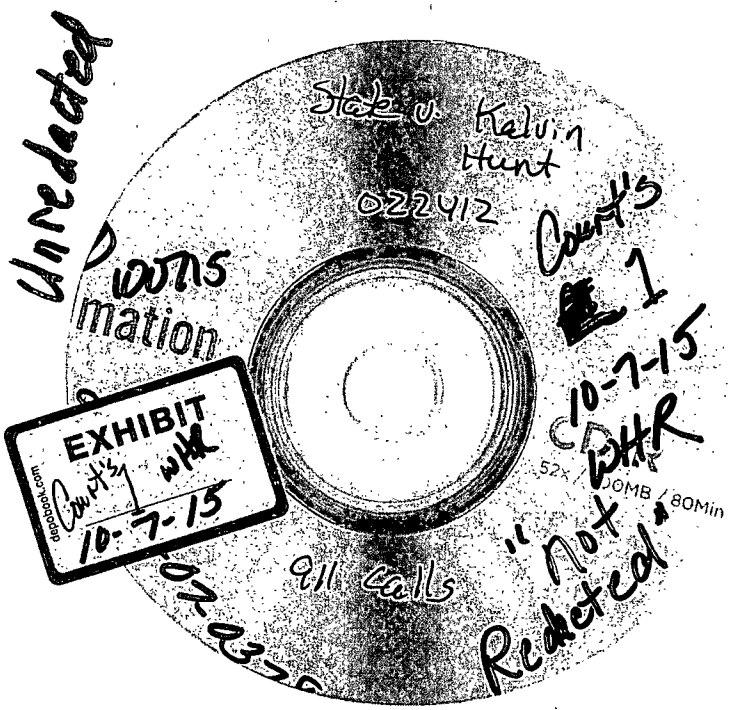
- Failed to exercise adequate degree of care in escorting Kalvin Hunt to the emergency department at NHB despite knowing that Mr. Hunt intended to injury himself and others.

As a direct and proximal result of the grossly negligent, willful and careless acts and/or omissions of Beaufort County through Beaufort County Office of Veteran Affairs and Edward Ray as a Veteran Affairs Officer and employee of Beaufort County, Justin Nicholas Miller suffered injuries and death.

I reserve the right to add to, subtract from and supplement this report as new evidence comes into discovery and as new opinions are formulated.

Respectfully submitted,

Terrance L. Baker, M.D.


Unredacted
State v. Kalvin Hunt
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Counts 1
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Miller Trial

Pope, Koren (Vol. 01) - 09/08/2014

1 CLIP (RUNNING 00:25:09.415)

Good morning, ma'am. ...

KP-0908-0000509 23 SEGMENTS (RUNNING 00:25:09.415)

1. PAGE 5:09 TO 5:13 (RUNNING 00:00:05.790)

Q Good morning, ma'am.
A Good morning.
Q Can you state your full name for the record?
A Koren Antoinette Pope.

2. PAGE 9:21 TO 10:16 (RUNNING 00:00:46.930)

Q And have you yourself ever served in the military?
A Yes, I have.
Q When did you serve in the military, and which branch?
A The Navy, and I was in from '96 to 2001.
Q What's the highest rank that you achieved in the United States Navy?
A E-3.
Q And what was your job classification in the Navy?
A Corpsman.
Q And for those of us unfamiliar with how the Navy works, what is a corpsman?
A Medical. So it's kind of the equivalent of a medical assistant.
Q And during the five years or so that you were in the United States Navy, what duty stations were you assigned to?
A I was at Camp Lejeune, North Carolina and Portsmouth, Virginia.

3. PAGE 10:17 TO 11:23 (RUNNING 00:01:11.840)

Q During your time as a corpsman in the United States Navy, did you have a particular focus within the medical field? Meaning, for example, you were always assigned to primary care physicians, or were you doing work with cardiologists, something like that?
A It was varied. I started in the surgical clinic. I went from there to the ICU, then I went from there to family practice, and then to admin.
Q Okay. What training did the Navy provide you in order to become a corpsman?
A You go -- well, you go to boot camp, of course, and then --
Q Yes, ma'am.
A -- after boot camp you go to what is called A school which is for, specifically for your job. So it was -- I can't remember exactly how long it was, but it's for -- it's medical assistant school, basically.
Q Okay. And where did -- where physically was your A school located?
A Great Lakes, Illinois.
Q And how long were you up there in

Illinois for that?
A About eight months, and that's including boot camp. So about eight months.
Q Okay. And was there classroom instruction that went along with A school? Or tell me how A school worked.
A Yes. It's classroom instruction plus hands-on training.

4. PAGE 13:02 TO 13:23 (RUNNING 00:00:57.340)

Q Okay. And then you said the bulk of the training was concerning patient care. What kind of training did you receive with that?
A Bedside manner. Small things like how to give baths, how to, you know, tend to patient's needs while they're there. Nothing too detailed. Because like I said, it's more of a medical assistant, so you have to work one-on-one with an RN. Anything detailed outside of that the nurse would do, we wouldn't, so...
Q Okay. At any point in time did you obtain any sort of license from any state agency as a result of your corpsman?
A No.
Q Okay. Ever have any instruction when you were in A school, I'm going to use this term broadly, concerning mental health issues?
A No.
Q During the time that you served as a corpsman in the United States Navy, was there periodic refresher training that you had to undergo?
A No.

5. PAGE 14:03 TO 14:09 (RUNNING 00:00:18.450)

Q Okay. Where did you go work after you left the Navy in 2001?
A I came back to Beaufort. I worked on Hilton Head for a while at an investment company. And then I worked at a cardiologist's office for a couple years. And then I went to the Naval Hospital.

6. PAGE 17:02 TO 17:10 (RUNNING 00:00:22.699)

Q Okay. All right. When you went to work in May of 2006 at the Naval Hospital, were you going in to work directly for the government?
A Yes.
Q Your employer beginning in May of 2006 was United States of America?
A Yes.
Q Is that who you're employed by today?
A Yes, Department of the Navy.

7. PAGE 25:13 TO 28:15 (RUNNING 00:03:45.596)

Q Ma'am, we're here today about an incident that took place on February 24th, 2012. Are you aware of that?
A Yes, I am.
Q And specifically we're here about an incident that involves a gentleman by the name of Kalvin Hunt. Prior to February 24th, 2012, had you ever met Mr. Hunt?
A No, I hadn't.
Q Where were -- strike that. Let me ask a foundational question.

Were you working at the Naval Hospital on February 24th, 2012?
A Yes, I was.
Q And on February 24th, 2012, what was your job title at the hospital?
A Medical Support Assistant.
Q Okay. And at that point in time, you were the medical support assistant in what department?
A Medical Home Port Team 2 on the second floor.
Q Okay. And what did the Medical Home Port Team do?
A It's pediatrics and internal medicine. It's -- so it's a mix of family practice, peds and internal meds.
Q But in the olden days they would have called it general practitioner?
A Yes.
Q Okay. And as in your role working for that team, what were your job responsibilities?
A Check in, DEERS checks, which is basically verifying insurance. Give directions to the hospital, answer phones, take messages. That's about it. It's very limited.
Q And would you have been the first point of contact for someone coming into that department?
A Yes.
Q Okay. Did anyone sit with you to also serve as a first point of contact?
A No.
Q Back in February of 2012, approximately how many people would have worked in this department?
A I believe at the time -- I'm not exactly sure. There might have been six or seven providers. And corpsmen vary, so it could be between 10 to 12 corpsman, and they rotate out. So I'm not exactly sure.
Q What were the typical hours that you were working at the Naval Hospital back in February of 2014?
A 7:30 to 4:00.
Q Those hours you work today?
A Yes.
Q And the Medical Home Port Team 2 department, what are the hours of that department?
A 7:30 to 4:00.
Q So this isn't a 24/7/52 type team?
A No, it's not.
Q Okay. What days of the week are personnel present for Medical Home Port Team 2?
A Monday through Friday.
Q 7:30 to 4:00?
A 7:30 to 4:00.
Q Do you recall what day of the week February 24th was?
A Friday.
Q I asked you a moment ago about a gentleman by the name of Kalvin Hunt. Prior to February 24th, 2012, had you ever met someone by the name of Edward Ray?
A No.
Q On February 24th, 2012, how did you come to have contact with Kalvin Hunt?
A He came to the second floor with Mr. Ray

to the desk.

8. PAGE 28:19 TO 30:01 (RUNNING 00:01:13.210)

when you say a desk, are you talking about a desk that's out in a common room? Are you talking about a window and a wall? Help me understand the Home Port Team 2.

A It's a -- it's a waiting area and a counter with an open area. So there's no window.

Q And you would have been sitting on one side of that counter?

A Yes.

Q Okay. And when Mr. Ray approached that counter, was he with someone?

A Yes.

Q Okay. And who was he with?

A Mr. Hunt.

Q Okay. Who were the two gentlemen there?

A They were the only two there.

Q Okay. And it was Edward Ray and Kalvin Hunt?

A Yes.

Q Okay. When they -- these two gentlemen approached the counter, who first spoke to you?

A Mr. Ray.

Q And did Mr. Ray identify himself?

A Yes, he did.

Q Okay. And did he tell you that he -- strike that.

Did he identify who he was employed by?

A Yes, he did.

Q And what was that information that he gave you?

A He just said, "I'm Mr. Ray with the Department of the VA and I want to know if you can help this young man."

9. PAGE 30:02 TO 30:23 (RUNNING 00:01:02.180)

Q Was Mr. Ray wearing some sort of name tag or badge around his neck on a lanyard, if you recall?

A I don't recall.

Q Don't know one way or the other?

A No.

Q Okay. But you had an understanding at that point in time, on February 24th, 2012, that Mr. Ray was there as some sort of Veterans' Affairs officer; is that fair?

A Yes.

Q And he wanted to know whether or not you could help this young man or not?

A Yes.

Q Did Mr. Ray tell you what kind of help Mr. Hunt needed?

A That he needed to be seen by a provider.

Q Anything else? And we're going to walk through this in kind of a slow, slow process. Anything else that Mr. Ray initially told you other than Mr. Hunt needed to be seen by a provider?

A No.

10. PAGE 30:24 TO 32:03 (RUNNING 00:00:55.245)

Q What did you do after learning that Mr. Hunt needed to be seen by a provider?

A I asked Mr. Hunt if he had ever been

seen at the Naval Hospital before.
Q And what did Mr. Hunt tell you?
A No.
Q What did you do next?
A I asked him his name.
Q Did he tell you his name?
A Yes, he did.
Q Okay. He said he was Kalvin Hunt?
A Yes.
Q Okay. And with the information that the gentleman on the other side of the counter next to Mr. Ray was Kalvin Hunt, what did you do?
A I asked him his last four of his social.
Q Did he provide you that information?
A Yes, he did.
Q And what happened next?
A I looked him up in the system to verify if he had ever been seen there before.
Q Okay. And the system, we're talking about a computer?
A Yes.
Q Okay. And what happened next?
A And he didn't come up.
Q And what system specifically were you using on a computer?
A CHCS.
Q CHCS?

11. PAGE 32:04 TO 32:17 (RUNNING 00:00:39.025)

A Yes.
Q Okay. And do you know what CHCS stands for?
A I have no idea.
Q Okay. CHCS, do you know if this is a program that's used exclusively at the Naval Hospital in Beaufort, or is it used elsewhere?
A It's nationwide.
Q Okay. So using CHCS, you put Mr. Hunt's name and last four of his social in and nothing came up. What did you do next?
A I said, "I'm not sure what we'll be able to do for you." And then I called Ms. Smith in the back.

12. PAGE 33:16 TO 33:21 (RUNNING 00:00:05.790)

know about the situation. How do you communicate with Ms. Smith? Do you go tell her something? Do you send her an email?
A I call her.
Q On the telephone?
A On the telephone.

13. PAGE 33:22 TO 35:07 (RUNNING 00:01:41.340)

Q Okay. And what information do you provide Ms. Smith?
A I let Ms. Smith know that there was a patient out there who wasn't registered here at the hospital, wanted to be seen by a provider, what could we do. And she said, "I'll come out and talk to him."
Q How soon after Mr. Hunt and Mr. Ray came to the counter did you call Ms. Smith?
A I don't think it was five minutes.
Q Were they still standing at the counter when you made that phone call?

A No. I told them to have a seat.
Q Okay. Now, on a Friday afternoon in this department, was the waiting room crowded or empty, or do you remember?
A It was empty.
Q They were the only ones there?
A They were the only ones there.
Q And typically in the Medical Home Port Team 2, are individuals seen who have appointments, or are typically folks seen without appointments?
A Everyone has -- has to have an appointment.
Q Okay. After you called Ms. Smith on the telephone, did she come up to the front?
A Yes, she did.
Q How soon after you called her did she come up to the front?
00035:01 A It wasn't very long, a few minutes.
Q Less than five minutes?
A Yes.
Q And when Ms. Smith came up to the front, did she go out into the waiting room or did she stand there at the counter where you sit?
A She went out to the waiting room.

14. PAGE 35:17 TO 35:20 (RUNNING 00:00:09.520)

Q Were you able to hear Ms. Smith's conversation with Mr. Ray and Mr. Hunt?
A There wasn't conversation. She just said, "Let's go back to my office."

15. PAGE 35:23 TO 36:02 (RUNNING 00:00:11.130)

Q Okay. So you see Ms. Smith go out into the waiting room, talk with Mr. Ray and Mr. Hunt. And the only thing that you heard her say was let's
00036:01 go back to my office?
A Yes.

16. PAGE 36:03 TO 38:09 (RUNNING 00:02:56.730)

Q Did Mr. Hunt or Mr. Ray say anything in response to that, that you recall?
A No.
Q What happened next?
A They went back to her office.
Q Okay. And how far from the front desk and the counter is Ms. Smith's office?
A It's a good little way. It's a very long hallway.
Q Did you go with them back to Ms. Smith's office?
A No.
Q You stayed at the counter?
A Yes.
Q When did you next see Mr. Hunt and Mr. Ray again?
A Ms. -- about a few minutes later, I'll say maybe five minutes later, Ms. Smith was escorting them downstairs.
Q All right. This -- this is painful, I know. But lawyers do this for a reason. So you see Mr. Ray and Mr. Hunt and Ms. Smith go back down the long hallway, then about five minutes later you see
00037:01 those three individuals come back?
A Yes.
Q Okay. Any doubt in your mind as you sit

here today that it was Ms. Smith who was walking Mr. Ray and Ms. Hunt into the waiting room at the Medical Home Port Team 2?
A No, no doubt.
Q Can you describe for us what Ms. Smith looks like?
A Ms. Smith is African-American, maybe about 5-6, 5-7. I think at the time she had dark hair, glasses. She always wears a white lab coat.
Q Did you see Mr. Hunt and Mr. Ray exit the Medical Home Port Team 2 area with Ms. Smith?
A Yes, I did.
Q Okay. And at some point in time did someone come back?
A Ms. Smith did.
Q How long had Ms. Smith been gone?
A Maybe 10 minutes.
Q Longer than the time that she'd spent back in her office with Mr. Hunt and Mr. Ray?
A Yes.
Q Did Ms. Smith tell you where she had gone with Mr. Hunt and Mr. Ray?
00038:01 A Yes, as she was walking out. She said, "I'll be right back. I'm going to take them to the ER."
Q This is as she's walking Mr. Hunt and Mr. Ray out of the Medical Home Port Team 2 area?
A Yes.
Q And when Ms. Smith came back, did she tell you any information?
A No.

17. PAGE 43:12 TO 46:22 (RUNNING 00:03:28.740)

Q Are you familiar with a database known as AHLTA?
A Yes.
Q Tell us what AHLTA is.
A AHLTA is -- it's an electronic recordkeeping system. So it has patients' medical records, demographics. That's about it. And it's nationwide so it holds a lot of information.
Q So it contained records of service members from the East Coast to the West Coast from the North to the South?
A Yes.
Q So for instance, somebody who's in the Marine Corps out in California, his or her medical
00044:01 records would get entered into AHLTA?
A Yes.
Q And if they were back here in South Carolina for some reason, their records from out in California, would they be accessible through the AHLTA?
A Yes.
Q Now this isn't a trick question. Do you have access to the AHLTA?
A Yes.
Q Do you have an understanding as you sit here today whether or not Ms. Sandra Smith has access to AHLTA?
A Yes.
Q She does?
A Yes, she does.
Q Okay. Pretty much everybody at the Naval Hospital who's working hands-on with patients have access to AHLTA?

A Yes.
Q And why is that, if you know?
A Because it's, it's patient care. So you would need that information, depending on what it is.
Q Is that something you were trained to do when you were in A school as a corpsman?
A No. AHLTA is fairly new. We didn't have AHLTA when I was in the military. So I got trained on AHLTA when I started working at the medical -- at the Naval Hospital.
Q Tell me about that training. Was that a classroom type training?
A Yes.
Q Okay. Is that something that everybody who works at the Naval Hospital had to go to?
A If you have access you have to go to training.
Q Okay. And how long does this training last, or did it last?
A About two days.
Q Oh, wow. Two whole days?
A No. Couple hours out of the day for two days.
Q But on two separate days?
A Two separate days.
Q Okay. And the training that you had on AHLTA, was it somebody standing up in front of a room explaining how it worked, or was there a hands-on component? Help me understand.
A It's both. It's someone -- it's hands-on, because you're -- everyone is sitting at a computer, but there is also an instructor.
Q Okay. Told me a lot of information there. So everybody's sitting at a computer, and there's an instructor, and so it's kind of guided hands-on training?
A Yes.
Q Was it good training?
A It was okay.
Q Okay. Were you able to use the AHLTA after you went through the two days of training?
A Yes.
Q Okay. Training wasn't so bad that you couldn't figure out how to use AHLTA after you sat through two days of training?
A No.
Q Okay. And the software itself, particularly after you had two days of training, was it fairly easy to use?
A Yes.
Q You had no trouble with it?
A No.

18. PAGE 46:23 TO 47:02 (RUNNING 00:00:13.800)

Q Who else was working on February 24th, 2012, in the Medical Home Port Team 2 department, if you recall?
A I can't remember who all was there that day.

19. PAGE 47:06 TO 47:09 (RUNNING 00:00:09.540)

Q Okay. So at the time that Mr. Hunt and Mr. Ray came in, was there a medical doctor present in the Medical Home Port Team 2?
A No.

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20. PAGE 48:02 TO 48:05 (RUNNING 00:00:11.580)

Q How late in the day was it that Mr. Hunt and Mr. Ray came into the Medical Home Port 2 Team area, if you recall?
A I know it was after 3:30. It was very

21. PAGE 48:17 TO 50:25 (RUNNING 00:03:02.290)

Q Okay. When you spoke with Kalvin Hunt on February 24th, 2012, how would you describe his appearance?
A He was neat, calm. I mean, normal, I guess. He just...
Q You believe you interacted with him for less than or more than a minute?
A Maybe right around a minute. The most I asked him was his name and his last four.
Q Did he know the last four of his social?
A Yes, he did.
Q Or he at least gave you four numbers?
A Yes.
Q Okay. Let me ask you this. If somebody comes in to the -- your department at the Naval Hospital and they give you a name. Let's say they come in and say they're Paul Detrick.
A Okay.
Q And they -- you put in four digits of a social security number that don't match up in the computer.
A Okay.
Q Would Mr. Detrick's medical records show up?
A No.
Q You'd have to have the combination of both the last name and the correct last four of the social?
A Yes.
Q And that would be true of whether or not we're talking about Mr. Detrick or Mr. Berlinsky or Kalvin Hunt?
A Yes.
Q Have you had any conversations with Mr. Ray since February of 2012?
A No.
Q Okay. Do you know any of his family?
A No.
Q I'm just going to go through a list of people, and it's going to be painful.
A Okay.
Q Do you know a lady by the name of Janice McDonald?
A No.
Q Okay. What about her husband, Joe McDonald?
A No.
Q Have you ever done any work with a medical doctor by the name of Christian Jansen?
A No.
Q Did you know any of the people who were working on February 24, 2012, in the emergency room at the Naval Hospital in Beaufort?
A I don't know who was working that day, so I don't know.
Q Okay. All right. Ma'am, I think those are all the questions I have for you. Some of these other lawyers around the room may have questions.

25 A Okay.

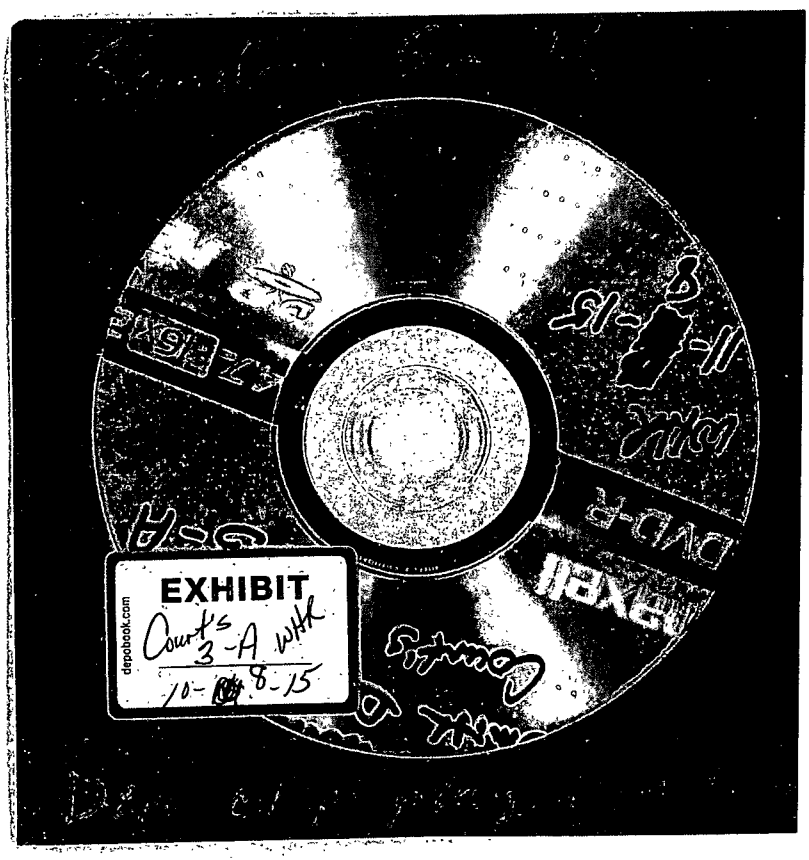
22. PAGE 63:23 TO 64:14 (RUNNING 00:00:25.040)

23 Q What was Mr. Hunt's demeanor that day?
24 What did he appear to you?
25 A He came in calmly. He was quiet.
00064:01 Answered my questions, sat down when I asked him to
02 sit down.
03 Q The only question you asked him, though,
04 was his last four digits of his social security,
05 that's the only --
06 A And his name.
07 Q That's the only conversation? And his
08 name?
09 A Yes, that was it.
10 Q That was it?
11 A Uh-huh.
12 Q Okay. And you didn't ask Mr. Ray
13 anything?
14 A No.

23. PAGE 72:10 TO 73:12 (RUNNING 00:01:15.610)

10 Q Okay. Did Mr. Hunt seem to know where
11 he was at the time you had an engagement with him on
12 February 24th of 2012?
13 A Yes, he did.
14 Q Okay. And was Mr. Hunt the person that
15 provided his last four of his social security number
16 on February 24th of 2012?
17 A Yes, he was.
18 Q Okay. Did he give -- strike that.
19 Did Mr. Hunt give you any indications
20 during your limited engagement with him that he had
21 any suicidal ideations?
22 A No.
23 Q Did he give you any indication that he
24 had any homicidal ideation?
25 A No.
00073:01 Q Did Mr. Hunt make any specific threats
02 regarding any specific individuals or readily
03 identifiable individuals in your presence?
04 A No.
05 Q Did Mr. Hunt have any type of behavior
06 that was posing imminent danger or threats or abuse
07 towards you or anyone in the waiting room?
08 A No.
09 Q Was his -- was Mr. Hunt's voice
10 aggressive towards you, or was it in a loud and
11 boisterous manner?
12 A No.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 00:25:09.415)


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Miller Trial

Smith, Sandra L. (Vol. 01) - 09/08/2014

1 CLIP (RUNNING 01:23:18.153)

Okay. Can you state your full name for ...

SS-0908-0001005 60 SEGMENTS (RUNNING 01:23:18.153)

1. PAGE 10:05 TO 11:17 (RUNNING 00:01:13.191)

Q Okay. Can you state your full name for the record?
A My full name is Sandra Lorraine Green Smith.
Q Thank you, ma'am. And where you current reside?
A I live at 260 Story Teller Road on St. Helena Island, South Carolina.
Q How long have you lived at the 260 Story Teller residence?
A I've lived on Story Teller over 50 years.
Q Did you grow up out there?
A Yes, I did.
Q From St. Helena Island originally?
A Yes, sir.
Q Okay. Where did you go to school?
A I went to high school at Beaufort High. I attended college at North Carolina A&T State University in Greensboro, North Carolina.
Q And what year did you graduate from Beaufort High School?
A In '76.
Q And you went on to A&T in Greensboro?
A Yes, sir.
Q My mother-in-law used to teach at A&T?
A Oh.
Q Did you graduate from A&T?
A Yes, I did.
Q What year did you graduate?
A 1980.
Q Okay. And what degree did you obtain from A&T?
A My bachelor's of science in nursing.
Q BSN?
A Yes, sir.
Q And you're a registered nurse?
A I am.

2. PAGE 11:18 TO 14:24 (RUNNING 00:03:09.770)

Q When did you became a registered nurse?
A Shortly after graduation I took the State Board of Nursing.
Q When you took the State Board of Nursing shortly after graduating from North Caroline A&T in 1980, did you take that up in North Carolina or did you come home to take that test?
A I came home to take my boards.
Q Okay. Have you continuously been licensed as an RN in South Carolina since then?
A Yes, South Carolina and Virginia.
Q Any further graduate work or anything like that after you finished at A&T?
A I do have a Master's in healthcare

administration and a degree in Christian counseling.
Q All right. You said a Master's in healthcare administration. Where is that degree from?
A Central Michigan University.
Q Is that a program that you did online or did you actually go up to Michigan?
A There was a program offered at the hospital, here at Naval Hospital.
Q A distance learning type thing?
A Distance learning, yes, sir.
Q Okay. And when did you obtain or go through that program through Central Michigan?
A That was 2001 I graduated.
Q And it's a Master's in healthcare administration?
A Yes, sir.
Q Okay. I want to get that straight. And then you have another graduate degree, that's in
00013:01 Christian counseling?
A Yes, sir.
Q And what's that degree through, which institution?
A Cathedral Bible College, which is out of Marion, South Carolina. And that was also a distance learning program through the church.
Q Okay. And when did you obtain your Master's degree in Christian counseling?
A I did not get a Master's in Christian counseling, I got a doctorate.
Q Oh, I apologize, ma'am.
A That's okay. I'm sorry. I didn't say.
Q Okay. So is this a Ph.D. or a -- tell me what the degree is.
A The degree is a doctorate in Christian counseling.
Q Okay.
A It allows me to counsel through church ministry.
Q I understand.
A Yes, sir.
Q And I mean no -- do you typically -- are you typically called Dr. Smith, or I don't --
A I am not typically called. Most people
00014:01 don't even know that I have a doctorate.
Q Okay. Okay. So if I call you Ms. Smith today, that's not going to offend you?
A That's not a problem at all.
Q Okay. I just wanted to make sure I understand that. And that was through Cathedral Bible College. And what year did you obtain the doctorate?
A In 2012. 2011. I believe that was 2011.
Q Okay. And you said that this distance learning program was through a church?
A Yes.
Q Okay. Which church was it through?
A It was through the Grace Hill Baptist Church on Grace Hill, South Carolina.
Q Other than the registered nursing license, do you hold any other licenses issued by the State of South Carolina, other than that and a driver's license?
A Not at this time, no.
Q Do you have plans to seek what's known

as a Licensed Professional Counselor license?
A I do.

3. PAGE 16:06 TO 16:14 (RUNNING 00:00:31.840)

Q Okay. Where do you currently work?
A I work at Naval Hospital Beaufort.
Q And how long have you worked at the Naval Hospital?
A I've been employed at the Naval Hospital Beaufort twice during my career as a nurse. Initially employed during 1988 to '93. Then again from 1995 through '97 in inpatient nursing. And then outpatient nursing from '97 to the present.

4. PAGE 18:05 TO 19:12 (RUNNING 00:01:16.290)

Q Certainly. Where did you work before you went to the Naval Hospital in 1988?
A Oh, I worked at Bayview Nursing Center from -- for a number of years, two years prior to -- from '80 to '84.
Q Okay.
A Yeah.
Q And where did you work after Bayview Nursing?
A After Bayview, 1995 to 1988 (sic) I worked at Kenner Army Hospital in Virginia.
Q Is that when you became licensed as an RN up in Virginia, about that timeframe?
A Yes. Yes, professional nurse in Virgina.
Q Okay. And then 1988, you started working at the Naval Hospital here in Beaufort?
A Yes, sir.
Q Okay. When you started working for the Naval Hospital in 1988, who was your employer, was it the Department of the Navy or was it a contractor?
A I was working for the Department of the Navy.
Q Have you continued -- strike that.
In the two separate timeframes that you've worked for the -- at the Naval Hospital, has that been employment with the Department of the Navy?
A Yes.
Q You never worked for a contractor such as CasePro or Sterling or anything like that?
A No, sir.

5. PAGE 20:09 TO 20:17 (RUNNING 00:00:24.000)

an immunization nurse. What other types of nursing duties have you done for the Department of the Navy?
A I've done progressive care which is step down from ICU.
Q Okay.
A Inpatient medical-surgical nursing, and ambulatory care nursing, which is primary care nursing dealing with pediatrics, family practice, internal medicine patients.

6. PAGE 21:05 TO 21:13 (RUNNING 00:00:16.784)

Q Okay. Have you ever worked in an emergency room setting?
A I have had some brief work in the emergency room, but never assigned to the emergency

room care.
Q The brief work that you've done in the emergency room, was that ever at the Naval Hospital here in Beaufort?
A No, it was not.

7. PAGE 24:19 TO 24:23 (RUNNING 00:00:11.960)

actually, that would be this year. Back in February of 2012, which department were you working in at the Naval Hospital?
A In the primary care, Medical Home Department.

8. PAGE 25:08 TO 26:14 (RUNNING 00:01:51.300)

Q Okay. Tell me about that department. How many people typically work in that department?
A Well, it's a very large department. And currently we occupy two floors. I would say there are close to maybe 60 people or more.
Q How many people on that team are RNs, approximately?
A Approximately seven.
Q Okay. And how many medical doctors staff that team?
A Oh, our providers come and go. But we have currently ten, about ten providers.
Q And what's a typical shift for you on this team as far as hours? When would you report to work and when would you leave?
A I arrive at 7:30 a.m. and leave at 1600, or 4 p.m.
Q Monday through Friday?
A Monday through Friday.
Q Nobody's there working on Saturday or Sunday; is that fair? In that department?
A In that department, no.
Q Okay. And what are your specific responsibilities as a registered nurse for that department?
A Currently, my responsibilities are to the pod, which consists of pediatric care. So I work with two, three doctors and one other nurse, and our job is to ensure the scheduling is correct, ensure patients are triaged correctly in person and by phone. We administer medication when necessary. We assist the providers in any way, and

9. PAGE 26:18 TO 27:06 (RUNNING 00:00:52.930)

Q Is that what you were doing in February of 2012, working primarily with pediatric patients?
A In February of 2012 I was actually doing a collateral duty which consisted of the support of women's health.
Q Tell me about that. What did that involve?
A That involved screening or assisting with the screening of women for cervical cancer. If cervical cancer or any abnormal tests that could lead to cervical cancer is noted, then I would assist those women in getting further treatment and scheduling within the team, or refer to the Gynecology Department.

10. PAGE 28:16 TO 29:01 (RUNNING 00:00:28.980)

The events that bring us here today

involve a gentleman by the name of Kalvin Hunt.
A Uh-huh.
Q Is that a yes?
A Yes.
Q Okay. Prior to February 24th, 2012, had you ever met Kalvin Hunt?
A No, sir.
Q Prior to February 24th, 2012, had you ever met a gentleman by the name of Edward Ray?
A No, sir.

11. PAGE 29:10 TO 31:02 (RUNNING 00:02:21.390)

Q And how did you first encounter Kalvin Hunt that Friday?
A He was brought to the -- I was asked to speak with him by Koren Pope.
Q And how did Ms. Pope ask you to do that? Did she come talk to you? Did she call you on the phone?
A She came to my office.
Q And what did Ms. Pope tell you?
A She said there was a gentleman that was there who was requesting medication refills, and she could not locate him in the system. And that he was accompanied by someone from the VA.
Q Do you know why Ms. Pope came to you?
A I was the nurse on duty at the time.
Q Was there any other registered nurse present in that department at that point in time on Friday afternoon?
A I don't recall any other nurses.
Q What did you do when Ms. Pope conveyed that information to you?
A When she conveyed that information, she also gave me some papers, which I looked at. And I told her to give me a moment, let me review the information and see what I could find out.
Q Could you describe the papers that she handed you?
A I can't describe them in great detail. I do recall that it mentioned he had been sent to Beaufort from a base in California. And the papers also mentioned that he was eligible to receive care at the Naval Hospital Beaufort.
Q Okay. Do you know where these documents came from?
A Mr. Hunt, I believe, had the documents with him.
Q Now, when it said that he was eligible to receive care, did it specifically state he was eligible to receive care at Naval Hospital Beaufort?
A It said at the nearest MTF to his location.
Q And what does MTF stand for?
A Military treatment facility.

12. PAGE 31:03 TO 31:24 (RUNNING 00:01:02.870)

Q And the paperwork, or papers that you're telling us about, did this bear the letterhead of the Department of the Navy, if you recall?
A I don't recall exactly what letterhead it bared (sic). They did look like official papers, but I don't recall exactly what letterhead was on the -- the papers.
Q Had you ever seen paperwork similar to this previous to February of 2000 --

A No, I had not.
Q Okay. That paperwork that Ms. Pope handed you -- I want to make sure I understand the timeline. Did she hand this paperwork prior to you speaking with Mr. Hunt?
A Yes, she did.
Q Okay. And about how many pages do you think this paperwork was?
A As I recall, there were approximately three pages of paperwork.
Q It wasn't a big, thick binder like I have in front of me?
A No, sir.

13. PAGE 32:16 TO 33:17 (RUNNING 00:01:31.880)

Q Okay. What did you do once you received that paperwork?
A I attempted to access some information from our system.
Q Now, I understand that there's a couple of different acronyms out there at the Naval Hospital, so just bear with me. When you're referring to the system, are you referring to CHCS, or to something known as AHLTA?
A They're both systems.
Q And what did you find when you attempted to locate Mr. Hunt?
A I noted that he was in the system, which showed that he was an active duty person eligible for care.
Q And what's the significance of that?
A That means that we can then care for him at our hospital.
Q I know it was a long time ago, and it's not a trick question. I can assure you there aren't going to be any trick questions today. People sometimes are just going to ask some inartfully-worded questions to try to obtain information.
As you sit here today, do you know if you found Mr. Hunt in CHCS or AHLTA or both?
A I recall that he was in both systems.

14. PAGE 35:09 TO 36:08 (RUNNING 00:01:17.046)

Q So I want you to know that. With respect to records that are in either AHLTA or CHCS, do they contain information that would follow the service member, whether or not he or she is receiving treatment from the East Coast to the West Coast, from the North to the South?
A That was the plan when, from my understanding, when the systems were created to ultimately connect them. So whether a member was on ship or in the dessert, or wherever they were, that all of these records could be linked and travel with them.
Q So a step further from my own question, it wouldn't matter if they're deployed in some sort of active theater or they're stationed at a base in California or South Carolina, they should all be there?
A They're working on getting it all there. It hasn't happened everywhere yet, but it is -- it's happening with more Internet access and more web-based programs.
Q Right. Might be some difficulties maybe

on a ship in the middle of the ocean, but certainly no difficulties here let's say in South Carolina where we have good Internet.

15. PAGE 36:10 TO 36:12 (RUNNING 00:00:06.830)

Q Is that fair?
A Well, it's based on what's available and what has been put in.

16. PAGE 36:24 TO 38:03 (RUNNING 00:01:29.517)

Q Before you talked with Mr. Hunt, you get some paperwork from Ms. Pope and you look Mr. Hunt up in the computer, okay? What information are you able to determine about Kalvin Hunt from the computer before you talked to him?
A That he was eligible for care because he was found in the system as an active duty member.
Q Okay. Did you review any of his past medical history at that point?
A No, sir.
Q And you understand what I mean by past medical history?
A His prior records, and...
Q So you have the paperwork from Ms. Pope, you look Kalvin Hunt up in the computer and you verify that he's in the computer, and don't look at any of his records; is that correct?
A May I just look at this to make sure?
Q Certainly.
A To make sure I'm following your timeline.
Q Sure.
A Okay. According to my statement for recall, I was able to find his name and review his last clinic encounter note which stated that he was seen for shoulder pain.
Q And for the record, you're using a two-page document to refresh your recollection, the state -- has your signature on the second page?
A Yes, sir.

17. PAGE 46:22 TO 47:04 (RUNNING 00:00:16.997)

the documents you've brought with you today, how many Sandra Smith's work at the Naval Hospital?
A I am aware of one.
Q And that would be you?
A And that would be me.
Q Okay. Not a dozen Sandra Smiths running around the Naval Hospital?
A Not to my knowledge, no.

18. PAGE 48:14 TO 48:14 (RUNNING 00:00:01.440)

that follows, How long...?

19. PAGE 61:10 TO 62:11 (RUNNING 00:01:13.930)

voices down. Do you have no opinion if mental health records are accessible, or is that something that you were told?
A I have no opinion or ability to answer your question based on what you're asking. I'm not clear on your question.
Q All right. Well, you wrote down on this piece of paper, "No opinion on if mental health records are accessible," correct?

A Right.
Q You wrote that?
A Yes, I did.
Q Why did you write that?
A I wrote that as a thought about the possibility of having to review mental health records.
Q You weren't referring to February 24th, 2012, when you wrote that?
A Was I referring to February 24th?
Q Yes, ma'am.
A Yes.
Q Okay. And you made a note that you had no opinion on if mental health records were accessible, why?
A Because I don't have an opinion on whether mental health records were accessible. I don't have an opinion on that.

20. PAGE 69:16 TO 69:25 (RUNNING 00:00:29.648)

there. Let's try and flush that out. "Whether I told them moaning and groaning," what does that mean? Why did you write those words?
A That was something I was thinking about as I read through this document.
Q All right. Are you -- were you questioning whether or not you told somebody whether or not Mr. Hunt was moaning and groaning?
A I thought about it as I was reading through the document.

21. PAGE 71:10 TO 71:25 (RUNNING 00:00:45.170)

Q Earlier today when I started asking you questions, you felt the need to consult papers that you brought with you. And the real purpose of a deposition is to obtain what information you have, not informations written on a piece of paper or otherwise.
A Okay.
Q So with respect to the notes that you made, I'm just trying to get a sense, was this a cheat sheet for your testimony, or what was this?
A This incident occurred two years ago. So I don't know what you would call something to jog your memory, but for me, that's what this was. Two years was a long time for me to remember and go back and think about all the things that happened, except for this statement that I have.

22. PAGE 80:07 TO 80:15 (RUNNING 00:00:22.070)

Q All right. I know the answer you're going to give me, but is that a memory from two years ago that you're not qualified to answer a question?
A No, that's a reminder to myself on who I am and what kind of training I possess. I am not qualified to answer anything that has to do with mental health. I'm not a mental health doctor. I am not an ER nurse.

23. PAGE 80:23 TO 81:09 (RUNNING 00:00:31.750)

Q All right. Back all those years ago at A&T when you were enrolled in nursing school, did -- did you just opt out of learning anything about mental health?

A I didn't opt out of learning anything about mental health. But we have a protocol to follow, and there are those that are more currently trained in mental health who I have access to as a resource, rather than me going back to my 20 years of mental health training, trying to take care of a patient that I know that I'm not qualified to take care of.

24. PAGE 83:22 TO 84:11 (RUNNING 00:00:46.390)

Q All right. Over here there's a word or some letters. Do you see that?
A "If."
Q If?
A Uh-huh.
Q What word's following, "no access"?
A "To mental health records."
Q Why did you write that on this piece of paper?
A Again, in preparation for this deposition. It was a thought that I had. After all of this occurred, and looking back knowing what I've heard in the community, there might have been mental health records. But I did not have access to those records.

25. PAGE 114:06 TO 114:21 (RUNNING 00:00:53.520)

Q Okay. Do you recall actually on February 24th, 2012, the day you first met Kalvin Hunt at the Naval Hospital in Beaufort, actually inputting information into the computer about your interactions with him?
A I do recall.
Q We'll use this as kind of a jumping off point to get back where we were some three hours ago, to a little bit of a chronology of that day. I believe you told us earlier that Ms. Pope came to see you back in your office?
A Yes, sir.
Q And that Ms. Pope had some papers with her and that you used those papers to look Mr. Hunt up in the computer; is that correct?
A Yes.

26. PAGE 115:01 TO 116:24 (RUNNING 00:02:20.300)

Q Is that a yes?
A That is a yes.
Q Do you believe that would be the time that Ms. Pope would have come back to your office with the papers for Mr. Hunt?
A No.
Q Do you believe it would have been before then or after that time?
A After.
Q Help me understand that. You believe Ms. Pope would have come back to your office after 2:30 in the afternoon?
A Ms. Pope did not come back after 2:30. I entered this documentation after I took Mr. Hunt to the emergency room.
Q Okay. So you would have made entries at 1430, 1435, 1554, 1556; is that correct?
A Essentially, I would have made the initial entry and the computer does some auto citing. And then if I open and close the note or if

I made any adjustments in the note, the final time of that, whatever I wrote, would have been stamped at the 1554. So the note can remain open as long as it takes me to write it.
Q Okay. So you believe you would have began writing this note at 1430 or 2:30 in the afternoon?
A Yes, sir.
Q And it took you to 1554 or 3:54 to finish?
A I may have stopped to do something else. I may have gotten a phone call. It's not uncommon that the note is not closed immediately.
Q And there was a signature down there, it says, "Signed by Smith, Sandra L., Registered Clinical Nurse, NH Beaufort at 1556." Do you see that?
A Yes, sir.
Q How does one sign electronically sign a document using the computer system at the Naval Hospital?
A This is automatically put into the system. So this -- there was nothing special that I needed to do except to type my code in to say I was done with this note.
Q And once you were done at 1556 this would have been a part of Mr. Hunt's permanent medical record, correct?
A Yes, sir.

27. PAGE 120:03 TO 120:14 (RUNNING 00:00:38.220)

Ma'am, with respect to the document that I've marked as Exhibit No. 7, it's your understanding as you sit here today that any person with the appropriate access to AHLTA and the appropriate skill with how to use AHLTA, at least at the Naval Hospital in Beaufort County, South Carolina, could, beginning at 2:30 in the afternoon on February the 24th, 2012, access the information as you had input it at that time concerning your encounter with Mr. Hunt, correct?
A Probably not in its entirety, but yes, they could look at the note.

28. PAGE 123:08 TO 123:14 (RUNNING 00:00:21.432)

to make sure of. Okay. All right. So we know that the last thing you did on February 24th, 2012, was sign off on your note in the computer. And it looks like that would have been done at about 3:56 in the afternoon or four minutes before quitting time, correct?
A Yes, sir.

29. PAGE 130:15 TO 131:06 (RUNNING 00:00:59.300)

Q Okay. At that point in time when you're back there in the office with these two gentlemen, do you pull anything up in the computer?
A I had already pulled up the visit that showed his shoulder pain, and it also brought up his medication, the two medications that I thought he was requesting.
Q Okay. Other than the -- was it a December 1st visit involving shoulder pain?
A I think it said December 11th, 2011.
Q The December 2011 shoulder incident, did

00131:01 you look for any additional records at that point in
02 time while they're sitting there in your office?
03 A When you pull up in records in AHLTA, if
04 there are others that you have access to, they would
05 come up. And at that time, that is all that I saw
06 for Mr. Hunt.

30. PAGE 124:17 TO 130:09 (RUNNING 00:06:09.220)

17 Q Okay. Good. Good. Once you determined
18 that Mr. Hunt was eligible for medical services at
19 the Naval Hospital, what did you do next?
20 A Are we saying that he's already in my
21 office now and -- I mean --
22 Q Well, where we left the story off --
23 A Right, that's what I'm trying to --
24 Q -- was it was just Ms. Pope in your
25 office.
00125:01 A Okay.
02 Q And she's handing you some papers.
03 A Okay.
04 Q And you told us about how you looked up
05 in the computer and found out that there was a
06 Kalvin Hunt in there.
07 A Yes.
08 Q All right. What happens next?
09 A I found out that he was in there. That
10 he had one encounter for shoulder pain. And that it
11 showed some medication that he had had. And so I
12 kind of assumed that he was trying to get the
13 medication for shoulder pain. But I walked out
14 there to help him to see what he needed.
15 Q All right. Now, prior to walking out
16 there, did you know whether or not Mr. Hunt had
17 arrived to your department by himself? Or did you
18 have an understanding that he was there with
19 somebody?
20 A Ms. Pope reported that he was with --
21 with the VA officer, or man.
22 Q Okay. And I believe you testified
23 earlier that you prior to that day, prior to
24 February 24th, 2012, you never met the VA officer or
25 VA man Mr. Ray; is that correct?
00126:01 A No.
02 Q Okay. So you go out to the waiting
03 room?
04 A Uh-huh.
05 Q And does Ms. Pope go with you?
06 A Ms. Pope left the papers and she was
07 already back at her station.
08 Q Doing whatever it is she needed to do?
09 A Yes.
10 Q Okay. So you go out into the waiting
11 room. And who do you talk with?
12 A I -- the waiting room was empty, except
13 for Mr. Hunt and Mr. Ray.
14 Q Now, I heard the waiting room earlier is
15 kind of a big room. Do you recall where within the
16 waiting room they were sitting?
17 A Yes, I do.
18 Q Where were they?
19 A When I came out of the hallway, they
20 were against the -- what is the pediatric playroom,
21 the chairs just facing the playroom.
22 Q Is the playroom kind of glassed in?
23 A Yes, it is glassed in.
24 Q So sick kids can be in there playing

while momma and daddy are hopefully not getting sick themselves?
A Yes, sir.
Q Okay. I've been to plenty of those myself. All right. So they're over there near the pediatric playroom. And when you go out there, are both gentlemen seated or are they standing up?
A Both gentlemen were seated.
Q This is South Carolina. I believe a man should stand up when a woman approaches. Did they do that?
A And they did.
Q Both of them?
A When I -- when I went into the room and I called his name, they both stood up.
Q Okay. And what happened at -- what happened at that point?
A And I called them back to my office.
Q All right. So you asked both Mr. Ray and Mr. Hunt to come back to your office?
A Yes.
Q Okay. Were any -- other than you inviting them to come back to your office, any type of conversation or anything else discussed out there in the waiting room?
A Only the, you know, the general courtesies of hello. And I introduced myself and told them, you know, I would try to find out what he needed and see if I could help him. And told him that I had the papers and we could go back and discuss what he needed.
Q Okay. And Mr. -- how was Mr. Hunt dressed?
A Mr. Hunt was neatly dressed. I remember some sort of striped white and yellow, maybe, shirt.
Q Okay.
A Like a Polo shirt that I bought for my husband this weekend, it's a simple shirt. And some slacks. But he was clean and well groomed.
Q Okay. Was he wearing shorts or long pants?
A He had on long pants, I believe.
Q Okay. And what about Mr. Ray? How was Mr. Ray attired?
A Mr. Ray was similarly dressed, but I think he was wearing a darker shirt and slacks.
Q Did Mr. Ray have a lanyard or anything like that around his neck with a name badge or anything like that, that you recall?
A I don't recall.
Q Could have, just don't recall; is that fair?
A Could have, don't recall. I know he introduced himself as the VA officer.
Q Did he give you a business card or anything like that?
A No, he did not.
Q Okay. So the -- were either gentleman carrying any type of file folder with them?
A Mr. Hunt had a file folder.
Q In his hands?
A Yes.
Q These two gentlemen, you invite them to walk back with you. How long did the pleasantries last out there in the waiting room? Are we talking 10 seconds, 10 minutes?

A Probably only, you know, less than an minute: Hello. How are you? I'm Ms. Smith. Would you please come back to my office and we can discuss your concerns.
Q So did both gentlemen follow you back to your office?
A Yes, sir.
Q Okay. Once they got back to your office, tell me what happened.
A I sat at my desk, and I offered them the two seats that were there.
Q Okay.
A Mr. Ray sat near the door, Mr. Hunt sat near, closer to my desk at a small sink area. And we discussed the papers that he had.
Q And by "papers," you're talking about the papers that said "leave" on them?
A The papers that said he was eligible for care.

31. PAGE 131:20 TO 135:04 (RUNNING 00:03:52.230)

Q Right. Let's use Paul Detrick as an example, because I did that earlier today. Let's say we wanted to find some of Mr. Detrick's records. How would you go find Mr. Detrick's records in the -- in AHLTA?
A Well, we would have to have some of Mr. Detrick's information. But once I had entered the card, and if Mr. Detrick was able to give me certain data on himself, then I would enter that.
Q Okay.
A And if he were eligible or actively enrolled in the system, then his name would come up along with address, phone number, doctor.
Q And assuming that Mr. Detrick was in the system and that he had some records in there, are these records that -- that a list comes up and you click on, or do multiple screens pop up? Help me understand what it looks like.
A Initially you're only getting the demographic screen.
Q Okay.
A Which says that Mr. Detrick is in the system, it tells us if he's an active duty member, retired member. You don't have anything about medical records, medications, anything at that point. And there's a section at the bottom that says whether he's enrolled or not enrolled. And then you can go from there as to where you want to go to look for more information on Mr. Detrick.
Q Well, let's assume Mr. Detrick's in the system. He's currently enrolled. It says he's been in the United States Marine Corps, oh, let's say from looking at Mr. Detrick, since he turned 18 years old. So a good 15 years ago. He's been in the service for 15 years. How would you then go through those 15 years of -- of medical records? Does a -- does a chronological list come up? Or can you go to some sort of search box. Help me understand. Because, you know, he doesn't look like he's a healthy guy. I mean, there might be a lot of records in there. How do you narrow down what it is you want to look at?
A Well, first of all, you may not get all of Mr. Detrick's records.
Q Yes, ma'am.

A And there may be only certain things based on where Mr. Detrick has been stationed as to what you will get.
Q Okay.
A I may get a small list of things. I may get a lot. But it just depends on the patient and where they have been stationed. As I said before, people that are in California and on ships and other places, while the system is trying to gather that information, it doesn't make it readily accessible for someone at my level of access always. So for -- it just depends on what I would be able to pull up on him.
Q Is there something in the AHLTA known as a problem list?
A There is a problem list.
Q Okay. And tell -- tell us what a problem list is?
A A problem list is a list of all the diagnoses that have been generated on -- on a patient. So -- and all of the things that they have been seen for in the past. It would be keeping a running list of all of the -- those concerns that a patient has had medically.
Q Okay. Do you recall as you sit here today one way or the other as to whether or not you reviewed a problem list on February the 24th, 2012 for Kalvin Hunt?
A A problem list did not come up until after this note was generated -- until this note was generated. So there was no problem list.
Q All right. You didn't see a problem list until after the note was generated; is that correct?
A Right.
Q Okay. After that note was generated, did you see a problem list?
A Yes.
Q Okay. Did you read it?
A Not really.

32. PAGE 136:07 TO 136:18 (RUNNING 00:00:36.860)

Q You -- as you sit here today, are you able to tell us one way or the other as to whether or not you knew on February 24th, 2012, as to whether or not Mr. Hunt had a problem with anxiety?
A Did I look at this list before I took Mr. Hunt to the emergency room?
Q No, no. I'm asking at any point in time on February 24th, 2012, any time that day, with your own two eyes, did you see listed as a problem with Kalvin Hunt, a problem of anxiety?
A I don't recall seeing that list. But Mr. Hunt did say he was anxious, so...

33. PAGE 137:23 TO 138:07 (RUNNING 00:00:29.500)

Q Okay. And that's my question. Do you know one way or the other whether or not you reviewed this list on that day, on February 24th, 2012?
A With the time that I spent with Mr. Hunt and the fact that I took him down right after talking with him, this list came up afterwards. I signed it out at 1556. I went home sometimes maybe 10, 15 minutes later. I cannot tell you that I reviewed all of these things on this list.

34. PAGE 140:04 TO 140:20 (RUNNING 00:01:00.452)

Q Okay. What questions do you ask these gentlemen while they're back there in your office?
A Well, the first question was how could I help him today so that he could explain to me what he, why he came to the clinic. And he showed me some of the same papers, or the same note that I had pulled up on him about his shoulder. And he said he needed a medication refill. And I told him at that time that these medications were issued back in December 2011 and that they were no longer active, and I wanted to know if he was trying to get refills on these medications. And he said no. And then he said -- and I said, well, what medications are you trying to get refills on?
Q Yes, ma'am.
A And he said that I wanted something for sleep. Sleep and anxiety, according to my note.

35. PAGE 140:21 TO 141:23 (RUNNING 00:01:02.598)

Q Okay. So when you asked him what kind of medication he was -- sleeping, he made clear he wasn't looking for medication dealing with some shoulder pain; is that correct?
A No.
Q He wanted something to help sleep better and deal with some anxiety he was experiencing; is that correct?
A Yes.
Q Okay. And he -- you mentioned that he showed you some papers. Did I hear that correctly?
A Well, he had the same note about his shoulder pain. He produced a document with the -- which is the exact same medical record, just that one report from 2011.
Q Did you ask Mr. Hunt if he had any other medical records?
A No, I didn't. But he didn't appear to have any -- anything other than the note and the forms that were given to me by Miss Koren.
Q Okay. Did you ever see him with a manila folder?
A It was a folder. I don't recall what color it was. But it was a very thin folder, probably smaller than this.
Q It's your testimony as you sit here today it was a thin folder?
A I was a thin folder, yes.

36. PAGE 142:01 TO 142:02 (RUNNING 00:00:05.620)

A Mr. Ray did not appear to have a folder with him. I don't recall a folder.

37. PAGE 142:07 TO 142:15 (RUNNING 00:00:21.910)

Q All right. Regardless of whether it was a thin folder, a thick folder, or some folder of some size in between, did you personally with your own two eyes review every single piece of paper within that folder?
A Between the three documents or the three pages that were given to me and the one that he pulled out, it appeared that I looked at most of them, because, I mean, he took them out to show me.

38. PAGE 142:23 TO 150:02 (RUNNING 00:08:36.670)

After Mr. Hunt tells you that he wants some medication to help him sleep and to deal with his anxiety, what do you do?
A I told him again that these medications were not on his list, and that we had two options for getting him care today. Because of the late hour, I did not have a doctor in the clinic, and I offered to get him to the ER to maybe speak with one of the doctors down there to get medications or the requested medications that he wanted. Or we could scheduled an appointment for the next working day in the first available slot so that he could be seen by one of our doctors and establish care and get the medications that he needs from one of the Med Home doctors.
Q Okay. Did Mr. Hunt specifically identify for you any medication he was seeking?
A No.
Q Like by name?
A He did not.
Q He just generically wanted medication for anxiety and -- and sleep?
A Yes.
Q Okay. When you told Mr. Hunt that those were his two options, how did he -- how did he respond?
A He seemed fine with it. And I asked him which choice he wanted. And he said, "I would prefer to take the appointment for Monday."
Q Okay.
A And so I scheduled the appointment as he requested.
Q And what time was he going to be seen that Monday, if you recall?
A My best recollection was the first available appointment, which would have been 7:00, 7:30, 7:40 in the morning.
Q Okay. All right.
A I think that -- it's on the sheet here, if I could look at it.
Q All right.
A 7:40.
Q All right. Did something happen while you were making that appointment for the following Monday, the 27th?
A Well, while I was making the appointment he became -- well, he just did one slight motion of rocking back and forth. He just kind of sighed, kind of moaned (indicating.)
Q Okay.
A So I asked him if he was okay. I didn't want to ask him.
Q Why did you not want to ask him?
A Because it didn't seem at the time anything that you would want to question a patient about. It was just more of an exasperated kind of moan. But in the back of my mind I felt that I should ask him if he was okay.
Q You had concern for him?
A I had a concern.
Q Okay. How -- how long was the moan?
A It wasn't really a moan. It was more like -- like a sigh of exasperation (demonstrating). Just -- just a simple sigh of exasperation and a -- a lean and a rock. Which as a nurse you feel the

sympathy for people that, you know, seem to be...
Q Seem to be what?
A Just whatever the situation is, you want to help. And so I wanted to know if he was okay.
Q He'd come there looking for help.
A For pills is what he came looking for. And he agreed to take the appointment on Monday for that.
Q Okay. And looking at your note from that day, you documented that Kalvin Hunt did not remember how long he'd been in Beaufort; is that true?
A When I asked him how long he had been there, he wasn't able to give me an immediate answer, no.
Q Did that give you a concern?
A That did. I thought it was odd that he didn't remember.
Q Was this before or after you heard the moan?
A I'm not sure. Did I write it down as a sequence? That would have been before.
Q Okay. People typically know how long they've been in a given city, that's fair?
A That's fair.
Q I didn't ask you your age a long time ago. But you're able to tell me how long you'd been in Beaufort County; is that fair?
A Yes, that's fair.
Q You're probably able to tell me how long your family's been here, too?
A Yes.
Q If people have all their wits about them, they know what's going on around them; is that fair?
A Yes.
Q But Mr. Hunt didn't know how long he'd been in Beaufort; is that fair?
A Mr. Hunt said he didn't remember how long he'd been in Beaufort.
Q And you had no reason to think he was making that up, did you?
A No, I didn't have any reason to think he was making it up.
Q Okay. And then some period of time later you hear a moan, and what you describe in the record, he rocks back and forth?
A Yes.
Q Okay. And you ask him if he's okay. And how does he respond?
A He -- I asked him -- when he rocked back and forth, I asked him if he was okay. And I told him, you know, we could go down to the ER if he wanted to try to get his medications this evening. And I think, according to my note here, he declined.
Q Okay. Did -- was -- did that strike you as -- as indicative of whether or not Mr. Hunt wanted to go to the ER or not go to the ER?
A It struck me as a person saying I can wait. I'm okay and I can wait.
Q Okay. But after that, you asked him whether or not he felt like hurting himself?
A Yes.
Q Why did you ask him that? Do you ask all your patients that?
A I don't.

Q I imagine particularly the pediatric patients you don't ask that.
A No, I don't.
Q Or the women coming in for cervical cancer screens?
A No, I don't. I don't ask them that typically.
Q I'm going to ask you a question. How many times in your career as a nurse do you think you've asked a patient that, whether they felt like hurting themselves?
A I've had to ask, unfortunately, a couple times.
Q Less than 100?
A Oh, very much less than 100. Maybe about three or four times during my career.
Q You've been a nurse for over 30 years?
A Yes, sir.
Q And in that 30 years you've only felt the need to ask three or four patients whether or not they feel like hurting themselves; is that fair?
A Yes.
00149:01 Q And Mr. Hunt was one of those folks?
A Yes.
Q Okay. His behavior in your presence and the way he answered your questions, that motivated you to ask; is that fair?
A No.
Q Why did you ask?
A I asked because I felt an inner instinct to ask. Mr. Hunt was very calm. He wasn't acting out in any way. And I just felt the nursing instinct to ask him if he was okay.
Q Okay. And what did he say?
A At first he said he was okay and he didn't want to go to the emergency room. But then when I asked him if he wanted to hurt himself, he said yes.
Q Okay. Did you ask him if he wanted to hurt other people?
A No, I did not.
Q Did you ask him any other question after you asked him the question "do you feel like hurting yourself"?
A I didn't ask him any other questions at that time.
Q Okay. At that point in time, you knew
00150:01 that this man needed to see a doctor?
A Yes.

39. PAGE 152:25 TO 153:06 (RUNNING 00:00:26.290)

Q Okay. All right. Back when Mr. Hunt
00153:01 and Mr. Ray were in your office, did Mr. Ray do any talking?
A Mr. Ray, I think, informed me that Mr. Hunt had come to his office at some point during that day. And that I think he assisted him in getting to Naval Hospital, but that's all I recall.

40. PAGE 153:11 TO 155:19 (RUNNING 00:02:20.800)

Q How soon after Mr. Hunt indicated that he did have thoughts of wanting to hurt himself did you begin the process of walking Mr. Ray and Mr. Hunt down to the emergency room?
A It was immediate.
Q Okay.

A Immediately I got up and we walked down the stairs to the ER.
Q Okay. And you told -- did you tell Mr. Hunt and Mr. Ray where you -- where y'all were going?
A I said, let's go to the emergency room, and follow me, please.
Q And did Mr. Hunt comply?
A Very cooperative. Calmly followed me down.
Q Now, you heard me reference earlier, and perhaps maybe that was the last witness, I don't know. There was a tour at some point at the hospital.
A A tour?
Q At the Naval Hospital. Most of the lawyers in this room got to go on it. I didn't. So I haven't been. So I apologize that I may be asking some questions that would seem kind of commonsensical to somebody who's been over there.
How does one get from where you were of the Medical Home Port Team to the ER?
A We would go back to the waiting area where I initially met Mr. Ray and Mr. Hunt.
Q Yes, ma'am.
A Immediately outside of that waiting area to the left there is a door, double doors that take you up or down the stairs.
Q Okay.
A We took those stairs down to the first floor.
Q Yes, ma'am.
A And we took an immediate right, and after passing maybe two doors we were at the emergency room.
Q How long did that take?
A Probably no more than a minute or two, maybe less than that. We didn't run, but I mean it was briskly to the ER.
Q You weren't lollygagging around?
A No, sir.
Q Okay. It was a, not a trot or a run, but a --
A Deliberate.
Q A deliberate pace?
A Yes. Yes, sir.
Q And why was that? Was that because you wanted Mr. Hunt to be seen by a medical doctor?
A Well, once a patient has made that -- you know, once he had said that he wanted to hurt himself, I wanted to make sure that he got there. His condition was calm at the time, and I wanted him to remain calm until he got to the emergency room.

41. PAGE 155:20 TO 156:01 (RUNNING 00:00:14.720)

Q And during the time that you went with Mr. Hunt down to the emergency room, was Mr. Ray with you every step of the way?
A Yes, he was.
Q He didn't peel off and go to the bathroom or go outside or anything like that?
A No, sir.

42. PAGE 157:10 TO 158:09 (RUNNING 00:01:14.410)

Q Okay. When you first met Mr. Hunt, Mr. Ray was with him, correct?

A Yes, sir.
Q When you brought Mr. Hunt back from a public waiting room within the four walls of the Naval Hospital to your office, Mr. Ray came with him, correct?
A Yes, sir.
Q Okay. And again, having not been over there to the Naval Hospital, I apologize if this is a silly question, but people who aren't patients or with the patient typically don't get to come back to your office; is that fair?
A We do have some liberal leeway with friends and -- and other acquaintances that want to come with patients. So sometimes that's tolerated. And in this case, Mr. Ray presented himself as an official. So it was okay for him to come back, since he brought him to the -- brought him to my office.
Q Mr. Ray never said anything along the lines of "I'm just here because I'm a friend," or "I'm just curious," or "I just wandered in off the street." He was there because he thought he was doing his job; is that fair?

43. PAGE 158:11 TO 158:14 (RUNNING 00:00:11.750)

Q You can answer.
A He said that he, Mr. Hunt, had been to his office sometime during that day, and he assisted him in coming to the Naval Hospital.

44. PAGE 158:15 TO 167:01 (RUNNING 00:09:42.750)

Q Now, when you and Mr. Ray walked Mr. Hunt into the ER, were there people sitting in the waiting room, or is it empty?
A We didn't go to the waiting room of the ER.
Q Okay.
A We went to the glass enclosure first to let them know that we were there.
Q Okay. And when you get to the glass enclosure, is it a sliding glass window kind of enclosure, or is it a window like you'd have at a gas station in a bad neighborhood where you got a circular hole that you talk through, if you remember?
A Well, it's been changed so I couldn't tell you what's there, whether it's the circular or the sliding, because we have had both. But I spoke through the glass to the person sitting at the desk.
Q Okay. And what did you tell the person sitting at the desk when you went down there?
A I told them who I was, where I had come from, and that I had a patient that needed to be seen, and I needed to see the nurse.
Q Okay. The person you spoke through to the glass, do you know if that person was a nurse, a clerk, a medical doctor, an x-ray tech?
A Usually there is a clerk or military paraprofessional sitting there at the desk.
Q Do you know if this person was a clerk or paraprofessional?
A I don't recall.
Q Okay. But you identified yourself as Sandra Smith?
A Yes, sir.
Q Okay. Didn't use some other name?

A No, sir.
Q Okay. And nobody else was with you from upstairs, it was just you, Mr. Hunt and Mr. Ray, correct?
A Yes, sir.
Q Okay. And when you told this information to the person on the other side of the window, was it a male or a female?
A I honestly don't recall. I think it was a male.
Q Okay.
A But I honestly don't recall.
Q Okay. Did somebody come out to assist you?
A Yes, a nurse came out.
Q Okay. The person who came out to assist you, who you said was a nurse, was it a man or a woman?
A It was a female.
Q Okay. Had you ever seen this person before?
A Yes, Ms. Janice.
MR. INFINGER: I'm sorry. Who?
THE DEPONENT: Ms. Janice.
Q You'd seen this lady before?
A Yes, sir.
Q Knew she worked at the Naval Hospital?
A Yes, sir.
Q Knew her name was Janice. Did you know her last name?
A I'm not very familiar with her last name. But I knew it was McDoogal (sic). She had her tag on, but I call her Janice all the time, so...
Q Did you call her Janice that day?
A I don't know that we had any pleasantries exchanged. I was more concerned about getting Mr. Hunt seen.
Q Okay. And your goal when you're talking with -- with Nurse Janice out there in the hallway isn't to make some sort of social plan or social arrangements, it's to make sure that Mr. Hunt gets to a medical professional, a medical doctor, right?
A Yes, sir.
Q Okay. So what information do you tell Nurse Janice when she comes out into the hallway?
A She said hello, and I said hello to her.
Q Okay.
A And I told her I have -- and the details, you know, are not probably totally word for word, but something to the effect of a 24-year-old male, Mr. Hunt, who came to my office with concerns, looking for medication refill. He presented papers, and at that time I gave them to her. And I told her that, but upon further conversation with Mr. Hunt, he expressed to me that he wanted to harm himself and he needed to be seen by a doctor.
Q All right. You told us a lot of information there. I just want to go through a few things to make sure that I heard them correctly.
A Uh-huh.
Q Whatever papers Mr. Hunt had showed up with, whether they were in a thin folder, a thick folder or some sort of in between folder, you gave that folder to Nurse Janice, correct?
A I didn't have the entire folder. Only

the three pages that said he was eligible for care. And I wanted her to be able to see that information at the time.

Q Because if she had that information, presumably she'd be able to access Mr. Hunt in whatever system she had access to?

A Yes.

Q Okay. So you equip Nurse Janice with the ability to find Mr. Hunt in the computer system by giving her those -- those papers. And you told her that he expressed a desire to harm himself, correct?

A Yes.

Q That's information you specifically told her, correct?

A Yes.

Q And you specifically told Nurse Janice that this young man, Mr. Hunt, needed to be seen by a medical doctor, correct?

A Yes. That's why he was being brought down. A doctor. I don't know if I said medical, but doctor.

Q Okay. Could have been doctor of osteopath?

A They know what's in the emergency room, so...

Q Okay. Whether they're born in Poland or Canada or South Carolina, correct, they know what's down there?

A Yes, they know what's down there.

Q Okay. Now, how long did this conversation between you and Nurse Janice last?

A It was very brief.

Q And I want to make sure -- and this is going to sound silly. It's so silly that I tried to get my office this morning to print out a picture of this lady. Can you describe for us what Nurse Janice looks like?

A Ms. -- Nurse Janet (sic) is a Caucasian female. At the time she had light colored hair, and she was wearing scrubs. She maybe is about -- about my height. And maybe around -- I wouldn't want to guess her weight, but she's not a heavy female. She's a slender woman.

Q She's proportionate?

A Yes.

Q Okay. How -- how -- and it's tricky thing for a man to ask this. But which generation would you put her in? It's a polite way of asking how old do you think she is.

A Well, it would be my guess that she's maybe a few years -- maybe a few years younger than myself. I would say maybe mid to late -- or maybe early 40s. Maybe early 40s. If not late 30s. I don't really know her age.

Q Okay. She wasn't some 20-something?

A No.

Q And conversely, she wasn't some 80-year-old?

A No.

Q Okay. And you said she was about your height. That would make her approximately how tall?

A Five-three.

Q And she had a name tag on her scrubs?

A Well, we wear badges, so...

Q She had a badge on?

A I believe she had her badge on that day.
Q And did the badge reflect her name?
A The badges do reflect your name, yes, sir.
Q Okay. Have you had an occasion to interact with this nurse since then?
A I'm thinking. Yes, I did.
Q Okay. Same lady?
A Same lady.
Q Nurse Janice?
A Yes.
Q Okay.
A But that was some time ago.
Q Okay. Do you know if Nurse Janice still works at the Naval Hospital?
A I have not seen her at the Naval Hospital lately.
Q Okay. What did you do -- strike that. You relayed certain information on
00166:01 February 24th, 2012, that you told us about to Nurse Janice McDonald. Did she say anything to you in response to receiving that information that you provided her?
A She essentially just said okay, and we'll see him. And she ushered him into the emergency room, and the door closed.
Q As far as you were concerned, at that moment she -- Kalvin Hunt was her responsibility?
A Well, not as far as I'm concerned. As it is, it -- he has become her responsibility and a patient of the emergency room.
Q Okay. Got a few -- after you -- did you actually with your own two eyes see Nurse Janice, Mr. Hunt and Mr. Ray go into the emergency room?
A Yes, sir.
Q And once you saw them go back into the emergency room, what do you do?
A I left. Went back the way I came, back to my office. And between interruptions and whatever, I completed this document.
Q Okay. The record that we previously talked about which is --
A A telephone consult.
Q Yes, ma'am, which is Exhibit No. 7?
00167:01 A Yes, sir.

45. PAGE 171:22 TO 175:23 (RUNNING 00:07:32.820)

Q We looked earlier at some notes that you yourself made. And I remember you went through and looked up some terms, medical terms trying to define them. Do you recall that?
00172:01 A Yes.
Q Okay. And we also earlier today, in looking at Exhibit No. 7, the two-page medical record that you prepared on February 24th, 2012, concerning Mr. Hunt, had a list of problems on that?
A Yes.
Q Okay. What's your understanding of what an adjustment disorder with anxious mood is?
A It is what I wrote on that paper.
Q Okay.
A And my understanding is very limited when it comes to that. It's a patient that is experiencing perhaps some anxiety related to life, a change, a major change in a life event, whether it's a death or a job loss or -- that would cause them to

react negatively to certain situations.
Q What about delusional disorder, do you have an understanding what delusional disorder is?
A That's the patient's that are -- have a perception of things that are not in reality.
Q Is that a concern -- would you have a concern as a registered nurse licensed to practice nursing in this state if someone presented to you and they had a past diagnosis of delusional disorder?
A Well, I could be concerned. You're always concerned. But a list like Mr. Hunt's is not uncommon. I mean, you could find this almost on anyone.
Q But again, going back to our "almost anyone," the example you've just given us, you told us earlier that there's only been one or two, maybe three times you've ever asked a patient in your 30-plus years of nursing as to whether or not he or she intends to hurt himself, correct?
A Whether he or she intends to hurt himself. But you were discussing the list, which is again not uncommon. These diagnosis exist for many people, and it doesn't mean that they want to hurt themselves, it doesn't mean they want to hurt others.
Q Is that information --
A Not always.
Q Strike that. I understand.
If you have someone who indicates that he or she wants to hurt himself, is it important information to have, to know past diagnoses such as delusional disorder, personality disorder?
A As a part of the workup of that patient, it would be good information. So once you've gotten that patient to a safe place where you know that the actions cannot be carried out --
Q Yes, ma'am.
A -- then you begin to gather other information on the patient that could be helpful in your further assessment of that patient. So this list would have been helpful for someone else.
Q And I believe you told us in your own handwriting on Exhibit No. 3 that the more information on a patient the better the treatment?
A Yes.
Q That's a general rule of nursing, isn't it?
A Yes, sir.
Q That's a general rule that any licensed, degreed medical practitioner should try and follow, correct?
A If they are conscientious, it would be a good rule to follow.
Q Okay. Somebody's having trouble getting a history on a patient, should they just give up?
A It depends on the circumstances, because there are other ways to obtain a history.
Q What are the ways one can obtain a history from a patient?
A Well, there may be a family member present. There may be someone else that has accompanied the patient that could help report the history.
Q Can one consult past medical records to determine a patient's history?

A If -- yes, the past medical records would give a patient's history.
Q For example, whether or not one has high cholesterol or bad breath or hemorrhoids or some sort of mental health disorder, correct?
A It could be found in the medical records if it were documented.
Q But again, in order to determine whether or not something is or is not documented in past medical records, one would have to look, correct?
A Yes, you would have to look.
Q Ms. Smith, what did you expect was going to happen to Mr. Hunt in the emergency room at the Naval Hospital on February 24th, 2012?
A Well, everyone is an individual, so it's difficult to say. I expected, however, that he would be seen by the doctor.

46. PAGE 180:04 TO 180:10 (RUNNING 00:00:13.490)

Q Ma'am, I may have some question for you a little bit later on. But I suspect anything that I missed or forgot to ask you will be covered by these fine lawyers. I'm just going to go ahead and pass -- pass you at this time. I appreciate your time and putting up with me. Thank you.
A Thank you, sir.

47. PAGE 183:04 TO 184:13 (RUNNING 00:01:22.020)

Q And I'm just looking at the entry for Mr. Hunt.
A Yes, sir.
Q And I believe you testified earlier that you made this appointment for him?
A Yes, sir.
Q All right. And my assumption, because it's still on here, was that that was never canceled; is that right?
A I am sure that some notation was put there. It wouldn't have just remained. But at the time that I printed it, it was not canceled. So that would have been the 29th.
Q Well, it says, "status, no show."
A Okay.
Q All right. So if it says "no show" it means that the appointment was never canceled; is that right?
A It means that the patient did not arrive for the appointment.
Q Okay. And so you -- you made the appointment before you took Mr. Hunt to the
00184:01 emergency room; is that right?
A Yes.
Q Okay. And then when you went back to work on your note, you just didn't cancel that appointment; is that right?
A I don't believe I canceled it, no.
Q In the section next to where it says no show, under the reason for visit, it shows, "Active duty with sleep disturbance and anxiety."
A Uh-huh.
Q Is that -- did you write that in?
A Yes, sleep disturbance and anxiety, that's what he reported.

48. PAGE 204:18 TO 205:24 (RUNNING 00:01:25.060)

Q Now, you -- you had Mr. Ray and Mr. Hunt accompany you back to your office. Once they got into your office and you said that they sat down in chairs across from you in your office, was there any conversation between Mr. Hunt and Mr. Ray?
A The only time I can recall conversation was when I asked about the appointment, and it seems that they were both in agreement that they wanted the appointment.
Q All right. And this is the appointment that -- that had been scheduled that is referred to on Exhibit 8?
A Yes, sir.
Q All right. Did Mr. Ray answer any questions on behalf of Mr. Hunt, that you posed to Mr. Hunt?
A Not that I recall.
Q All right. Did Mr. Hunt have to refer to Mr. Ray for the answers to any questions that you asked him?
A Not that I recall.
Q When you asked Mr. Hunt for personal information, did Mr. Hunt provide that to you, or did Mr. Ray provide that to you?
A I don't recall asking for any personal information that was not provided by Mr. Hunt. I don't recall getting any answers from Mr. Ray.
Q Okay. Did Mr. Ray explain to you at any point why he was there?
A Again, he said that Mr. Hunt had been at his office that day and that he had brought him over to assist him in getting his medication refill.

49. PAGE 222:05 TO 223:04 (RUNNING 00:01:07.340)

Q So you have somebody that reports to you that is there for medication for anxiety, he does not tell you what type of medication he's on, and you do no further history to determine that; is that correct?
A That is correct.
Q Okay. And why?
A Because I am not qualified to prescribe medication for him. He needed to see a doctor. I offered to take him to the ER to get the prescriptions on that same day. He declined. He preferred to have an appointment where he could discuss his medication with a doctor. That was his choice.
Q Did he ever refuse to discuss his medication with you?
A He didn't refuse, but he didn't know.
Q Okay.
A He didn't know what his medications were. He --
Q Okay. Sorry.
A He gave me this.
Q Okay. Gave you what?
A The list of medications you see here is what he -- he had.

50. PAGE 224:08 TO 224:11 (RUNNING 00:00:13.540)

Q As a nurse with a nursing background, is that a concern to you that somebody is taking anxiety medication and has not been on those

medications for a long time?

51. PAGE 224:14 TO 225:02 (RUNNING 00:00:36.650)

Q Please answer the question?
A Patients go on and off anxiety medications all of the time. So it's not like an alarm bell that he was not taking medication, no, sir.
Q Okay. So that's not an alarm to you whatsoever at this time?
A Not at the time that I saw him, no.
Q No, no, no. So wait a minute. Not at the time you saw him?
A Not at the time. I see patients frequently that are on and off anxiety medications. It happens. I mean, they're not prescribed for long term, always, not for long-term use.

52. PAGE 239:05 TO 240:08 (RUNNING 00:01:11.760)

Q Okay. When you -- you testified earlier that you -- when you took him down to the ER, I won't go through all the other stuff, you saw Janice McDonald, correct?
A Yes, sir.
Q Now, you don't know what records were either with Mr. Ray or completely with Mr. Hunt, correct?
A Correct.
Q All right. But when you had the conversation with Janice McDonald, you said to her that you -- and I might be paraphrasing. You can correct me on this.
A Yes, sir.
Q That he wanted to cause harm to himself?
A Yes, sir.
Q Okay. Is that a fair representation of the paraphrase?
A Yes, sir.
Q Okay. Did you ever mention to her that he was off anxiety medication?
A I don't recall mentioning that.
Q Okay.
A I did mention he was there to get medication.
Q Okay. Did -- do you recall ever mentioning that he was off any medication?
A I mentioned he came to get medication, so...

53. PAGE 241:06 TO 241:17 (RUNNING 00:00:37.550)

Q Did you -- did you mention to her that he didn't know what medications he was taking?
A I don't recall.
Q Okay. Do you remember -- you do not recall, or do you recall whether you mentioned moan or groan or rocking back and forth?
A I don't recall mentioning that to her.
Q Okay. But you did put it in your note?
A And he was not rocking back and forth when he went to the emergency room.
Q He was standing.
A He was standing. He was calm.

54. PAGE 242:02 TO 242:25 (RUNNING 00:01:10.380)

Q All right. Let me delve in that in just

a little bit. I want to make sure about this. First you were trying to set him up with just an appointment to get medications, correct?
A Yes.
Q And then when he answered your question about harming himself, you pretty much immediately took him to the ER?
A Yes, sir.
Q Was there any discussion about why he was going to the ER on the way down from your office down to the ER?
A When he answered yes, I said, "Then we need to go down to the emergency room and see a doctor."
Q All right. And then in front of him, in front of the nurse, you told them he had threatened to harm himself and that he had been off medications and he was -- he wanted to get medications, correct?
A I told her that he wanted to harm himself. Initially he was in to see me because he wanted medications. But I don't recall whether we discussed that in any detail. The focus at that point was him harming himself.

55. PAGE 255:06 TO 255:13 (RUNNING 00:00:23.740)

But I imagine there were some discussions about the fact that Mr. Hunt had escaped from the Naval Hospital and stolen a fire truck and killed somebody. And I just want to know what you heard in the hospital.
A Well, in any incidents of this magnitude, people were surprised that it had happened.

56. PAGE 259:09 TO 260:03 (RUNNING 00:01:09.660)

Q You also mentioned, too, but you didn't mention it in -- you didn't mention it in your report that was done on February 24th, 2012. But in this particular, what's Exhibit No. 2, you mentioned that he had, his eyes appeared to be troubled.
A Uh-huh.
Q Is that correct?
A Yes, that is correct.
Q Okay. You didn't put that in your note of -- of February 24, 2012; is that right?
A That's right.
Q So when you asked him the question about do you intend to harm yourself, is that when you noticed his eyes appeared to be troubled? Or when did you notice his eyes appeared to be troubled?
A When I walked into the waiting room, I noticed his eyes. But while sitting there, he didn't appear to be troubled at that point. You could just look at someone that looked like they needed sleep.

57. PAGE 263:21 TO 263:25 (RUNNING 00:00:16.500)

go this way. There's obviously information that you've stated here today that you did not orally relay to Janice McDonald, which is the rocking back and forth and the moan and groan, correct?
A Correct.

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58. PAGE 279:19 TO 280:10 (RUNNING 00:00:37.370)

Q Okay. Let me point out one other thing on the first page of Exhibit 2 about the middle paragraph. When I arrived at the waiting area, a young handsome, decently dressed and neat appearing black male patient was seated next to an older man with a badge.
A I thought he had his badge.
Q Because we earlier had talked about it, and you couldn't remember.
A Yes.
Q But you say he had a badge, that Mr. Ray had a badge?
A Yes.
Q Okay. And that badge probably meant something that he has some -- some invitation to come with Mr. Hunt and be with him?
A Yes.

59. PAGE 280:12 TO 280:22 (RUNNING 00:00:19.448)

A Yes.
Q The -- the -- any medications that Mr. Hunt wanted would have to have been written, prescriptions written by a doctor; is that correct?
A Yes, sir.
Q And you said there was not a -- a -- a doctor's appointment left that day?
A Right.
Q And he would have to go to the emergency room to get a prescription?
A Yes.

60. PAGE 302:20 TO 303:09 (RUNNING 00:00:48.300)

Q So that's a situation that we have on February 24th, 2012. Based on that situation of all those things that we just talked about, why did you as a registered nurse, licensed to practice nursing in this state, who holds a bachelor's degree, a master's degree and a doctoral degree, not ask Kalvin Hunt whether or not he intended to harm others?
A Because I think the first question was enough to get him where he needed to be. And I didn't need to now any further information at the time. He wasn't combative. He wasn't acting as if he wanted to harm someone else at the time. And so with the -- armed with the first information is the reason that I took him to the emergency room.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 01:23:18.153)

Counts
Exh 7 - 10-13-15
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EXHIBIT
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Count's 1 with
10-13-15

Miller Trial

Martin, Craig (Vol. 01) - 05/28/2015

1 CLIP (RUNNING 00:56:24.615)

Can you please state your full name for the ...

CM-0528-0000616-001 32 SEGMENTS (RUNNING 00:56:24.615)

1. PAGE 6:16 TO 20:13 (RUNNING 00:18:44.220)

Can you please state your full name for the record?
A Craig Martin.
Q And, Mr. Martin, where do you currently reside?
A I reside at 9741 Coppercreek in Converse, Texas.
Q And for those of us from South Carolina, where generally is Converse, Texas located?
A It's on the northeast side of San Antonio. It's a suburb.
Q And do you work here in the San Antonio area?
A I do.
Q What do you do for a living, sir?
A I work for another Government contractor.
Q At one point in time were you employed by CasePro, Incorporated?
A Yes, sir, I was.
Q How long were you employed by CasePro?
A Approximately four years.
Q During the four years that you were employed by CasePro, Incorporated, what was your job title?
A Program manager.
Q What does a program manager do at CasePro, Incorporated?
A A program manager is responsible for the day-to-day operations of the contracts for which he is assigned. You are the interface with the Government, you are the interface with the employees, and are basically responsible for the financial success of that contract.
As well as a smooth operation. Make sure the deliverables of the contract are met, make sure all of the contract requirements are followed, make sure that, you know, those types of things are fulfilled so that you complete the requirements of the contract success -- successfully.
Q What year did you begin working for CasePro, Incorporated?
A 2007 I believe.
Q You told us earlier that you worked for the company for four years. So does that mean you left the company sometime in 2011?
A I did, November 2011.
Q During that four year time frame, who did you direct report to at CasePro?
A Well, I started with James Steele and then ended up reporting to Mike McCabe.
Q And Mr. McCabe is here present in the room today?
A Yes, he is, uh-huh.
Q Who is James Steele?
A He at the time was the Executive Director of contracting.
Q Did Mr. Steele leave the company?
A Not while I was there, no.
Q Okay. Why did you transition from direct reporting to Mr. Steele to Mr. McCabe?
A That was Mr. McCabe's decision.
Q Okay. How many program managers did CasePro,

Incorporated have on its payroll while you were working for the company?
A There were two, possibly three. But two that I'm familiar with, Mr. Steele and myself.
Q Okay. And during the time frame that you worked for
00009:01 the company, was there specific contracts or a specific geographic region that you, yourself were responsible for?
A Yes.
Q Tell us about that.
A I had the Navy contracts. I started off with the Carolina MATO, which was North and South Carolina. Then I had Southeast MATO, which was Pensacola and Jacksonville. I had Southwest, which was 29 Palms and Fresno and that area in California. And then I had Portsmouth. There were two contracts in Portsmouth. So it was a large number of Navy contracts.
Q Okay. And how many employees of CasePro, Incorporated were associated with those contracts that you were responsible for?
A The contract personnel?
Q Yes, sir.
A All of those total? Around 800 I -- I believe, somewhere in that neighborhood.
Q It sounds like a pretty big responsibility?
A Yes, sir.
Q What was your background before coming to work at CasePro?
A Program manager for another Government contractor. And I've also had experience in marketing and business development, proposal writing and development.
00010:01 Q Can you give the court and jury the benefit of your education?
A I have a Bachelor's Degree in Public Relations, and that was my background in the Air Force as well.
Q So you're actually a Veteran, sir?
A Yes, sir.
Q How long did you serve this country through the Armed Forces?
A Almost 18 years.
Q Thank you for your service, sir.
A Thank you.
Q And I understand that in addition to your private sector employment as well as your service in the Armed Forces that you've also served as the Mayor of your city --
A I have.
Q -- Converse, Texas?
A Yes, sir.
Q How many years were you the Mayor of Converse, Texas?
A Eight years.
Q We are here today to primarily talk about a gentleman by the name of Christian Jansen. Do you know Dr. Jansen?
A I do.
Q Have you met him personally?
00011:01 A Yes, I have.
Q How many times do you think you've met Dr. Jansen?
A Oh, six, seven times at least.
Q When CasePro took over the contract for the emergency room at the Naval Hospital in Beaufort, South Carolina, were you involved in the hiring of Dr. Jansen to work for CasePro?
A Yes, sir.
Q I have marked as Exhibit Number 2 to your deposition here today a series of documents that has been produced by CasePro in this litigation. And I'll represent to you that

all of these documents have been deemed confidential pursuant to a Consent to Confidentiality Order entered by the court in Beaufort County.

So you did not have an opportunity to see these documents prior to today, but I will tell you that these are documents that came out of Dr. Jansen's personal file.

A Okay.

Q Okay. If you look at the first page of the document that I've marked as Exhibit Number 2, can you tell us what this appears to be, this Recruiting Activation Sheet?

A It is a Recruiting Activation Sheet that we use to hire anyone for CasePro on any contract.

Q And there are some various check marks and initials and those kind of things on this document. Is this something that you would have had a hand in filling out?

A Yes, sir.

Q Okay. And with respect to things like salary and benefits, would you have been the person for CasePro, Incorporated who would have negotiated those type items with Dr. Jansen?

A Recruiting would have done that, as well as myself in conjunction with Mr. McCabe.

Q So Mr. McCabe actually would have had a hand in setting Dr. Jansen's salary?

A Yes.

Q And from reviewing the documents, it's my understanding that Dr. Jansen originally started with the company as an independent contractor and that he then transitioned to a W-2 employee. Do you recall that?

A I don't recall that specifically for him, but I do recall that we did that with those providers at Beaufort Navy Hospital.

Q Okay. What's the significance of transitioning someone from an independent contractor agreement to a W-2 employee?

A We -- we -- there was a requirement in the contract for -- I -- as I recall, insurance purposes or coverage by Title 10 U.S. Code that they needed to be employees of the company.

Q And as an employee of the company, would Dr. Jansen have had to submit himself to certain policies and procedures of CasePro, Incorporated?

A Yes.

Q Including a sexual harassment policy?

A Yes.

Q Including a drug and alcohol substance abuse policy?

A Yes.

Q Including a HIPAA privacy policy?

A Absolutely.

Q Okay. And just so we're all clear, Dr. Jansen's paycheck would have actually come from CasePro, Incorporated headquartered here in San Antonio, Texas?

A Correct.

Q Now, I know Dr. Jansen was doing his work on a day-to-day basis in South Carolina and you were here in Texas. Who was doing the scheduling of Dr. Jansen and the other doctors in the emergency room at Naval Hospital Beaufort?

A I did the scheduling with assistance from two -- well, it started off with one doctor and ended up being two doctors -- but I did the scheduling for the physicians, scheduled their shifts.

Q So if Dr. Jansen was going to show up to work on Monday instead of a Thursday, you were the person making that decision?

A Yes.

Q Turn with me midway through this stack of papers

that we've marked as Exhibit Number 2 to page that's Bates stamped in the lower right-hand corner 272. It's an e-mail that you printed out bearing a date of June 26th, 2009.
A Okay. Can I take a moment to read it?
Q Absolutely. Take as much time as you need to look at that page, and let me know when you're ready for some questions about it, sir.
A Okay.
Q And does this reflect some negotiations between Dr. Jansen and yourself about Dr. Jansen's compensation?
A Yes.
Q Okay. And it appears from my reading of this e-mail that Dr. Jansen was seeking a rate of $114.90 an hour with benefits.
A Correct.
Q Okay. Would that have placed Dr. Jansen on the low end or the high end of doctors that CasePro, Incorporated was employing to work at Naval Hospital Beaufort?
A I don't recall.
Q Don't know one way or the other?
A Right.
Q Okay. In looking at this page, there are some initials and dates on here. Do you know whose initials and dates those are?
A Yes, I do.
Q Whose are they?
A Mike McCabe.
Q And Mr. McCabe would have dated this document June 26th, 2009?
A Correct.
Q And the handwriting that says add corporate benefit, whose handwriting is that?
A That is his.
Q Okay. And if you turn to the next page, sir, we have some internal communications between Liz [sic] Keen and Mike. Do you see that?
A I -- I do.
Q Who is Lin Keen?
A She is the contracts manager for CasePro or was at the time.
Q She worked in the corporate office here in --
A Yes.
Q -- San Antonio?
A Yes.
Q Okay. And the Mike that is refereńced Mike at CaseProInc.com; is that Mr. McCabe?
A Yes.
Q Okay. And this is discussing Dr. Jansen's compensation and benefits, correct?
A Well, if you'd give me a moment to read it.
Q Certainly.
A Okay. And what was your question?
Q Certainly. Does this document reflect that Mr. McCabe was involved in communications back in the 2009 time frame about Dr. Jansen's pay rate and benefits?
A Yes.
Q Okay. And Mr. McCabe writes: Do not offer any leave. They have plenty of time off.
A Correct.
Q Turn with me to the next page, sir. And we have a document that appears to be from the 2010 time frame.
A Yes.
Q Okay. And do you recognize the handwriting on this page?
A I do.
Q Whose handwriting is that?

A Mr. McCabe.
Q Okay. And is this adding a 401k and a continuing medical education benefit as well as two weeks of vacation for Dr. Jansen?
A Yes.
Q And who approved those changes?
A Mr. McCabe.
Q If you'll turn with me to the next page, sir, we have a page -- a letter dated April 12th, 2010. Do you see that?
A I do.
Q Certainly take as much time as you need to read that document, and let me know when you're ready for some questions.
A Okay.
Q And does this appear to be a letter sent to Dr. Jansen by Liz Keen on April 12th, 2010 reflecting the changes that we've previously seen, the two weeks of vacation, the continuing medical education allowance and 401k benefits?
A Yes.
Q Okay. So what we know from looking at the documents so far is that as of early April 2010, Dr. Jansen is a W-2 employee of CasePro, Incorporated?
A Yes.
Q And CasePro, Incorporated has determined how much he's going to get paid each paycheck?
A Yes.
Q Whether or not he's going to have vacation?
A Yes.
Q Whether or not he's going to get a continuing medical education allowance?
A Yes.
Q Whether or not he's going to have a 401k?
A Yes.
Q Okay. Turn with me, sir, to the next page of the document I've marked as Exhibit Number 2 to your deposition. And this document that I want to spend a good bit of time talking with you about is actually a two-page document that's been Bate's stamped in the lower right-hand corner as Def RRFP 333 through 334.
A Okay.
Q Do you see that document?
A I do.
Q Have you had an opportunity to review that document?
A I would like to review it now.
Q Take as much time as you need, sir.
A Okay. I've read the document.
Q Okay. I think I know the answer to this, but I just want to ask you a threshold question.
Do you have a copy of this e-mail from April 29th, 2010 in your possession today?
A Right here, yes.
Q Okay. But not at home or somewhere --
A No.
Q -- else?
A No.
Q Fair to say that today is the first time you've seen this document since you left the employment of CasePro?
A Yes.
Q Back in April of 2010, were concerns about Dr. Jansen brought to your attention?
A Yes.
Q Who brought those concerns to your attention?
A Dr. Scott Moore.
Q And who employed Dr. Scott Moore?
A CasePro.

Q He was a employee of CasePro, Incorporated?
A Yes, he was.
Q And where did Dr. Scott Moore do his work?
A He worked for CasePro at Beaufort Navy Hospital in the same emergency room.
Q Have you, yourself ever been in that emergency room at Beaufort?
A Yes, I have.
Q Okay. How would you describe that emergency room; is it big or ...
A It's a medium-sized. It started off with two bed, and it was very busy depending on the time of year. Then they expanded the emergency room as the mission expanded. Became larger. They added additional requirements. But it was a busy fairly fast-paced.
Q How did Dr. Moore bring certain concerns about Dr. Jansen to your attention?
A Called me on the phone.
Q Called you on the telephone?
A Yes, he did.
Q And at that time you were the program manager for CasePro, Incorporated for CasePro's employees doing work in Beaufort?
A Yes, I was.
Q Including Dr. Moore?
A Yes.
Q Okay. Was it unusual for Dr. Moore to pick up the telephone and call you out here in Texas?
A He -- it -- it was not unusual, no.

2. PAGE 20:14 TO 21:11 (RUNNING 00:01:11.270)

Q What did Dr. Moore tell you on the telephone?
A That the standard of care was not followed in the death of a Marine that was under the care of Dr. Jansen.
Q Was Dr. Moore concerned about that?
A He was.
Q Do you recall any other information that Dr. Moore told you in that telephone call?
A He felt uncomfortable doing the peer reviews, because he's a CasePro employee, Dr. Jansen is a CasePro employee, I am a CasePro employee. It kind of puts us in an awkward situation, because his job was to do the peer reviews for the Navy. So we would never see the peer reviews. And in most cases he didn't tell us what was in it, because he couldn't. It was for the Navy. So he did the peer reviews for the Navy's purposes.
And he was concerned that Dr. Jansen was not a good doctor.
Q Okay. Did he tell you Dr. Jansen wasn't a good doctor?
A He told -- he told me words to that effect.
Q Is that information that you, yourself took seriously?
A Of course.

3. PAGE 21:19 TO 23:11 (RUNNING 00:02:32.810)

Q How long did your conversation with Dr. Moore on the telephone last?
A I don't recall how long it last. I was in an airport. He called me on his cell phone. So I was traveling at the time, but we talked at length. If I -- I -- I can't tell you how long the conversation occurred.
Q But this isn't a -- a casual comment?
A No.
Q This was the point and purpose of him calling you?
A That was the only reason he called me.

Q What did you do once you had the information that Dr. Moore provided you on the telephone?
A I informed Mr. McCabe.
Q And how did you inform Mr. McCabe?
A Verbally.
Q Did you call him on the phone or did you physically go see him?
A I -- as I recall, I waited until I got back to the office and talked to him in person.
Q How much time had lapsed between the phone call from Dr. Moore and you going in to see Mr. McCabe if you recall?
A I don't recall, but I was on my way back.
Q Okay.
A So it would have been the next day at the latest.
Q Not information that you sat on?
A No, absolutely not.
Q When you went to meet with Mr. McCabe, was anyone else present for that meeting?
A I don't recall, but more than likely no.
Q What did you tell Mr. McCabe?
A The standard of care was not met.
Q What was Mr. McCabe's response?
00023:01 A I don't recall his exact response, but he wanted proof.
Q What did you do as a result?
A I asked Dr. Moore for a copy of the peer review, but I knew I wasn't going to get it.
Q Did Dr. Moore ever send you a copy of the peer review?
A He did not. It belongs to the Navy.
Q Did Dr. Moore ever send you any records about the care of the United States Marine who passed away?
A No.

4. PAGE 23:12 TO 23:15 (RUNNING 00:00:09.490)

Q But even without any documents from Dr. Moore, you had Dr. Moore's verbal report that the standard of care was not met?
A Yes.

5. PAGE 23:16 TO 23:22 (RUNNING 00:00:17.370)

Q Did you and Mr. McCabe have any conversation about this incident subsequent to your request of Dr. Moore that he forward the peer review?
A This same incident?
Q Yes, sir.
A I don't recall specifically. No.
Q Okay. That's a good question, sir.

6. PAGE 23:23 TO 30:09 (RUNNING 00:10:37.520)

Were there other incidents involving Dr. Jansen that gave you concern?
A There were other allegations of his quality of care.
00024:01 Q Were these allegations concerning Dr. Jansen's quality of care made before or after you learned in the April 2010 time frame about a dead United States Marine?
A As I recall, there were concerns before and after.
Q Let's talk about the concerns before.
A Okay.
Q We know that in looking at the document I've marked as Exhibit Number 2 that Dr. Jansen started working for CasePro back in the 2008 time frame.
A Okay.
Q All right. How soon after Dr. Jansen was hired in 2008 were your concerns about his quality of care brought to

your attention?
A I don't recall.
Q Okay. What's the first incident that you recall being brought to your attention?
A I recall that several of the nurses felt that Dr. Jansen was taking too much time in sleeping on his shifts as opposed to clearing out the emergency room, not spending enough time with the patients.
Q Do you recall -- I know it was a long time ago -- do you recall the names of any of the nurses who made those complaints?
A I recall the name of one, yes.
Q And who was that?
00025:01 A That would be Nicole Gates.
Q Was Nicole Gates a CasePro employee?
A Yes, she was.
Q And how did Ms. Gates provide you that information that Dr. Jansen was spending more time sleeping than he was treating patients?
A She would call me on the phone.
Q And when you obtained that information that Dr. Jansen was spending more time sleeping on his shift than treating patients, what did you do with that information?
A I would have informed Mr. McCabe.
Q And what did Dr. McCabe do with that information?
A I have no knowledge of what he did with that information.
Q He never told you -- strike that.
After you provided that information that you had obtained from Nurse Nicole Gates about Dr. Jansen to Mr. McCabe, did Mr. McCabe direct you as the program manager for the CasePro employees at Naval Hospital Beaufort to do anything?
A He would have wanted proof.
Q All right. What's the -- was there an incident about Dr. Jansen after you received the report from Nurse Nicole Gates about Dr. Jansen?
A There may have been. I don't recall specifically.
00026:01 Q Okay. But at least there's no doubt in your mind as you sit here today under oath that prior to the concerns expressed in April of 2010 about a dead United States Marine that there had been concerns raised by Nurse Nicole Gates about Dr. Jansen sleeping on the job instead of treating patients?
A Yes.
Q That's information that not only you had, but information that Mr. McCabe had for the company?
A Yes.
Q And even though CasePro, Incorporated had that knowledge from Nurse Nicole Gates about Dr. Jansen sleeping on the job instead of treating patients, Dr. Jansen was not fired?
A He was not. But I would like to point out there were beds there for the doctors to sleep in for the overnight shifts.
Q You told us some information about the concerns that you obtained from Dr. Moore in April of 2010. You also indicated to me that there were concerns raised about Dr. Jansen after April of 2010?
A Yes.
Q What was the first concern about Dr. Jansen brought to your attention after April of 2010?
A That he may not have been diagnosing patients
00027:01 correctly.
Q Do you recall who brought that concern to your attention?

A Dr. Scott Moore.
Q How did Dr. Scott Moore bring that information to your attention?
A Called me on the phone.
Q Did Dr. Scott Moore offer specific examples of how Dr. Jansen was not correctly diagnosing patients?
A He did.
Q Do you recall what those specific examples were?
A I do not.
Q When Dr. Moore called you about those concerns, is that something that you, yourself took seriously?
A Absolutely.
Q What did you do once Dr. Moore called you on the telephone about Dr. Jansen not correctly diagnosing patients?
A I would have informed Mr. McCabe.
Q And did you call Mr. McCabe on the telephone, send him an e-mail or did you go talk to him in person?
A Talked to him in person.
Q And would you have relayed to him all of the information that Dr. Moore had provided you?
A Yes.
Q And what was Mr. McCabe's response?
00028:01 A He would have wanted proof.
Q Did you attempt to obtain any proof concerning Dr. Moore's concern that Dr. Jansen was not correctly diagnosing patients?
A Yes.
Q What did you do, sir?
A I asked for copies of the peer reviews.
Q Did you obtain them?
A No. They belong to the Navy.
Q Did you inform Mr. McCabe that you were unable to obtain the peer reviews?
A Yes.
Q Did Mr. McCabe direct you to do anything further?
A No.
Q We now have three separate reports of concerns about Dr. Jansen. First one being sleeping on the job instead of treating patients; the second being the dead United States Marine; and then the third concern about Dr. Jansen not correctly diagnosing patients.
Did you talk to Dr. Jansen personally about any of those three concerns?
A Yes.
Q Was Mr. McCabe aware of those conversations with Dr. Jansen?
A I would have told him I talked to Dr. Jansen, yes.
00029:01 Q Okay. Did Mr. McCabe ever talk to Dr. Jansen?
A To my knowledge, no. He left that to the program managers. That was my responsibility.
Q And you re -- you raise a very good word there, sir, responsibility. As part of your job as a program manager for CasePro, Incorporated, did you have the authority of the company to terminate someone's employment?
A I did not.
Q Who at CasePro, Incorporated held that authority?
A Mike McCabe.
Q Do you have any recollections of your conversations with Dr. Jansen about the three incidents we've talked about today?
A I have some recollection.
Q Tell me what you remember, sir.
A Dr. Jansen said it's just another doctor's opinion. He had his opinion; another doctor had his opinion.
Q Before you left the employment of CasePro, Incorporated in 2011, were there any other concerns about

Dr. Jansen other than the three you've told us about today?
A I don't recall.
Q How many years have you worked in this industry, sir?
A Oh, boy. About 20 years.
Q Did you have more experience in this industry than Mr. McCabe?
A I think so.
Q Do you know what Mr. McCabe's background was before he came to work at CasePro, Incorporated?
A I do.
Q Do you know?
A He ran Unilever plants.
Q Making things like butter and Ragu?
A Soup and canned tomatoes, things like that.

7. PAGE 30:10 TO 30:16 (RUNNING 00:00:25.020)

Q If it had been up to you to make a decision about Dr. Jansen prior to your leaving the company -- so we'll just say any point in time before November of 2011 --
A Uh-huh.
Q -- if the decision had been yours, would you have fired Dr. Jansen?
A I would.

8. PAGE 30:18 TO 31:02 (RUNNING 00:00:33.056)

Q (By Mr. Hoyle) I'll ask the question a different way.
A All right.
Q Based on your years of experience in the healthcare industry and as the program manager for CasePro, Incorporated with respect to the CasePro employees doing work at Naval Hospital Beaufort, if the decision had been yours, would you have terminated Dr. Jansen's employment from CasePro incorporated prior to November of 2011?
A Yes.

9. PAGE 31:04 TO 31:06 (RUNNING 00:00:16.108)

Q (By Mr. Hoyle) Why?
A Standard of care was not met. I'm a Veteran. He's taking care of military people. Standard of care was not met.

10. PAGE 31:07 TO 31:18 (RUNNING 00:00:37.650)

Q Did Mr. McCabe ever serve in the military?
A No, sir.
Q Did anyone who owns the shares of CasePro, Incorporated to your knowledge ever serve in the military?
A To my knowledge, no.
Q When you began working for the company, did you know a lady by the name of Shirley Hill?
A I did.
Q And how was Ms. Hill related to Mr. McCabe?
A It's his mother.
Q And I understand Ms. Hill is no longer with us?
A Correct.

11. PAGE 34:08 TO 36:06 (RUNNING 00:01:52.790)

When you left CasePro, Incorporated, who succeeded you as the program manager for the CasePro, Incorporated employees working in the Beaufort area?
A I believe it was Tracie Braswell.
Q Did you work alongside Ms. Braswell for any period of time?
A She worked there in the credentialing department

while I was there.
Q And what's the difference between someone working in the credentialing department and being a program manager?
A Credentialing department, they're pretty much checking boxes, making sure documents have been returned, doing verifications. That's what they do in the credentialing department.
Q Sounds like a clerical type task?
A Shuffling papers and checking boxes and making sure everything has been submitted and verified and make sure it's correct, yes.
00035:01 Q Were you surprised that she succeeded you as the program manager?
A I didn't give it much thought because I had gone by then.
Q You had moved on?
A Yes.
Q Before I tell you that I have no further questions and my friend Mr. MacKelcan conducts his examination, I just want to make sure that this record is clear today.
When we began this deposition, the Court Reporter was kind enough to administer you an oath.
A Uh-huh.
Q An oath to tell the truth, the whole truth and nothing but the truth. Do you recall that?
A Yes, sir.
Q Okay. Have you given us truthful testimony here today?
A I have.
Q And you understand that the testimony you've given here today -- even though we're sitting in your lawyer's office in San Antonio, Texas -- has the same full force and effect as if you were testifying in front of a court and jury in Beaufort, South Carolina?
A I do.
Q And are you on any medication or under the influence
00036:01 of any substance such as alcohol or otherwise that would impair your ability to give us truthful testimony here today?
A No, sir.
MR. HOYLE: Sir, I very much appreciate your time.
At this time I will pass the witness.

12. PAGE 36:13 TO 36:18 (RUNNING 00:00:25.920)

What is your understanding of this lawsuit?
A My understanding is that there was a patient of Dr. Jansen's that somehow was released or got out of his care in the hospital, got into a fire truck and ultimately killed someone.
Q Okay. How did you obtain that information?

13. PAGE 36:22 TO 37:10 (RUNNING 00:00:31.590)

A When Mr. Hoyle initially called me and asked who I was --
Q When did --
A -- he --
00037:01 Q When did he call you?
A Oh, geez. Three weeks ago maybe, four.
Q And the two of you spoke on the phone?
A Yes.
Q All right. What did -- what did you talk about?
A I told him what my job was at CasePro.
Q That was the extent of your conversation?
A Well, he -- he had asked a few questions about Dr. Jansen or if there were any issues or concerns with Dr. Jansen, and I told him yes.

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14. PAGE 38:08 TO 39:06 (RUNNING 00:01:03.360)

Q So now, you are not a medical doctor; is that correct?
A That is correct.
Q Okay. So you were -- you're not qualified to conduct a peer a peer review on a doctor in any State?
A You are correct.
Q All right. And you're not qualified to give a standard of care opinion?
A I am not.
Q Okay. And that -- that would also be true of a nurse; you're not a nurse, are you?
A No, I am not.
Q Okay. So you would -- you're not qualified to give a standard of care opinion for the conduct of a nurse?
A Correct.
Q When you were at CasePro under the contract with the Navy that we've been talking about today, could a CasePro employee begin working at the Beaufort Naval Hospital without approval from the United States Navy?
A No.
Q Okay. So that -- approval from the Navy is a requirement for any CasePro employee to set foot on the Beaufort Naval Hospital and perform medical care?
A Yes.

15. PAGE 39:19 TO 39:23 (RUNNING 00:00:11.570)

Q Is it accurate to say that your responsibility in the Navy's credentialing process is just to provide the information required under the contract on the -- on the front end?
A That is correct.

16. PAGE 40:04 TO 40:23 (RUNNING 00:00:42.190)

Q Once you have submitted that information to the Navy --
A Uh-huh.
Q -- is that the end of your involvement with the credentialing process?
A Yes.
Q The Navy has their own credentialing process?
A Correct.
Q Do you -- have you ever been involved in the Navy's credentialing process for the healthcare workers?
A I have not.
Q Have you ever seen any of the documentation from a Navy credentialing file?
A I have not.
Q Okay. So essentially what happens is you provide this information, and at some point -- depending on the time sounds like it can vary -- at some point the Navy will return a decision to CasePro saying yes, this person can work at the Naval Hospital Beaufort or no?
A That's correct.

17. PAGE 41:09 TO 41:25 (RUNNING 00:00:59.610)

Q Okay. So CasePro actually doesn't hire anyone until the Navy is -- has approved that person for the particular position at the particular hospital?
A That is correct.
Q Okay. And CasePro wouldn't hire someone if the Navy denied that particular healthcare provider access to the facility that they would be assigned to?
A That is correct. And that happened a number of

times.
Q Okay. Were you ever involved -- well, while working at CasePro -- with any performance reviews for the CasePro employees at the Beaufort Naval Hospital?
A No.
Q And is that because the contract dictates that the Navy is responsible for the medical performance reviews of the CasePro employees at the Beaufort Naval Hospital?
A That's right.

18. PAGE 42:10 TO 42:13 (RUNNING 00:00:14.769)

Q (By Mr. MacKelcan) Mr. Martin, I've handed you what's been marked Defense Exhibit 1 to your deposition. It has the Bates label of Def RRFP 00949 and is also marked confidential. As Mr. Hoyle mentioned earlier in the

19. PAGE 42:21 TO 43:02 (RUNNING 00:00:14.966)

Do you recall preparing and sending this letter to Mr. Joe -- Joe McDonald?
A Not specifically this letter, but I -- I mean it's my name on it. I would have prepared it.
Q You don't have any reason to believe that it's not from you?
A No.

20. PAGE 43:05 TO 45:03 (RUNNING 00:02:56.600)

Q And my question goes to something we talked about a minute ago. If you look at the last sentence of the first paragraph that states: This offer is contingent upon arrival by the U.S. Navy to continue performing healthcare -- approval. I'm sorry. This offer is contingent upon approval by the U.S. Navy to continue performing healthcare services as an incumbent provider under the new contract.
A Yes.
Q All right. Is that what we were talking about before that Mr. McDonald would not have been offered employment unless the Navy approved him?
A That is correct.
Q In this particular case Mr. McDonald was already working at the Beaufort Naval Hospital --
A That's correct.
Q -- prior to CasePro obtaining the contract?
A That's right.
Q And he was performing the same job that he performed under the contract with CasePro?
A Yes.
Q Okay. Can you use Exhibit 2 that we've already been marked? That was the packet provided by Mr. Hoyle. And I'm going to go back to page 333 that we looked at earlier.
A That was the e-mail?
Q That was the e-mail.
A Okay.
Q Who is Amanda Rutten?
A She was either the contracting officer or the contracting specialist at Naval Medical Logistics Command. To my recollection she was the contracting officer at this time.
Q For those of us that don't know much about this --
A Uh-huh.
Q -- unique area of Government contracting, what does a contracting officer do?
A The contracting officer is responsible for making sure that the contractors abide by the requirements of the contract. She is the person who runs the contract for the Navy on the Navy Government employee side of the house.
Q And then what would a contracting specialist do?

A The specialist is a person that basically fields all the information and then filters out what needs to go to the contracting officer. So it's prob -- it's more the staff person as opposed to going all the way to the top.
Q Okay. So they are in the same department, but it sounds like the --
A Yes.
Q -- specialist would report to the officer?
A Correct.
Q Okay.

21. PAGE 45:07 TO 46:07 (RUNNING 00:01:22.020)

Q Okay. If you look at number one, and this is an e-mail that you sent to Amanda; is that correct?
A Yes, that is correct.
Q All right. So she was clearly aware of this situation as well?
A Very clearly. She said thank you, Craig in her response.
Q Okay. So in number one your statement says: Dr. Moore, one of our ER physicians for DO#0103, was asked by the Navy to conduct a peer review.
A Uh-huh.
Q Okay. Is that typically how peer reviews originated while you were at CasePro?
A There was a requirement by the contract -- and I'm sure you all have obtained a copy of the contract -- to provide a certain number of peer reviews on emergency room doctors over a period of time. Some occasions they were random. Other occasions they were very specific. In the case a death, they would automatically review that case.
And a peer review is done by another -- for in this case in the emergency room -- it would be done by an emergency room doctor board certified in emergency medicine.
Q And but again in the question is that the Navy dictated that this particular peer review was conducted; is that correct?
A Absolutely.

22. PAGE 47:06 TO 48:16 (RUNNING 00:01:27.090)

Q But -- but that particular --
A Very clearly.
Q -- particular doctor was conducting the peer review for the Navy, not for CasePro?
A That's correct.
Q Okay. And just to be clear -- and I think you've already testified about this -- but you never saw any documentation regarding this particular peer review or any peer review?
A No peer reviews.
Q The only thing that you know about them is what information may have been passed along to you by Dr. Moore or a nurse?
A Correct.
Q Okay.
A Or other doctors.
Q But you never saw any documentation?
A No peer reviews were ever provided to CasePro.
Q Never participated in any interviews with the providers or witnesses?
A Regarding the peer reviews?
Q Regarding the peer review.
A No.
Q So you weren't involved in any way with any of the --
A No.

Q -- peer reviews?
A No.
Q All right.
A No one at CasePro was, other than other staff that may have been involved at Beaufort Navy Hospital.
Q Okay. Did you personally ever receive documentation from the Navy that indicated the standard of care had not been met by Dr. Jansen?
A I -- I do not recall that I did, but it would have been in his file if I'd have received notification.

23. PAGE 48:21 TO 49:10 (RUNNING 00:00:53.450)

Q Okay. Ult -- excuse me. Ultimately, the Navy allowed Dr. Jansen to retain his privileges at the Beaufort Naval Hospital; is that correct?
A That is correct.
Q And again, we've already talked about today that if
00049:01 the Navy didn't allow him to work there, CasePro would not have been able to have him work there?
A Correct.
Q All right. In number six you said: I requested documentation in writing as to the CO's directions and reasons for termination and have not received documentation to date.
In looking through all the records, I have not seen any documentation that would be responsive to your request, but I'll ask you do you recall receiving any documentation responsive to your request?

24. PAGE 49:12 TO 49:24 (RUNNING 00:00:31.304)

A We did not receive documentation to my recollection.
Q (By Mr. MacKelcan) Okay. So you initially at some point said Dr. Jansen was going to be terminated from the Navy. That was a Naval decision; is that correct?
A If they wanted him terminated, that would be a Naval directive.
Q Okay.
A To terminate.
Q And then at some point they changed their mind and decided that he was still able to provide medical services at the Beaufort Naval Hospital?
A To my knowledge while I was there we did not receive any notification to remove him from the contract.

25. PAGE 51:02 TO 53:22 (RUNNING 00:04:22.560)

Q Is it also true that for Dr. Jansen to set foot at the Beaufort Naval Hospital, it required approval from the Navy?
A Well, he could set foot in it.
Q Provide medical services at the Beaufort Naval Hospital?
A You are correct.
Q Okay. And that his job offer was contingent on approval by the Navy?
A Yes.
Q All right. Okay. Would it be accurate to say that your job responsibility at CasePro with respect to the contract with the Navy involved in this case was to ensure that CasePro complied with the terms of the contract?
A Yes.
Q Okay. And did the contract outline specific requirements for CasePro to follow to meet that?
A Yes.
Q While you worked at CasePro, do you believe that you did exactly that, that you met the terms of the contract with the Navy?

A Yes.
Q Okay. And you had Government contracting experience before you came to work at CasePro; is that right?
A Yes.
Q And you are working in this field right now?
A Yes.
Q Okay. Other than your conversation with Mr. Hoyle, do you have any firsthand knowledge about the incidents on February 24, 2012 that are involved in this case?
A No.
Q You weren't working at CasePro at that time?
A In 2012? No.
Q Right. Earlier you testified about -- we talked about the three instances of concern regarding Dr. Jansen.
A Uh-huh.
Q And you recall -- I think you testified that you would have spoken to Mr. McCabe about them?
A Yes.
Q All right. Do you recall specific conversations with Mr. McCabe about them or were you just testifying as to what would have been your standard practice?
A I recall telling Mr. McCabe that the standard of care was not met, and I had very grave concerns about the quality of care that he was providing in the incident where the Marine died.
Q Okay. And you testified earlier that the Navy never provided CasePro with any documentation as to a deviation from the standard of care; is that correct?
A That's correct.
Q The only information that you were basing this on was the telephone call from Dr. Moore; is that right?
A That's correct.
Q Okay. And you said that Mr. McCabe -- well, and I believe you testified that he would have wanted documentation. Do you recall that he specifically asked for documentation from the Navy?
A Yes.
Q All right. And you recall specifically trying to get that documentation --
A Absolutely.
Q -- from the Navy?
A Uh-huh.
Q So there's no doubt in your mind that the Navy was aware of these same concerns that you testified about today?
A There is no doubt in my mind.
Q Okay. But the Navy never provided you or CasePro with any documentation or information that stated these concerns are a deviation from the standard of care or anything that would have supported the termination of Dr. Jansen by CasePro?

26. PAGE 53:24 TO 53:24 (RUNNING 00:00:02.526)

A Not prior to --

27. PAGE 54:03 TO 54:08 (RUNNING 00:00:28.557)

A Not prior to my leaving, no, there was no documentation about it.
Q (By Mr. MacKelcan) And you would agree that it was reasonable for Mr. McCabe to want documentation on the basis of firing an employee?
A Yes.

28. PAGE 55:23 TO 56:01 (RUNNING 00:00:08.330)

Q There have been some questions by my friend, Mr. MacKelcan, about Dr. Scott Moore. Have you actually met

Dr. Moore in person?
A Absolutely.

29. PAGE 56:03 TO 56:13 (RUNNING 00:00:30.180)

There were some questions by my friend, Mr. MacKelcan, about the whole peer review process and -- and -- and Dr. Moore's involvement with that. Did the Navy actually say we want Dr. Moore to do the peer reviews or was that CasePro's decision to say that Dr. Scott Moore should be doing those?
A That was CasePro's decision, but Dr. Moore did it with the previous contractor. So we wanted to keep that continuity.
Q Okay. There --
A And they were pleased with his performance, so.

30. PAGE 56:14 TO 57:10 (RUNNING 00:00:58.190)

Q Did you ever have any concerns brought to your attention about Dr. Scott Moore's abilities as a medical doctor?
A No.
Q Never had nurses calling you up on your telephone about Dr. Moore sleeping on the job?
A No.
Q Ever had any concerns about dead United States Marines being treated by Dr. Moore?
A No.
Q When Dr. Moore called you on the telephone about Dr. Jansen, I believe you've already told us you took his concerns seriously?
A I did.
Q Did you believe Dr. Moore was calling you with any type of ulterior motive?
A No.
Q He didn't have an axe to grind with Dr. Jansen, did he?
A No.
Q He was calling you because he wanted this brought to your attention?

31. PAGE 57:12 TO 57:16 (RUNNING 00:00:11.609)

A Yes.
Q (By Mr. Hoyle) And I believe you testified in response to questions by Mr. MacKelcan that you relayed to Mr. McCabe that you had very grave concerns?
A Yes.

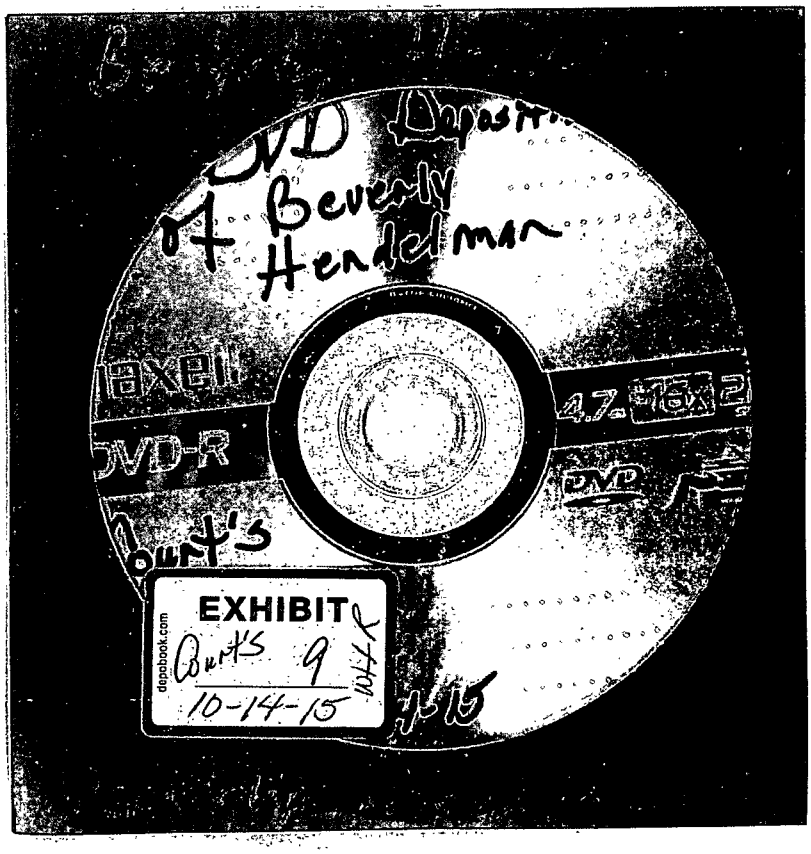
32. PAGE 57:17 TO 58:09 (RUNNING 00:00:50.920)

Q The answer may be obvious, but what were those very grave concerns about Dr. Jansen?
A If the standard of care is not met in those emergency situations, my grave concern is that there are other people that could get misdiagnosed or could die or could have serious injuries result of any substandard care that they may receive. I would not want my spouse to be seen by Dr. Jansen. I would not want to be seen by Dr. Jansen. I would not Mr. McCabe seen by Dr. Jansen.
Q And you certainly wouldn't want a uniformed member of the United States military --
A I would --
Q -- seen by --
A -- not.
Q -- Dr. Jansen?
A I would not.
MR. HOYLE: Those are all the questions I have,

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09 sir.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 00:56:24.615)


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Miller Trial

Hendelman, Beverly (Vol. 01) - 09/10/2014

1 CLIP (RUNNING 00:44:00.778)

Ma'am, would you please state your name ...

BH-0910-0001823 42 SEGMENTS (RUNNING 00:44:00.778)

1. PAGE 18:23 TO 21:25 (RUNNING 00:04:02.980)

Q. Ma'am, would you please state your name for the jury?
A. My name is Beverly Ilene Hendelman.
Q. What's your occupation?
A. I'm a psychiatrist.
Q. Do you have a specific area of specialization or concentration?
A. I work with children, disabled children, particularly autistic and Asperger's and I work with adults with PTSD and TBI.
Q. Dr. Hendelman, is it your understanding that you are here testifying today regarding the events that transpired involving Kalvin Hunt on February the 24th, 2012 at the Naval Hospital in Beaufort County?
A. Yes.
Q. What was your job at the Naval Hospital on February 24, 2012?
A. Staff psychiatrist.
Q. Do you recall a Dr. Jansen working at the Naval Hospital?
A. Yes.
Q. Back on February 24, 2012, what was Dr. Jansen's role at the Naval Hospital?
A. He worked in the emergency room.
Q. Dr. Jansen testified in this action that you called him around 4:05 p.m. that day and you told him that Kalvin Hunt obviously needed to be admitted. Do you have a recollection of that conversation with Dr. Jansen?
A. Briefly, yes.
Q. Let me ask you, is there a difference between admitting a patient and committing a patient?
A. Committing a patient means that you have filed paperwork to say that that patient needs to be held against his will. Admitting a patient states that you are admitting a patient to a hospital and that's a voluntary.
Q. After your conversation with Dr. Jansen on February 24, 2012, what was your understanding as to whether or not Mr. Hunt was going to be admitted or committed?
A. My understanding is he was going to be admitted.
Q. What's the process then after you tell Dr. Jansen that Kalvin Hunt obviously needed to be admitted, what was supposed to happen next?
A. The techs would escort him to the hospital by ambulance.
Q. When you say techs, who are you referring to?
A. The two techs that were on duty that day, it was Manning, and I forget the other guy's name.
Q. Before the techs could get to Kalvin Hunt,

where was he located? Was he in the techs' presence?
A. He was in the emergency room.
Q. Did you have an expectation that the staff there in the emergency room would keep him there until the techs could get to him to take him to the hospital?
A. I have no control over that. I expect that he would stay, but I don't have any control over what goes on in the emergency room.
Q. I understand. Where was he being taken to, was that Beaufort Memorial Hospital?
A. Yes.
Q. Dr. Hendelman, this isn't a trick question so I'm not trying to trick you. But do you have an understanding of what the word obvious means as it is commonly used in the English language?
A. It means clearly.
Q. So if I were to ask you, what does the word obvious mean to you, what would your answer be?
A. Clearly.
Q. What's the opposite of obvious?
A. Unobvious.

2. PAGE 22:12 TO 22:14 (RUNNING 00:00:07.470)

it again: Would you agree with me that it doesn't necessarily require a medical school education to recognize a condition that is obvious?

3. PAGE 22:16 TO 22:19 (RUNNING 00:00:13.021)

A. It depends. It depends on what you are talking about. I mean, a limb being absent is one thing. When you are talking about a mental health condition, you are talking about something else.

4. PAGE 22:21 TO 23:09 (RUNNING 00:00:35.470)

Q. Ma'am, obvious means obvious, right? Obvious is clear, correct?
A. No, that depends on who you are talking to and what language you are talking with them about.
Q. I am talking about the commonly accepted definition as obvious is used in the English language, okay? And you said that --
A. When Kalvin Hunt obviously --
Q. -- when you said obviously -- let me finish my question. You told Dr. Jansen that Kalvin Hunt obviously needed to be admitted. If something is obvious, it's obvious, it's clear. That's what you just testified to, correct?
A. That's correct.

5. PAGE 23:22 TO 24:03 (RUNNING 00:00:18.909)

Q. Based on your recollection of the events of February 24, 2012, was it obvious to you that Kalvin Hunt needed to be admitted?
A. It was clear that he had a danger to self, therefore he needed to be admitted.
Q. It was also clear that he presented a danger to others, correct?

6. PAGE 24:05 TO 24:08 (RUNNING 00:00:10.560)

A. I was aware of the danger to self. I had not heard about the danger to others. But danger to self, danger to others or gravely disabled, requires

admission to the hospital.

7. PAGE 24:16 TO 26:13 (RUNNING 00:03:50.760)

Q. Let me ask you to take a look at what's previously been marked as Exhibit 2 to this deposition. It is a series of medical records. Just let me know when you have had an opportunity to look at it.

(Witness reviewing documents.)

BY MR. SWETT:

Q. Ma'am, have you seen those documents before?

A. No.

Q. Have you seen any of these documents before?

A. No.

Q. On February 24, 2012, did anyone provide these documents for your review?

A. No.

Q. Did you ask for any documents that were completed or filled out on February 24, 2012?

A. No.

Q. Did you ask for any triage records?

A. No.

Q. Let me ask you to look at Page 112. On the left-hand side, it is in handwriting, do you see "suicidal thoughts" circled there, the left-hand side?

A. Yes.

Q. I am going to read the handwriting there. It says, "and thoughts of hurting others."

Do you see that written there?

A. Yes, and something other -- okay.

Q. But "no specific plan," right?

A. "And no specific plan," yes.

Q. But again, this document which was filled out on, looks like February 24, 2012, states that Kalvin Hunt had thoughts of hurting others, correct?

A. Yes.

Q. Based on this document alone, is it your testimony that it was a requirement that Kalvin Hunt be admitted?

A. Yes, it was based on the fact that he was a danger to self and a danger to others. He needed to be admitted, yes.

Q. Why?

A. Because he is a danger to self and a danger to others by his own admission.

Q. And that's pretty obvious, correct, because it is by his own admission?

A. That makes him in need of hospitalization.

8. PAGE 29:12 TO 30:02 (RUNNING 00:00:42.830)

Q. Dr. Hendelman, if a patient says that they have thoughts of hurting others, they have a history of depression and PTSD and they have suicidal ideations, is it obvious to you that that person needs to be physically restrained?

A. No.

Q. Why is it that that person may not need to be physically restrained?

A. Physical restraint is only used when a person becomes agitated and is threatening at that moment.

Q. So if someone comes in and says, hey, I have thoughts of harming others, that person doesn't

need to be restrained?
A. No, they need to be talked to and hospitalized.

9. PAGE 32:17 TO 37:07 (RUNNING 00:05:40.810)

Q. Let me back up a little bit and get some basic information from you. Where do you currently live?
A. I currently live here in Columbus, Georgia.
Q. How long have you lived in Columbus, Georgia?
A. About a year and three months.
Q. Where did you live prior to living in Columbus, Georgia?
A. Beaufort, South Carolina.
Q. How long were you in Beaufort?
A. About two years.
Q. Where did you live prior to Beaufort?
A. Dublin, Georgia.
Q. Are you married, Dr. Hendelman?
A. No.
Q. Do you have any kids?
A. I have a daughter.
Q. Is your daughter over the age of 17?
A. Yes.
Q. What is her name?
A. Elena Kemmerer.
Q. Where does she live?
A. With me.
Q. Where did you grow up?
A. I was born and raised in Detroit, Michigan.
Q. Did you go to high school in Michigan or somewhere else?
A. I went to high school in Detroit.
Q. If you could, how about just walk us through your education after high school until you had taken your first medical job.
A. I completed high school. I taught school for approximately four years; spent a year in Israel, approximately a year in Israel; came back from there, taught in inner city Detroit for another year; did graduate work in physiology, biochemistry and ed psych and was in the midst of obtaining a master's, and decided to go to medical school.
I went to, then went to medical school at Michigan State, completed medical school; did an internship at Mount Zion and my first year residency; finished my adult residency at Stanford; and then did my child fellowship at McAuley Institute in California, all in California.
MR. BERLINSKY: You left out college.
A. Oh, I went to the University of Michigan for college and then graduate work at Wayne State.
Q. Thank you, ma'am. Are you familiar with the National Board of Medical Examiners?
A. Yes.
Q. My understanding is that there are three parts of the test that laypeople like me commonly call the medical boards. Are you familiar with that test?
A. Yes.
Q. Did you have to take that test?
A. Yes.

Q. Did you pass all three parts of that test?
A. Yes.
Q. On the first try?
A. Yes.
Q. Are you licensed to practice in any state?
A. I'm licensed to practice in Indiana, California and Alaska.
Q. Are you board certified in any area?
A. No.
Q. After you passed the boards, where was your first medical job?
A. I had a private practice in California.
Q. About how long did you have that private practice?
A. Ten years.
Q. Primarily, what were your, I guess you were a psychiatrist at that time as well?
A. Yes.
Q. What were your primary duties or the typical patients you would see in those ten years?
A. I saw mostly children with a few adults.
Q. What issues were those patients dealing with?

00036:01 A. Soup to nuts, all kinds of issues.
Q. Just across the board?
A. Yes.
Q. How about your next job?
A. I became medical director of a facility in Marin County. I worked there for a while and then I, let's see, then I went to North Dakota.
I went to a variety of states and then I went to New Zealand and spent a couple years there; came back, went to Indiana. Then I went to Alaska, spent some time there and then came back to California. And then I came over to working at the VA in Dublin.
Q. So you have been a psychiatrist all over the world, sounds like.
A. I've had a good time, yes.
Q. How many years were you a practicing psychiatrist before you made it to Beaufort County?
A. 35 years or so.
Q. What year did you first come to the Naval Hospital in Beaufort County?
A. In Beaufort, that would have been what, probably the year before all this, this was '12. That would have been '11; is that right?
Q. At that time you had been practicing for

00037:01 about 36 years?
A. Yes.
Q. During those 36 years as a practicing psychiatrist, did you gain experience assessing individuals with a history of depression, thoughts of suicide and a history of violence?
A. Absolutely, yes.

10. PAGE 37:08 TO 38:25 (RUNNING 00:02:06.500)

Q. As a practicing psychiatrist, how do you typically evaluate an individual who has thoughts of hurting others, a history of depression and suicidal thoughts?
A. I do a complete psychiatric evaluation, just learning about them from the time they were born until the current time, evaluating their thought process, evaluating their childhood, substance abuse and all components related to those

things.
Q. So you learn about everything you can learn about them, correct?
A. That's correct.
Q. What makes up, you mentioned a complete psychiatric evaluation. What is that composed of?
A. Just as I stated, learning about their history, learning about what their thoughts are at that time; evaluating whether they are thinking
00038:01 clearly; hallucinating, delusions; the whole mental status; then doing their history; what's been going on with them; where they are living; who they are; then evaluating their history from their childhood on up, their education, development; the problems they have had; just a whole history of the person.
Q. How do you gather that information, do you interview the patient?
A. Yes.
Q. I guess do you review the patient's prior medical records?
A. If I have access to them, yes.
Q. What other techniques of information-gathering do you use as a practicing psychiatrist?
A. Well, with children, I interview parents, interview teachers.
Q. So you may call a family member and ask them for information to see what's going on, correct?
A. Sometimes, yes.
Q. Do you put eyes on the patient physically, you observe the patient to see how they are behaving?
A. Yes.

11. PAGE 42:17 TO 46:25 (RUNNING 00:05:30.770)

Q. Let me go back and have you look at Dr. Jansen's statement again, 118. The middle of that first paragraph, five lines down, I'm going to read it and ask you if I have read it correctly. It says, "I called mental health about 1520 and asked to have psych evaluate him in the ER."
Did I read that correctly?
A. Yes.
Q. That's at 3:20 p.m., right?
00043:01 A. That's correct.
Q. Do you know who in the mental health department Dr. Jansen talked with?
A. I would expect he would have called to see where the techs were and called the techs to have the techs come. I don't know specifically who he would have called.
Q. Do you have any way of knowing what was said during that conversation?
A. No.
Q. Would there have been any notes or anybody required to do a report or a little writeup about what was said in that conversation?
A. No.
Q. So you testified that the first time you knew Kalvin Hunt was at the Naval Hospital was after a tech had already spoken with him and came back to your office; is that correct?
A. That's correct.
Q. Let me ask you to look at what's been marked Exhibit 3.

(Witness reviewing document.)
Q. I am just going to paraphrase this document, but it basically says at 1555, that's 3:55, correct?
A. Yes.
Q. "Petty Officer Manning comes up to our office, staff patient, he had just been called in to see in the ER." Okay?
A. Yes.
Q. So does it look like to you, the first time -- is it your testimony that the first time you knew Kalvin Hunt was even at the Naval Hospital was at 3:55 when Mr. Manning came up to your office?
A. That's correct.
Q. At that time, did Mr. Manning discuss what he had learned from Kalvin Hunt with you?
A. Yes.
Q. Can you tell me what was discussed?
A. I can't tell you the details because I no longer remember the details, but I did make the decision based on what I had heard from him that the patient needed to be hospitalized. And the details of that would have been at least that he is a danger to self or a danger to others because those are the criteria for hospitalization.
Q. So if you made the recommendation, if you decided Kalvin Hunt needs to be admitted, then you had made the determination that he was either a danger to self or a danger to others, correct?
A. That's correct.
Q. You can't tell me, you don't recall anything you discussed with Mr. Manning?
A. No.
Q. Nothing sticks out in your mind?
A. No.
Q. But based on your conversation with Mr. Manning, you decided that Kalvin Hunt obviously needed to be admitted, correct?
A. That he needed to be admitted, yes.
Q. Do you recall what time -- strike that.
Did you then relay that recommendation to Dr. Jansen?
A. Yes, the conversation, yes.
Q. Do you recall what time you notified Dr. Jansen of that?
A. No. It's in your document somewhere.
Q. Let me ask you to look back at Exhibit 2, 118. Again, the first paragraph three lines up says, "Dr. Hendelman called back around 1605 and told me that patient obviously needed to be admitted."
Do you see that?
A. (Indicating affirmatively.)
Q. Is that your recollection?
A. Yes.
Q. So you made a recommendation to Dr. Jansen at that time that Kalvin Hunt obviously needed to be admitted?
A. Yes.
Q. After your discussion with Dr. Jansen, was it your understanding that Kalvin Hunt was going to be admitted?
A. Yes, but that is the emergency room's decision on that matter because the emergency room is an independent, functioning unit and they have the right to take the recommendation of the

psychiatrist or not take the recommendation of the psychiatrist. They are in charge of the unit and whatever decision they make is their decision. I can make a recommendation, I cannot make the decision for the doctor.
Q. I understand, ma'am.
A. Okay.
Q. But you as a medical doctor, this is what you do, a psychiatrist, correct?
A. I'm a psychiatrist, yes.
Q. You as the psychiatrist recommended to Dr. Jansen that Kalvin Hunt needed to be admitted?
A. That's correct.

12. PAGE 47:01 TO 47:13 (RUNNING 00:00:33.357)

Q. Let me ask you, how did you come to form that recommendation?
A. Because he was a danger to self.
Q. And others?
A. He can be a danger to self and others, one or the other, doesn't matter. Both are criteria for admission, either one of them.
Q. Do you recall whether or not Mr. Manning told you that Kalvin Hunt was a danger to others?
A. I do not recall that, no.
Q. Do you recall whether or not he told you Kalvin Hunt was a danger to himself?
A. I know he told me he was a danger to self.

13. PAGE 48:11 TO 48:23 (RUNNING 00:00:27.780)

Q. What else did you take into consideration in making your recommendation that Kalvin Hunt obviously needed to be admitted other than your conversation with Mr. Manning?
A. Only my conversation with Mr. Manning, he was a danger to self. That is a criteria for hospitalization. That's the standard of practice.
Q. So you didn't have a face-to-face interview with Kalvin Hunt?
A. No.
Q. Did you review Kalvin Hunt's prior medical records?
A. No.

14. PAGE 49:08 TO 50:08 (RUNNING 00:01:02.911)

Q. What is AHLTA? How do you pronounce it?
A. "AHLTA," it is a computerized system of recordkeeping.
Q. Was that in place at the Naval Hospital on February 24, 2012?
A. Yes.
Q. Do medical doctors have access to that system?
A. Yes.
Q. Did you have access to that system?
A. Yes.
Q. Did you review Kalvin Hunt's prior medical documents in that system on February 24, 2012?
A. No, nor did I need to. The point is that he was a danger to self. Danger to self is criteria for admission. That is the protocol. That is what you do, you admit.
Later on when he came out, yes, I would have reviewed his records and interacted with him. But when you are admitting a patient to the hospital

at night, danger to self is criteria for admission.
Q. And danger to others is also a criteria for admission, correct?
A. Yes, that's correct.
Q. And Kalvin Hunt presented a danger to others on that day, did he not?

15. PAGE 50:10 TO 50:12 (RUNNING 00:00:04.640)

A. According to the notes here, yes, he presented as a danger to self and a danger to others.

16. PAGE 50:20 TO 54:07 (RUNNING 00:04:27.010)

Q. Did you call in family members of Kalvin Hunt to inquire about what may be going on in his life?
A. No, he is presenting as a danger to self, danger to others. That is criteria for admission.
Q. But if medical records are available, does
00051:01 a medical doctor typically review those records?
A. No, not at that point. The point is that he is going to the hospital. All of that can be dealt with afterwards.
The point is that he is a danger to self, he needs to go to the hospital. He needs to be evaluated, he needs to be treated. The rest of it comes later.
Q. Let me make sure I have your testimony correct. Let me just ask you: On February 24, 2012, did you need to review any of Kalvin Hunt's prior medical records in order to make your recommendation that he obviously needed to be admitted?
A. No, the criteria he is a danger to self, hearing that he is a danger to self is criteria enough to admit a patient to the hospital.
Q. Again, criteria is that he was a danger to others as well, correct?
A. Yes.
Q. Ma'am, do you recall Nurse Janice McDonald?
A. I don't really remember her, no.
Q. So do you know back on February 24, 2012 what Nurse McDonald's role at the Naval Hospital
00052:01 was?
A. No, not really.
Q. I will represent to you that Nurse Janice McDonald has given testimony in this case that you should have conducted a face-to-face interview with Kalvin Hunt. In fact, I believe she testified that the reason you didn't was because it was Friday afternoon and you were ready to go home.
A. Well, the -- go ahead.
Q. Can you tell me, is that in fact the reason you didn't conduct a face-to-face interview with Kalvin Hunt?
A. No, that is not the reason. Between the hours of eight and three o'clock, a doctor will come down and do a face-to-face examination. Technically we take call as of four but we cut it off at three. We do not do face-to-face.
Then the on-call doctor, regardless of whether the doctor is at Parris Island Air Station or at the hospital, they take over. And you do not do face-to-face examinations when you are on call.
Q. Do you believe that you should have

proceeded differently or done more before making your recommendation with respect to Kalvin Hunt on that day?
A. No. My decision was appropriate for what was going on. He was a danger to self, danger to others. That's the criteria for admission. I wanted him admitted. All this other information would have been just supportive evidence that he needed to be admitted.
Q. You concluded that Kalvin Hunt needed to be admitted because you were concerned that he might actually hurt himself or others, correct?
A. He was saying that, yes.
Q. Let me ask you this: Does the fact that someone has prior training as a United States Marine concerning when that person has thoughts of harming others?
A. He has skills to take care of it, yes.
Q. Because Dr. Jansen testified that enlisted men in the United States Marine Corps are trained killing machines. Do you agree with Dr. Jansen?
A. They are trained. I would hope they are not killing machines.
Q. He stated they were trained to kill. Do you agree with that?
A. They are trained to use weaponry to defend this country, yes.
Q. So it is concerning when a Marine, someone who has lethal training, has thoughts of harming others, correct?
A. If he is having thoughts of harming himself -- it doesn't matter if he is a Marine or if he stands five foot or whatever. If he is a danger to self and a danger to others, he has met the criteria for admission to the hospital.

17. PAGE 54:15 TO 55:07 (RUNNING 00:00:46.130)

Q. Were you aware that Kalvin Hunt's medical records indicated major depression as an active problem?
A. No.
Q. When someone has thoughts of harming others, what's the significance of the fact that they have a history of major depression?
A. The problem here is that you are confusing admission to the hospital with medical history. You can have a psychiatric history, you can be actively hallucinating.
You cannot be admitted to the hospital for being depressed or hallucinating, delusional or any of those things. That is not criteria for admission to a hospital.
The criteria for admission to a hospital is very clear: Danger to self, danger to others and gravely disabled, any of those criteria.

18. PAGE 55:08 TO 55:12 (RUNNING 00:00:17.216)

Q. I understand, ma'am. I am trying to ask you as a medical doctor, what significance those prior problems indicated in medical records have on the fact of someone who does present a danger to others. Does that not go into the equation?

19. PAGE 55:14 TO 55:15 (RUNNING 00:00:03.220)

A. Not at the time you are making that

15 decision, no.

20. PAGE 56:24 TO 58:17 (RUNNING 00:01:39.910)

24 Q. Were you aware that Kalvin Hunt's medical
25 records indicated adjustment disorder with
00057:01 disturbance of emotions and conduct as an active
02 problem?
03 A. No.
04 Q. What's the significance if someone has
05 adjustment disorder with disturbance of emotions and
06 conduct to the fact that they have thoughts of
07 hurting others?
08 A. Anyone presenting with thoughts of causing
09 harm to self or others will be admitted to the
10 hospital. That is the criteria. That's the
11 protocol.
12 Q. Were you aware that Kalvin Hunt's medical
13 records indicated personality disorder as an active
14 problem?
15 A. No.
16 Q. What's the significance if someone has a
17 personality disorder to the fact that they have
18 thoughts of harming others?
19 A. Anyone will be admitted to the hospital
20 because that is the protocol if they have thoughts
21 of harming themselves or others.
22 Q. You tell me it doesn't matter if they have
23 all these other problems? They can have, like Mr.
24 Hunt, multiple, multiple problems, active problems
25 and it doesn't matter to you?
00058:01 A. It matters to me that he said he had
02 thoughts of harming himself or others. That is the
03 criteria to justify hospitalization.
04 Q. And that's all you needed?
05 A. That's all I needed.
06 Q. At that point, Kalvin Hunt should have
07 been admitted?
08 A. At that point, the recommendation was to
09 admit.
10 Q. At that point, Kalvin Hunt should have
11 been admitted?
12 A. At that point, recommendation was made to
13 admit. I cannot admit.
14 Q. Should Dr. Jansen and his staff have
15 admitted Kalvin Hunt at that point?
16 MR. MacKELCAN: Object to the form.
17 A. That's Dr. Jansen's decision.

21. PAGE 60:15 TO 60:18 (RUNNING 00:00:10.340)

15 Q. How about this one: Were you aware that
16 Kalvin Hunt had a history of impulsiveness in his
17 medical records on February 24, 2012?
18 A. No.

22. PAGE 61:16 TO 62:18 (RUNNING 00:01:14.500)

16 Q. Dr. Hendelman, are you familiar with the
17 drug Seroquel?
18 A. Yes.
19 Q. Please tell the jury what the drug
20 Seroquel is prescribed for.
21 A. Seroquel is a neuroleptic. It is
22 prescribed primarily for people with psychotic
23 disorders, thought disorders.
24 Q. So it is an antipsychotic?
25 A. Yes.

00062:01 Q. Were you aware that Kalvin Hunt had been
02 prescribed Seroquel and was taking over
03 300 milligrams a day in June 2011?
04 A. No.
05 Q. Were you aware on February 24, 2012 that
06 Kalvin Hunt had not been taking his Seroquel for an
07 indeterminate amount of time?
08 A. No.
09 Q. When someone has thoughts of harming
10 others, what's the significance of the fact that
11 they have been prescribed antipsychotic medication
12 and they haven't been taking that medication?
13 A. Either they have cleared or they need
14 their medicine.
15 Q. Is it concerning to you as a medical
16 doctor when someone has thoughts of harming others
17 and they are not taking their antipsychotic
18 medication?

23. PAGE 62:20 TO 62:20 (RUNNING 00:00:03.000)

20 A. He needs to be evaluated and in treatment.

24. PAGE 64:18 TO 65:23 (RUNNING 00:01:31.050)

18 Q. After reading that, does that refresh your
19 recollection that Mr. Manning was concerned enough
20 about Mr. Hunt's unpredictable demeanor that he
21 asked someone to come downstairs with him?
22 A. He didn't convey that to me as I remember.
23 He just conveyed the patient as being at risk of
24 self-harm.
25 Q. Let me ask you this: If he was solely
00065:01 worried about Mr. Hunt hurting himself, there would
02 be no need to ask Mr. Clifton to come down there
03 with him, would it?
04 A. There may be lots of reasons to ask him to
05 come down there with him, but I was not aware that
06 he had even asked him to come down there with him.
07 When I saw Mr. Manning, I saw actually both of them
08 together standing in my office and they both left
09 together.
10 Q. Would you agree with me that it appears at
11 least from this statement that Mr. Manning was
12 concerned for his own safety around Mr. Hunt?
13 MR. MacKELCAN: Object to the form.
14 A. I didn't get that from him at the time.
15 BY MR. SWETT:
16 Q. Ma'am, earlier you told me you don't
17 remember what he said to you on that conversation so
18 how do you know if you got that from him or not?
19 A. Because if he had been that uncomfortable
20 about the patient, then I would have gotten that
21 from him. But I didn't get that. All I remember is
22 him coming and presenting the patient in standard
23 form and my saying, yes, he needs admission.

25. PAGE 66:15 TO 66:19 (RUNNING 00:00:12.541)

15 Q. As you sit here today, can you tell me why
16 you recommended admission?
17 A. Because he was a danger to self. If he is
18 a danger to self or a danger to others, they need
19 admission.

26. PAGE 69:05 TO 69:10 (RUNNING 00:00:17.221)

05 Q. Dr. Hendelman, would you agree with me
06 that on February 24, 2012 it was foreseeable that if

07 Kalvin Hunt was allowed to leave the Naval Hospital
08 without being admitted on his own accord, he would
09 inflict harm on someone, whether it be himself or
10 someone else?

27. PAGE 69:12 TO 69:19 (RUNNING 00:00:23.218)

12 A. No one can predict when a patient is going
13 to become violent. No one can predict that at all.
14 What sets one person off will not set another person
15 off.
16 It depends strictly on the patient. You
17 can predict the potential for violence but you
18 cannot predict the time when the violence will
19 occur.

28. PAGE 71:15 TO 71:17 (RUNNING 00:00:05.960)

15 Q. Kalvin Hunt's risk was much greater than
16 your average patient because of his prior medical
17 history, correct?

29. PAGE 71:19 TO 71:24 (RUNNING 00:00:21.460)

19 A. Again, you cannot predict when a patient
20 will become violent. Lots of people have the risk.
21 I've had patients in my office with the
22 risk. All the time, I see patients who are at risk.
23 But you cannot predict when they are going to become
24 violent.

30. PAGE 75:11 TO 75:13 (RUNNING 00:00:08.890)

11 Q. But it would have been the reasonable
12 thing to do for Dr. Jansen and his staff to closely
13 supervise Kalvin Hunt on February 24, 2012, right?

31. PAGE 75:15 TO 75:16 (RUNNING 00:00:07.580)

15 A. If the patient is non-violent at the time,
16 one cannot restrain them.

32. PAGE 76:25 TO 77:12 (RUNNING 00:00:34.920)

25 Q. Would it have been the safe thing to do to
00077:01 have kept Kalvin Hunt under close supervision?
02 A. I would prefer to keep my patients under
03 close supervision when they tell me that kind of
04 information.
05 Q. When they say they have thoughts of
06 hurting others, correct?
07 A. Yes.
08 Q. Would it be the reasonable and safe thing
09 to do to take precautions to prevent someone like
10 Kalvin Hunt from leaving the facility prior to him
11 being admitted after he has indicated he has
12 thoughts of harming others?

33. PAGE 77:14 TO 77:16 (RUNNING 00:00:10.380)

14 A. I prefer to keep them under close
15 supervision and stay right with them when they have
16 suicidal or homicidal thoughts.

34. PAGE 94:16 TO 95:19 (RUNNING 00:01:52.590)

16 Q. What kind of questions is Mr. Manning
17 required to ask the patient such as Mr. Hunt in
18 order to make his psychiatric evaluation?
19 A. He basically asks questions about his
20 thinking and whether or not he is suicidal,

homicidal, if he can designate which person he might want to hurt, if he is having delusions, hallucinations, if he is paranoid. They ask the basic mental status kind of questions.

Q. If the patient, or if he brings someone with him, has his medical records with him, should the psych tech look at those records in order to get as good a history of that patient as they should to be getting and doing their evaluation?

A. Once he's done an initial eval if he feels that he needs more clarification, which clearly he didn't need at that point, he can go ahead and look at the records, but it was very clear that this man had met criteria for admission and that is when he comes up and presents it to me.

Q. Mr. Manning came to your office, correct?

A. Yes.

Q. If you would, tell us everything you remember about the conversation between you and Mr. Manning.

A. He just presented the patient, information about the patient. I said he meets criteria for admission, and we'll admit him to the hospital and to go ahead and get that process underway.

35. PAGE 139:18 TO 140:04 (RUNNING 00:00:42.570)

Q. So if you testified earlier today in this deposition that you would not have allowed a person like Mr. Hunt who had suicidal ideations and threatening to harm other people to leave the hospital, that would be incorrect?

A. As I testified earlier today, I would not allow them to leave my office on their own. My office currently is not in a hospital.

At Beaufort, I would have escorted him down from my office on the fourth floor to the emergency room on the first floor because that was the standard protocol in Beaufort.

36. PAGE 140:05 TO 140:18 (RUNNING 00:00:32.880)

Q. What would you have done to make sure that he did not leave the hospital when you escorted him down to the ER?

A. I would have turned him over to the care of the ER and gone ahead and recommended that he be transported and called for a tech.

Q. You would have also informed them that you would not want, for example, Mr. Hunt to leave the hospital, correct?

A. Yes.

Q. You would have had to have told that to the doctor in the ER because he wouldn't have done any evaluation, correct?

A. That's correct.

37. PAGE 157:03 TO 157:14 (RUNNING 00:00:49.270)

Q. So if Dr. Jansen had informed you that he was angry in the ER, would that have made a difference on any of your recommendations to Dr. Jansen?

A. He did not inform me that he was angry in the ER. He did not inform me --

Q. If he had informed you or Psych Tech Manning had informed you that he was angry in the ER, would that in any way have added to your

recommendations?
A. If he was not acting up, he can be angry all he wants. We have lots of angry patients.

38. PAGE 157:24 TO 158:12 (RUNNING 00:01:02.190)

Q. If you had had the knowledge that he was psychotic or delusional on top of the fact that he was angry, and on top of the fact that you were giving a recommendation of admitting or involuntarily admitting, would you have given additional recommendations to the fact that, not to let him leave the hospital?
A. Patients are able to sit there and remain there voluntarily until they do something. And that's the status quo. They will stay there and wait until they are going to go to the hospital.
Some patients can explode and act up and some will not. If they explode and act up, then you have to do something to restrain them.

39. PAGE 201:24 TO 202:06 (RUNNING 00:00:31.950)

Q. If Manning had been concerned for his own safety when he was interviewing Mr. Hunt in the ER, what options were available to him in terms of action that he could have taken at that time with respect to Mr. Hunt?
A. He could have called another tech down to sit with him or he could have called hospital security to come in and watch him.

40. PAGE 211:02 TO 211:04 (RUNNING 00:00:08.840)

Q. In this case, on February 24, 2012, did the staff in the ER manage Kalvin Hunt safely on that day?

41. PAGE 211:06 TO 211:12 (RUNNING 00:00:14.460)

A. Looking in retrospect?
BY MR. SWETT:
Q. Sure.
A. Clearly, since he eloped, no.
Q. Should Kalvin Hunt have been allowed to leave the facility that day prior to being admitted at Beaufort Memorial?

42. PAGE 211:14 TO 211:15 (RUNNING 00:00:02.714)

A. No, he shouldn't have been allowed to leave.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 00:44:00.778)

THE SOUTH CAROLINA DIVISION OF VETERANS AFFAIRS,

Defendants.

DEPOSITION OF ARTHUR MANNING

Taken on behalf of the Plaintiffs pursuant to Notice, on Thursday, May 22, 2014, commencing at 8:46 a.m., at the Kaneohe Marine Corps. Base, Building 215 Conference Room, Kaneohe Bay, Oahu, Hawaii.

[redacted] = Defendants ? designated

= Plaintiff ? designated

___ Manning

" " ___ both Δ + Π designated

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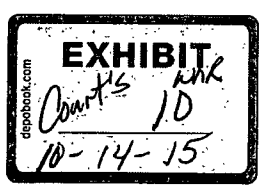
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= Plaintiff

= Defendants

IN THE UNITED STATES DISTRICT COURT

= FOR THE DISTRICT OF SOUTH CAROLINA

Manning BEAUFORT DIVISION

" " both Δ & π designated

CHRISTOPHER D. MILLER, Plaintiff, v. CASE PRO, INCORPORATED; THE UNITED STATES NAVAL HOSPITAL; THE UNITED STATES OF AMERICA; AND THE SOUTH CAROLINA DIVISION OF VETERANS AFFAIRS, Defendants.	Civil Action No. 9:13-3395-DCN DEPOSITION OF ARTHUR MANNING TAKEN ON: MAY 22, 2014
LATTANNISHA ROBERTS, Plaintiff, v. CASE PRO, INCORPORATED; THE UNITED STATES NAVAL HOSPITAL; THE UNITED STATES OF AMERICA; AND THE SOUTH CAROLINA DIVISION OF VETERANS AFFAIRS, Defendants.	Civil Action No. 9:13-3394-DCN
KELLI R. FRANKLIN, Plaintiff, v. CASE PRO, INCORPORATED; THE UNITED STATES NAVAL HOSPITAL; THE UNITED	Civil Action No. 9:14-cv-00289-DCN

Page 6

(Pursuant to Rule 14 of the Rules Governing Court Reporting in Hawaii, the reporter's disclosure was made and is attached hereto.)

(Exhibit 1 is marked for identification.)

ARTHUR MANNING,

having been called as a witness and being first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. DETRICK:

Q Mr. Manning, this is Paul Detrick. Would you please give us your full name, please, sir.

A Arthur Gerard Manning.

Q And, Mr. Manning, according to the rules of our depositions, if you don't understand my question or the other attorneys who are asking questions after me, you should direct to them and tell them you don't understand the question, and they'll rephrase the question or I'll rephrase the question. Is that okay?

A Okay.

Q And since the deposition has started, you're not allowed to communicate either verbally or with hand motions or anything with the lawyer for the United States. Is that fair?

A Yes.

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Q Okay. Could you tell us -- You're in the military; is that correct?

A Yes.

Q And what is your present rank?

A E-5.

Q What does that mean to someone who doesn't know anything about the military, thank God?

A Shoot. I guess I don't understand that question. E-5 is like -- that's the E-1 through E-9. I'm enlisted. I'm on the enlisted side. When you first initially enlist, you usually start at E-1. So I've made it to E-5, and highest rank would be an E-9. Does that make sense, I guess?

Q I guess so. Where are you presently stationed?

A 3rd Marine Regiment with 3rd Marine Division.

Q Where at?

A In Kaneohe Bay, Hawaii.

Q Is that where we're taking this deposition today?

A Yes.

Q We were given, it says, HM-3 before for Arthur Manning. Can you explain what HM-3 means?

A Yes. That's -- HM is the rate that I am in the Navy, which is a hospital corpsman. And the HM-3 is just an E-4, but I'm E-5 now. So it's HM-2.

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Q When you were -- where were you stationed prior to being in Hawaii?

A I was in Parris Island, South Carolina.

Q Did you have duties at the Beaufort Naval Hospital?

A Yes.

Q What were those duties?

A I mean, we were a detachment of the naval hospital.

Q How long were you detached there?

A Four years.

Q Okay. And that would be during the period of February 24, 2012; correct?

A Yes.

Q Did you have any particular duties in the hospital?

A Just with -- I work in psychiatry. So the only duty I had with the hospital was being the psychiatric technician on duty.

Q Psychiatric technician on duty? Is that what you said?

A Yes.

Q Now, tell me about what is a psychiatric technician.

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A We basically -- we work with -- within a psychiatric unit. So where I was at Parris Island, we were the mental health unit. It's an outpatient clinic. When patients come in, we would do the initial intakes. We would do evaluations on patients, and then we would staff the doctor with the information that we get, whether it's the demographics, the current issues going on with the patient, and our opinion of what's going on. Then the doctor would go on to do their evaluation for diagnosis and treatment, and then if -- when the treatment was made, we would also carry out whatever treatment plan that the provider has laid down for the patient.

Q Okay. What kind of training did you have to have in order to be a psychiatry technician?

A Just a -- first we go to A school, which is where you get your basic -- your hospital corpsman rate. After you get your hospital corpsman rate, you would go to C school, which C school stands for career school, and that's where we would get training for to become a psychiatric technician, and it's like directed towards psychiatry/psychology.

Q Now, at the Beaufort Hospital, who would you work with? Who were your supervisors?

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A Who were my supervisors?
Q Yes, sir. At Beaufort Naval Hospital during this period of time we're referring to.
A I don't understand that question because, I mean, like the naval hospital was over us, but I was -- my supervisors would have been at Parris Island. So like, I mean, the director -- the director of mental health was Dr. Cowan, but, I mean, he was just our director. So he was just who we fell under at the naval hospital administratively. So that's why I don't understand.
Q Who would be your direct boss, in other words?
A Okay. The psychologist that was the department head --
Well, do you want just for the time period in February?
Q Yes, sir. That's fine. Unless I say otherwise in the questions, the time period is February 12th or 2012 -- 24th, 2012.
A Okay. It was a Lieutenant Rose, but I think her name is like Lieutenant Hiers now.
Q R-o-s-s?
A No. Rose, R-o-s-e.
Q R-o-s-e?

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A Right. And I think she's gotten married. So I think she's Lieutenant Hiers, H-i-e-r-s, now or Rose-Hiers. I'm not sure.
Q How do you spell that again, please?
A H-i-e-r-s.
Q Oh, Hiers. What was her capacity?
A She was the department head and she was a clinical psychologist.
Q She was at the Beaufort Naval Hospital?
A No. She was in Parris Island.
Q How about whenever -- now, tell me like in a regular day, would you report to the Beaufort Naval Hospital every day or how did that work?
A No. I was only at Parris Island, and if need be, if the naval hospital needed help, they would call us, but we did not report to the naval hospital at all.
Q So on a regular basis, you all would not report to Beaufort Naval Hospital?
A No.
Q How is it that you happened to be, if you were, at the Beaufort Naval Hospital on February 24, 2012?
A I was the psychiatric technician on duty. So on the day that that -- well, the day of the event, I

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was called into the naval hospital.
Q Who would have called you?
A The ER.
Q Okay. The ER meaning who?
A Who is the ER?
Q Who from ER called you and said to report?
A I'm not sure. It would just be a nurse at the front desk. It was a pager duty. So they would page the pager, and then we just call the ER. So it's not a specific name we will call for.
Q That nurse who would do the pager duty, would that be an employee of Case Pro?
A I'm not sure. I don't know.
Q Okay. All right. How often would you be paged to be a psychiatry technician at Beaufort Naval Hospital?
A How often?
Q Yes. I'm trying to get an idea how often you were there.
A It just depends -- I mean, you can't guess what's going to happen in psychiatry. So, you know, whenever there was a patient, whether it was alleged psychosis or suicidal ideations, anything like that, they would call us in, and this is for the naval hospital, Parris Island, wherever it was.

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Q On February 24, 2012, were you there all day, or did they page you because of a situation with Mr. Hunt?
A I was paged then. I was at Parris Island when they paged.
Q I gotcha. Do you remember who paged you?
A No. I don't know who would have paged me. Like I said, the number comes through for the ER number and I called it.
Q Okay. And it's not very -- it doesn't take you very long then to get to the naval hospital from where you're at at Parris Island?
A Not long.
Q About how long?
A Shoot, I mean, it could have been -- I'm not exactly sure how long it took, but, I mean, it's like a 15-minute drive to get from Parris Island to the naval hospital if, you know, all goes well.
Q Okay. Is there -- in situations such as Mr. Hunt, would they just page you to come to the naval hospital, or would they page a psychiatrist or other personnel?
A It would just be -- it's not a specific person they would page. They would just page -- they would just page the duty pager.

Q Who would report to the hospital in situations -- at Beaufort Naval Hospital from Parris Island in situations such as Mr. Hunt? I'm trying to get is there a team of persons, psychiatrists, psychologists, psychiatry technicians or what, who would report or how would that work?

A There's no specific like -- I'm not understanding your question. I think it's like -- I think it's a general thing. Like in any situation that the pager is called, the technician on duty will respond. So it's not like for this specific situation, something was going to happen. It's a general standard that always happens. So if the ER pages the pager, whoever the technician on duty is will respond and call the ER, and the ER will say, "We have a patient that needs to be seen," and that's what happened.

Q Okay. And we hadn't been provided much. So we don't have much. So I don't have much knowledge, and that's the reason I'm asking these questions.

A I understand.

Q And I want to know somewhat about how the parties got to the table at the Beaufort Naval Hospital. I did notice a Dr. Hendelman. Are you familiar with her?

A Yes.

Q Now, how would she have gotten there on February the 24th, 2012? Was she just there or was she also part of the paging system?

A No, no. She just happened to be in the hospital. The hospital was -- basically, it was the end of the day, and all the outpatient clinics were closed or closing down. So when I was paged in, she was the doctor on duty. So I gave her a call and she said that she was in the hospital, so...

Q Okay. Now, how does that work as far as -- She's a psychiatrist?

A Yes, she is.

Q How does it work as far as the call of a psychiatrist at the Beaufort Naval Hospital?

A How does it work for what now?

Q Someone on call all the time or --

A Yes.

Q Okay. So someone -- some psychiatrist that can be on call --

A A psychiatrist or psychologist.

Q Okay. Either one?

A Right.

Q Okay. All righty. Now, as far as working, can you give me a general idea about the working -- your working with the staff at the Beaufort Naval Hospital,

and when I'm referring to that is any work with doctors, nurses, other employees such as that?

A How they work together?

Q Yes. Would you work with the doctors?

A Like not on a daily basis. You mean just like in a situation like this?

Q Yes, sir.

A Yes. I mean, I would go to -- Like with this situation or in a general situation, the standard will be --

Q Just general situation we'll start off with, if you don't mind.

A General situation, the technician's called in. We would go to the ER. We report to the nurses' station. The nurses tell us what's going on, and the doctor would say, you know, what their concerns are. Then we get the ball rolling on whatever -- whatever it is that needs to be done as far as like if we're talking to the patient doing just a standard -- a safety evaluation and getting in contact with the doctor, letting the doctors know what's going on, and getting the treatment plan right then and there for us to carry out that treatment plan.

Q Okay. I'm trying to keep up with all that. My understanding is the first thing you do is report to

the nurses' station, and they will give you a general idea of the situation involved; correct?

A Right.

Q Then you go from there to whatever doctor is involved with the patient, and that doctor tells you what his concerns are --

A Right.

Q -- correct?

And then you decide what kind of evaluation is needed of the patient? Generally, a psychological evaluation --

A Okay. Yes.

Q -- is that correct?

A Yes.

Q Okay. And one of those would be a safety -- you call it a safety evaluation?

A Right.

Q And what do you refer to with that?

A A safety evaluation, basically, is where we -- the technician, you know, you ask like what we call like a mental status exam. We find out what's going on with the patient and, you know, like self-explanatory, evaluating their safety. So if there's any risks or concerns that are like right there that -- right then, right there that we need to deal

with.
Q All right. I do some writing. So that takes me a little bit of time here.
Okay. Now, so that we can both be talking the same and I'll know somewhat about what went on, have you had a chance to review what has been marked Exhibit No. 1 before the deposition?
A Yes.
Q Okay. If you don't mind, if you would take that and let's go through it just a little bit. Hopefully, you can read some of the writing I couldn't read.
A Okay.
Q If you got it in front of you --
MR. INFINGER: Paul, what page number are you on?
MR. DETRICK: I'm not on any yet.
THE REPORTER: Who is speaking, please?
MR. DETRICK: That was Paul Infinger. I'm Paul Detrick.
Q (By Mr. Detrick) Let's go to -- it would be -- I think I can read everything up until No. 01549. Mr. Manning, could you turn to that page, please?
MR. BERLINSKY: There's a little number on the bottom corner.

THE WITNESS: Okay.
Q (By Mr. Detrick) Do you know whose writing this is? My guess is it would be Nurse -- a male -- McDonald, Joe McDonald, I guess his name is?
A I'm not sure whose writing this is.
Q You don't know whose writing that is?
A No.
Q Are you able to read the writing on the right-hand corner, right-hand side of the page for me, or you're no better than me?
A Yeah, for the most part, I can see some of it.
Q I just thought you might be more familiar with it in your practice.
A Okay.
Q I assume on the right-hand side there would be the time 1430. Is that up at the top looks like?
A Yes.
Q And that looks like a trial was done at that time, an evaluation pending?
A A triage.
Q Triage. I'm sorry. Correct?
A Yes.
Q And at 1500, it looks like -- can you read that for me?

A "Report from Veteran Affairs with patient." I don't know what that next word is to the "ER." I don't know what the rest of that is.
Q Okay. And the next would be 1510, it looks like to me, is that correct, next entry?
A Yes.
Q What does that say?
A They -- he -- he contacted or I don't know what the first -- that first thing is, but it says, "Beaufort Memorial." I guess they called Beaufort Memorial to inquire bed availability.
Q Do you have any remembrance of why at 1510, they would be calling Beaufort Memorial to determine whether a bed was available?
A Say that again.
Q Do you know or do you remember, since you were there some of this, why at time 1510, they were calling Beaufort Memorial to determine if there was bed availability?
MR. BERLINSKY: I'm going to object to the form of the question.
MR. DETRICK: That's okay.
MR. BERLINSKY: But you can still answer the question, Mr. Manning, if you know it.
Q (By Mr. Detrick) You can still answer if you

know.
A I can only assume that they're calling -- they're calling Beaufort Memorial for bed availability because they're looking to do inpatient -- to have them admitted to inpatient.
Q Okay. Do you know whether this already would be the psychiatric ward at Beaufort Memorial at Maryland?
A Yeah. That's the only place you would inquire about a bed availability.
Q Okay. So at 1510, they already have somebody -- Nurse McDonald or someone is inquiring whether there's a bed availability for Mr. Hunt in the psychiatric ward; is that correct?
MR. MACKELCAN: Objection. This is Doug Mackelcan.
Q (By Mr. Detrick) That's okay. Go ahead, Mr. Manning.
A What's the question?
Q Well, let me ask you this. Do you remember that time that's set forth in this exhibit, 1510, whether at that time there was -- someone was already checking to see if there was bed availability in the psychiatric ward for Mr. Hunt?
A I'm not sure. I just see that in the note

that it says that.
Q Okay. And I see the next entry is 1525. Could you read that for me?
A Yes. "Psych Tech Manning, eval in progress."
Q And from your memory, is that the approximate time you would have been doing an evaluation for Mr. Hunt?
A I only know that because it says it there. I don't remember what time it was.
Q All right. And just so – if you would just to get your help on reading this, would you please go and read the remaining entries for me on 01549?
A So at 1612?
Q Yes.
A It says, "Patient --"
I don't know what the next word is.
"-- to bathroom returned. Veteran Affairs rep," something, "Ray states, 'We're getting some air.'"
And then at 1625, "Mr. Ray returns to ER stating, 'He took off through the gate.' Psych tech returned 10 ago." I don't know. "Has been looking for patient and Mr. Ray."
I don't know what that Q -- it's a Q. I don't know what it says after that. "Security gate." I

don't know what the rest of this says.
And then 1635, "OOD, PMO, ER medical doctor," or "ER MD," something, "director," and I don't know what the rest of it says.
Q All right. Do you know what OOD stands for?
A Officer of the day.
Q And PMD?
A PMO is --
Q Oh, PMO. I'm sorry.
A Yeah. It's military police. I don't remember what PMO exactly stands for, but it's military police.
Q Looks like to me it says, "Notified of AMA." Do you know what AMA stands for?
A No. AMA?
Q If you would, could you next go to 01551, please?
A Okay.
Q This looks like an Emergency Physician Record; correct?
A Correct.
Q And it says, "Psych Disorder, Suicide Attempt, Overdose." Is that a record that's filled out by the doctor with those conditions of the patient?
A I'm guessing so.

Q You hadn't seen this similar record before?
A No, I wouldn't do this. So this isn't something I would fill out.
Q Okay. I assumed not, but a chance to clear this out.
Have you read Mr. Jansen's writing before?
A No.
Q You're not much help.
A No, not at all.
Q Reading most of it, it says, "suicidal thoughts." You see that circled?
A Yes.
Q Can you read what that says?
A It just says, "medication refill."
Q No. I'm talking about -- I don't see where you're at.
A Under where you said it's circled "suicidal thoughts," it says, "medication refill."
Q Some writing there, it says, "and thoughts," it looks like to me.
A Huh? "And thoughts"? Oh, okay, I see. "And thoughts of hurting --"
Shoot. I don't know.
"-- bad disrespect." I'm not sure what that says.

Q Looks like, "others, but no specific plans"?
A Oh, Okay. Yeah, okay. "Thoughts of hurting others with no specific plans."
Q Was those "thoughts of hurting others, but no specific plans" ever communicated to you by Mr. Hunt?
A I don't remember the specifics of what we talked about.
Q We'll go into that. If you would just go to the next page, 01552.
A Okay.
Q And over here on the times on "Progress" --
A Uh-huh.
Q -- can you help me with some of the writing there of 1510, 1520, 1440 and 1510?
A All right. 1510, "Called mental health. Asked for psych tech."
1520, I don't know. Looks like --
Q "Called mental health again," maybe?
A Yeah. And then it says, "tech coming." The last two words are "tech coming."
And then 1540, "Mr. Manning present." I don't know the next word.
And then 1610, "Call," something. Looks like the last word is my name. I think the last word is "Manning" or I don't know.

Q And then something about, "Discussed with Dr. Hendelman at 1605"?
MR. BERLINSKY: Mr. Detrick, can you speak a little bit louder for us, Paul?
MR. DETRICK: Yeah, I sure will. I'm sorry.
Q (By Mr. Detrick) It says, "Discussed with Dr. Hendelman, 1605"?
A Oh, yes, yes.
Q All right. Well, I thought you could do better than that. You're not much better than me, but we'll get Dr. Jansen and the other nurses to help us. Okay?
A All right.
Q Now, as far as you're concerned, Mr. Manning, it's my understanding that there's nothing in writing of anything you did or your opinions, et cetera, on February 24th, 2012, regarding Mr. Hunt; is that correct?
A Right.
Q You never made any notes, any memos, no reports?
A No.
Q Do you know of any such that Dr. Hendelman may have completed?
A She never got a chance to see the patient.

Q She never got a chance. Okay. Well, we'll go into that.
All right. If you would, why don't we go kind of from the beginning, Mr. Manning. You were paged to come to the Beaufort Hospital regarding Mr. Hunt, correct?
A Yes.
Q And you don't remember who, but it would have been a nurse in the ER; is that correct?
A Yes.
Q What specifically do you remember was told to you by the nurse as the reason you needed to come to the naval hospital regarding Mr. Hunt?
A You mean on the initial contact when they first called or paged?
Q They just page you and you go, correct, and then you don't know what your purpose is?
A Right.
Q Okay. All right. And then you got there, and I think the first thing you said is you would report to the nurse?
A Right. To the nurses' station.
Q All right. And what do you remember, if you would tell us about when you reported to the nurses' station, who you talked to and what they may have told you?

A I remember -- I remember I got there. I talked to the nurses' station. There was the doctor -- Dr. Jansen. Dr. Jansen was there, and he told me that he had tried to talk to the patient, but he wasn't -- he didn't open up very much to him, and that's all I remember. And then I went in and started talking to him.
Q What was Dr. Jansen talking to him about that would require you to come to the naval hospital?
A Well, it would be suicidal thoughts and depression. I mean, that's what the note says anyway.
Q That's what what note says?
A The note where he circled "suicidal thoughts" and "depression."
Q Didn't it also say that he had thoughts of hurting others and himself?
A Right. Yeah, that page.
Q So that was -- did you discuss that part with Dr. Jansen if he was present when you got there?
A It would have been a part of the conversation, but I don't remember specific like him -- the specifics of the conversation. I just remember -- the one thing I remember, Dr. Jansen saying was the guy wasn't -- he wasn't opening up to him. So he wouldn't

talk to him much.
Q But there was a mention by Dr. Jansen that Mr. Hunt had thoughts at least of hurting himself and others?
A Like I said, I don't remember specifics --
MR. MACKELCAN: Objection.
THE WITNESS: -- of the conversation.
Q (By Mr. Detrick) I'm sorry. He was objecting. I didn't hear your answer.
MR. MACKELCAN: I tried it about two questions prior as well.
THE REPORTER: Who is objecting?
MR. MACKELCAN: Doug.
MR. DETRICK: Okay. Doug. Doug was objecting. This is Paul Detrick again.
MR. BERLINSKY: Paul, hold on for a minute.
MR. DETRICK: Yeah.
MR. BERLINSKY: Let's try to help the court reporter by remembering to identify who you are before you speak unless it's an objection, and then state who it is that's objecting, and also let's try to make sure that we don't cross-communicate so that she can make an accurate record.
MR. DETRICK: We'll do the best we can, Madam Court Reporter. We apologize when we make your

job difficult.
Q (By Mr. Detrick) Mr. Manning, what do you remember regarding the conversations with Mr. -- I mean, with Dr. Jansen involving any suicidal inclinations or thoughts of hurting others, if anything?
A I don't remember anything. Like I said, the only specific thing I remember is he said the guy wouldn't talk to him.
Q Well, what was the purpose -- did Dr. Jansen tell you what the purpose was that he called you, a psychiatry tech, to come to the naval hospital for Mr. Hunt?
A Did he tell me in our conversation? Is that what you're asking?
Q In some way or another, how did you find out why you went there?
A When I like got there, that's when they told me.
Q Well, what did they tell you?
A I don't remember any specifics of that conversation.
Q What were the generalities for the purpose for you to be there as a psychiatry technician?
A I mean, if I'm getting a page on the pager, I can only assume it's either a psychosis, somebody

wants to kill themselves or hurt themselves, and that I'm going to be doing like a transport possibly.
Q All right. Have you told us -- I understand you didn't make any notes. You didn't make any reports.
A No.
Q We don't have any idea what exactly happened as a result of that, but can you please tell us what you remember specifically that anyone told you, nurses or doctors, when you arrived at the Beaufort Memorial -- Beaufort Naval Hospital regarding Mr. Hunt?
A I don't remember any specifics. I mean, I can -- I remember them telling me where he was. That's about it.
Q Where was he?
A In the third bed of ER.
Q And that's all you remember?
A Yes.
Q Okay. All right. Well, then what did you do, Mr. Manning?
A After they told me where he was, I went into the little section that he was in and I started talking to him.
Q Can you tell us what you talked about, what questions and what his responses were?
A I don't remember like details of the

conversation, but I know that I went through my normal -- the standard mental status exam and the --
I don't remember any specific answers he gave me. I remember his body language. Like I can see him sitting in front of me right now, but I don't remember any like detailed conversation we had.
Q Would you have been doing what I've seen in the records would be an emergency mental health evaluation?
A Would I be doing --
Q Is that what you would have been doing? Your questions and answers would have been an emergency mental health evaluation?
A Is that like a paper you're looking at?
Q Yes.
A No, I don't know what you're talking about.
Q You don't call it that?
A No.
Q You call it a standard mental status exam?
A Right. It would be a mental status exam.
Q What's the purpose of that mental status exam as far as Mr. Hunt's concerned? Why are you doing it?
A It's basically like a safety evaluation. I'm looking for -- I'm looking for any kind of altered

thought process, any thoughts of like a right here, right now, are they oriented to where they are, who he is, a time frame; is he thinking about killing himself or is he thinking about killing himself right now, those kinds of things. That will be a part of the mental status exam.
Q Would a part of the mental status exam be whether he had thoughts of injuring other persons?
A Yes.
Q Did you ask Mr. Hunt that?
A I can only assume that I did.
Q And what was his response?
A I don't remember.
Q Would it have been that he did, or you wouldn't have done the recommendations you made later?
A Ask that question again.
Q I know you didn't do any notes. Okay? That's giving us a problem, but we'll deal with it.
A Right.
Q But you said you would have assumed you asked him that?
A Right.
Q Well, can you give me -- based on what your actions were after that, can you give me what you assume his answer was?

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A No, I couldn't, actually. But the only thing that I could say is that according to my actions, there -- there was not a concern of him like hurting someone right then and right there. Like there was no -- because if there was some kind of specifics to him hurting someone, then it would have been a different situation.

Q What you were doing was a safety evaluation; correct?

A Yes.

Q What does that mean?

A It's a safety -- like I'm evaluating for safety.

Q Safety of him and others; correct?

A Right.

Q Now, the purpose of the safety evaluation would be to determine what kind of recommended treatment you would have for Mr. Manning -- I mean, Mr. Hunt?

A That and, you know, what needs to be done as far as like making sure the patient is safe and those around are safe.

Q If you were concerned about his safety or those around him, what would have been your recommendation?

A Basically, the same thing. I'd have let the

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doctor know my concerns and gotten a treatment plan from the doctor. I'm a technician. I can't -- I can't like make --

The only thing I can do is if the patient was an immediate threat to himself or someone else while I was there, then I can make an on-spot decision, but if there's nothing, then it is my job to let the doctor make that decision of what's going to happen next.

Q Okay. So your -- well, what were your concerns as you told the doctor?

A My concerns, I do remember that he -- he was not -- it did not seem that he was oriented to like what was going on right then and there. I remember that his -- the way he was talking to me, it was very disorganized. It didn't seem like he had a grasp of like time right then and there, and I also felt that the way that he was talking and his -- the demeanor and body language was -- it was very aggressive.

Q What do you mean by his demeanor and body language was very aggressive?

A The way he was talking. The way he was sitting. I mean, it's like little things that we're taught to look for. It's kind of like -- it's called psychomotor agitation. Just the same way you would read a person that you're talking to, you know, body language

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tells a lot about a person regardless of what their words are. So like little simple things, you know, common communication, I guess you could say.

Q Very aggressive, meaning he was very angry?

A Yes. He was very agitated. I wouldn't say angry. I would say agitated.

Q And being agitated, did he indicate during your conversation that he had any thoughts of suicide?

A I don't remember any like details of our conversation.

Q And you don't remember whether he expressed those thoughts to any of the other staff, doctors and nurses?

A No, not other than what's in the notes. No, I don't remember.

Q But you do remember what was in the notes?

A What's that?

Q You do remember those in the notes?

A I mean, I see what's in the notes because it's in front of me.

Q Right. I'm talking about the time of February 24, 2012. You knew those were in the notes that they had been communicated to --

A No. I have nothing to do with what the ER notes are. I don't -- I don't do anything with them.

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Q Okay. You did your safety evaluation; correct?

A Yes.

Q And you said you asked the standard mental status examination questions?

A Right.

Q Is that something in writing or is that something you just got memorized?

A Right. That's something I memorized.

Q What are those questions?

A First, I would ask about if they're having thoughts of suicide. I would ask them about if they're having any thoughts of hurting themselves. I would ask -- if it's right here, right now, so like if I ask about suicide, I would say, "Are you thinking about suicide right here, right now? Do you want to kill yourself right here and right now? Do you want to harm yourself? Have you had these thoughts in the past? Have you had them in the last week? Did you have them yesterday? Did you have them this morning," that kind of line of questions.

And then I would ask the same thing about hurting themselves. I would ask the same thing about killing someone. I would ask the same thing about hurting someone. I would also ask, "Do you know where

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you are? Do you know your full name? Who is the President of the United States? Where are you from? Where were you yesterday? What did you eat for breakfast? Are you seeing or hearing things other people can't see or hear." And then I would explain, you know, like, "Are you hearing voices? Is the voice coming from inside your head?" I mean, if they say yes, "Are the voices coming from inside your head? Do you hear them on the side of you? Do you hear them behind you?"

Let's see. And then I just observe how they respond to those questions and things like that, looking for, you know, if they are actually having internal conflict; does it look like they're talking to somebody; does it look like they know what -- are they understanding my questions; are they responding slowly; are they responding fast; is their speech pressured; are they answering relaxed; are they answering --

You know, like I said, he was agitated. So he was answering very agitated. He was aggressive. His body language was aggressive. So all that happens like all at once while I'm talking to them.

Q Okay. Is this some sort of a form or anything on these kind of questions you're supposed to ask? Are they written anywhere?

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A No. This is stuff that I was taught by doctors.

Q Okay. Are you supposed to or is it the policy and procedure of the Navy to keep a record of this examination, the safety evaluation?

A In a normal clinical environment, yes, because we would be doing that inside of an office with the patient, but in the ER, we don't have the resource to do that and it's not -- this isn't a situation that we're trying to like -- this isn't a situation for me to write a note. This is a situation for me to get the information and relay it to the doctor.

Q If you relay it to the doctor, are they supposed to keep notes?

A When the doctor -- when the doctor gets to the patient, they would.

Q I'm sorry?

A I said when the doctor gets to the patient, they would.

Q All right. Let's go through your memory or thoughts. I tried to put down some of what you said. The thought -- the gist of the conversation regarding thoughts of hurting himself and others -- hurting himself or suicide, do you remember specifically what he said?

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A No, I don't.

Q You don't remember whether he said yea, nay or neutral?

A No.

Q Do you remember specifically what he said about like the questions you referred to about killing someone or thoughts of killing someone or hurting someone?

A No, I don't.

Q You don't remember whether he said yes or no?

A No.

Q What do you remember, if anything, about his answer to your question about hearing other people in his head, hearing voices and such as that?

A I don't -- I don't remember.

Q Why is that concerning to you?

A Why is that concerning?

Q Yes.

A You're looking -- Well, are you talking on like a clinical standpoint?

Q Safety evaluations.

A Well, in that situation, what you're looking for is a psychosis.

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Q Do you know whether Mr. Hunt had a history of such, hearing voices and --

A No, I don't know that.

Q Did you ask him that?

A No. I wouldn't have asked about that, not in a safety evaluation.

Q All right. Have you told us all you remember regarding the safety evaluation of Mr. Hunt?

A Yes.

Q Now, after you did that, you're supposed to what? I mean, you're supposed to form an opinion, give a recommendation or just tell the facts to the psychiatrist or psychologist?

A All of that.

Q All of that?

A Yes.

Q Okay. All right. What did you tell -- did you then contact Dr. Hendelman?

A Yes.

Q Am I correct on that?

A Yes.

Q Okay. Now, with Dr. Hendelman, did you contact her in person? Is this a voice or --

A No. I called -- first I called her, and she said she was still upstairs. So I went upstairs to find

her.
Q Okay. So you went upstairs to personally talk with her?
A Yes.
Q All right. If you would, tell us what you told Dr. Hendelman.
A Well, I relayed the message or I relayed whatever the information was that I talked about with the patient, and I do remember telling her like my concerns that, you know, like I felt like he needed to be admitted to an inpatient ward and that he was very aggressive in how he was speaking, and I told her that me and -- and I grabbed another psych tech who was still at work and told him like, "Hey, we're going to go down with her when she talks to him."
Q Why?
A Because I felt -- like I said, I felt he was agitated and he was aggressive. So, you know, it was just a concern that I had.
Q You were concerned for the safety of Dr. Hendelman?
A And the patient.
Q Okay. All right. You recommended he be admitted as an inpatient in the psychiatric ward; correct?

A Yes.
Q And would this have been an involuntary admission; in other words, you didn't go down and ask him, "Mr. Hunt, you've got a choice"? It wasn't any choice at all. He was being admitted; right?
A No. I didn't ask him if he wanted a choice.
Q He didn't have a choice, did he?
A He wouldn't have had a choice if the doctor -- well, if it would have went through.
Q Okay. All right. Well, tell us -- now, you told Dr. Hendelman that. You asked another psychiatry technician for your safety and his safety. What else happened with Dr. Hendelman --
A What else --
Q -- when you went to see her, if anything?
A What do you mean?
Q What did she say?
A She just agreed with what I was saying and said that she would come down so we can start to get the patient admitted.
Q Okay. Would you have told her about if he -- you told me you don't remember, but if you did; would you have told her about any thoughts of suicide, hurting himself, killing other people, hurting someone else, hearing voices such as that? Would you have told her those facts?
A Yes.
Q Okay. Now, you told me everything you remember Dr. Hendelman would have said in response to your facts and opinions and recommendations?
A Yes.
Q Tell me what happened after that.
A After that, we -- along with Clifton or this other psych tech, I went downstairs.
Q What is the other psych tech's name? I'm sorry.
A It was Clifton.
Q Clifton?
A Yes.
Q Clifton who?
A That's his last name. I don't know his first name.
Q Oh, I'm sorry. Where is Clifton at now, do you know?
A I have no clue.
Q Okay. All right. I'm sorry to interrupt you. Go ahead.
A All right. We went back downstairs. When we got to the ER, he -- Kalvin Hunt was gone.
Q Let me ask you this. Was there any

communication -- there are some notes somewhere about Dr. Hendelman speaking with Dr. Jansen. Was that done in your presence or do you remember anything about that?
A No, I don't -- I don't remember anything about that.
Q It may have been done after you left or you just don't know?
A Yeah. I mean, I just don't remember.
Q Just what you know is --
One other thing. Did Dr. Hendelman go with you and Mr. Clifton down to the ER? Did you all leave her, or how did that work?
A From what I remember, she came downstairs.
Q She came with you?
A Yes.
Q In your presence, do you remember her calling anybody or someone calling her, like Dr. Jansen?
A No, I don't remember that.
Q Do you remember one way or the other or is that just --
A I just don't remember if she like -- I mean, I know it's common practice, but I don't remember if it happened in front of me or what -- when it happened. I don't know.

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Q What is common practice then?
A That the doctors would talk.
Q Would it be common practice after your recommendation for Dr. Hunt (sic) to then speak to the treating doctor --
A Who's Dr. Hunt?
MR. BERLINSKY: Object to the form.
Q (By Mr. Detrick) I mean Doctor -- I'm sorry. Hendelman to speak to the treating doctor, Dr. Jansen, about recommendations?
A I mean, yeah, the doctors would talk.
Q All right. That's normal practice; correct?
A Yep.
Q All right. Dr. Hendelman did agree, though, with your recommendation?
A Yes, she did.
Q And so you all were going down to the ER in order to involuntarily admit Mr. Hunt to the Beaufort Memorial psychiatric ward?
A Right.
Q Would Dr. Hendelman have done anything else, or would she already have made her choice -- you know, she's already made her treatment plan before going to the ER?

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A That -- hold on. Say that again. Would she --
Q She already decided on what she was going to do, and she didn't need to see Mr. Hunt? Is that the way you remember it?
A I mean, I know she made her decision on what was going to happen, but, I mean, that's all I know.
Q Okay. So decision was already made to involuntary admission of Mr. Hunt to Beaufort Memorial psychiatric ward prior to you all arriving in the ER?
MR. BERLINSKY: Object to the form of the question.
Q (By Mr. Detrick) Correct?
A I don't -- can you repeat the question again? I just want to hear it one more time.
Q Okay. The question then would be did Dr. Hendelman already arrive at her decision when you all were talking to admit Mr. Hunt to the Beaufort Memorial psychiatric ward?
A Yes. When she was talking to me, yeah, she had already decided that that was going to happen.
Q Do you know anything about the arrangements for admission to the psychiatric ward for Mr. Hunt, who made them, if they were even made?
A No, I don't know.

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Q What would be the normal policy and procedure who would make those arrangements?
A The nursing station.
Q You wouldn't have nothing to do with that, though?
A No. I would only be -- once the decision has been made for him to be transported to or go inpatient, I would do the transport or I would be the escort.
Q I'm sorry. Say that one more time.
A I said after the decision had been made for him to go inpatient, I would do the transport. I would be his escort.
Q Okay. So you would have basically taken him into custody and taken him to the Beaufort Memorial Hospital for admission?
MR. BERLINSKY: Object to the form of the question.
Q (By Mr. Detrick) You would have escorted him to Beaufort Hospital if he had been in your custody; is that correct?
A Not in like my custody. I would just be his like -- I would be kind of like the representative, you know, like a -- like the pass-off. A continuance of care is what you could call it.

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Q Once he got -- you know, once you were his escort and taking him in the process of transporting him, you weren't about to let him escape, were you?
A No.
Q Why is that? That's because he was a danger?
A No. It's more --
MR. MACKELCAN: Object to the form. Doug Mackelcan.
Q (By Mr. Detrick) Why is that?
A I mean, it's my job to make sure the patient is safely transported, but I mean, I have no control over if he -- I mean, I don't know. I have no control over what the patient decides to do after that, but I will make sure that he's safely transported.
Q If he was to try to escape during your escort or in any part when you were starting your escort, what would you have done?
MR. BERLINSKY: Object to the form of the question. No. I withdraw the objection. Sorry.
MR. DETRICK: And that was Doug, but thank you.
MR. MACKELCAN: No. That was Lee.
MR. DETRICK: Oh, I'm sorry. I apologize. You all sound alike.

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THE WITNESS: Can you repeat the question again?
Q (By Mr. Detrick) Okay. Whenever -- you know, what I'm saying is you were going down to the ER; correct?
A Right.
Q And the reason you were going down to the ER is an arrangement was going to be made to escort Mr. Hunt to the psychiatric ward for admission to Beaufort Memorial Hospital; correct?
A Right.
Q And could you tell us now how he would get -- how you would actually go about escorting him? How would you take control of that process?
A The hospital has a -- what is the truck called? Damn it. What's the truck called? The paramedic rig. So they have like the paramedic-type truck or we call it a rig. I don't know. So we would -- the hospital actually has two duty drivers. The two duty drivers would be -- they would drive the truck, and I would sit in the back of the rig with the patient, and then they would drive us to the hospital.
Q I'm not familiar with this truck --
A It's --
Q -- Mr. Manning. Could you describe it,

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please?
A You know the paramedic truck?
Q Yeah.
A You know the paramedic, it's the same truck. Same thing.
Q You're talking about a regular paramedic truck?
A Yes.
Q Okay.
A The thing with the lights and sirens and all that.
Q I gotcha.
A Yeah, that thing.
Q And there would be two duty drivers in order to escort along with you --
A Yes, and then --
Q -- and Mr. Hunt?
A And then Clifton was going to ride along with me.
Q You all were going to have four people to make sure he didn't escape?
A No.
Q You were going to have four people in the truck?
A Right.

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Q Mr. Clifton was going to also sit in the back?
A Yes.
Q Do you know -- I don't assume you knew who the drivers were supposed to be?
A No, I don't.
Q They're on duty at all times?
A Yes.
Q And then, of course, by the time you got to the ER, Mr. Hunt had already escaped?
MR. MACKELCAN: Object to the form. Doug Mackelcan.
Q (By Mr. Detrick) Tell us what happened to Mr. Hunt.
A I don't know what happened to Mr. Hunt. I came to the ER and he was gone.
Q If you all had gotten Mr. Hunt in the paramedic truck with the two duty drivers and you and Mr. Clifton, and he had attempted to leave, what would you have done?
MR. BERLINSKY: Object to the form of the question.
MR. DETRICK: Who was that?
MR. BERLINSKY: Berlinsky.
MR. MACKELCAN: Can we agree going forward

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that one objection will be an objection for all?
MR. DETRICK: That's fine. I agree to that.
Q (By Mr. Detrick) What is your answer, Mr. Manning?
A Honestly, I mean, we would do -- we would do everything we can to make sure the patient is safe, but if the patient tries to escape, that's -- I mean, the best we can do is try to keep them safe, but if they get away, we're not -- we are not allowed to do anything.
Q Would you have called any authorities?
A Excuse me?
Q Would you have called any kind of legal authorities?
A Yes.
Q Would you have made sure he didn't get away and kept within your sight?
A We can -- if we can do that, we can try, but it's not something that is required. We just have to -- we can watch where they're going and, you know, report to whoever, whether it's PMO or the naval hospital ER, the doctors, everything like that, but --
Q I mean, this is an involuntarily --
A -- I'm not going to --
Q I'm sorry.
A I'm not going to chase him down. I'm not

going to do that.
Q But it's involuntary admission. So he doesn't have any choice and he's a service member; correct?
MR. BERLINSKY: Objection to the form of the question.
Q (By Mr. Detrick) This is an involuntary admission; correct?
A There was no admission. So I don't know what you're talking about.
Q It would have been an involuntary admission?
A It would have been.
Q Okay. All right. If you would now, as you got down to the ER, tell me what happened as far as you were concerned after that on this February 24, 2012.
A After -- after I got to the ER, the -- and he was gone, all I remember is I went to the quarterdeck of the hospital and I called for a code for missing patient.
Q Quarterdeck, explain to me why you went there and where that's at.
A Quarterdeck, it's like -- it's where like the main -- the PA system is and everything like that. So it would be a person on duty at the quarterdeck. It's like the information desk at a normal hospital, but

it's a quarterdeck for the, you know, Navy. We try to keep things like across the board the same thing.
Q I gotcha. And someone would announce a code for missing patients; correct?
A Yes.
Q Who would actually receive that? I mean --
A It would go through the whole hospital, and then they alerted the front gate where the master-at-arms are.
Q Who would have alerted the front gate?
A The quarterdeck.
Q Do you remember who -- was it someone assigned to the quarterdeck to do this?
A It was, but I don't know. It's the same just like a duty. So, you know, it changes.
Q What else did you do, if anything?
A Really, that's all I remember other than I know me and -- me and Clifton, we drove around the campus or the base to see if we could find him and that was it.
Q Did you see him or any evidence of where he'd been when you drove around the base?
A No.
Q Did you talk with Mr. Edward Ray, who was a Veterans Affairs officer?

A No.
Q At any time that day, did you ever talk with Edward Ray?
A I mean, he was there. I didn't have like a direct conversation. He was just a part of the conversations I had.
Q What part of the conversations you had?
A He was in the ER when I arrived.
Q Was he present during your safety evaluation?
A No.
Q Just so we'll have it, what do you remember about any conversations you may have had with Edward Ray?
A I didn't have a conversation with him.
Q All right. He never said anything to you. You never said anything to him. He just may have been present some?
A Right.
Q Okay. Now, you yourself, did you have any conversations with any of the guards or the persons at the front gate?
A No, I didn't.
Q After you arrived at ER and found out that Captain Hunt had escaped, did you have any conversations

with Dr. Jansen?
MR. MACKELCAN: Object to the form. Doug Mackelcan.
Q (By Mr. Detrick) Did you have any conversations with Dr. Jansen after you arrived at the ER and found that Mr. Hunt was gone?
A I mean, I don't exactly remember, but I mean, I'm pretty sure I did talk to him, but I don't remember what we would have talked about other than, "Hey, he's gone." I don't know.
Q Do you remember the specifics of any conversation?
A No, I don't.
Q I think there were two nurses there, the McDonalds, is that correct, or do you know?
A I mean, according to the note, it says they were there.
Q Right. Well, did you have any specific conversations with the McDonalds after Mr. Hunt had left that you remember?
A I don't remember any conversations with them.
Q Okay. Do you remember any conversations with anyone with Case Pro and/or the Navy after you found out Mr. Hunt had left?

A I don't know the difference between -- I don't even know what the Case Pro thing is. All I know is there was nurses and doctors and me.
Q Well, let's just put it this way. Do you remember any specific conversations with anyone after you found out that Mr. Hunt had left?
A No, I don't remember any specific conversations.
Q Other than meetings with the attorney for the United States, afterwards, were there any meetings with any of the personnel to discuss Mr. Hunt's leaving or anything that occurred at the naval hospital on February 24, 2012, regarding Mr. -- Mr. Hunt?
A Can you ask that question again?
Q Yeah. I'm interested in any gatherings or meetings, anybody getting together talking about Mr. Hunt leaving or his condition on February 24th, 2012, after February 24, 2012.
A I mean, other than Commander -- oh, God -- Commander Watson, he talked to me, but that was it.
Q Okay. When did you talk to Commander Watson?
A I don't remember.
Q Who's Commander Watson?
A I don't even know who he was either. I just

remember him. Little short guy.
Q When did this conversation occur?
A I don't remember.
Q What transpired? What was said?
A I mean, I don't remember. I don't remember any specifics of the conversation. I just -- you know, he was like one of the officers there.
Q I'm sorry?
A He was just one of the officers at the hospital. I just remember him asking about what happened.
Q When did this meeting occur?
A I don't remember.
Q What was the purpose of the meeting?
A I guess he was asking about what happened. That's all.
Q Any report or file regarding this meeting or do you know?
A I don't know.
Q You don't remember anything about the meeting?
A No, I don't.
Q There's a note which we have been provided. It is Bates stamped 01513. Have you got that? I think that's -- is that part of what's in front of you? It

may not be. It probably is as a matter of fact.
MR. INFINGER: This is Paul Infinger. It was on the disk.
MR. DETRICK: Yeah, I don't know whether Mr. Manning has it, though.
Do you all have that, Lee?
MR. BERLINSKY: I don't have anything like --
Q (By Mr. Detrick) That's okay. No big deal.
Let me read what it says to you, Mr. Manning. It says this is from -- apparently, from the guards. It's at 1616.
MR. BERLINSKY: Hold on one second. Paul, you're fading away.
MR. DETRICK: I'm sorry. Can you all hear me?
MR. BERLINSKY: Yes.
Q (By Mr. Detrick) Okay. Mr. Manning, you can hear me? I apologize if I fade away.
MR. BERLINSKY: What is the document that you're referring to?
MR. DETRICK: 01513.
MR. BERLINSKY: I don't know what that is.
MR. DETRICK: Apparently, it's the notes of the guard shack or the watch or person on duty or

whatever. It's just stated at the top, "24 February 2012."
MR. BERLINSKY: I don't know what it is. So you can ask Mr. Manning if he knows what it is.
Q (By Mr. Detrick) Well, I was going to ask it -- I think it speaks for itself kind of.
Mr. Manning, it says in here -- take me at my word this is what it says. It says, "Psych tech notified watch of missing patient. Code Pink initiated. OOD, COD, security front gate notified."
Is that what you were talking about when you said you went to the quarterdeck?
A Yeah. It's like -- yeah, it's talking about what I would have done at the quarterdeck, I guess.
Q And that Code Pink, I assume, is the missing person code?
A Yes.
Q Okay. Mr. Manning, did you at any time look around and find any clothing of Mr. Hunt or someone else do that?
A No. That was not me.
Q Do you have any information as to how Mr. Hunt left the Beaufort Naval Base?
A No, I don't.
Q Okay. Do you have any information, any

knowledge about --
In the notes, it said something about they were going outside for some air is what Mr. Ray had said. Do you have any knowledge where we're talking about, what door he would have used, what location they would have been in when he did this?
A I know the door that they're talking about, but I don't --
What are you trying to ask about it?
Q I want to know the door they're talking about, could you tell me where that door is located, please, sir?
A Right across from the ER.
Q Right across from what?
A The ER.
Q All right. I'm not real familiar with the naval base there. Can you kind of tell me -- you know, I've seen the gate. Okay?
A Right.
Q Can you tell me if I'm entering the gate, where would the ER be and then where this door would be as I go in the ER?
A That would be really --
Q If you can tell me.
A That's like really difficult. I don't --

you couldn't see this door from the gate. You couldn't even drive up to it. It was like -- it's like an interior yard to the hospital. So like you wouldn't be able to see it from the -- driving around the hospital, you wouldn't be able to see that door.
Q Would you be able to see the ER from the gate?
A No. No, you couldn't see the ER from the gate.
Q Where is the ER located? Can you kind of tell me?
A If you go through the gate, there's a little road. Once you go through the gate, you turn left, and then the ER is like the first parking lot that you pull up to.
Q I assume they got signs of that, huh?
A I'm hoping. I don't remember.
Q And then I go through into the ER -- let's say, through the normal doors, a person would go through the ER. Now, where would this door be? How would I get to this door that Mr. Hunt went out of once I entered the ER?
A It's like right there. I don't -- I don't know. There's like -- it's weird because where the ER is in the hospital, it's like -- it's not like a normal

ER where it has a whole section to itself. It's like right in the middle of the hospital is the ER.
Q Okay. And I know it's a little bit difficult because you said it's weird, but can you do the best you can to tell me if I went through the front door of the ER, how I would get to the door where Mr. Hunt went out of?
A Can you ask the question again?
Q If I'm going like I would go in the ER doors, you know, if I'm a patient or someone taking a patient, I'm walking in the door, how would I get to this door he went out of?
A That's what I'm saying. It's weird. Like in the middle of the hospital is the ER. So the door was like there's the ER. There's the waiting room for the ER that's just right across the hallway from the entrance to the ER and then that door. It's all like right there. It's hard to explain.
Q Is it to the right, to the left or --
A To the right or to the left?
Q When you're talking, do I keep going straight? Do I go right, left or --
A That's what I'm telling you. It's so I don't even know how to explain that because of how the location of the ER in the hospital.

Q All right. If you would exit that door that he went through --
A Right.
Q -- where would you be going to? What would you see?
A If you exit the door, I guess it would take you -- if you kept walking the little sidewalk, it takes you back to the quarterdeck which was -- the quarterdeck is once you go through the front gate and you drive straight where the flagpole is, that's the quarterdeck.
Q How far from that door would the quarterdeck be?
A I mean it's --
Q Approximately.
A I don't know.
Q I want an estimate, please.
A I am not good with numbers. I don't know. I don't know.
Q Are we talking about a pretty good walk or small walk?
A I mean, yeah, it's a little short walk, but --
Q Now, when do you -- if someone exited that gate --
I'm trying to get some ideas.

-- and walked in the direction of the gate or the gates, when would that person be seen? What keeps him from being seen or --

A I mean, just trees and a gazebo. That's why you couldn't see the door, but like once you walk out down the sidewalk, I mean, eventually, you'll get seen because it leads --

Q How far is that -- where you would be seen, how far is that from the gates, approximately?

A I don't know.

Q A fairly good distance? Is it 10 yards? 10 feet? 100 yards? 200 --

A Oh, heck no. It's a hell of a lot longer than 10 yards or 10 feet.

Q How about football fields, can you tell that?

A Probably -- I mean, football fields, probably like --

It's a good distance if you measured in football-field length.

Q I guess it's still like that. So we can see. I was just trying to get an idea where it's located.

Mr. Manning, right now, I think that's all the questions I have. These gentlemen can ask the

questions after me, please.

MR. INFINGER: You all ready to start now?

MR. DETRICK: Yeah.

EXAMINATION

BY MR. INFINGER:

Q Mr. Manning, my name is Paul Infinger. I represent Jonas Armstrong. He was one of the people involved in the wreck with the fire truck.

A Okay.

Q The day after -- I mean, the day after that you saw Mr. Hunt in the naval hospital, did you read about the incident with the stolen fire truck in the paper?

A No, I didn't.

Q When did you first learn, if you ever learned, that there was an incident with a stolen fire truck and some people hurt, one killed?

A The same time we were looking for him in the hospital.

Q I can barely hear you.

A I said the same time we were looking for him in the hospital, I heard that there was a fire truck that was stolen.

Q Did you know it was Kalvin Hunt that you had just interviewed?

A No, I did not.

Q When did you learn it was Kalvin Hunt?

A I think like the next week.

Q When you learned that Mr. Hunt was driving that truck, did you decide you needed to report your involvement with him to anybody at the naval hospital?

A Did I decide that? No.

Q Yes. Did you decide you needed to go in and make a report about him being at the hospital and running away?

A No.

Q So you never made any kind of written report of any kind to anybody regarding Kalvin Hunt?

A Who are you referring to?

Q I'm referring to you making any kind of report to anybody, a written report regarding your involvement with Kalvin Hunt at the naval hospital before he ran away.

A The naval hospital already knew my involvement. So --

Q Nothing was in writing, though, was it?

A Not on a clinical standpoint, no.

Q What kind of standpoint was there a writing?

A Like I said, I talked to Commander Watson. That was the report that was given to the commanding

officer, I'm guessing.

Q You wrote a report and gave it to him?

A No, I did not.

Q So that's what I'm trying to find out. You never wrote anything down --

A No.

Q -- at all?

Okay. Prior to when you -- how long were you in service before you became an HM, hospital corpsman, involved in psychiatry?

A I was in for boot camp before I became a corpsman, and then right after I became a corpsman, I became a psych tech. So, let's see, I was in for two months. Then I became a corpsman. Then six months later, I was a psych tech.

Q During your training, did you actually come in contact with people who needed psychiatric care?

A That's my job.

Q So you did come into contact with people with psychiatric disabilities?

A Yep.

Q And were those in the emergency room, or those were people who were already in custody, or treatment of some kind?

A No. Not everybody who has a psychiatric

problem is emergent. So anybody with stress, depression, anxiety, any of those realms. I mean, I've gone from major to minor. So, you know, just needing sleep therapy or relaxation therapy. It's all around.

Q What would you have characterized the situation with Kalvin Hunt?

A What do you mean?

Q Well, I mean, anxiety, the kind of things you were just talking about.

A I'm not a doctor. I don't diagnosis people. So I don't know.

Q Well, how would you know what to discuss with the doctor after you evaluated him?

A Just from what I've been taught.

Q But you didn't characterize it one way or the other whether he needed a holiday anxiety or some other kind of anxiety?

A Right. I'm not a doctor. I don't diagnose people.

Q Okay. Do you make recommendations to the doctors?

A Right.

Q Okay. And then you are out of it after you make a recommendation?

A Yes. Once I make my recommendation, it's

the doctor's decision on, you know, what happens. I just can make a recommendation.

Q On the day that you were called or texted -- not texted.

A Paged?

Q What do you call it?

A Paged.

Q How do they get in touch with you?

A Page. A pager.

Q They paged you?

A Right.

Q You said you went to the hospital, Beaufort Naval Hospital --

A Right.

Q -- correct?

You went to the emergency room?

A Yes.

Q Is that correct?

A Yes.

Q And you did not see any papers or documents or intakes anyone else had done --

A No.

Q -- prior to meeting with Kalvin Hunt?

A No.

Q And have you since seen those documents that

maybe Mr. Berlinsky has with him --

A Yes.

Q -- regarding the emergency room intake and notes on those documents?

A Yes.

Q All right. And those documents, and I'm referring to Bates stamp 01551, 01552, 01549, 01560, 01559, those particular documents make reference to him when he was there that morning?

A Yes.

Q Wait a minute. Yeah, let me get the page I want to here that he had -- that he had or he had discussed with those people who wrote those records. Specifically starting with 01551 at the top is a form that's called "Emergency Physician Record, Psych Disorder, Suicide Attempt, Overdose." Now, was that typed onto this, this particular document, or does this document come with that already typed onto it?

A I don't know. This isn't a document I would use.

Q But, I mean, a psych disorder, suicide attempt, overdose, would that fit Kalvin Hunt?

MR. MACKELCAN: Object to the form. Doug Mackelcan.

Q (By Mr. Infinger) Does that fit Kalvin Hunt?

A I don't understand your question.

Q Those --

A Does the title of this paper fit Kalvin? I don't understand that. What does that mean?

Q What I mean is does it reflect the condition that he had? I'm looking at the stamp. It looks like a stamped or typed logo on the top of 01551. Do you have that with you?

A Yes.

Q Okay. It says, "Psych Disorder, Suicide Attempt, Overdose." Does that apply to Kalvin Hunt or did it apply on that day, February 24?

MR. BERLINSKY: Object to the form of the question.

THE WITNESS: I really don't know how to answer this question because, I mean, like the title of the paper and the evaluation, I don't understand what you're asking. I really don't.

Q (By Mr. Infinger) Okay. We'll stick to the left-hand side.

A All right.

Q That particular document, whoever completed it, it looks like a time at the top of that page. It says, "14." Is that 1400, you think?

A I don't know what they're trying to say

right there. It actually looks like something's cut off of it.
Q It looks like somebody maybe had a hole in it or something --
A Yeah.
Q -- but I don't know. But it says, "Chief Complaint: Suicidal thoughts --"
A Right.
Q "-- depression," and he came for a medication refill; is that correct?
A That's what it says.
Q And it says, "Situational problems. Patient dishonorably discharged from USMC and is appealing decision. Visiting with grandmother in Beaufort. She called Mr. Ray concerning a concern about his depression."
So he's got suicidal thoughts and depression. Then it says, "Suicidal thoughts: Only thought of hurting others, but no specific plans." Do you agree with that?
MR. BERLINSKY: Objection to the form of the question.
Q (By Mr. Infinger) Do you agree it says that?
A That's what it looks like it says.
Q And on the right-hand column, it says,

"Other problems: Alcohol, drug abuse, depression."
A Oh, wait a minute. I'm sorry. You said, "only thoughts of hurting --"
It says, "and thoughts," but not "only thoughts."
Q Okay. All right. And thoughts. That's fine with me.
A Okay. I didn't mean to cut you off. Go ahead. What were you doing?
Q "And thoughts of hurting others, but no specific plans"?
A Right.
Q Then in the right-hand column --
A Right-hand problem.
Q -- it says, "Other problems: Alcohol, drug abuse, depression, prior suicide --"
I don't know what that word is. "Gestures" or something. I don't know.
MR. BERLINSKY: Objection.
THE WITNESS: Right. Okay.
Q (By Mr. Infinger) Do you agree with that?
MR. BERLINSKY: There's no question there, is there?
THE WITNESS: Yeah, I don't know what you're saying.

Q (By Mr. Infinger) But I mean, do you agree that that's what this record says?
A That's what's written down on the paper.
Q And then on page 01552, "Physical Exam: Patient doesn't deny nor confirm ideations," and they're talking about suicide; is that correct?
MR. MACKELCAN: Object to the form. Doug Mackelcan.
Q (By Mr. Infinger) Is that what it appears to say, Mr. Manning?
A No, I don't know what that says. It just says, "ideations." So there's many ideations that we have.
Q Right, but the question says, "On direct query, patient admits/denies continued consideration of suicide as an option," and right above that, it says, "Suicidal ideation," which is typed.
A Oh, okay.
Q I can't read what's in there. It's something.
A It does say, "For suicide attempt." So, yeah. All right. I'm guessing they're talking about he doesn't confirm -- I don't know. He doesn't deny nor confirm ideations. It does say that in the box. Yes, it does. I'm sorry. I didn't understand your question.

Q So if you have seen these records prior to the time you did an evaluation of Mr. Hunt, would it have changed your decision and made him more consideration -- there had been more consideration for safety of others?
MR. BERLINSKY: Object to the form of the question.
THE WITNESS: If I would have seen this evaluation?
Q (By Mr. Infinger) If you had seen all these things involving dishonorably discharged, depression, anger, suicide thoughts, thoughts of hurting others, alcohol and drug abuse, would that have been a pretty serious problem patient?
MR. MACKELCAN: Objection to the form. Doug Mackelcan.
THE WITNESS: Would that have been a serious -- your question is weird too. I don't understand what you're asking me.
Q (By Mr. Infinger) What I'm asking you is would you have made any recommendation any different to Dr. Hendelman than you did make?
A I would have still done my -- regardless of this information, I would have still done my evaluation and made my own recommendation.

Q Regardless of what has already been said just before you got there?
A Right. Well, no. You're saying if I had these papers, would I have changed my recommendation? I would have done my own evaluation, my own safety evaluation. I mean, this would have been collateral information, but, I mean, I don't think it would have affected --
Just because they talked to them, like I said, before I even --
If before I would have done my evaluation had this paperwork, I would have still done the same thing. I'd have done my own evaluation and asked the same questions that I asked.
Q One thing I haven't heard you talk about is Bates stamp 01560, which is the chronological record of medical here. Do you have that?
MR. BERLINSKY: I'm not sure that Mr. Manning has seen that document.
Q (By Mr. Infinger) Well, this document, Mr. Manning, it has a paragraph written in it by Saundra Smith, and it says, "While appointment was being scheduled for Monday, 27 February 2012, patient began to moan and rock back and forth. I informed him that he could be seen in the ER if needed, but he declined. As

the behavior continued, I asked the patient if he felt like hurting himself and he said, 'Yes.' Patient escorted to ER and turned over to ER nurse following a brief report. Will leave pending appointment in schedule for possible follow-up care with a PCM in this area if needed."
Were you aware of that report before you saw Kalvin Hunt?
A No, I wasn't.
Q Did you have any information that he had been in the intake room rocking back and forth and moaning?
A What intake room?
Q I can't hear you.
A I said, "What intake room?"
Q Well, I don't know. Wherever this was taken. The written note written by Saundra Smith on February 24, 2012, at 1554, do you know where this was written, Mr. Manning?
A No. Do you know where it was written?
Q It just has a chronological record of medical care, and it's talking about that day. Well, it's talking about other medications, but it's talking specifically about that day. You are not familiar with that?

A No.
Q Does anybody follow behind you after you've done an evaluation?
A The doctor.
Q Pardon me?
A The doctor.
Q The doctor?
A Yeah.
Q That was Hendelman?
A No. Whichever doctor -- you said an evaluation. It would be after -- see, after a technician sees a patient, the doctor follows it.
Q That would have been Dr. Hendelman?
A In this certain situation, yes.
Q Okay. And did you have any conversations with Hendelman?
A Yes, I did.
Q And what was your conversation with him?
A Dr. Hendelman is a female.
Q Oh, okay. Her.
A I don't remember any details.
Q Would those have helped you remember what you did and what you said and what you thought?
A Notes of what?
Q Notes of your involvement with Kalvin Hunt

that day at the naval hospital.
A Like if I had what notes? What are you talking about?
Q Would it have refreshed your memory more about what went on that day? You don't remember much of anything, do you?
A I mean, not with details of conversations. I see -- I mean, I see like -- when I was at Parris Island, I was seeing like 500 patients a year. So I'm not going to remember every detail of what I talked about with a patient.
Q How many patients of that 500 killed somebody?
A I'm not sure. I don't know.
Q You never heard of any one of your patients having killed somebody else?
A No. I mean, I don't understand your question. Of the patients that I saw --
Q Have you ever been told or read or seen any information that one of your 500 patients may have killed somebody?
A No.
Q Well, you know one, don't you? You know Kalvin Hunt.
MR. BERLINSKY: Object to the form of the

question.
Q (By Mr. Infinger) You did know Kalvin Hunt, didn't you?
A I do not know Kalvin Hunt other than seeing him in the ER.
Q That's what I'm talking about. I'm talking about all your patients that would have been seen in the hospital setting or ER or wherever.
A Okay.
Q Okay. So none of those other 500 -- can you think of any of them that killed somebody?
A No, I don't.
Q Okay. I'm just hesitating because I think Paul Detrick has already asked a lot of questions that I wanted to ask.
MR. DETRICK: Let me interrupt a minute. Do you all got a fax number there, Lee, that I can fax something to you?
MR. BERLINSKY: I wouldn't have any idea. We're stuck in a conference room.
MR. DETRICK: Can anyone make that determination for me? I need to fax something to Mr. Manning.
MR. INFINGER: Do you want to step outside and ask somebody, Lee?

MR. BERLINSKY: I don't even know where these folks are. I can make a couple of phone calls. Is it something that I may have here?
MR. DETRICK: Apparently not. I didn't have it myself. It's a statement that, apparently, Mr. Manning gave that we were provided, but you may not have had it either. I'm not sure.
MR. BERLINSKY: Well, I sure would like to know if Mr. Manning has given a statement because I haven't seen one.
MR. DETRICK: I hadn't either, but I've got it now. That's the reason I want to fax it to Mr. Manning so he could look at it.
MR. BERLINSKY: Let me think of how I can find these folks. I know I can. Do you want to go off the record? Do we want to go off the record?
MR. SWETT: Do you want to come back to it, Paul, I mean, after we --
MR. DETRICK: That's fine. Why don't you ask him to go -- let him go ahead and get a fax on, if he can. If he can do that, I'll fax it immediately.
MR. MACKELCAN: You can email it.
MR. DETRICK: I can email it. That's fine.
MR. BERLINSKY: Well, that's not going to be --

MR. INFINGER: He won't be able to print it, though, right away.
MR. BERLINSKY: If you want to take a five-minute break, I'll call over to the legal contact. They might be in the same building. I just don't know where they are. They've met me in lobbies.
MR. DETRICK: At the very least, if we have to, we can email it and he can at least look at it and see if it's his signature and we can deal with it in that manner.
MR. BERLINSKY: Okay.
MR. INFINGER: Would you like a five-minute break?
MR. BERLINSKY: Okay.
MR. DETRICK: That sounds good. I'm not going to hang up, though.
MR. BERLINSKY: Just remember that everybody's on a live call.
(Recess taken from 10:19 a.m. until 10:39 a.m.)
MR. BERLINSKY: So I think it's pursuant to local Rule 30 that there was an off-the-record discussion between Mr. Berlinsky and Mr. Manning regarding a document that was just sent by email. We have not received a fax yet. But according to

Mr. Manning, he recognizes his signature on the document and indicates that it is a statement that he produced and had made a mention of this to me, and I hadn't had a chance to confirm it. So this is a confirmation that that is a document that he prepared.
MR. DETRICK: We agree with that statement, and we have no problem with Mr. Berlinsky conferring with Mr. Manning about the document.
MR. BERLINSKY: When the document gets here, we'll mark it as an exhibit.
MR. DETRICK: Okay. Cheryl says she can't get confirmation on this first fax number. What was the other fax number?
MR. BERLINSKY: Well, it's (808) 257-1829. Do you know where that goes to upstairs or no?
THE WITNESS: No.
MR. BERLINSKY: So we'll just have to track it down.
MR. DETRICK: If she gets confirmation, I'll let you all know whichever number it is.
MR. BERLINSKY: Okay. But in the meanwhile, we can pull it up on my BlackBerry. I can't make the screen any bigger.
MR. INFINGER: Let me mention one thing to

you, Lee. This is Paul Infinger. The documents I referred to with the Bates numbers, I'd like to offer those as exhibits, the Bates numbers I gave Mr. Manning.

MR. BERLINSKY: I think it's already been admitted collectively as Exhibit 1.

MR. INFINGER: Oh, okay. All right. I may have missed that.

MR. BERLINSKY: Okay.

MR. INFINGER: Paul Detrick, I'm just going to let you do anything else that's needed with your exhibit. So we're waiting right now to --

MR. SWETT: Well, we can go ahead and then come back to Paul Detrick.

MR. INFINGER: Does he got Manning there?

MR. BERLINSKY: Was that Mr. Swett?

MR. SWETT: Yes.

MR. BERLINSKY: Okay.

MR. SWETT: Is everybody present?

MR. BERLINSKY: Yes.

MR. SWETT: I guess the question is if everybody's ready.

MR. BERLINSKY: Everybody's here. That was Mr. Swett.

Q (By Mr. Infinger) All right. This is Paul Infinger again resuming the deposition. I've just got a

few questions.

Mr. Manning, when you came down and you were paged to come back to the hospital as a psych tech for the evaluation of Hunt, you did not talk to anyone about his condition or their opinions of his condition; is that correct?

A What are you talking about? At what time?

Q When he was paged to come back -- to come over to the Beaufort Naval Hospital to do an evaluation of Hunt --

A When I was paged?

Q -- you did not talk to anyone about Kalvin Hunt's conditions or what their opinions of his conditions were?

A I mean, I talked to -- I would have talked to the nurses' station and the doctor then. I just don't remember what the details of the conversation --

Q You don't remember what they might have said about his condition or what their opinion of his condition was?

A No.

Q Okay. Is it common procedure not to take notes of a psych tech evaluation for people who they're called in to evaluate?

A Is it not common practice?

Q Is it common procedure not to take notes, written notes, on a psych tech evaluation?

A No. I was saying that earlier in a clinical environment where we're in our offices, yes, we take notes, but in situations where it's in the ER, no.

Q And what's the reason for that?

A That's beyond my pay grade. I don't know.

Q That's beyond your pay grade. So you could have taken notes if you wanted to, but it's just not common procedure to do that?

A There was no resources for us to take notes. I mean, unless you bring your own pen and paper.

Q Okay. So you were missing a pen and paper?

A No, no, no. That's not what I said. That's not what I'm saying.

Q Tell me what you said so I get it right.

A I mean, it's not a common thing that we would take notes for an ER visit because we're already in the ER, and the ER are the ones that have taken notes.

Q Okay. But you hadn't seen their notes or read their notes?

A No. I have nothing to do with their notes.

Q Do you recall that Kalvin Hunt came in for a medication refill or did you know that?

A No, I didn't know that.

Q You're just learning this as I tell you?

A Oh, no. I thought you were talking about when I came to the ER.

Q No. When Kalvin Hunt came in to the Beaufort Naval Hospital that day, he was coming in for -- he was coming in, in his mind, for a medication refill?

A Right.

Q Okay. And when was he told he was going to be admitted?

A I don't know.

Q You didn't tell him?

A No. I didn't say anything to him about being admitted.

Q During your conversation with him, you didn't say, "You should be admitted and treated and --"

A No. I'm not a doctor. So I don't make those kind of decisions.

Q Okay. Did you hear any doctor tell him that?

A Did I hear a doctor tell him that? No.

Q Right. You weren't present when any doctor said, "Rather than filling your prescriptions, we're going to admit you and give you medications," or --

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A Is that what a doctor said?
Q -- something to that effect; is that correct?
A Are you saying that a doctor said that? I don't understand what you're saying.
Q I mean, did you hear a doctor tell him that --
A No, I didn't hear a doctor say that.
Q -- tell him, "Mr. Hunt," a doctor, "Mr. Hunt, you came in for medications and we're going to admit you today"?
A No, I didn't hear that.
MR. INFINGER: Okay. All right. I think that's all I have, and Paul Detrick wants to put his document -- exhibit in.
MR. DETRICK: Chris, you want to go ahead and --
MR. SWETT: Yes. Let me --
MR. DETRICK: Before you do that, Cheryl said that the second number did go through, that (808) 257-1829, if somebody wants to go check and see that.
MR. BERLINSKY: Okay. Do you want to go forward now, or do you want me to take a break and go look for that?

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MR. DETRICK: It's up to you all. I don't care.
MR. SWETT: I've only got about maybe a dozen questions. I won't be long at all.
MR. DETRICK: That's fine. However you all want to proceed.
MR. INFINGER: Chris, who do you represent?
MR. SWETT: I represent --
MR. DETRICK: Excuse me, Chris. She said that both of them ended up going through.
MR. SWETT: I represent the Estate of Justin Miller, the deceased.
EXAMINATION
BY MR. SWETT:
Q Mr. Manning, how are you, sir?
A All right.
Q Good. Good. First, I just want to say thank you for your service and let you know I'm not going to try and trick you or anything. Some of my questions may sound similar, but they're a little different. So I just don't want you to think I'm trying to trick you when I ask you and it may sound like some questions you already heard, but I assure you I'm asking them for a reason. Okay?
A Got it.

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Q I couldn't tell from your earlier testimony, after you performed your mental status exam on Mr. Hunt, were you concerned at that time that he may harm himself?
A Was I concerned that he might harm himself?
Q Yes, sir.
A I don't quite remember. I mean, I had a concern, but I don't remember my concern was that he was going to harm himself.
Q Okay. But you had a concern; correct?
A Right.
Q And that concern was such that you actually went and talked with Dr. Hendelman, and your recommendation was that he be admitted; correct?
A Right.
Q Okay. Do you recall whether you had a concern after your initial mental status exam that he may harm someone else?
A Like I say, I don't remember details of the conversation I had with him. I just remember having those -- like my concern was that he needed to go inpatient.
Q And I understand that and that's what I'm trying to get to. I'm not really asking you the conversation, but you tell me you had a concern. So I'm

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just trying to figure out if you recall what your concern may have been. Basically, if you can tell me why was it that you thought he needed to be admitted?
A Like I said, it was the demeanor -- like I said, he wasn't really -- he wasn't talking in an organized manner to me. Like I said, his body language and everything like that, that was my concern because of him not being -- like within my mental status, he had a lot of red flags as far as the cognitive part of it.
Q Okay. Do you recall whether you had any concern of any imminent action he might take; any immediate action he might take?
A No. Like I said, if it was an immediate thing like right then, right there and there was some threat or danger, the situation would have been totally different.
Q Okay. When you say the situation would have been totally different, what would have happened differently than what actually happened?
A The police would have been involved.
Q Okay. Who would have called the police?
A I would have.
Q Okay. Now, let's see here. I want you to take a look -- you've already looked at a document. I think it's Bates stamped 01549. Tell me when you find

that.
A Yes.
Q Is that a document, it looks like, by a Nurse McDonald, and it starts at the top with a time of 1430?
A Yes.
Q Okay. And I just want to try and establish a time frame here, a rough time frame if you can just help me with this. If you look at the 1525 --
A Uh-huh.
Q -- would you agree with me that this document reflects that you -- your evaluation of Mr. Hunt was in progress at 1525?
A Right.
Q Okay. Do you recall about how long your mental status exam of Mr. Hunt lasted?
A No, I don't remember exactly a time frame.
Q Okay. You don't have a rough estimate as you sit here right now?
A I mean, in a -- in a normal situation, it would probably be about 20 minutes.
Q Okay. Fair enough. Let me ask you to look at the next entry. It looks like 1612. It says -- at the beginning, it says, "Patient ambulates to the bathroom." This is basically when they said they were

going to go out and get some fresh air.
A Right.
Q Do you agree with me? Okay.
MR. MACKELCAN: Object to the form. Doug Mackelcan.
MR. SWETT: I'm sorry. Was there an objection there?
MR. MACKELCAN: Yes. Doug Mackelcan. Objection.
Q (By Mr. Swett) Okay. Let me ask you whenever Mr. Hunt left the ER, were you still present or had you already gone up to speak with Dr. Hendelman?
A When he left the ER, yeah, I was -- I wasn't -- I was still upstairs or on my way, whichever one.
Q Okay. Okay. So just to get a rough outline, your evaluation was going on about 1525. It lasted about 20 minutes or so. And by 1612, it was over. It had been over because you weren't there whenever Mr. Hunt left; correct?
A Correct.
Q Okay. Now, if you look at the 1525 entry next, this is sort of when -- would you agree with me that this is when Mr. Ray returned and stated that Mr. Hunt took off through the gate?

A You mean 1625?
Q Yes, 1625 entry.
A That's what the entry says, "Mr. Ray returned to ER."
Q Okay. And then right after that, would you agree with me that it says, "Psych tech returned approximately 10 minutes ago"?
A Yeah, I see that.
Q Okay. So let me just run through the time frame again and tell me whether or not you agree with me on this. So at 1525, you were examining Mr. Hunt. At some point, your examination ended. It ended maybe around 1545. At that time you went up to speak with Dr. Hendelman, and while you were upstairs around 1612, Mr. Hunt left the ER. Are you with me so far? You agree with that?
A Okay.
Q And then about 1615 was when you returned from upstairs back downstairs. Would you agree with me on that?
A I mean, I don't know if that's the exact time, but --
Q I understand, but would you agree with me that --
A The paper, yes.

Q -- that's basically what this document reflects?
A Right. Right.
Q Do you have any information to indicate to you that that time frame would not be accurate?
A No, I don't.
Q Okay. Fair enough. So let me ask you this. Do you recall -- there was some testimony about this earlier. When you were upstairs talking with Dr. Hendelman, as we've sort of gone through this deposition, now do you recall whether or not she came back downstairs with you or whether or not it was just you and Clifton that came downstairs?
A What do you mean?
Q Well, earlier there was a little bit of confusion. I don't think you recall. After you talked with her, you gave her your recommendation and she agreed with your recommendation that he should be admitted. You basically said that you came back down with Clifton, but there was some confusion on my part whether or not Dr. Hendelman actually walked back downstairs with you or not, and my question is would you agree with me that she didn't? It was just you and Clifton that went back down to the ER?
A Yeah. I think it might have been just me

and Clifton. I mean --
Q Okay.
A -- I don't remember that. I mean, it could be -- I think it was just me and Clifton.
Q And if you've given any statements or if any records reflect that you and Clifton walked back downstairs and there's no mention of Dr. Hendelman coming back downstairs, would you dispute those documents?
A Say that again.
Q If documents indicated it was just you and Clifton, would you have any reason to question the accuracy of those documents?
A No. I mean, if it says -- yeah. No.
Q And I guess the whole point I'm trying to get to with all this is if there is another record somewhere in these piles of records that we have that says that after speaking with you, Dr. Hendelman called Dr. Jansen at 1605 and told him that the patient obviously needed to be admitted, would you have any reason to dispute that that happened?
A No.
Q All right. So you see where that falls on on our time line? All right. So, basically, you finished your examination. You'd gone upstairs to talk

to Dr. Hendelman. Dr. Hendelman calls Dr. Jansen at about 1605, tells him that Mr. Hunt needs to be admitted, and then at 1612, document 01549 indicates that Dr. Jansen allowed Mr. Hunt to leave the ER. Would you agree with me?
MR. MACKELCAN: Object to the form. Doug Mackelcan.
THE WITNESS: I don't see where it says Dr. Jansen allowed him to leave the ER.
Q (By Mr. Swett) Okay. Well, would you agree with me that at 1612, those present in the ER with Mr. Hunt allowed him to leave their presence?
A Yes.
Q Is it common practice -- I mean, do you have procedures that you have to follow as a tech? Is there any --
Well, let me ask you that first. Is there any procedures that you have to follow as a tech, written procedures?
A Yes.
Q Okay. What are those? Are those codified or can you explain those to me?
A I mean, I don't remember the exact procedures that like from Parris Island or anything like that, but -- well, I mean, it would depend on --

What are you like looking for here?
Q Well, I wasn't asking for the specifics. I just didn't know if you all had a book that you all received or --
A Yeah. It's like a standard procedure for each clinic and all that kind of stuff.
Q Okay. Is that something individual -- would you have any reason to know if that is something individual to what you do or are other employees --
A No. It's individual -- it's individual for each section. So I mean, like, you know, just I guess the same thing for, you know, with you guys. Like your office might have a standard procedure how you want things, while Paul or one of the Pauls has a different procedure for their office. So, you know, you do the same job, but you have different procedures. So it depends on where you're at.
Q Sure. And so for Beaufort Naval with what you're doing, would the nurses or any of the doctors have the same procedures that you had?
A I don't know. I don't know their procedures. I didn't work in the ER.
Q Bear with me one moment. I don't want to duplicate any questions.
Sort of switching gears just a little bit,

prior to you starting your testimony today when we first got started, in the past month before that, had you spoken with anyone about the subject of your testimony today?
A So you're talking this past month?
Q Yes. Just in the previous month up to -- from last month all the way up to the moment you started your testimony today, had you had any conversation with anyone about your testimony today?
A No.
Q Okay. I mean, did you meet with Mr. Berlinsky yesterday to talk about your deposition today?
A Oh, yes. Yeah.
Q Okay. Who was --
Yes?
A Huh? Who was yes?
Q Oh, I'm sorry. I thought someone said something. I got some feedback on the phone. I apologize.
Who was present for that conversation?
A Myself and Mr. Berlinsky.
Q Okay. Was anyone conferenced in on a conference call or anything like that?
A Not for our talk. I mean, we checked the

phone if you're -- I don't know what you're --
Q Okay. Other than speaking with Mr. Berlinsky, have you spoken with anyone else in the past, let's say, six months about the subject matter of this testimony?
A No. I mean, other than like let my command know about what's going on? Is that what you're saying?
Q Not really. I understand that. That's okay. No, that wasn't really what I was referring to. I understand what you're saying.
Who's present in the room with you right now? I don't know if we ever got who all is there.
A It's Mr. Berlinsky and the court reporter.
Q And yourself?
A And myself, yes.
Q Okay. I believe that may be all the questions I have, Mr. Manning. I appreciate your time, sir.
A All right.
MR. MACKELCAN: Paul Detrick, do you want to go and then I go after you, or do you want me to go ahead?
MR. DETRICK: That's totally up to you all. You just tell me how you want to proceed. You want me to go ahead?

MR. MACKELCAN: Yeah, go ahead.
MR. BERLINSKY: We do not have that form yet. Do you want me to go look for it?
MR. DETRICK: It's supposed to be at both places. So, yeah, why don't you go look for it.
MR. BERLINSKY: It will take me about two minutes.
MR. DETRICK: That will be fine. I'll take a quick bathroom.
(Recess taken from 10:59 a.m. until 11:04 a.m., and Exhibit 2 is marked for identification.)
EXAMINATION
BY MR. DETRICK:
Q This is Paul Detrick, Mr. Manning. Since we obtained, apparently, a statement from you, the other parties wanted me to question you regarding that statement, and I think that you've been handed Exhibit No. 2; correct?
A Yes.
Q And have you had an opportunity to review that exhibit?
A Yes.
Q Is that a statement by you given shortly after this February 24, 2012, incident?
A Yes.

Q Tell me the circumstances regarding the giving of this statement, if you remember.
MR. BERLINSKY: Before we go forward, Paul, this is Lee Berlinsky. I just wanted to make a quick note. Seeing it for the first time, it looks like it's dated February 23rd of 2011; is that correct?
MR. DETRICK: I was going to ask him that.
MR. BERLINSKY: Okay. Well, then let's proceed until he can identify the date of when it was written because it might be that this is a protected document, and we'll just have to ask under what circumstances he was asked to write that document, but it looks like it might have been under the direction of the JAG investigation in anticipation of litigation.
MR. DETRICK: Well --
MR. BERLINSKY: So I'll let him look at that and see when it was written.
MR. FLEMING: Well, I can chime in on that.
MR. DETRICK: I'm sorry?
MR. FLEMING: I can chime in on that.
MR. BERLINSKY: Who's talking?
MR. FLEMING: This is Cory Fleming.
MR. DETRICK: Cory, if you don't mind, state for the record how this document is contained.
MR. FLEMING: This document is contained in

the criminal investigation file produced to me from the Port Royal Police Department in the criminal case, not in any civil matter.
MR. DETRICK: All right. Are we ready to proceed with the questions, Mr. Lee?
MR. BERLINSKY: Yeah. I just want to know when it was written, you know.
MR. DETRICK: All right. Well, I'll ask him that. There's no privilege here.
Q (By Mr. Detrick) Mr. Manning, as your lawyer was talking or said, the top of it says February 23rd, 2011. Do you see that?
A Yes.
Q And, obviously, it wasn't written then; correct?
A I don't know. What day was the --
Q The incident was February 24, 2012.
A Yeah. So I guess I just put the wrong date on there.
Q Is that your handwriting?
A Yes, that is.
Q Okay. At the bottom, apparently, it was faxed to someone from the naval hospital, apparently, on February 27th, 2012.
A Right.

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Q Do you see that?
A Yes.
Q Did you fax this to someone?
A No.
Q Okay. But you read it. Does it contain an accurate statement of the facts of February 24, 2012, regarding Mr. Hunt?
A Yes.
Q And it has your signature at the bottom?
A Yes.
Q And given that it was faxed -- well, do you remember when you gave this statement?
A I think it was the same night that it happened. That's when I typed it up.
Q Was this statement given to Port Royal Police Department?
A I gave it to my command. I was asked by my command to type it up.
Q Okay. Let's go through it some, if that suits you. The first sentence there says, "I was called to talk to said named member due to possible need of inpatient admission"; correct?
MR. BERLINSKY: Mr. Detrick, you have to speak a lot louder for the court reporter's benefit, please.

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Q (By Mr. Detrick) I apologize.
The first sentence in this statement says, "I was called in to talk to said named member due to possible need of inpatient admission." Do you read that? Did I correctly read the first sentence?
A Yes.
Q And does that refresh your memory now that the first call, there was concern for inpatient admission?
A Yes.
Q Does it refresh your memory there was concern about whether Mr. Hunt was a danger to himself or others --
A No, it doesn't.
Q -- therefore, needing inpatient admission?
A No.
Q You remember that now?
A No. I mean, that sentence doesn't say that he was going to hurt himself or others.
Q I wanted to -- see, sometimes statements such as this given shortly thereafter will refresh memories, and that's the reason I was asking that question.
A All right.
Q It says you spoke to the patient who did not

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seem to be able to respond in a normal manner and seemed to be in an altered mental state; correct?
A Yeah, altered mental status.
Q Mental status. I'm sorry. And you already testified to that; correct?
A Yeah. That's what the paper says.
Q And that was a part of your safety evaluation?
A Right.
Q All right. You made your safety evaluation, and you said what you basically considered regarding that safety evaluation. Had you at that point in time, after making that safety evaluation, knew that you were going to make a recommendation to Dr. Hendelman for inpatient admission of Mr. Hunt?
A Yes. After my evaluation, I did know I was going to make that recommendation.
Q Okay. And you have Mr. Hunt in the room you talked about; correct?
A Say what?
Q In your evaluation, what room did you have him in?
A We were in the ER in the third bed.
Q Third bed in the ER?
A Right.

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Q Where was Mr. Ray at that time?
A I don't know.
Q Were other personnel of the naval base or Case Pro present in the room or close there by?
A I mean, they were close, but they weren't with me and Mr. Hunt when I was doing my evaluation.
Q Okay. After you made your evaluation, did you just leave Mr. Hunt to take care of himself, or did you give any instructions to any persons regarding Mr. Hunt?
A After I got done with my evaluation, I told Dr. Jansen and the -- well, I just told Dr. Jansen that I would be going upstairs because I called Dr. Hendelman and she said she was upstairs.
Q Did you tell Dr. Jansen what your recommendation was going to be to Dr. Hendelman?
A Yes.
Q Who all was present to hear what your -- who did you communicate this recommendation to before you went to see Dr. Hendelman?
A Nobody.
Q Just Dr. Jansen?
A Dr. Jansen.
Q Is that correct?
A Right.

Q Was Mr. Ray present? Did he hear you?
A I don't remember.
Q Okay. Did you give any precautions to Dr. Jansen or any of the personnel regarding making sure Mr. Hunt did not leave?
A No. I didn't -- I didn't give any kind of specific type of thing like that.
Q Did you assume when you left and they knew what your recommendations were regarding involuntary admission that precautions were going to be made to make sure that Mr. Hunt did not leave?
A Can you ask that again?
Q Did you assume, after you told Dr. Jansen and Mr. Ray about your recommendations regarding involuntary admission of Mr. Hunt, that they were going to take some sort of precaution to ensure that Mr. Hunt did not leave before you got back?
MR. BERLINSKY: I'm going to object.
MR. FREEMAN: This is Mike Freeman. I object to the form.
MR. BERLINSKY: Exactly.
MR. SWETT: The same.
Q (By Mr. Detrick) You can answer it.
A Yes, I guess I made that assumption.
Q What did you think, Mr. Manning, that was

going to be done between -- from the time you told them of your recommendation and you were going up to see Dr. Hendelman, what did you think was going to be done to make sure that Mr. Ray was going to be there when you got back?
A Mr. Ray?
MR. FREEMAN: This is Mike Freeman. I object to the form of the question.
Q (By Mr. Detrick) If anything. Go ahead.
A Why would I except Mr. Ray to be there?
Q Okay. You didn't expect Mr. Ray. What did you expect as far as Mr. Hunt?
A That he was going to be in Bed 3.
Q How did you figure he was going to be in Bed 3? Why did you figure he was going to be in Bed 3 when you returned?
A That's where he was when I left.
Q Well, did you assume that someone, either Dr. Jansen or someone down there, was going to take precautions to make sure that Mr. Hunt was in Bed 3 when you returned?
A Did I assume that someone was going to make sure he was in the bed? I mean, I don't understand. I don't know.
Q Well, they knew about what recommendations

were going to be -- that you were going to recommend he be involuntarily admitted to the psychiatric ward of the Beaufort Memorial Hospital --
A Right.
Q -- correct?
A Yes.
Q Okay. And given that they knew what your recommendations were going to be, what precautions did you expect them to take to make sure he was going to be present after you talked to Dr. Hendelman?
MR. MACKELCAN: Doug Mackelcan. Objection.
THE WITNESS: I'm not sure. Like I said, I'm not a doctor. So my recommendation is just a recommendation. If Dr. Hendelman would have said a totally different thing, that's what was going to happen.
Q (By Mr. Detrick) But you did expect precautions to be taken by someone to make sure that Mr. Hunt was going to be present when you returned after your recommendations were given to Dr. Hendelman; correct?
A I don't know. I mean, I can't really say 'cause this is -- I mean, it was a weird situation. I don't know. I can't really say.
Q Well, you did expect Mr. Hunt to be in the

ER in the bed --
A When I came back.
Q -- after you returned; correct?
A Yes.
Q All right. Now, you left to go see Dr. Hendelman and make your recommendations to her; correct?
A Yes.
Q Okay. And Mr. Swett was going into some of the time line. So we can have the time line even a little better, how long does it take for you to go from the ER to wherever Dr. Hendelman was to make your -- to see her and make your recommendation, approximately?
A Less than two minutes.
Q Okay. And then you went up and saw Dr. Hendelman. How long did it take you to make your recommendation to her that he be involuntarily admitted?
A I'm not exactly sure.
Q Approximately.
A It could have taken 10 minutes. It depends on -- I mean, I don't remember. It could have been about 10 minutes.
Q So we're talking about approximately, give or take a few minutes, 10 minutes for you to make your recommendation to Dr. Hendelman and her accept your

recommendation; correct?
A Yes.
Q And then another two minutes for you and Mr. Clifton to go back to the ER?
A Right.
Q Is that approximately right?
A Right.
Q Okay. All right. She's told you, as you set forth in Exhibit No. 2, that she was going to recommend that the patient be sent inpatient to either Beaufort Memorial Hospital or Fort Stewart; correct?
A Yes.
Q And you would assume, since the recommendation was made to go to Beaufort Memorial Hospital, that she must have communicated that to someone before you even got to the ER; correct?
A Well, she was making arrangements while I -- you know, that kind of thing.
Q She was making arrangements while you left and proceeded downstairs, correct --
A Right.
Q -- to the ER?
A Right.
Q The next sentence in this Exhibit No. 2 says, "When I returned to the ER accompanied by HM --"

Excuse me. Let me back up. The sentence -- I missed a sentence. I apologize.
The next sentence, "I also asked HM Clifton to assist me as I was not comfortable with the patient's mental state and his somewhat unpredictable demeanor"; correct?
A Correct.
Q And you already testified that you were concerned about danger to himself or danger to you and possibly Mr. Clifton as the reason you asked Mr. Clifton to accompany you; correct?
A Yes.
Q And then the next sentence says, "When I returned to the ER accompanied by HM Clifton, the ER staff reported that he had left with VA officer for a walk, but no one had seen them return." And then it says, "HM Clifton and I walked to the quarterdeck and HM1 Ballinger, the COD, to report that it was possible patient eloped from the ER."
A Right.
Q Did I read that correct? Is that a true statement?
A Yes.
Q And so at that time, you had concerns about whether Mr. Hunt had eloped from the ER; correct?

A Right.
Q What do you mean by the word "eloped"?
A It means that he left or he -- yeah, he left.
Q He ran away somewhat.
MR. BERLINSKY: Object to the form of the statement.
Q (By Mr. Detrick) Okay. I'll withdraw that. But that was before you had these concerns about -- why?
A Say what? I'm sorry.
Q Why did you have those concerns -- that someone in the ER said that he and the VA officer just left for a walk, why did you have concerns about the patient eloping?
A I mean, I'm guessing in the time line, it was after he had not come back for a while.
Q Okay. Were you informed by people in the ER that Mr. Hunt -- it had been a while since he had left the ER?
A I don't remember any kind of details of someone telling me like that.
Q But you had those concerns as a result of that; correct?
A Correct. Yeah. I had that concern.

Q And this is before the VA Officer Ray had come back and said he had gone --
A Right.
Q -- correct?
A Right.
Q You already -- and then next sentence says you went to the quarterdeck and you asked them to call the code right then; correct?
A Right.
Q And that was before -- again, before Mr. Ray had even told anybody that Mr. Hunt had run?
A Right.
Q And then at that time before Mr. Ray even told anybody that Mr. Hunt had run, you started your search outside on the hospital grounds; correct?
A Yes.
Q You and Mr. Clifton?
A Yes.
Q Tell me about that search. What did you find?
A Nothing. We drove around. We didn't see anything.
Q You didn't see the clothing or anything? I think you already testified to that; correct?
A Right.

Q And then when it says, "When we returned from searching the immediate area, that's when the VA officer was back in the ER and reported that the member did run from him when they were outside and he could not keep up"; correct?
A Right.
Q We got a correct time line now. You already knew he or thought he had run or eloped before Mr. Hunt -- I mean, before the VA officer had stated to you that he had actually did run; correct?
A Correct.
Q And then it says, "I reported the situation to DFA Commander Bristol and Chief Geter who were walking down the hall."
A Right.
Q Who are they?
A The DFA, he's one of the directors. I can't remember what FA stands for. Dang it. What is FA? And Chief Geter was just my chief.
Q Next sentence refers to a Captain Simmer. Who is that?
A Captain Simmer, he was the executive officer. He's also a psychiatrist.
Q Okay. All right. We have this report which now you've testified to. Are there any other reports

that you made that you haven't told us about?
A No. This -- no.
Q Now, Mr. Manning, whenever -- would you consider this, whenever Mr. Hunt came to see you or was sent to you or you went to him really, an evaluation and disposition of a person with suicidal inclinations or behavior? Would it come under that standard or subject?
A Can you repeat the question again?
Q All right. Would the subject of your evaluation come under an evaluation disposition of persons presenting with suicidal --
I can't pronounce it.
A Ideations?
Q -- inclinations or behavior?
A Suicidal ideations, yeah.
Q Yeah, ideations. Yes, sir.
A Right.
Q Would you agree that's what Mr. Hunt was when you evaluated -- that's what kind of evaluation this was?
A Yes.
Q And are you familiar with Naval Hospital Directive 6520.1F?
A I mean, I heard it. I don't know it word for word or anything like that.

Q On No. 3 of that, doesn't it require that any evaluation and assessment that you make under those subject matter that you said you agree with me on will be made on an SF 600 in the patient's medical record?
A Which is what -- which is what the ER would do.
Q Doesn't it require you to do that?
A No. Like I said, in this situation, it's the ER. In my office, I would -- if he was seen in mental health, then that would be my note, but this was the ER's patient and it's the ER that does that.
Q Then let me ask you this. It says here -- I'll read it for you. Tell me if I'm reading what is required policy under 6520.1F for Mr. Hunt's evaluation.
No. 3 says, "Upon completion of the mental health evaluation," first it says, "the member's command will be notified of the finding, typically by telephone contact with his supervisor or division officer," period. "Documentation of the evaluation and assessment will be made on SF 600 in the patient's medical record and, when necessary and appropriate, in official correspondence to the command."
A Who is that command?
Q Did I correctly read what is required on the evaluation you did with Mr. Hunt?

MR. BERLINSKY: Mr. Detrick, I pulled out my copy of that so that Mr. Manning could read along, but since you're not in the room, and I just wanted the record to indicate that I pulled this instruction out.
MR. DETRICK: I do appreciate that. I'm glad you did that. I wasn't aware that you had it with you. I'm sorry. Maybe I should have asked before I started the question.
You got that in front of you?
MR. BERLINSKY: He's got my copy of it.
MR. DETRICK: Yes.
THE WITNESS: Okay.
Q (By Mr. Detrick) Did I correctly read No. 3 of that --
A Yes, you did.
Q -- policy?
MR. INFINGER: Paul. Paul Detrick, is that part of the Bates stamped documents?
MR. DETRICK: No, it's not. I'm sorry.
MR. INFINGER: Okay. All right. Go ahead. I'm sorry.
Q (By Mr. Detrick) I correctly read that policy; correct?
A Yes, you read No. 3 correctly.
Q And that policy should have been followed in

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the mental health evaluation of Mr. Hunt, shouldn't it?
A No.
Q Why is that?
A One, he wasn't active duty at the time.
Q He was considered a service member, and he appealed his decision as set forth; correct?
A I mean, at that time, I don't think so. I don't think we were treating him as active duty, though.
Q Okay. This applies to service members; correct?
A Yeah, number --
Q What you have in front of you, 6520.1F?
A No. 3, yeah, you're reading under "Active Duty Personnel."
Q Right. I mean, it applies to service members; correct?
A To active duty personnel.
Q I'm saying it applies to marine recruits too. What classification do you consider him that --
He was entitled to benefit as a military personnel, as a service member. So what classification did you consider him to where he would not come under this standard?
A From what I understand, he wasn't -- he was like on appellate leave for discharge or something like

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that.
Q So you disagree that you were supposed to --
Wait a second. Was an SF 600 supposed to have been filled out?
A From what I see, it was, though. That's what you have in like this --
Q Okay. If the SF 600 was supposed to be filled out, and I think it was filled out by the first nurse that saw him; correct?
A The first nurse who saw --
Q That's what you're referring to is 01559 and 01560; correct?
A Yes.
Q And that is an SF 61; right? I mean 600.
A This is a version -- that's the electronic SF 600, yeah.
Q Okay. Well, it was required to be filled out by her. So, apparently, Standard Form 600 applied to Mr. Manning -- I mean, Mr. Hunt; correct?
A Excuse me? You're talking about the ER, though. I think that's where the confusion is coming in. Like the instruction, yes, it says that, but we were in the ER at the time. So it was the ER's responsibility is the one to record what's going on

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because it is their patient.
Q Isn't it your responsibility to see that the ER documented your evaluation and assessment?
A No.
Q Well, how are they going to know what to document on SF Form 600 about your evaluation and assessment if you don't tell them?
A My evaluation goes to the psychiatrist.
Q Did you expect after your evaluation or assessment, did you expect that a Form SF 600 should have been completed by the ER?
A My evaluation has nothing to do with the ER. It goes to the psychiatrist, and then the psychiatrist off of that, off of my evaluation and recommendation, she will make her own if she's going to see the patient or --
Dr. Hendelman we're talking about.
-- would make her recommendation from there, which would be recorded in the notes of the ER. We didn't even make it that far.
Q You did make it that far, Mr. Manning, because you knew that Dr. Hendelman had already recommended inpatient admission of Mr. Hunt and, as a matter of fact, was in the process in front of you of making arrangements for that admission; correct?

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A Right.
Q And so either you or Dr. Hendelman, someone by the rules and standards and policies, should have put something in writing because that recommendation had been made, arrangements had been already entered into, and there should have been something in writing regarding either your evaluation and admission and assessment and Dr. Hendelman's recommendation for admission, shouldn't it? It should have been in writing, should it not?
MR. BERLINSKY: Object to the form of the question.
Q (By Mr. Detrick) Should it not have been in writing, Mr. Manning, in some manner?
A But it's in the ER note that we were -- of what was happening. Everything that we did was in the ER note, and then after that, he was gone.
Q Where is there anywhere that you could point to me in the ER note which you have before you in Exhibit No. 1 that sets forth your evaluation and assessment? Could you please point that out to me and Bates stamp number?
A "Psych Tech Manning, Eval in Progress."
Q Okay. What else?
A That's me doing my evaluation.

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Q Yes, sir. Where is it in your assessment?
A What are you asking?
Q Well, should your assessment have been in writing --
A No.
Q -- like what the standard requires?
A Like I said, my assessment, it's not a part of that. My assessment is for the psychiatrist.
Q What about the assessment of the psychiatrist, whenever she recommends, as a matter of fact, and makes arrangements for involuntarily committal, shouldn't that have been in writing?
MR. BERLINSKY: Object to the form of the question.
THE WITNESS: What assessment did the psychiatrist make?
Q (By Mr. Detrick) She made an assessment of his involuntarily admission of Mr. Manning (sic) for some reason which we don't have because we don't have the writing.
A Dr. Hendelman made a recommendation for him to be put inpatient. She didn't make an assessment.
Q Doesn't she have to make some sort of assessment before she could involuntarily admit a military serviceman?

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A Dr. Jansen and Dr. Hendelman spoke, and she also got my collateral information from me talking to the patient and she made a recommendation. That's not an assessment.
Q So you disagree with me that should have been in writing by Dr. Hendelman for you, or do you disagree with that?
A I'm saying that it was documented. That's what I'm saying.
Q Again, I'll back up and we'll get off this line of questioning. Where is this assessment of Mr. Hunt anywhere in the documentation that I can look at?
A It says, "Psych Tech Manning, Eval in Progress."
Q Is there any specifics in the record regarding what you found on your evaluation or even what kind of evaluation you did?
MR. BERLINSKY: Object to the form of the question.
THE WITNESS: That's where the recommendation for him to go inpatient.
Q (By Mr. Detrick) Where is that? If you would point that out to me and --
A That's what Dr. Jansen -- Dr. Jansen said

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that he talked to Dr. Hendelman.
Q Specifically read that and tell me -- I know that's in there. Tell me what you see specifically regarding Dr. Jansen's notes.
A Dr. Jansen says, "Discussed with Dr. Hendelman. Time 1605."
Q That's 01552?
A Yep. 01552.
Q And read where that is and tell me where it's at.
A Progress -- in his progress notes, he said, "Discussed with Dr. Hendelman 1605."
Q That's all there is as far as anything in the records regarding any kind of assessment or evaluation?
A Then in his clinical impression, it says, "Patient left ER --"
Well, whatever the rest he says right there, that's basically what happened.
Q (Inaudible.)
A Huh?
Q You're talking about the part that says at the bottom, "Clinical Impression --"
A Right.
Q "-- patient left ER and escaped from Case,"

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I guess, "case of Mr. Ray -- care of Mr. Ray"?
A Oh, is that what that says?
Q Is that what you're referring to?
A Yes. That's his clinical impression.
Q Do you consider that a documentation of your assessment and evaluation --
A My assessment --
Q -- what you just said in the record?
A What I did for -- with Mr. Hunt only went to the psychiatrist. That was only for the purpose of the psychiatrist.
Q I meant to ask you, and I'll leave you alone about that, 01554, it says something about LWCC. Do you know what that means?
A Hold on. Where are you at again?
Q It's on 01554. At the very bottom, "Discharge Instructions," do you know what those letters mean, LWCC?
A I mean, I'm not like perfect, but I'm pretty sure that means left without being seen.
Q You had mentioned something about a report to your Commander Watson. Are you referring to what we now have as Exhibit No. 2, or is there something else?
A No. Talking to Commander Watson, I don't know. I think that was just something for the CO. I

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don't know what that was. He just sat down and was like asking questions.
Q What is Commander --
Is it Watson, W-a-t-s-o-n?
A Right.
Q What's his name, do you know?
A No, I don't.
Q What is his -- do you know where he is? Was he at Beaufort Naval Base?
A Yes, he was.
Q Do you know was he there when you left?
A I don't know.
MR. DETRICK: All right. That's all I have.
EXAMINATION
BY MR. MACKELCAN:
Q Mr. Manning, my name is Doug Mackelcan. I represent a company called Case Pro in these lawsuits, and I've got a few questions for you as well.
A Okay.
Q Do you need to take a break for any reason, or should we just keep going?
A No. Go ahead. Sorry. Hold on.
MR. BERLINSKY: The court reporter has indicated the need to rest her fingers.
MR. MACKELCAN: Okay. Let's take five

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minutes then. If people need to use the restroom or whatever, we can do that and start up in five.
(Recess taken from 11:37 a.m. until 11:42 a.m.)
Q (By Mr. Mackelcan): Mr. Manning, when were you born?
A February 1st, 1987.
Q Where did you grow up?
A Tampa, Florida.
Q What year did you enter the military?
A 2007.
Q Did you graduate from high school?
A Yes.
Q Where did you go to high school?
A Blake High School in Tampa.
Q What year did you graduate?
A 2005.
Q What did you do between 2005 and 2007?
A Work.
Q Where did you work?
A So many places, it's ridiculous. I just jumped around jobs.
Q Why did you decide to join the military?
A Excuse me?
Q Why did you decide to join the military?

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A I wanted a job I couldn't quit.
Q Where did you go to boot camp?
A Great Lakes.
Q Where is that?
A Chicago or Illinois.
Q And then were you stationed in Parris Island immediately out of boot camp?
A No. I went to Virginia for training.
Q Where in Virginia?
A Portsmouth.
Q How long were you there?
A About eight, nine months.
Q And then how long at boot camp?
A Boot camp is like two months.
Q Then after Virginia, you went to Parris Island?
A Yes.
Q Do you remember generally when you started at Parris Island?
A In like August. August, September. It was September maybe.
Q What year?
A 2008.
Q And were you a psych tech right from the start at Parris Island?

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A Yes.
Q You had already done your training for psych tech?
A That's where I came from. I went from training as a psych tech to Parris Island.
Q Do you have any family in South Carolina?
A No. Not that I know of, anyway.
Q Did you go to Hawaii from Parris Island?
A Yes.
Q So in your -- are you currently still a psych tech?
A Yes.
Q Okay. All right. Starting in August of '08 through February 24, 2012, I believe you said you saw approximately 500 patients a year; is that right?
A Just about.
Q You saw over 1,500 patients probably in the time you were at Parris Island before you saw Mr. Hunt?
A Yes.
Q Okay. Had you dealt with patients that had anxiety?
A Had I dealt with them? Yes.
Q Had you evaluated patients with depression?
A Yes.
Q Had you evaluated patients with PTSD?

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A Yes.
Q Had you evaluated patients with suicidal ideations?
A Yes.
Q How would you define suicidal ideation?
A Suicidal ideation is just -- how would I define it? Okay.
Q Well, what is your understanding of what suicidal ideation is?
A It's basically a person with a thought that they would take their own life.
Q Is there any time frame for suicidal ideation?
A Is there a time frame? What does that mean?
Q Well, what I mean by that is in order for that to be the diagnosis or the evaluation, does the thoughts of suicide need to have happened within the last 12 hours, 24 hours, week, you know, month? I mean, how is that part of the evaluation?
A No. I mean, if a person had a thought of killing himself a year ago, that's still considered a suicidal ideation.
Q So that doesn't mean that somebody is thinking of killing himself right now?
A No.

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Q Have you ever evaluated a patient prior to seeing Mr. Hunt who had suicidal plans?
A Suicidal plans? Yes.
Q Okay. And have you had any experience with patients that had suicide attempts?
A Yes.
Q And I'm going to jump around a little bit. I heard a lot of questions. So I apologize if I shift gears quickly on you, but when you were at Parris Island, had you ever heard of a company called Case Pro?
A No.
Q In this deposition, you have referred to your recommendation and I believe -- or Dr. Hendelman's recommendation that Mr. Hunt would be inpatient at Beaufort Memorial Hospital; is that correct? You used the word "inpatient"?
A Right.
Q Some of the lawyers that have asked you questions have been using the term "involuntary admission."
A Yes.
Q You heard them use that?
A Yes.
Q Okay. Those two terms, "inpatient" and "involuntary admission," are not the same thing necessarily, are they?

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A No.
Q Okay. Is it possible that a patient could -- well, let's say is it possible that you could have come down to the ER and Mr. Hunt was seated in Bed 3, and you could have said to him, "Mr. Hunt, we think you need to be admitted at Beaufort Memorial Hospital. We'd be happy to give you a ride over there," and then he would just go and be admitted? Is that possible that it could work out that way?
A Yes.
Q Okay. So in that circumstance that I just described, that would not have been an involuntary admission; right?
A No.
Q So we don't really know if he was going to be involuntary -- involuntarily admitted or not, do we?
A At the time, yes, we did.
Q Why is that?
A Because once the recommendation was made, there was going to be -- it wasn't a question. He was going to go.
Q But you just answered my question to say that he could have agreed with the plan, in which case it would not have been involuntary; it would have been

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voluntary; right?
MR. DETRICK: I object to the form of that question. It misstates your question.
THE WITNESS: You were saying -- you're saying in a situation, can a patient be in the ER and they say, "Hey, I want to be admitted"? Then, yes, that's a voluntary admission. But when the recommendation came from the doctor, if he was like, "No, I don't want to go to the hospital," there is no, "No, I won't go." It's, "You're going to the hospital. You're going to be admitted."
Q (By Mr. Mackelcan) I understand that.
A So that's involuntarily admitted.
Q I believe you testified that you never told Mr. Hunt one way or the other what was going to happen to him; is that correct?
A Right.
Q You never said to him, "You're going to be admitted"; right?
A No, I didn't.
Q And you're not aware of anyone that ever said to him he was going to be admitted?
A Right.
Q Okay. So my question is do you know whether or not he would have agreed for admission?

A Do I know if he would have agreed? No, I don't.
Q I understand that your testimony was that one way or the other, he was going to go over there, and I understand that. But my question is you really -- you really don't know whether it was involuntary or not because it could have been voluntary?
MR. DETRICK: Object to the form of this question. It was already asked and answered.
THE REPORTER: Who else is objecting?
MR. MACKELCAN: You can answer the question.
MR. DETRICK: This is Paul Detrick. I'm sorry.
MR. BERLINSKY: It was echoed.
THE WITNESS: What's the question again?
Q (By Mr. Mackelcan) The question was are you aware of Mr. Hunt's being given the option of admission or not?
A No.
Q Okay. So the question was so we don't really know one way or the other whether it was going to be voluntary or involuntary because he was never given the option; is that correct?
A No.
MR. DETRICK: I'll object to the form of

that question as already asked and answered. This is Paul Detrick.
THE WITNESS: There was no -- there was no option. The recommendation was made.
Q (By Mr. Mackelcan) So the recommendation was for him to be inpatient at Beaufort Memorial Hospital?
A Right.
Q Okay. If you felt that after your safety evaluation of Mr. Hunt that he needed to be restrained, what would you have done?
A If I felt what? There was never an evaluation that you're going to feel that a patient needs to be restrained. I don't get -- that didn't make sense. I don't get your question.
Q If you were conducting a safety evaluation of a patient that you feel presents an immediate risk to himself or others around him, what action do you take?
A You call the police.
Q But you do not feel that was necessary in this circumstance?
A No.
Q Could patients have been -- this is a general question. Could patients be sent to Beaufort Memorial Hospital for psychiatry without being evaluated by a psychologist?

A Not on my call. So like you're saying if a person wants to go to Beaufort Memorial?
Q Yes.
A Yes. I mean, if you're just some Joe Schmo walking down the street and you want to go to Beaufort Memorial, then that's your choice.
Q How about in an involuntary situation?
A What do you mean?
Q If you were going to have a patient involuntarily admitted to Beaufort Memorial, does a psychiatrist need to evaluate the patient?
A Yes. Well, not really that a psychiatrist needs to evaluate the patient, but the psychiatrist or psychologist has to make that recommendation. They have to be consulted with at least.
Q So is it common practice for a psychologist or psychiatrist to make recommendations without actually seeing the patient?
A Is it common practice for them to make the recommendation without them seeing the patient?
Q Well, was it common practice at that time is the question.
A Yes.
Q What is the distinction between Dr. Hendelman giving a recommendation and issuing an

order?
A Giving a recommendation or issuing an order?
Q You had clarified one of the questions that was asked earlier and said that she had given a recommendation. She hadn't given an evaluation or she hadn't given some sort of -- now I'm trying to look for the word that you used. You specifically said that she made a recommendation that he be admitted, and I'm wondering what's the distinction? What's the difference?
A Well, doctors don't give orders. Like if your doctor ordered you to get a surgery, would you just do it? Like it's a recommendation. But her recommendation was to -- the patient was in the ER. So it's Dr. Jansen's patient. So when Dr. Hendelman was consulted basically through me, she gave the recommendation this person needs to be inpatient, and then the recommendation is put to Dr. Jansen in which we would do the escort for the inpatient, but the patient has no choice in that.
Q I guess who makes the final decision of what happens with the patient?
A That would have been -- that would have been Dr. Jansen: But I mean, it's not like Dr. Jansen going to be like, "I disagree with you, Psychiatrist, because,

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you know, I don't trust your word," or something like that. That's not going to happen.

Q So, typically, the doctor would follow the recommendation of the psychiatrist?

A Right. And this was a concern for safety. So he had no choice.

Q You testified that you had not reviewed any of Mr. Hunt's medical records. Would you typically review a patient's medical records before doing your safety evaluation?

A No.

Q Do you recall when you first found out why Mr. Hunt was at the naval hospital?

A Do I recall first finding out?

Q Yes.

A Not any details, but what are you -- like when I first walked in the door?

Q Well, the record we discussed earlier said that he was there for a prescription refill.

A Okay.

Q And I was just wondering when you first found out that that's why he was there.

A I don't know. I don't know. I don't think I ever found out that he was there for a prescription refill. That's not what I was there for.

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Q When you were speaking with Dr. Hendelman and making your recommendations, was Dr. Jansen present for that conversation?

A No. He was in the ER.

Q Okay. How about either of the ER nurses, were they present for your conversation with Dr. Hendelman?

A No.

Q When you left the ER to go speak with Dr. Hendelman, did you give any specific instructions to either of the nurses or Dr. Jansen?

A No.

Q I'm a little unclear as to whether Dr. Hendelman was planning to come to the ER or not with you and Clifton. Do you know if she intended to evaluate Mr. Hunt or not?

A No, I don't.

Q Are you aware of any naval hospital policy that was broken by either of the ER nurses or Dr. Jansen?

A Say that again.

Q Are you aware of any naval hospital policies or procedures that were broken by or not followed by either of the ER nurses or Dr. Jansen?

A No.

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Q Had you worked with either of the ER nurses or Dr. Jansen in the past?

A Possibly. I mean --

Q You didn't know them personally, though?

A No, I don't know them personally.

Q Was there anyone else in psychiatry other than Dr. Hendelman who had any involvement in deciding how to treat Kalvin Hunt?

A Not that I know of.

Q Did you speak with anyone else other than Dr. Hendelman about Kalvin Hunt?

A No.

Q I asked you before of your experience with psychiatric patients while you were stationed at Parris Island. Did you have as of February 24, 2012, experience with patients with homicidal ideation?

A Yes.

Q How about homicidal plans, did you have experience with that?

A Yes.

Q Is it fair to say that Kalvin Hunt did not present you with a situation that you had not been in before or experienced?

A Yes.

Q That's all I have. Thank you for your time,

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Mr. Manning. Appreciate it.

A All right.

MR. BERLINSKY: The only person left is me. This is Lee Berlinsky. Is there anybody on the other end of the phone that may have questions for Mr. Manning?

MR. FREEMAN: This is Mike Freeman. I don't have any questions.

MR. FLEMING: Cory Fleming. I don't have any questions.

MR. SAWYER: Wesley Sawyer. I don't have any questions.

MR. BERLINSKY: Just give me one or two minutes. I just want to correct a couple of things for the record if I can.

EXAMINATION

BY MR. BERLINSKY:

Q Mr. Manning, if you look at Exhibit No. 1 and just flip through a couple of the nurses' progress notes up in the top pages, there's been a reference that you made to Mr. Manning (sic) being in Bed 3 or Room 3, and I just wondered if you could look at any of those documents and see if you needed to correct the record. Specifically, you can look at 1547 at the top or --

MR. DETRICK: Object to the form.

MR. BERLINSKY: I'm just trying to muscle through.
MR. DETRICK: This is Paul Detrick.
MR. BERLINSKY: I don't want to lead too much. I just want to save the memory of the court reporter's stenography equipment.
THE WITNESS: Oh, right here?
Q (By Mr. Berlinsky) Correct.
A All right.
Q Does that give you a better indication that the records may have accurately depicted what room Mr. Manning was -- Mr. Ray was in versus your memory going back a couple of years?
A Yeah. Well, I mean, yeah. There are four -- there are four beds in ER, but one room is like off to the back and it's for like -- it's a separate room, and then there are three beds that are in the front. So Room 1 is the back room, and then 2, 3, 4, but that's why I said Bed 3 because there's numbers 1, 2 and 3. But, yeah, it was Bed 4.
Q Okay. And you were describing for Mr. Detrick a truck or you called it a rig that has lights and a siren. Are you talking about an ambulance that would transport Mr. Ray to the hospital?
A Mr. Hunt?

Q Mr. Hunt.
A Yeah.
Q Is that a typical ambulance that would be at the access for the Beaufort Naval Hospital or the Beaufort Memorial Hospital?
A The naval hospital.
Q And so are you tasked with transportation of Mr. -- would you have been tasked with transportation of Mr. Hunt, or are you there as a person that sits in the back?
A No. I will be the person to transport him.
Q You're driving the ambulance?
A No. No, no, no. The duty drivers would drive, but I am responsible for him. Like I'm the pass-off.
Q Well, I want you to think about the question I just asked you. I'm asking you are you driving the ambulance with Mr. Hunt?
A No.
Q Okay. Are you in the back with Mr. Hunt?
A Yes.
Q Are you an escort?
A Yes.
Q Okay. When Mr. Detrick asked you that question, you made it sound like you were driving an

ambulance, and I just want to make sure that you are clear on your answer.
A Okay.
Q Okay? And Mr. Mackelcan was asking you a question to distinguish between an involuntary admission and an inpatient admission. Do you remember those questions just recently?
A Yes.
Q In this case, you agree with the testimony that you provided earlier that this discusses an inpatient admission of Mr. Hunt, does it not, the medical records?
A The medical records?
Q The medical records that are Exhibit No. 1, those discuss --
A An inpatient.
Q -- inpatient admission?
A Right.
Q Other than Mr. Detrick and maybe Mr. Infinger using the word "involuntary admission," did you see anything in those medical records that discuss an involuntary admission?
A No.
Q Okay. Now, there was questions regarding the medical records about Mr. Hunt having a suicidal

ideation and also thoughts of hurting others, but no specific plan, and that was on page 1551. Do you remember those questions?
A Yes.
Q And do you have that record in front of you?
A Right.
Q During your evaluation, did Mr. Hunt make any specific threat to any identifiable person or readily identifiable third party?
A I don't remember any details of the conversation we had, but in my actions, I can say that he wouldn't have made that statement to me because it would have went a different direction.
Q Well, I don't understand what that means.
A Like if he would have made direct threats to a third-party person, then it would have been like -- it would have been a legal issue instead of just a mental health issue.
Q If he would have made a statement that specifically threatened a third party or a readily identifiable third party, are you indicating that that statement would have triggered a response by you to have called law enforcement?
A Well, not law enforcement, but it would have been a legal issue because I would have had to have

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identified the third party and then get the chain of command involved, in which that's when PMO would have been involved.

Q Did you get the chain of command or the PMO involved?

A No.

Q Okay. Does that lead you to believe that he did not make a readily identifiable threat or specific plan to hurt someone else?

A Yes.

Q And if you look at the bottom of Dr. Jansen's note that Mr. Detrick was asking you about on page 1552, do you see Dr. Jansen's signature on the bottom of that page?

A Yes.

Q And do you see a time stamp just above that?

A Yes.

Q And what time stamp is that?

A 1620.

Q Okay. And if you look back at his notes of progress, do you see the note that's time stamped at 1540?

A Yes.

Q And I think it's been read into the record. "Mr. Manning present. Evaluating patient," is that what

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that says, or the best that we can determine since Dr. Jansen is not here to testify to his writing?

A Correct.

Q And I believe you testified that after that evaluation, you went up to talk to Dr. Hendelman; correct?

A Right.

Q And do you see on this document your indication that -- an indication that Dr. Jansen discussed with Dr. Hendelman at 1605 Mr. Hunt's patient progress?

A Yes.

Q Okay. Would you have seen Dr. Jansen's medical records that he wrote at 1620?

A No.

Q So you didn't know what's in this record until you saw it here today at the deposition?

A Right.

Q And when Mr. Detrick asked you if you were familiar with these documents earlier, when did you first see these medical records?

A Yesterday.

Q And did you specifically look at each and every page and try to identify what these writings were yesterday?

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A I tried. I couldn't read any -- I couldn't read most of it.

Q Okay. All right. If Dr. Jansen wrote an addendum to this 1552, which means a supplemental report, you don't have any indication as to what he did after this report, do you?

A No.

Q And if it's in the record, then it's in the record; right? You wouldn't have seen it --

A Right.

Q -- other than maybe in preparation for a deposition?

A Right.

MR. BERLINSKY: Okay. I don't have any other questions of Mr. Manning at this time.

MR. DETRICK: I don't have any further questions. This is Paul Detrick.

MR. INFINGER: Paul Infinger. I do have one or two questions. You ready?

THE WITNESS: Yes.

EXAMINATION

BY MR. INFINGER:

Q Mr. Manning, when you went into the -- after being paged and you went from Parris Island over to the Beaufort Naval Hospital and you understood you were to

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do a safety evaluation, could you have asked emergency room personnel to let you look at whatever records they had that they had just gotten for Mr. Hunt?

A Could I have asked?

Q Yes. Could you have asked them -- is there any reason they would not have let you look at the records they had?

A I'm not sure. That's not something that's a procedure that we would follow.

Q But if you wanted to look at the records because you had somebody there for a psychiatric evaluation, you could have asked for those records, whatever they had, a couple of pages, whatever they had that morning and looked at them; is that right?

A Well, it was in the afternoon. It wasn't morning.

Q Afternoon then.

A Like I said, I'm not sure. That's not a procedure that a technician would follow. If I was a doctor, that might be something, but I'm not a doctor. I'm a technician.

Q Well, they aren't doctors either, the ones who took the initial -- the notes, the intake notes.

A Right.

Q There's no reason, no legal reason you know

of that you couldn't have looked at those if you wanted to, is there?

A Like I said, I'm not sure. That's not a procedure that a technician will follow.

Q In all your time as a psych tech, you've never asked to look at notes or records or anything when you went in to evaluate somebody?

A In an ER? No.

Q So if they had threatened somebody in the ER, you wouldn't know about it?

A If he had threatened somebody before I got there, that -- he would have been in handcuffs. They would have called the police.

Q Well, I mean, it depends on how the threat was, wouldn't it?

A If he's directly -- if he immediately threatened somebody right there while they're waiting for me to get there.

Q What if he said, "I might hurt some other people"?

A But that's not a direct threat. He's saying, "I might hurt some other people."

Q You don't view that as a threat?

A No. It is a threat, but I mean, there's no direct threat. It's just that's the same as somebody

saying, "I'm going to kill myself."

Q I understand that, but since he had already made a statement to that effect before you got there, Mr. Hunt had --

MR. BERLINSKY: Objection.

Q (By Mr. Infinger) -- that he might hurt himself or others, you weren't interested in knowing that, were you?

MR. BERLINSKY: Objection to the form of the question.

THE WITNESS: I was interested. That's why I went in and did my evaluation, and I would have asked him questions.

Q (By Mr. Infinger) I know, but it would have been helpful if you had known that before you did your evaluation, wouldn't it?

A Not really.

Q Not really? It wouldn't have helped you any?

A Not really.

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

MR. DETRICK: Anybody have any questions?

MR. FLEMING: Nope.

MR. DETRICK: I want to know when Lee's

coming back.

MR. BERLINSKY: We're off the record?

MR. DETRICK: Yeah, we're off the record.

(Whereupon the proceedings were adjourned at 12:15 p.m.)

I, the undersigned, ARTHUR MANNING, being first duly sworn say:

I have read and/or had translated the foregoing deposition and know the contents thereof, and I certify that the same is true of my own knowledge, except as to those matters which are therein stated upon my information and belief, and as to those matters, I believe it to be true.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on _____, 2014, at _____

_____

ARTHUR MANNING

Signed before me this_____day of_____, 2014.

_____

Witness to Deponent's Signature

Miller, et al., vs. Case Pro, et al.
Civil Action No. 9:13-3395-DCN, etc., May 22, 2014
by Laura Savo, RPR, CSR

CERTIFICATE

STATE OF HAWAII)
) ss.
CITY AND COUNTY OF HONOLULU)

I, LAURA SAVO, a Court Reporter in and for the State of Hawaii, do hereby certify:

That prior to being examined, the witness herein, ARTHUR MANNING, was sworn by me to testify to the truth, the whole truth and nothing but the truth;

That the foregoing deposition was taken down by me in machine shorthand at the time and place herein stated, and was thereafter reduced to typewriting under my supervision;

That the foregoing is a full, true and correct transcript of said deposition;

That pursuant to Rule 30(e), if signature was requested by the witness or by counsel, the witness was notified through counsel, by mail, or by telephone to appear and sign; that a signed copy of the changes made will be appended hereto; that if the transcript is filed without signature, either the reading and signing were waived by the witness and all parties, or the witness has failed to appear and the original has been sealed unsigned.

I further certify that I am not of counsel or attorney for any of the parties to this case, nor in any way interested in the outcome hereof, and that I am not related to any of the parties hereto.

Dated this 3rd day of June, 2014, in Honolulu, Hawaii.

LAURA SAVO, RPR, CSR NO. 347
STATE OF HAWAII

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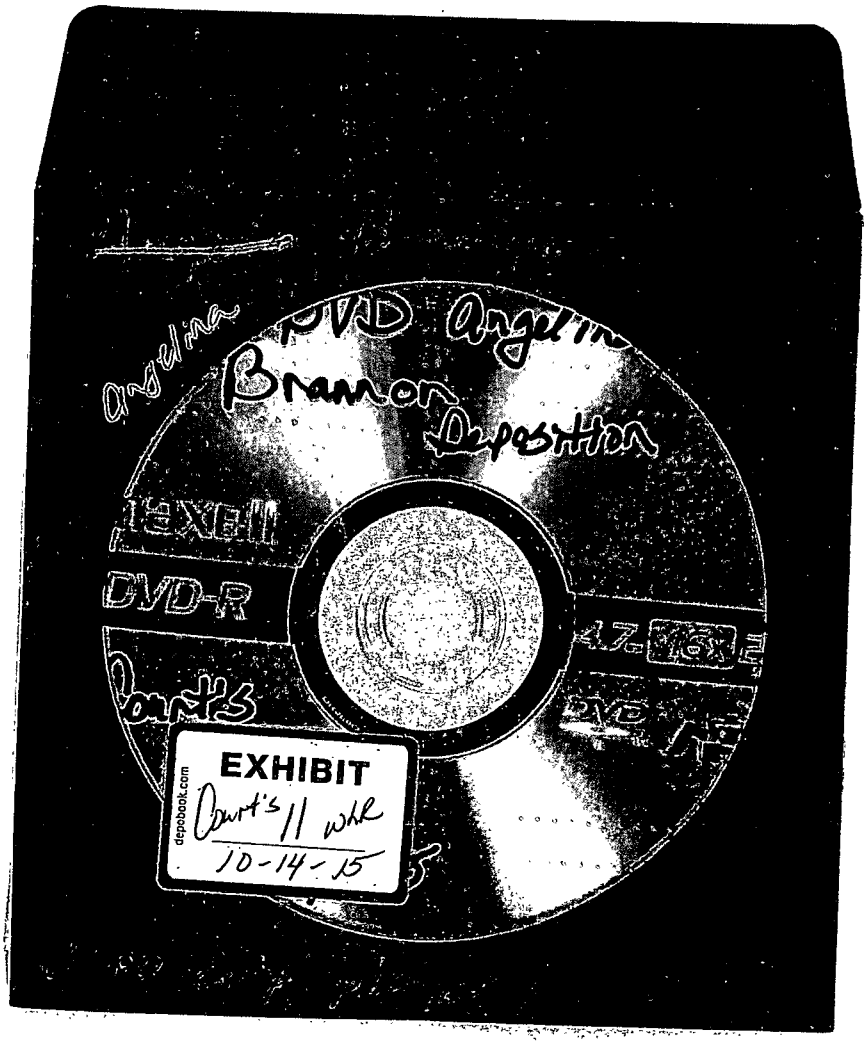
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Miller Trial

Brannon, Angela (Vol. 01) - 09/27/2015

1 CLIP (RUNNING 01:11:05.289)

Lieutenant Brannon, good afternoon. ...

BRANNON CLIP 55 SEGMENTS (RUNNING 01:11:05.289)

1. PAGE 9:10 TO 15:22 (RUNNING 00:09:58.439)

Q. Okay. Lieutenant Brannon, what is your full legal name?
A. Angelina Delores Brannon.
Q. Are you currently a member of the United States Military?
A. Yes, I am.
Q. What branch are you a member of?
A. The United States Navy.
Q. What is your rank in the Navy?
A. I'm a lieutenant, which is an O3. And I have been selected for promotion, so I'm O4 select, lieutenant commander select.
Q. Congratulations.
A. Thank you.
Q. How long have you been in the Navy?
A. On January 13th it will be 18 years.
Q. So 1998?
A. Yes. I enlisted first in the Navy on January 13th, 1998.
Q. How old were you when you enlisted?
A. 20.
Q. Were you stationed at the Naval Hospital Beaufort in Beaufort, South Carolina, on February 24, 2012?
A. Yes, I was.
Q. Are you generally familiar with the incident that is the subject of -- of the case that you are here to testify about?
A. Yes, I am.
Q. Are you also a licensed medical provider?
A. No, I'm not a licensed medical provider. I'm a licensed registered nurse.
Q. When did you first obtain your RN license?
A. In 2007.
Q. Where did you do that?
A. In Virginia.
Q. Beginning with your first assignment in the Navy, can you walk us through your employment history in the Navy?
A. Well, when I first enlisted in the United States Navy, I come in as an E3, because I had prior college credits so they promoted me to the rank of E3.
I went to recruit training command in Great Lakes, Illinois, and that was roughly about nine weeks of training followed by basic hospital corpsman school, which is -- for civilians, it's basically being a medic. After graduating from that training, I went to Pensacola, Florida, where I was stationed at the Naval Hospital for two years. And I worked in the OBGYN department and with the anesthesia providers.
Upon completing my tour of duty at Naval Hospital Pensacola, I was selected for training to go for field medical service school training, which is to be a combat medic, and that was in Camp Johnson, North Carolina. Roughly five weeks of training.

Upon completing that training, I went to surgical technologist training school. And that was in Portsmouth, Virginia, and that training was approximately six months.

Upon graduating from surgical technologist training school, I proceeded to my following duty station, which was Naval Medical Center, Bethesda, Maryland, which has now been changed. It's no longer existing, because they have merged with other branches.

I was there a year. I elected to leave early, because I was married. My husband was on a ship in
00012:01 Norfolk on the USS Ponce. So I requested co-location
02 orders, and I was allowed to leave after a year.

At that point, I was stationed at Naval Medical Center, Portsmouth, Virginia, for approximately three years, where I worked in the operating room department. And I was one of the education and training petty officers or the individual who helped with orientating new technologists and managing training records.

At that point, I was selected for a very competitive program called the Medical Enlisted Commissioning Program, in which I was selected and allowed to attend the -- a four-year university to obtain my Bachelor's Degree in nursing.

I began my studies at Hampton University in 2005, and I graduated in 2007. Upon graduating Hampton University, I proceeded to my former duty station, Naval Medical Center, Portsmouth, where I had a three-month orientation to the command, just experience in the different departments. Command orientation, any nursing training that was required at that time. And my first assignment was in one of our complicated, high-risk OB departments, labor delivery, where I worked for approximately one year, nine months.

Labor and delivery, when you are a brand new nurse to a large command, it's not where you want to go.
00013:01 It's the needs of the Navy. So there was a need for a
02 nurse in that department, which is where I was assigned.
03 My passion has always been emergency nursing, so I
04 requested to transfer to the emergency department.

I was working in the Emergency Department of Naval Medical Center, Portsmouth, from approximately January 2009 until I left in July 2011. The emergency department there were 42 bed, ER. We had a patient volume of approximately 60,000 patients per year.

And I started off as one of -- just regular floor nurses. I was selected for charge nurse, and I was later selected for team leader, in which I was in charge of approximately ten registered nurses and roughly nine to ten hospital corpsmen, which is medics.

And I -- at that point, called my detailer, which is the individual who we call in order to select a future duty station and Beaufort Naval Hospital was one of the options that I had available, and so I selected it.

And then I proceeded to Naval Hospital Beaufort. I checked on board July 29th, 2011. And I left Naval Hospital Beaufort pretty recently, in August of this year.

While I was working in -- at Naval Hospital Beaufort, my first assignment was as the department head
00014:01 or as the civilians may call it, a supervisor of the
02 emergency department, which is much smaller than the
03 previous command that I'd come from. We were
04 essentially a four bed ER, and a four bed urgent care.

I was there from July 2011 until I deployed.

As I have mentioned before, I have been on -- in the Navy almost 18 years. My career was not operational. I wanted to do something big. I wanted to contribute. I didn't want to spend 20 years of my career and never have experienced a deployment. So I spoke to my director of nursing and requested if a deployment did happen to come up that I would like to get selected.

And that's where I went. In 2013, I was selected to a deploy with the Marine unit. And I deployed to Camp Leatherneck in Afghanistan for roughly ten months, where I was a medical regulator responsible for working in the combat operation center, providing med/evac assistance, which is evacuation of casualties from the battlefield to the next level of care, whether it be an actual treatment facility or another unit.

Upon returning from deployment, the ER department had now been closed. So the only other place where I could work and actually engage in clinical practice as a nurse would be the post-anesthesia care unit, which is a recovery room where I was a recovery room nurse. And I also worked in the ambulatory care unit, which is the unit in which patients first check on board in order to get checked in for surgery and for surgical prescreening where we screen patients for surgeries.

And now, while I was deployed I applied for another very competitive program called Duty Under Instruction by the Navy Nurse Core. And with my love of emergency nursing, the only way that I could stay in emergency nursing was to specialize as a clinical nurse specialist. I applied. There was only two billets. There was seven of us applying, and I was selected.

So right now I have just began my studies at the University of California, San Francisco, where I am studying for a Critical Care Trauma Clinical Nurse Specialist program with the hopes of graduating in June 2017.

And I don't know where I will be stationed next. That's all upon, you know, the Navy and where the needs are.

Q. Okay. Thank you for that. That was a lot of -- that was a lot.

2. PAGE 16:02 TO 16:12 (RUNNING 00:00:37.197)

risumi quite that well, so I'm impressed. I want to focus on your time at the Naval Hospital Beaufort. Could you repeat for me what your title was when you began there in July of 2011?

A. Yes. Department head.

Q. Did you also say that you were a supervisor?

A. It's kind of difficult to kind of switch the military terminology to civilian, but essentially that's what it is. A supervisor. When we are in charge or responsible for overseeing contractors, we are in a supervisory role.

3. PAGE 16:17 TO 17:24 (RUNNING 00:02:05.825)

Q. Who does the department -- who did you report to as the department head?

A. The director of medical services, who at the time was Commander Thier, who is now Captain Thier.

Q. Who did you supervise while you were in the department head of the ER?

A. I supervised CasePro employees, which included physicians, nurse practitioners, PAs, and LPNs. Did I say registered nurses already? No? Registered nurses.

00017:01 Q. Did you supervise any other personnel while you
02 were the emergency room department head?
03 A. Are you asking about the specific time in
04 question from -- in February 2012?
05 Q. Yes.
06 A. Yes. They were -- there was some other
07 contract employees, but they were from a different
08 contractor. They were non-personal contract.
09 Q. Did you supervise any active duty military?
10 A. We had enlisted corpsmen that at that time only
11 worked in the urgent care department. And a corpsmen is
12 a medic.
13 Q. Did you supervise corpsmen?
14 A. Yes. Or led. As an officer, a naval officer,
15 I'm in a leadership position when I'm overseeing
16 military personnel. It's a completely different role.
17 I'm a leader. There's different leadership that comes
18 into play when you're leading military personnel.
19 Q. How many people did you supervise at any given
20 time while you were at Naval Hospital Beaufort?
21 A. I don't know the exact number but I -- do you
22 mean personnel, non-personnel, everybody?
23 Q. Everybody that you were responsible for.
24 Everybody that reported to you.

4. PAGE 18:11 TO 19:02 (RUNNING 00:00:47.377)

11 THE WITNESS: Well, I just want to be more
12 specific. When it comes to the military personnel,
13 which I was leading, I supervised, I managed, I led, I
14 mentored. It is a completely different relationship.
15 As far as the contract personnel, non-personal and
16 personal contract, I supervised. I don't know the exact
17 number, but I believe it was over 30 of them. Not all
18 of them were CasePro employees.
19 MR. MACKELCAN:
20 Q. Is the 30 the contract -- personal services
21 contract personnel?
22 A. Can you repeat the question?
23 Q. When you say 30, are you including the active
24 duty military or is that just --
25 A. No. No. And these are all estimates, because
00019:01 it's been a long time. It's been since 2012, so I don't
02 remember the exact figures.

5. PAGE 19:22 TO 20:02 (RUNNING 00:00:21.512)

22 Q. For the benefit of the judge and jury, where
23 are you currently located right now?
24 A. In Mountain View, California.
25 Q. I believe you -- you touched on this in your
00020:01 testimony regarding your employment, but could you
02 specifically tell us about your education?

6. PAGE 20:07 TO 21:02 (RUNNING 00:01:10.911)

07 A. High school. I graduated high school in 1995
08 from Ysleta. After graduating high school, I went to El
09 Paso Community College. After that I enlisted in the
10 Navy, and I went to basic training which is also
11 training.
12 I went to hospital corpsmen basic school, which
13 is medic training. I went to field medical service
14 school training, which is combat medic training. I went
15 to surgical technologist training to be a surgical tech.
16 I obtained my Associate's in Arts in 2000 -- I believe
17 it was 2001 or 2002.
18 I obtained my Bachelor's of Science in nursing

in 2007. I have a Masters of -- Master of Arts in Management and Leadership that I obtained in 2012. And I'm working on my second Master's Degree in nursing right now. That's more of the formal training.
I have non-formal training that includes leadership training, officer training. When I first became a naval officer, I went to Rhode Island where I went to officer training school and we had leadership training courses. I have had ongoing leadership

7. PAGE 21:25 TO 22:16 (RUNNING 00:01:02.261)

question, so that -- that's good. When you are talking about the committee, you mentioned patient safety, quality management. Were there other committees that you participated on while at the Naval Hospital Beaufort?
A. Yes. But I don't recall all of them. I was very involved within the command and the department.
Q. Were contract workers involved in -- in those committees that you referenced?
A. In those specific committees that I referenced, no.
Q. Were those hospital management-type committees?
A. They're usually -- in order to participate in a hospital-wide committee, you have to be active duty or you'd have to be a federal employee, because contract employees cannot go outside the scope of their contract. So a committee would be outside.

8. PAGE 22:20 TO 23:04 (RUNNING 00:00:35.672)

Q. As of -- as of February 2012, what was, at the time, Commander Thier's job?
A. He was the director of medical services. I'm trying to make it more simple, because I know you are not familiar with the military system. He's essentially the executive who is in charge of Medical Home Port, which you may know it as family practice and internal medicine and the emergency department and the urgent care. He answers to the executive officer and to the commanding officer.

9. PAGE 23:13 TO 23:23 (RUNNING 00:00:37.163)

Q. Recognizing that you did not serve in either of these roles, what is the -- what are the duties or responsibilities, generally, of the commanding officer versus the executive officer?
A. I can't speak to the extent of the responsibilities and duties, because I'm not thoroughly familiar with them. But I know in order to better simplify it for you, it would be the equivalent to a CEO of a hospital, and the XO would be the second person in line. I don't know if there's an assistant CEO or what their -- the terminology is.

10. PAGE 23:25 TO 25:18 (RUNNING 00:03:08.547)

So -- so the CEO or the commanding officer was the person in charge of the hospital?
A. Yes, that's correct.
Q. And the XO worked for the commanding officer?
A. Yes.
Q. Okay.
A. They're the two most senior people inside the command -- of any command.
Q. Did at the time Commander Thier report to the CO and the XO?

A. Yes, that's correct.
Q. And you reported directly to Commander Thier?
A. Yes.
Q. Did -- did I hear you say that you treat -- also treated patients at the Emergency Room at Naval Hospital Beaufort on occasion?
A. It was on occasion. We were a small department, so there were times when the nurses would need assistance. And I, as a fellow registered nurse and an ER nurse, I would assist when -- when needed.
Q. Were you physically present at the Naval Hospital Beaufort on February 24, 2012?
A. I was present. I had left for the day when the incident happened.
Q. Do you recall when you were there?
A. Roughly from 7 in the morning until, I don't know, after working hours. Sometime after 15:30.
Q. So you were -- 15:30 is 3:30 in the afternoon, for those of us non-military?
A. Yes, roughly. But I don't recall the exact time. I just remember I had already left for the day when I received the phone call.
Q. Is 3:30 the time that you would typically -- would have typically left for the day?
A. No, not typically. My days were pretty long. I'd get there at 7 in the mornings. Sometimes I was there until about 18:00, which is 6 p.m., depending.
Q. How many days a week would you work at the Naval Hospital Beaufort?
A. Five days a week.
Q. Monday through Friday?
A. Yes, that's correct. But the hours that I told you were not set in stone. It's all depending on what was going on.

11. PAGE 25:25 TO 26:15 (RUNNING 00:00:39.295)

Q. Were you there at the Naval Hospital at 14:00 hours?
A. Yes.
Q. Okay. Were you there at 15:00 hours?
A. Yes.
Q. Were you there at 15:30?
A. I believe I was, but I can't say exactly.
Q. Okay. So beyond 15:30 that you are not exactly sure if -- that you were there?
A. That's correct.
Q. Did you have an office at the Naval Hospital Beaufort?
A. Yes, I did.
Q. Where was your office located?
A. It was around the corner from the emergency department. I had two offices. The initial office that

12. PAGE 26:24 TO 27:06 (RUNNING 00:00:27.750)

Q. How long would it take for you to walk from your office to the emergency department?
A. Seconds. Less than 30 seconds.
Q. On a typical day, recognizing that every day is different, but on a typical day, how many times would you physically set foot in the emergency department at the Naval Hospital Beaufort?
A. Approximately three, four times, give or take.

13. PAGE 27:13 TO 27:17 (RUNNING 00:00:21.747)

Q. Do you recall whether you were physically

present in the emergency department on February 24, 2012?
A. In the department? I don't recall. That's a long time ago. I was at the hospital, and everyday --

14. PAGE 27:22 TO 28:21 (RUNNING 00:01:03.885)

A. Oh. Every day, part of the -- the normal routine that I do, I come into the department. You know, I check on the staff, see what the patient volume is. See if there's any pressing issues, and I collect the ER medical records.
And I get prepared for morning report, which starts at 07:30, where I go -- it's myself, usually inpatient ward, and other pertinent parties and the executive officer, commanding officer or directors are all there. And we go over, you know, how many patients we are seeing. And if there's anything which is a command interest patient.
Say, for instance, an active duty member was admitted to the hospital, then that would be something relevant that the commanding officer and director should know. So at that time I would let them know there's a command interest patient or if there's something that's pressing or concerning that would be the time to report it.
So every day I made my rounds to the department. Now on that day I can't recall how many times I did.
Q. Did I hear you say that you collected the records each day?
A. Yes.

15. PAGE 30:17 TO 31:07 (RUNNING 00:00:55.757)

Q. Did you personally review medical records from the emergency room?
A. What do you mean by review?
Q. Well, you, I believe, testified that you collected the records and brought them to the morning report and various hospital executives would discuss the treatment that had been rendered in the emergency room. The -- my question is in -- either prior to that meeting or really, at any time, did you personally look through the records to review them?
A. Yes.
Q. How frequently did you review emergency room medical records?
A. I don't recall the frequency.
Q. Was it a daily, weekly?
A. More so weekly. On -- I have to explain to you

16. PAGE 32:14 TO 33:06 (RUNNING 00:01:06.674)

Q. I -- I don't -- I'm not asking you about a specific peer review, meaning a specific medical provider's peer review. But I'm just asking, generally, were you involved in peer reviews and performance evaluations?
A. I was not directly involved in the peer review of the providers, which is the physicians, the physician assistants, or the nurse practitioners. We didn't have a formal peer review type process for the nurses.
But I would review periodically charts just to make sure that there are certain things that, you know, are relevant, such as certain stop times for certain IV push medications, certain start and stop times of fluids, piggyback medications, reassessment of a

patient, vital signs frequency.
Q. Did you conduct performance reviews for the contract workers who performed services in the emergency department that reported to you?

17. PAGE 34:06 TO 35:21 (RUNNING 00:02:07.588)

A. Okay. For the nurses, there is something called the ACPA. I don't remember what the actual acronym stands for. It's a credentialing form. It's like two pages, and it's done every year. And it's due in December. And that goes over the individual's time that they've worked there, the period.
Have they completed any type of training or have they conducted any type of training with other personnel. It also asks more personal questions. Have they -- gosh, I can't even remember, been convicted of -- of anything, they would have to address those there. It all goes to credentialing.
Certifications they may have obtained. The length of stay of the average patient, the patient population. And then on the back, there's a small part for narrative, in which the supervisor would then, you know, write a brief description of is the individual a competent nurse or not. And that's per the credentialing department.
And then the member would sign, the supervisor signs, the director of nursing signs. And it goes to the credentialing department. And the -- I'm sorry. The director of medical services would actually review the part of the chain of command.
For the physicians, there's something different. I believe it's called an OPPE, but I don't remember the exact terminology. It does require supervisor signature. And if I recall correctly, that also -- you have to document number of peer reviews done.
But I wouldn't do the peer reviews for the physicians or any of the providers, because I'm not a physician. It would have to be another physician conducting those peer reviews.
Q. When you -- you referenced the credentialing department. Is that a department at the Naval Hospital Beaufort?
A. Yes, it is.
Q. Who was in that department while you were there in 2011 and 2012?
A. Ms. Kirkwood was. There was a new employee. I

18. PAGE 35:24 TO 36:03 (RUNNING 00:00:20.036)

Q. Was Ms. Kirkwood the person who actually issued the -- the credentials or privileges?
A. Yes.
Q. Was Ms. Kirkwood a GS worker?
A. Yes, she is.

19. PAGE 36:12 TO 38:20 (RUNNING 00:03:40.955)

Q. Lieutenant Brannon, there's been some testimony in this case that the emergency department did not use AHLTA, the electronic medical records system. Is that your recollection as well?
A. Do you know what AHLTA is at all? Do you know the extent of it? I'm just trying to understand just what your knowledge base is, so I can explain.
Q. I think it's -- I think it's fair to say that I don't know --

A. Okay.
Q. -- a whole lot about it.
A. Okay.
Q. If you could describe what AHLTA is for us, that would be helpful.
A. Okay. AHLTA is an electronic medical record. It's primarily used like in Medical Home Port as if -- like you would go to your -- your primary care manager now. The physician would document an AHLTA, and that's only at a military treatment facility.
Also like on Parris Island, the recruits, all documentation is done in AHLTA. AHLTA has access to CHCS, which is our oldest computer system. CHCS, it's an old program, and that's where we enter all of our lab orders, radiology records, if we are going to check in or check out a patient say for an appointment, that's where you would do it. It's very very extensive, and it's a very old database.
AHLTA is more for like the primary care areas. There at Naval Hospital Beaufort, we were still using paper charting. Some of the nurses and physicians may have had access to AHLTA, but it's not something that we use on a day-to-day basis. Because through AHLTA, you can actually access CHCS to retrieve lab and radiological reports or look at a patient's medication list.
And then there's also ESSENTRIS, just in case it ever comes up. That is another electronic medical records system that we have which we didn't also use in the department.
Q. I'm sorry. That you did not use?
A. No. We were all paper charting for the most part.
Q. Can you describe for me what you mean by paper charting?
A. Yes. Instead of having a digital record of an ER visit, we old-fashioned paper -- paper charts. The nursing note was in paper. We had -- well, they were paper T sheets, which are the treatment records that the physician would document on. Discharge information was printed on -- from online and then printed -- it's all just like a stack of papers that was the -- the emergency treatment record, the paper chart.
Q. Lieutenant Brannon, as you know, this case involves Calvin Hunt's stealing a fire truck and hitting a pedestrian after he'd left the Naval Hospital Beaufort. Are you aware of any policy in place at Naval Hospital Beaufort on February 24, 2012, that prevented patients from leaving the emergency department?
A. No, I'm not aware.

20. PAGE 40:03 TO 40:09 (RUNNING 00:00:23.701)

Q. How about for just stepping outside of the emergency department, not necessarily leaving without treatment as you described before? Was there a policy that prevented patients from stepping outside, either into the hallway or outside of the building for a few minutes with the intent of returning?
A. Not to my knowledge.

21. PAGE 40:12 TO 41:09 (RUNNING 00:01:44.320)

Q. After the incident on February 24, 2012, did you contact anyone at the CasePro corporate office to discuss the incident?
A. I don't ever contact CasePro directly. My liaison is a contract officer representative, which

would be Deb Mayo. She would make contact with them.
Q. Do you know one way or the other if Deb Mayo had any contact with CasePro about the incident after -- afterwards?
A. I don't know if she did.
Q. If you had a concern about the care rendered in the emergency department by CasePro personnel, you would -- would you convey that concern to Deb Mayo?
A. Yes, I would. And I would also keep my director in -- in the loop, so he's not caught off guard.
Q. Would it surprise you to find out that CasePro corporate office first found out of this incident in November 2012 when the -- when it was served with this lawsuit?
A. Well, yes, I would be surprised.
Q. Why would you be surprised?
A. Just because of the length of time.

22. PAGE 42:03 TO 42:16 (RUNNING 00:01:02.598)

Q. If the Navy had concerns about Dr. Jansen, Joe McDonald's, or Janice McDonald's treatment of Calvin Hunt in the Emergency Department at the Beaufort Naval Hospital on February 24, 2012, did the Navy have authority to take action with regards to their privileges at the Naval Hospital?
A. There is a mechanism in place.
Q. Is that a yes?
A. Yes.
Q. Okay. To your knowledge, was any disciplinary action taken by the Navy in response to the treatment provided to Calvin Hunt to the Emergency Department of Beaufort Naval Hospital on February 24, 2012?
A. No.

23. PAGE 44:11 TO 44:13 (RUNNING 00:00:10.557)

Q. Do you believe that Dr. Jansen, Joe McDonald, and Janice McDonald had adequate medical training and experience to treat a patient like Calvin Hunt?

24. PAGE 44:16 TO 45:05 (RUNNING 00:00:48.841)

THE WITNESS: Part of the hiring process, the providers, which are your medical providers and your nurses, must meet certain criteria per the contract. So they have to come to the department ready and experienced in order to be licensed. Then the assumption would be made that they are qualified based on their training, their licensure, and certifications they may carry.
MR. MACKELCAN:
Q. And I'm you asking specifically as the supervisor for these personnel at that time approximately six months you had been their supervisor. Did you -- do you believe that as of that date they had adequate medical training and experience to treat a patient like Calvin Hunt?

25. PAGE 45:08 TO 46:04 (RUNNING 00:01:27.028)

THE WITNESS: Okay. During that short period of time, I personally did not have any problems with the care that either of those individuals provided.
MR. MACKELCAN:
Q. I -- I -- just to clarify, I asked about Dr. Jansen and Joe McDonald and Janice McDonald.
A. Yes. That's correct.

Q. So your answer would be to all three of them?
A. Yes. During that period of time, I did not have any problems or concerns with the care that they had provided.
Q. Are you -- how familiar are you with the care that was provided to Calvin Hunt on February 24th, 2012?
A. I don't remember the actual chart. I just -- it's very vague. I was hoping that there'd be a copy of it so I could review it, but there isn't. So I'd say vaguely familiar.
Q. Okay. Do you have a recollection that Dr. Jansen requested a psychiatric consultation?
A. Yes, I am.
Q. Was that an appropriate action for Dr. Jansen to take according to hospital policy?

26. PAGE 46:07 TO 46:11 (RUNNING 00:00:13.190)

THE WITNESS: Again, that's something -- that's at the discretion of the medical physician who is there in the ER department. Just as if a patient presented with a broken leg, they would consult or seek expert consultation with an orthopedic surgeon.

27. PAGE 47:07 TO 49:02 (RUNNING 00:02:43.732)

Q. If -- is it also your understanding that when the psychiatric consultation was requested by Dr. Jansen the first step of that process is a psychiatric technician comes to the ER to interview the patient?
A. Yes, I'm aware that that's how the psych -- the psych department conducts their consultations.
Q. Did you know -- I believe his name is Arthur Manning, who is -- who was the psych tech on that day?
A. Do I know him? No.
Q. But you are generally familiar with -- with the fact that -- or are you generally familiar that -- that Mr. Manning came down and interviewed Calvin Hunt?
A. I'm aware that a psych tech came down to evaluate Mr. Hunt, yes.
Q. What is your understanding of the purpose of a psychiatric tech interviewing a patient?
A. My understanding is that the psych tech comes down and does the initial intake of a patient and then reports back to their -- the mental health provider that's assigned to them.
Q. If the psych tech was concerned for the patient's safety or concerned about the patient causing harm to others at the end of his interview with the patient in the emergency department, would you expect the psych tech to convey those concerns to the nurses and doctors on duty in the emergency department?
MR. HOYLE: Objection. Form. Witness can answer.
THE WITNESS: I wasn't there, but had I been there, I would hope that the individual would convey that message to me.
MR. MACKELCAN:
Q. And I'll recognize that you weren't there. I'm asking you as the -- department head of the emergency department whether you would expect the psych tech to convey concerns to the doctors and nurses?
A. Yes, I would. We have a system in place throughout Navy medicine we call SBAR in which, you know, nurses, corpsmen, doctors, anybody that's part of the health care team, we communicate with each other. The hope is through SBAR, which means we present to each other say, for instance, I'm given report or hand off on

a patient, what the situation is, the background on that patient, my assessment, and any recommendations. And by doing that, hopefully we capture everything that's pertinent to that patient.

28. PAGE 53:04 TO 53:12 (RUNNING 00:00:25.491)

Q. In 1.12 where it defines supervisor, the definition is "the government official whose duty it is to provide day-to-day direction to and oversight of contractor personnel including supervisory functions such as time and attendance." Did I read that correctly?
A. Yes, you did.
Q. Was that you?
A. Yes, that would be me.

29. PAGE 53:24 TO 56:09 (RUNNING 00:03:55.225)

Q. I'm sorry. 108. In 9.6, beginning at the end of the first line, it says "the supervisor is best served by supervising the contract personnel in the same manner as they supervised the government personnel of their staff." Did you supervise contractor personnel on the same manner as government personnel?
A. Well, when I first got there, I didn't have any government personnel. Are you considering the enlisted as government personnel?
Q. That's really up for you -- up to you to decide how you want to answer. I'm not sure what that means.
A. Well, this is very -- a very vague question, because there's a lot that goes into the supervisory aspect of supervising personnel. Because it's not like working at AT&T or Google. You know, we are dealing with patient's lives every day, and every decision or inaction affects someone.

So in the sense of supervising, is the environment safe? Are they rendering safe patient care? Are they treating our patients and beneficiaries with the utmost respect and dignity that they deserve? Then yes.

They were not treated any different in the sense that I render the same amount of respect as I would to a contract employee as I would to a government employee as I would to military personnel. And as far as requirements ensuring that, you know, their certifications are current or anything like that, then yes. Ensuring they're ready for work, they're wearing their staff badges, that they're communicating effectively, that they're working as part of the team, then yes.

Q. Did you do all of those things --
A. Yes.
Q. -- with regards to the CasePro health care workers?
A. Yes. Because it's all part of patient safety.
Q. And that -- that was one of your responsibilities --
A. Yes.
Q. -- as a supervisor?
A. That was one of many, yes.
Q. In 9.7, the paragraph below, states "the supervisor's responsibility for supervision of contractor personnel extends to the normal feedback that should be provided to any employee regarding the quality of their performance." Did you provide feedback to contractor personnel?
A. Yes, I did.

Q. If you could go back or go to the front of the document, page three. In B6a where it states "performance of health care worker services at any Department of Defense or Coast Guard Military Treatment Facility within the States of North Carolina, South Carolina, and Tennessee shall be considered within the scope of this contract."
A. Okay. I see that.
Q. Okay. On -- on February 24th, 2012, were Dr. Jansen, Joe McDonald, and Janice McDonald performing services that were within the scope of the contract?
A. Yes.

30. PAGE 56:22 TO 57:23 (RUNNING 00:01:11.145)

THE WITNESS: Okay. I haven't read the entire contract from its entirety, so within the scope of this contract to my understanding the portions that I do know, then I would say yes. But I'm not an expert in contracts.
MR. MACKELCAN:
Q. What -- what services was Dr. Jansen providing on February 24th, 2012?
A. He --
Q. What was his role?
A. He was the attending physician in the emergency department.
Q. Okay. And what role was Joe McDonald?
A. Joe McDonald was the bedside nurse and ER nurse.
Q. And -- and Janice McDonald's role -- what was her role?
A. She was the ER nurse that day, and she was in triage.
Q. Were the McDonalds performing nursing services on February 24th, 2012, in the emergency department at Beaufort Naval Hospital?
A. Yes, they were.
Q. Okay. Was Dr. Jansen performing doctor services at the emergency department at Beaufort Naval Hospital on February 24th, 2012?
A. Yes, he was.

31. PAGE 58:02 TO 58:14 (RUNNING 00:00:39.341)

Q. Okay. 2.3 states that HCWs, which is -- is that the health care workers?
A. Yes, it is.
Q. Okay. "HCWs providing services under this contract shall be rendering personal services to the government and shall be subject to day-to-day supervision and control by government personnel." Did I read that correctly?
A. Yes, you did.
Q. Okay. What other government personnel did you, and possibly Dr. Jordan, depending on when she took on that role -- what other government personnel provided day-to-day supervision to the health care workers?

32. PAGE 58:17 TO 59:06 (RUNNING 00:00:58.137)

THE WITNESS: In an indirect manner, I would say perhaps the director of medical services, but he's not directly involved in the day-to-day supervision. He relies on his leaders which are under him to actually carry out those tasks.
MR. MACKELCAN:
Q. You use the term leaders there. Are you

referring to yourself and other department heads?
A. Yes, I am.
Q. Paragraph 2.3 goes on to state "supervision and control is the process by which the individual HCW receives technical guidance, direction, and approval with regard to a task within the requirements of this contract." Did I read that correctly?
A. Yes, you did.

33. PAGE 59:16 TO 60:20 (RUNNING 00:01:35.728)

Q. What sort of guidance did you provide to them?
A. There is the guidance that comes out all the time. For instance, the Emergency Nurses Association has statements on, let's say, triage of patients. And so my role is to make sure if something new comes out that I stay abreast of new information so that I can go ahead and implement it in the department.
Such as, just so you understand, door to EKG times. If a patient comes in, and they're exhibiting any cardiac symptoms or symptoms that could potentially indicate that the patients may be having a cardiac event, then the standard would be to bring the patient in and actually conduct an EKG within ten minutes. Because as you may or may not know, door to EKG time is critical to identifying patients who are at risk for having an acute MI. That would be one example.
Reassessment of patient's vital signs. There's certain periods that they should be reassessed. So when it came to things like this, yes. And they were provided feedback.
As far as the physicians, I'm not a physician. So for me to tell a physician how to be a physician would not be within the scope of my nursing practice.
Q. Who was -- who did that at the Naval Hospital Beaufort?
A. I would -- I'd be making an assumption here, but I would assume it would be the director of medical services since he's also a family practice physician. Or guidance would come down from the Executive Committee on Medical Services.

34. PAGE 61:25 TO 62:04 (RUNNING 00:00:12.926)

Q. Can a contract health care worker provide services at the Naval Hospital Beaufort if they do not have approval from the credentialing department at Beaufort Naval Hospital?
A. They would not be allowed to work there.

35. PAGE 62:10 TO 62:17 (RUNNING 00:00:23.959)

Q. Did you ever personally share the results of any peer reviews or performance evaluations with CasePro?
A. I never interacted directly with CasePro. With Ms. Mayo, yes, if there was something. But the majority of the time there was no issues. But she was kept abreast of any issues that they were. I always kept her in the loop.

36. PAGE 66:07 TO 66:24 (RUNNING 00:01:06.814)

Q. So in the next sentence in -- in that paragraph that I had been reading from says "the emergency room will operate under the clinical oversight of the ER medical director who does not provide regular staff physician service in the emergency room."
A. I see that.

Q. Okay. So if on February 24, 2012, Dr. Jordan had not assumed the role as ER medical director, there was nobody in that position?
A. Not in the department itself.
Q. So that -- would that role have been served by the director of medical services?
A. I would be making an assumption, but I would assume yes. But he's not ER trained. So I don't know if this oversight -- ER medical director, if the intent was specifically for it to be an emergency room physician who is the director or if it's just a medical director who oversees the ER.

37. PAGE 66:25 TO 67:09 (RUNNING 00:00:35.991)

Q. Who provided clinical oversight prior to Dr. Jordan taking on that role?
A. Clinical oversight of the physicians would have fallen under our director medical services.
Q. That was --
A. Commander -- yes.
Q. Commander Thier?
A. Yes.
Q. Was Dr. Jordan a GS employee?
A. Yes, she was.

38. PAGE 70:07 TO 70:15 (RUNNING 00:00:26.299)

Q. And when you say an internal document, are you referring to Department of Navy?
A. No. I believe -- I'm not sure if the civilian sector uses something similar to this, but it's something tied into what the Joint Commission on Accreditation does. It's a quality management system.
Q. So is it -- you are referring to a government system?
A. I believe it's a government --

39. PAGE 70:19 TO 71:01 (RUNNING 00:00:21.068)

Q. Do you know whether CasePro had any involvement or -- with or access to patient safety reports?
A. No, that would be a Hippa violation.
Q. So they did not -- CasePro did not have access to those --
A. No.
Q. Is that your --
A. No, they don't. Neither does Deb Mayo.

40. PAGE 86:19 TO 86:24 (RUNNING 00:00:17.732)

Q. This particular instruction defines a personal service contract as a contract that its expressed terms or as administered makes the contract or personnel appear in effect to be government employee. Did I read that correctly?
A. Yes.

41. PAGE 89:05 TO 89:09 (RUNNING 00:00:27.000)

clarity. But I believe the word appearance refers in terms of how the contractors appear to the patient. Is -- would there be any way for a patient to know that a particular health care provider was a contractor versus a GS employee at the Naval Hospital Beaufort?

42. PAGE 89:13 TO 90:02 (RUNNING 00:00:43.947)

THE WITNESS: Okay. Not unless the contract employee actually identified themselves as such, because

we have a mix. The majority of our employees, the federal employees, and the contract employees that work there, they make up the majority of the -- just the staffing there. The military, we're a small percentage of it. And I don't think --

MR. MACKELCAN:

Q. Do they have different uniforms?

A. No. We all -- well, the military wear their uniform. We're in scrubs. Civilian -- the GS personnel may wear their own scrubs. The contractors may wear their own scrubs. There's no way to distinguish them, because we're all essentially there to provide patient care.

43. PAGE 93:17 TO 93:23 (RUNNING 00:00:20.692)

Q. In the next paragraph it says PSC shall be subject to the same quality assurance, risk management, credentials review, and clinical privileging standards, including licensure, as those required military and civil service HCP." Was that your experience at Naval Hospital Beaufort while you were there?

A. Yes.

44. PAGE 97:21 TO 98:08 (RUNNING 00:00:45.536)

Q. Lieutenant, are you familiar with the document that I have just handed -- or has just been handed to you?

A. Yes.

Q. So you have seen this document before?

A. Yes.

Q. Was this the policy at the Naval Hospital in Beaufort in effect as of February 24th, 2012?

A. I would like to say yes, but I know that the mental health department was actually in the process of redoing this instruction or another instruction that pertained to said patients. So whether it was in effect at that time or not, that's above my pay grade.

45. PAGE 101:21 TO 102:10 (RUNNING 00:00:37.163)

Q. Lieutenant Brannon, good afternoon.

A. Good afternoon.

Q. My name is David Hoyle. I'm a lawyer from Mount Pleasant, South Carolina. We met earlier today through the miracles of video conferencing. Let me begin by, one, thanking you for your service, and two, thanking you for agreeing to do this deposition on a Sunday. I'm sure there are a number of other things you'd rather be doing today.

A. You're welcome.

Q. Ma'am, if I understand your testimony correctly, you did not manage or control the actual medical care and treatment of Calvin Hunt on February 24, 2012, correct?

A. That is correct.

46. PAGE 102:13 TO 103:23 (RUNNING 00:01:17.464)

Q. I'm sorry, ma'am? Your answer?

A. Yes, that is correct.

Q. Further, you did not manage or control the actual nursing care rendered to Calvin Hunt on February 24th, 2012, correct?

A. That is correct.

MR. MACKELCAN: Object to the form.

MR. HOYLE:

Q. In fact, you were not involved in the

day-to-day directing of medical services performed by Dr. Jansen at the Naval Hospital in Beaufort, South Carolina, correct?
A. That is correct.
Q. For example, you did not tell Dr. Jansen what tests to run on patients, correct?
A. That is correct.
Q. For example, you did not tell Dr. Jansen what differential diagnosis to make with respect to patients at the Naval Hospital Beaufort, correct?
A. That's correct.
Q. For example, you did not tell Dr. Jansen what diagnosis to make with respect to patients at the Naval Hospital Beaufort, correct?
A. That is correct.
Q. For example, you did not tell Dr. Jansen what treatment to render to patients at the Naval Hospital at Beaufort, South Carolina, correct?
A. That is correct.
Q. For example, you did not tell Dr. Jansen what medications to prescribe patients for the Naval Hospital in Beaufort, South Carolina, correct?
A. That is correct.
Q. And lastly, for example, you did not direct Dr. Jansen whether or not to admit a patient at the Naval Hospital in Beaufort, correct?
A. That is correct.

47. PAGE 104:01 TO 106:07 (RUNNING 00:02:36.489)

Q. Lieutenant Brannon, is it fair to say that you did not stand over CasePro employees in the emergency room at the Naval Hospital Beaufort and dictate what they were to do with particular patients?
A. That is correct.
Q. In other words, you did not tell the CasePro employees working in the emergency room at the Naval Hospital in Beaufort what to do with respect to a patient or what not to do with respect to a patient?
A. That is correct.
Q. Your job, as I understand your testimony, was basically an administrative one unless you were called on to assist in an emergency as you previously testified, correct?
A. That pretty much sums it up. And with the administrative task involves anything else that would fall under it, such as standard operating procedures or anything related to patient safety.
Q. Thank you, ma'am. As a registered nurse, do I understand correctly that you could not have supervised the medical care provided by Dr. Jansen?
A. That is correct.
Q. In other words, as a registered nurse, even with your advanced education and your advanced training and experience, you would not have been able to tell him how to practice medicine, correct?
A. That is correct.
Q. That would be outside the field of your expertise, correct?
A. That is correct.
Q. And I believe your testimony as you sit here today is you do not know the exact date in 2012 that Dr. Gina Jordan became a civilian employee at the Naval Hospital in Beaufort. Is that correct?
A. That is correct.
Q. Lieutenant Brannon, earlier today you in response to questions by prior counsel, talk about a

hypothetical patient coming in to the emergency room with a possible case of tuberculosis. Do you recall that?
A. Yes, I do.
Q. Have you ever actually treated someone with tuberculosis?
A. Yes, I have.
Q. Okay. Is tuberculosis what's known as a contagious disease?
A. Yes, it is.
Q. And what can happen if somebody with tuberculosis, oh, I don't know, walks out of a medical facility and decides to go to Wal-Mart? What could happen?
MR. MACKELCAN: Objection to the form.
THE WITNESS: They could potentially expose other people to tuberculosis.
MR. HOYLE:
Q. Would that be putting people at risk?
A. Yes, it would.

48. PAGE 106:11 TO 107:22 (RUNNING 00:01:34.796)

Ma'am, if someone came into an emergency hospital setting in which you were the nurse tending to that patient --
A. Yes.
Q. -- and he or she had tuberculosis. And they asked permission to just get up and walk right on out of the emergency room, would you give it to them?
MR. MACKELCAN: Objection.
THE WITNESS: Well, I can't grant permission or take away permission. But my job as a nurse would be to talk to the patient and explain what is going on and that I have a concern.
At that time, I would notify the physician and -- who would then talk to the patient. The patient can very well say I don't want to be here. I want to leave and decide to leave. But anyone in the health care setting know that that patient poses a risk, you know, to other people. So we would notify the authorities.
MR. HOYLE:
Q. And by the authorities, you are referring to law enforcement?
A. Yes. At a military setting, we have -- we have security. Our own security team. And if they need to make the notifications to get like the sheriff, the police department involved, then that would be taken up that way.
Q. But your testimony as you sit here today as a registered nurse who's practiced in military hospitals for a good long while --
A. Yes.
Q. -- is that if our hypothetical patient who presents to the emergency room with tuberculosis --
A. Yes.
Q. -- asks for your permission to leave the emergency room, you would first notify the attending physician. Did I hear that correctly?
A. I would notify them, yes.

49. PAGE 110:17 TO 112:13 (RUNNING 00:02:29.473)

Will you agree with me, Lieutenant Brannon, that there may be other situations that present in an emergency room setting other than a potential tuberculosis case in which there could be a concern developed that the patient may elope and may pose a risk

of harm to persons outside the hospital?
A. There's many. I think there's -- off the top of my head, anything. CDIFF is highly contagious. There's -- I mean, latest in the news was the ebola. There's many many things that could happen.
Q. Let's assume somebody's been traveling to West Africa.
A. Okay.
Q. And they show up in the ER with a fever and some of the textbook signs of ebola. And that's one of your concerns; that this person may be a potential carrier for ebola.
A. Okay.
Q. If that patient asked your permission to walk right on out of the emergency room and you felt fairly certain that he or she would follow your advice, what would you tell them?
A. I would just tell them I have a concern. I know you are scared. But let me explain to you the seriousness of this. I would, you know, tell them that I know that they have families and loved ones. Usually patients can connect when you make whatever it is personal.
Ask them about their family. Do you have any family members. Do you have any children. I have been able to deescalate situations like that. Just trying to calm down, make non-threatening gestures, because I have seen that sometimes when a patient's already anxious doing all this makes the situation even worse.
Trying to make them feel like a person. And let them understand the seriousness of what is going on. And that they will be kept informed.
They have rights as a patient. They have a right to know the treatment plan. They have a right to be treated with dignity and respect. We will keep them abreast of anything that's going on. We will keep them informed, and we will provide the best care.
Everybody's experience is different. I'm very comfortable in a hospital setting, and mostly it's because I have worked there my entire Navy career. But the ER setting can be very intimidating for a lot of people.

50. PAGE 114:18 TO 115:04 (RUNNING 00:00:32.084)

Q. And -- and certainly, ma'am, you did not see these records until after Calvin Hunt had left the medical -- Naval Hospital in Beaufort, correct?
A. That is correct.
Q. And prior counsel did not show them to you here today, correct?
A. That is correct.
Q. All right. Will you agree with me, ma'am, that if something is obvious that it is not hidden?
A. Is this a leading question? I am --
Q. It is not a leading question.
A. Okay. Yes. I agree with you.

51. PAGE 116:01 TO 119:23 (RUNNING 00:04:38.254)

Q. Did I hear correctly that the badges that the contractors, such as CasePro employees, would have worn in the Naval Hospital at Beaufort were different than the badges that you and other uniform badges in the United States Navy would have been wearing?
A. The actual staff badge? The only -- I'm taking a wild guess here, so I don't really want to be put on the record as this being fact. But I know on my

military badge or the staff badge, not the CAT card, that it would say registered nurse, and it may have my service affiliation.

And as far as a contractor's, without actually seeing them, I think they may say contractor or just RN. But I'm not sure.

Q. Okay. Not a hundred percent sure --

A. No, I'm not.

Q. -- as you sit here today. Is that fair?

A. That's fair.

Q. Okay. There were some questions earlier, and I'm not going to slide down to the other end of the table to pick them up, but there were some questions that prior counsel asked you about the contract between the federal government and CasePro. Do you recall that?

A. Yes.

Q. Okay. And there were some questions that prior counsel asked you about the task set forth within the contract. Do you recall that?

A. Yes.

Q. Okay. And we actually looked at something known as a task order. Do you recall that?

A. Yes.

Q. For your purposes for what you were doing at the Naval Hospital in Beaufort, were -- was your job as the department head to make sure that the task order was being fulfilled?

A. Well, my portion, the -- if you have looked at the task order, it's pretty lengthy. So for me to know every single detail that doesn't pertain to me would be irrelevant. When I first assumed the role, I had the part that was specific to me that was -- that led to the actual -- the staffing and basically the guidelines and -- of the actual contract that pertained to the ER setting in addition to the supervisory role.

The larger portion of the contract I didn't receive until after the fact until -- I have my certificates at home. But I actually attended the contract officer's course, and it was a three-day course. And then I knew now, you know, getting a little bit more advanced training, all -- not all, I can say more the intricacies that are involved in federal government, contract acquisitions, and you know, more about the rules and can'ts and do's and don'ts with contract employees.

So I need to ask and you know at that point is when I asked Ms. Deb Mayo well can I get a copy of the contract so I can see it. Some of it, even now I mean, I can review it, but some of the lingo that's in there is probably written by a lawyer. Because I couldn't understand it.

Q. That's certainly -- certainly fair, ma'am. When you referenced the staffing, you were referencing the fact that under the contract, the federal government paid CasePro, a company out in Texas, cash money to have one medical doctor and two registered nurses in the emergency room at Naval Hospital, Beaufort, 24/7/52. Is that correct?

A. That is correct.

Q. And that's one of the things you were concerned with, making sure that these people showed up and the ER was staffed, correct?

A. Yes.

Q. And I believe you told us that in -- a rare circumstance where one of these didn't come to work -- or a nurse didn't come to work that you would actually

fill in yourself. Did I hear that correctly?
A. Yes, that's correct.
Q. How frequently did that happen, ma'am?
A. I think when I was there, maybe twice. CasePro actually was pretty good about actually staffing the facility. But there was twice that they didn't work out. During that period of time, 2012. We had plenty of other issues with staffing after the fact.
Q. And we'll talk a little bit about that more in a minute. But let me continue down my train of thought, ma'am. I know there were some questions by prior counsel about how you treated various folks there in the emergency room at Naval Hospital, Beaufort, regardless of whether or not they were civilian, contractor, or uniform military. Do you recall that?
A. Yes.
Q. Is it fair to say that you treated everyone the same because that's what statute -- the Equal Opportunity Act required you to do?
A. That is correct.
Q. But certainly from a chain of command standpoint, I know for a good long while you were an enlisted member of the service, correct?
A. That is correct.

52. PAGE 120:25 TO 122:15 (RUNNING 00:01:57.709)

Q. I take it that as someone who is soon going to be promoted that you have persons who from time to time have to salute you. Is that true?
A. Yes.
Q. Okay. Certainly someone who salutes you is underneath you in the chain of command, correct?
A. That is correct.
Q. And then I imagine that there are times where there are persons above you in the chain of command that you yourself have to salute. Is that fair?
A. That is correct.
Q. And that would include people like the commanding officer of a military hospital, correct?
A. That is correct.
Q. Did any of the CasePro employees that we've been talking about -- Chris Jansen, Joe McDonald, Janice McDonald, did any of those three persons ever salute you?
A. No.
Q. Did you ever salute them?
A. No.
Q. They weren't in your chain of command one way or the other. Is that correct?
A. That is correct.
Q. If someone is within your chain of command and you give them a lawful order under the Uniform Code of Military Justice, what can happen to that person if he or she doesn't do what you lawfully ordered them to do?
A. They can be charged under the UCMJ, which is the Uniform Code of Military Justice.
Q. And they can end up being court-martialed. Is that correct?
A. They could.
Q. What about with respect to a contractor employee, such as Chris Jansen, Joe McDonald, or Janice McDonald? If they didn't do something that you told them to, could they be charged under the UCMJ?
A. No.
Q. That's a little bit different than a military court, correct?

15 A. Yes.

53. PAGE 131:25 TO 132:02 (RUNNING 00:00:05.468)

25 Q. Sure. Sure. We have been talking about
00132:01 policies and procedures and instructions. Is that fair?
02 A. Yes.

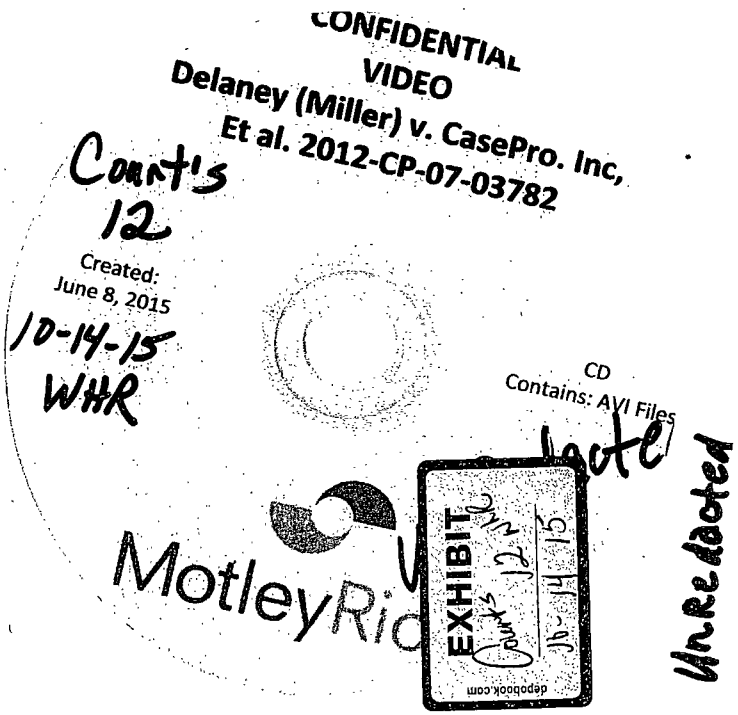
54. PAGE 166:19 TO 166:23 (RUNNING 00:00:19.006)

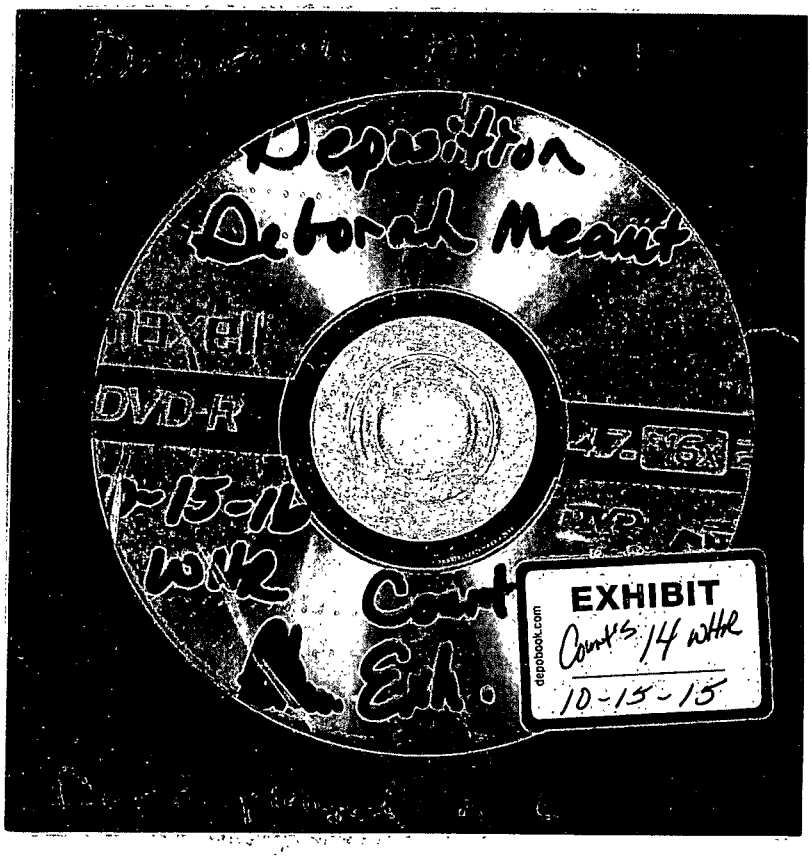
19 this is how I asked it earlier. Can -- could -- could
20 Dr. Jansen have provided medical care in the Emergency
21 Room at Beaufort Naval Hospital on February 24, 2012, if
22 the Naval Hospital Beaufort had revoked his privileges?
23 A. No.

55. PAGE 168:06 TO 168:23 (RUNNING 00:00:47.794)

06 Q. Finally, ma'am, if the CasePro employees in
07 question, including but not limited to, Dr. Chris Jansen
08 really were within the United States Navy's chain of
09 command, could the commanding officer of the Naval
10 Hospital in Beaufort, South Carolina, see to it in 2010
11 that Dr. Chris Jansen no longer treated patients?
12 A. If he was an active duty medical officer?
13 Q. Yes, ma'am.
14 A. Yeah. She could do pretty much anything.
15 Q. Not the same story when you are dealing with a
16 government contractor, correct?
17 A. No, it's completely different.
18 Q. And you have testified to those differences
19 here today, correct?
20 A. Yes, that is correct.
21 Q. Those are all the questions I have.
22 MR. HOYLE: Thank you.
23 THE WITNESS: Thank you.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 01:11:05.289)


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VIDEO
Delaney (Miller) v. CasePro. Inc,
Et al. 2012-CP-07-03782
Counts
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Miller Trial

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1 CLIP (RUNNING 00:59:19.845)

Where do you currently work? ...

DM-0916-0001102 46 SEGMENTS (RUNNING 00:59:19.845)

1. PAGE 5:03 TO 5:07 (RUNNING 00:00:08.300)

Q Good morning, Ms. Meaut.
A Good morning.
Q My name is Doug MacKelcan. As you just heard, I represent CasePro, Inc. who's the defendant in this lawsuit. We're here today to take your

2. PAGE 9:04 TO 9:09 (RUNNING 00:00:17.330)

Q All right. When did you first learn of the incident on February 24th, 2012?
A I don't really recall.
Q Were you working at the Naval Hospital, Beaufort on that day?
A Yes.

3. PAGE 9:15 TO 9:22 (RUNNING 00:00:27.355)

Q Following the incident, what was your involvement at the Naval Hospital with any response to the incident or investigation?
A Nothing. No involvement.
Q Did you have any conversations with anyone from CasePro's corporate office about the incident following February 24th, 2012?
A No.

4. PAGE 9:25 TO 10:12 (RUNNING 00:01:01.230)

Q Did you have any communications with other federal employees either at the Beaufort Naval Hospital or in Virginia, or wherever the -- your bosses are located, about this incident?
A No.
Q Can you state your full name for the record?
A Deborah Jane Meaut.
Q What is your home address?
A 584 Broad River Boulevard, Beaufort, South Carolina, 29906.
Q How long have you lived there?
A Twelve years. Almost 12 years.

5. PAGE 11:02 TO 13:17 (RUNNING 00:03:31.970)

Q Where do you currently work?
A The Naval Hospital, Beaufort, South Carolina.
Q What is your title at the Naval Hospital, Beaufort?
A Contracting officers representative.
Q How long have you served in that capacity?
A Since January of 2010.
Q What did you do for work prior to that?
A I worked in the commanding officer's office at the Naval Hospital.
Q When did you start in that position?

A October of 2006.
Q How about before that position in the CO's office?
A I wasn't employed. We had just moved back to Florida.
Q So since you've lived in Beaufort County, you have only worked at the Naval Hospital, Beaufort?
A I helped my husband with his business before I did that.
Q Okay. What was your job when you worked in the CO's office?
A Secretary/administrator assistant.
Q Who was the CO at that time?
A When I started, it was Captain Elaine Wagner.
Q And then who was it after that?
A Captain Mark Bernier.
Q How do you spell that?
A B-E-R-N-I-E-R.
Q What led you to switch to become the COR, or a COR I should say? Are there more -- is there more than one COR?
A Yes.
Q Okay. What led you to switch to become a COR at the Naval Hospital, Beaufort?
A Promotional opportunity and to get back into a field I was working in.
Q Had you worked as a COR before?
A I worked as a contract specialist before.
Q Where did you do that?
A Department of the Army in Warrenton, Virginia.
Q When did you work as a contract specialist in Virginia?
A 1990 to 1993.
Q Have you had any other jobs in contracting in your professional career?
A No, just that.
Q Okay. So you got the three years in the Department of the Army, and then over five years now at the Naval Hospital, Beaufort?
A Yes, sir.
Q What is your educational background?
A Graduated from high school. Went to Mohawk Valley Community College, Utica, New York, with an Associate's degree in legal stenography.
Q Did you work as a stenographer?
A No, never did.
Q Do you have any other education other than the Associate's degree and high school?
A No.

6. PAGE 17:03 TO 20:04 (RUNNING 00:04:53.000)

Q When you're working -- when you have been working as the COR at the Naval Hospital, Beaufort, how many different contracts are you responsible for?
A Me individually? Somewhere, anywhere between 15 to 25.
Q At the same time?
A Yes.
Q Do you recall serving as the COR for the contract with CasePro, Inc.?
A Yes.

Q How would you describe your job as a COR?
A I'm the liaison between the contracting officer at Navy Medicine Logistics Command and the contract company who was given the award, the contract award.
Q All right. And as the liaison, what do you do on a daily or weekly basis?
A Multiple things: Bring the new contract employees on board once the company provides me all their pertinent information; I approve invoice payments to the contract company; I monitor the expenditures throughout the course of the fiscal year.
Q Is there anything else?
A There's a lot more. But I mean, it's just the day-to-day operation of -- of the COR office.
Q And -- and what -- what does that do? I'm sorry. We just -- that's just not something that I'm familiar with, so I'm trying to understand what that involves.
A Okay. As an example, let's say we have a vacancy -- and this is just an example. Let's say we have a vacancy for a nurse position within the hospital, the contract company would recruit for an employee to fill that position. They've gotten the award for the contract to fill that position, so they do all the leg work. It's their employee, their. They hire the employee. They negotiate the terms of their employment, how much they make, what benefits they're going to give them. We're not part of that. But what they do is they provide us with a credentials package prior to that employee starting work. And once I receive that package on an individual, we route that for the credentials process. I ensure that they have the requisite security clearance to work on a military facility. I ensure that they meet occupational health requirements so that -- they're working in a hospital environment, and you know, it's much different than working at the local hardware store. They have to meet certain occupational health requirements before they come on board. We bring that person on board. Just a day-to-day -- that's -- that's bringing in new hires.
We also issue government credentials, CAT cards we call them, so that that employee can work and access government computer systems.
I also review invoices every two weeks to make sure that what's invoiced is proper in accordance with the contract and ensure that the company is paid.
Q You mentioned that you serve as a liaison between the contractor and Naval Medical Logistics. Who is your direct supervisor at Naval Medical Logistics?
A Contracting officer that I would call there for questions -- I technically report to my boss physically at the Naval Hospital.
Q Who is that?
A Lieutenant Lucas Ricker, R-I-C-K-E-R. But my point of contact at NMLC would be Andrea Greybush-Mangroo, M-A-N-G-R-O-O. G-R-E-Y-B-U-S-H-Mangroo. She is a warranted contracting officer at NMLC.

7. PAGE 20:13 TO 21:13 (RUNNING 00:01:16.830)

A And of course, you know, lieutenants -- the military officers change about every two years, so I've had a couple of different lieutenants that I reported to.
Q Who are the other lieutenants that you've reported to?
A Lieutenant Terri Osner; I can't believe I remembered her name. And Lieutenant Rachel Smith.
Q Do you recall who was the lieutenant you reported to on February 24th, 2012?
A I don't recall. I'd have to go back and look and see who was here.
Q And when you say you report to that lieutenant, what -- what does that mean?
A In the chain of command with the military. I mean, there's a definite chain of command that you go to if I have an issue for anything, whether it's specifically related to my job or it's a personal issue. You start with who your department head is and you work your way up.
Q Do they do your performance reviews?
A Come from Lieutenant Ricker -- actually, they come from my assistant department head who is Lori Beck.
Q Is she at the Naval Hospital, Beaufort?
A Yes.

8. PAGE 23:21 TO 25:07 (RUNNING 00:02:30.770)

Q Okay. So it sounds like your, to summarize, and I realize not everything is going to fit into this category. But it sounds like administratively with your job at the Naval Hospital you report to a lieutenant, but anything that has to do with performance under the contract you're going to report to the Naval Medical Logistics; is that accurate?
A Yes, that's accurate.
Q Okay. And the question that I asked before, is Naval -- the Naval Medical Logistics in Maryland is the agency that has issued the contract to CasePro; is that correct?
A Correct.
Q Who assigns a particular contract to you as the COR?
A I have a coworker in my office and we divide the contracts according to dollar value, complexity, just to balance the workload.
Q How familiar are you with the CasePro contract with the Naval Medical Logistics Command?
A Pretty familiar.
Q What is the -- just in your own words, what is the purpose of the contract?
A Purpose of the contract is, the government has hired CasePro to provide qualified employees in accordance with a specific task order to provide services at our facility.
Q What -- who determines whether the healthcare workers are qualified? To use the word that you just used in your last answer.
A Who determines if they're qualified? CasePro, or whoever has the award, it's their responsibility to hire employees to fill that contract. So that contract company needs to determine their -- if their qualifications meet the

07 standards outlined in the contract.

9. PAGE 25:14 TO 26:07 (RUNNING 00:01:01.250)

14 Q Does the government have a role in
15 determining whether healthcare workers are qualified
16 to perform services at the Beaufort Naval Hospital?
17 A Not whether they're qualified, but if
18 they're credentials. If they can meet credentialing
19 requirements.
20 Q What's the difference?
21 A I'm not a credentials expert, so I can't
22 answer to that. You know, we have a separate
23 department that handles that. And the contract
24 companies provide us with all the required
25 credentialing information that goes to the
00026:01 Credentials Department to verify whether or not they
02 meet credentialing standards.
03 Q So what you're -- what you're describing
04 is a separate department in the United States
05 government that's entire job is to determine whether
06 the healthcare workers are properly credentialed?
07 A Correct.

10. PAGE 26:20 TO 27:08 (RUNNING 00:00:37.010)

20 Q Ms. Meaut, what I'm handing you is a
21 copy -- what I believe to be a copy of the contract.
22 I'm going to ask you whether it is. But I've
23 labeled -- it's going to be marked as Exhibit 1.
24 And we have Bates labeled the bottom right-hand
25 corner -- those are our numbers, not -- not the
00027:01 government's numbers -- DEF RRFP 00001 through
02 00131.
03 A Uh-huh.
04 Q Does this appear to be a copy of the
05 contract between CasePro and the Naval Medical
06 Logistics Command that you operated under as the
07 COR?
08 A Yes.

11. PAGE 27:16 TO 28:20 (RUNNING 00:01:43.370)

16 Q Okay. How frequently would you refer
17 to -- and this is a general question, not
18 specifically to the CasePro contract -- but how
19 frequently do you refer to the contracts that you
20 work on as the COR at the Naval Hospital, Beaufort?
21 A All the time.
22 Q And when you say "all the time," is it
23 daily, week --
24 A Daily. Daily.
25 Q Daily, okay. All right. If you would
00028:01 look at page 00003, I asked you earlier to describe,
02 you know, in general the purpose of the contract.
03 And your answer was fairly close to what's written
04 in the contract. But I'm going to read that for
05 you. It says: Services, B.1. The Contractor shall
06 furnish qualified Health Care Workers in accordance
07 with Section C (Statement of Work). Individual Task
08 Orders for these services, and all other terms and
09 conditions set forth herein. Government
10 requirements for contracted health care personnel
11 shall be filled in response to Task Orders issued by
12 the Government against the contract.
13 Did I read that correctly?
14 A You did.
15 Q All right. Is there anything outside of

that in terms of the statement of work and the task orders that describes the responsibilities CasePro has to the United States government under this contract?
A No.

12. PAGE 31:02 TO 31:08 (RUNNING 00:00:12.720)

Q Okay. All right. If you look at 1.1, it says: The Contractor shall provide the health care personnel in accordance with the terms and conditions of this contract and each task order issued under this contract.
Did I read that correctly?
A Yes, you did.

13. PAGE 33:24 TO 34:16 (RUNNING 00:00:53.450)

Q In 2.3 it states: HCW's providing services under this contract shall be rendering
00034:01 personal services to the government and shall be subject to day-to-day supervision and control by government personnel. Supervision and control is the process by which the individual HCW receives technical guidance, direction and approval with regard to a task within the requirements of this contract.
Did I read that correctly?
A Yes, you did.
Q Okay. Who -- do you recall who the supervisor was for the CasePro workers involved in this case, Joe McDonald, Janice McDonald and Dr. Jansen on -- on February 24th, 2012?
A Yes, I believe it was Lieutenant Brannon; I don't remember her first name. And Dr. Gina Jordan.

14. PAGE 34:20 TO 34:22 (RUNNING 00:00:07.900)

Q Okay. Did you have any interactions with Lieutenant Brannon during the time she was supervising the CasePro employees?

15. PAGE 34:24 TO 34:24 (RUNNING 00:00:01.424)

A No.

16. PAGE 34:25 TO 35:17 (RUNNING 00:00:45.450)

Q Okay. Who did you communicate with
00035:01 about the CasePro contract?
A Who did I communicate with regarding the CasePro contract? I mean, CasePro had a lot of different task orders.
Q Who was your point person for discussing issues about the contract?
A At CasePro?
Q At CasePro.
A At the time, it was Tracey Braswell, I believe.
Q Okay. Would you speak directly with the health care workers? Or did everything you did go through Tracey Braswell?
A It would go through Tracey.
Q All right. Who was your source of information from within the federal government?
A Lieutenant Brannon and Dr. Jordan.

17. PAGE 35:23 TO 36:04 (RUNNING 00:00:23.100)

Q Following this incident February 24th, 2012 -- I apologize if I've asked you this question already -- but do you recall receiving any communications from anyone in the government indicating that Dr. Jansen, Joe McDonald or Janice McDonald did anything inappropriately during their time at the Naval Hospital, Beaufort on that day?

18. PAGE 36:07 TO 36:13 (RUNNING 00:00:20.863)

A No.
Q If you had received that, what would -- any information that was indicating concern about they -- how their involvement in this incident, generally what would be your response as the COR?
A I wasn't even aware the incident had transpired.

19. PAGE 36:20 TO 37:04 (RUNNING 00:00:29.690)

in any of your contracts, when you're made aware of a performance concern, attendance concern, any of the issues that you deal with as the COR, what is your response to that?
A I would reach out to the project manager, in this case Tracey Braswell, and we'd have a discussion over the phone about, you know, a plan of action, what -- what did they plan to do with their employee. Because ultimately it was up to them to figure that out.

20. PAGE 37:05 TO 37:11 (RUNNING 00:00:15.110)

Q Okay. And if you had -- if you had been -- but you were never contacted about any -- any issues with the incident on February 24th, 2012?
A No. No.
Q All right. So that was why that you had no communications with CasePro about the incident?
A Correct. Correct.

21. PAGE 47:18 TO 48:08 (RUNNING 00:00:47.248)

Q Ms. Meaut, looking back onto page 29 of Exhibit 1, 7.11.1 states: Each HCW providing service under this contract or resultant Task Orders shall undergo an orientation.
Did I read that correctly?
A Yes.
Q Where does that orientation take place?
A At the Naval Hospital.
Q Who conducts the orientation?
A Various people throughout the hospital. It's a two-day sit-and-learn event about all the various departments within the hospital and what they offer.
Q Is it run and organized by the government?
A Yes, education and training.

22. PAGE 49:18 TO 50:06 (RUNNING 00:00:34.780)

stated. You can answer.
A That's what it states here in the contract, you know, that that's the preference to have --
Q Is that your experience?

A Yes, we tend to get people that work for a significant amount of time.
Q Are there health care workers who worked at the Naval Hospital under a different contract and then assumed responsibilities under a new contract but perform the same job?
A Yes.
Q Is that fairly commonplace?
A Yes.

23. PAGE 51:03 TO 52:12 (RUNNING 00:01:53.400)

Q The question is, does the government encourage new contractors to hire health care workers that are already working or have already been working at the Naval Hospital, Beaufort under a different contract?
A The -- I'm not quite sure how to answer this. I think there's some clause. I can't -- don't quote me on the clause, but it's non-displacement of a current worker, they're encouraged to hire the incumbents.
Q Okay.
A So if I understand your question correctly, I think you're meaning going from one contract company to another contract company.
Q You -- you -- I think you answered my question.
A Yeah.
Q Thank you.
Page 40 deals with general duties. In 9.2 at the bottom it references the Joint Commission. What is that?
A It's an organization that accredits hospitals, and that's all I know about it.
Q And this paragraph states: Comply with the standards of the Joint Commission, applicable provisions of law, and the rules and regulations of any and all governmental authorities pertaining to licensure and regulation of health care personnel and medical treatment facilities, the regulations and standards of medical practice of the MTF and the bylaws of the MTF's medical staff. Adhere to and comply with all Department of the Navy, Bureau of Medicine and Surgery and local instructions and notices which may be in effect during the term of the contract.

24. PAGE 53:13 TO 53:21 (RUNNING 00:00:19.810)

Q All right. Now, as -- as the COR, you -- one of your responsibilities is to ensure that the terms of this contract are complied with by CasePro.
A Uh-huh.
Q Is that right?
A Yes.
Q Okay. And so one of those being 9.2?
A Uh-huh.

25. PAGE 67:13 TO 67:17 (RUNNING 00:00:25.450)

Q All right. So CasePro had satisfactory performance under the contract?
A Yes.
Q Okay. All right. In page 103, can you tell me what the surveillance plan is?

26. PAGE 68:17 TO 68:25 (RUNNING 00:00:25.007)

Q Okay. In 2.5 on page 104, it states: The government supervisory personnel specified in the task order are responsible for providing day-to-day supervision and control of contract personnel. This includes provision of technical guidance, direction and approval of tasks performed to satisfy requirements of the contract/task order. Did I read that correctly?
A Yeah.

27. PAGE 69:03 TO 69:06 (RUNNING 00:00:11.290)

Q What did your surveillance plan involve to ensure that the government's supervisory personnel referenced in 2.5 were supervising the health care workers?

28. PAGE 69:09 TO 69:18 (RUNNING 00:00:25.450)

A What did -- what did I do? Repeat that for me again, please.
Q Yeah. What did -- this is in the section Surveillance Plan, so --
A Uh-huh.
Q -- what did you do through your surveillance plan to ensure that the government supervisory personnel, in 2.5 that we just talked about, were actually providing day-to-day supervision and control of contract personnel?

29. PAGE 69:20 TO 70:16 (RUNNING 00:00:48.530)

A I walked through the department, make sure they're there, see if they have any issues. I mean, I'm just a presence.
Q And you're talking about Brannon, Angela Brannon or Gina Jordan?
A Uh-huh.
Q All right. So you would walk through, you would talk to them, make sure that they're there?
A Yeah, make sure the employees are there.
Q Where in particular would Ms. Brannon or Ms. Jordan be within the Naval Hospital?
A They would be in the ER, or they would be in their office. Dr. Jordan had an office adjacent to the ER.
Q All right. So you would physically walk past into the ER, past the ER, past her office to --
A Many times.
Q Okay. To ensure that she was there?
A Right.
Q And supervising the contract personnel?
A Right.

30. PAGE 74:22 TO 75:08 (RUNNING 00:00:36.251)

Q Okay. Is that something that you look for when you're overseeing Brannon and Jordan or anyone else?
MR. BERLINSKY: Object to the form.
MR. HOYLE: Plaintiff joins.
A I mean, it's just -- you're expected to treat everyone the same, while they are different. You know, you're supervising them on a day-to-day basis. You're approving leave, you're not approving leave. You would be doing the same whether you're,

07 in this situation, whether you're a government
08 personnel or you're a contract personnel.

31. PAGE 75:25 TO 76:20 (RUNNING 00:00:57.600)

25 Q Yeah, it does. Did you ever have any
00076:01 personal interaction with Janice McDonald?
02 A Only on a couple of occasions.
03 Q Do you know who she is?
04 A She was one of the nurses in the ER.
05 Q All right. Do you recall ever hearing
06 any concerns about her performance related to the
07 incident on February 24th, 2012?
08 A Not at all.
09 Q Okay. Do you recall Joe McDonald?
10 A I do know who he is, yeah.
11 Q Okay. Do you recall receiving any
12 concerns about Joe McDonald's performance on
13 February 24th, 2012?
14 A No.
15 Q Okay. And then the same question for
16 Dr. Jansen who was in the ER on February 24th, 2012.
17 Did you receive any correspondence from anyone in
18 the government regarding any errors or mistakes made
19 by Dr. Jansen on that day?
20 A No.

32. PAGE 77:06 TO 78:13 (RUNNING 00:00:42.694)

06 Q Ma'am, good afternoon.
07 A Good afternoon.
08 Q We met earlier today. My name is David
09 Hoyle. I'm a lawyer from Mount Pleasant, South
10 Carolina. I'm here today to ask you a few questions
11 in response to examination by prior counsel. I want
12 to make sure I understand a little bit about your
13 background. You have an Associate's degree from the
14 Mohawk Valley Community College; is that correct?
15 A Yes.
16 Q I understand that that Associate's
17 degree is in legal stenography, correct?
18 A Uh-huh.
19 Q Is that a yes?
20 A Yes.
21 Q Okay. Do you yourself have any legal
22 experience?
23 A No.
24 Q Not a lawyer?
25 A No.
00078:01 Q What about with respect to any type of
02 medical training or health care training, do you
03 have any of that kind of background?
04 A No.
05 Q Not a doctor?
06 A No.
07 Q Not a nurse?
08 A No.
09 Q Not a licensed practical nurse or a
10 physical therapist?
11 A No.
12 Q Nothing like that?
13 A No.

33. PAGE 80:12 TO 87:06 (RUNNING 00:06:09.187)

12 Q Okay. Let me start over. So in 2006
13 you went to work for the Naval Hospital, correct?
14 A Yes.

Q And originally you were working as an administrative assistant/secretary; is that correct?
A Yes, at the Naval Hospital, 2006, right.
Q Okay. What training, if any, did you have in order to become an administrative assistant/secretary at the Naval Hospital?
A Previously when I worked for federal government I had worked in that field.
Q Okay. Doing administrative type tasks?
A Right.
Q Okay. And then in 2010 you transitioned
00081:01 from being an administrative assistant/secretary in the office of the commanding office to being a COR, correct?
A Correct.
Q Okay. What training, if any, did you undergo when you became a COR?
A When I got the job here at the Naval Hospital?
Q Yes, ma'am.
A Contracting officer training through NMLC.
Q And that training, is that something you had to go to a specific place in order to receive instruction, or was it done through a book? Was it done online? Help me understand.
A Right. I went to Camp Le Jeune, North Carolina.
Q And how long were you up there at Camp Le Jeune?
A A week.
Q Okay. And you had classes or instructions in some sort of classroom-type setting?
A Yes.
Q And did you receive written materials that you had to review?
00082:01 A Yes.
Q Is there any type of test you had to take?
A No.
Q Okay. And again not to belabor the point, but you became a COR in 2010, correct?
A Correct.
Q If you look at the document that my friend Mr. Mackelcan marked as Exhibit No. 1 to your deposition, it's a document that he spent some time examining you on, correct?
A Uh-huh.
Q That's a yes?
A Yes. That's a yes.
Q Okay. And if you on the very first page of the document that's been marked as Exhibit No. 1, the page that is Bates stamped in the lower right-hand corner as 00001, we have an award contract with an effective date of September 28th, 2007, correct?
A Yes.
Q Not to state the obviously, but September 28th, 2007, was before you were the COR for this particular project, correct?
A Correct.
00083:01 Q Okay. So when CasePro came in to the Naval Hospital here in Beaufort and began providing services under the contract that has been marked as Exhibit No. 1 to your the deposition here today, you were not the initial COR, correct?

A Correct.
Q When CasePro came in to the Naval Hospital in Beaufort, South Carolina and began providing services in response to the contract marked as Exhibit No. 1 to your deposition here today back in 2007, you would have had no personal firsthand involvement with the implementation of that project until sometime in 2010, correct?
A Correct.
Q Almost three years later?
A Yes.
Q Okay. There was a term I heard earlier, I believe it was the word "incumbent." Do you recall using that?
A Yes.
Q Okay. What is an incumbent?
A The individual who's been in that job up until that point.
Q Okay. So fair to say somebody who leaves the employment of a contractor and has a break in service, let's say that individual goes and works somewhere else, like at the Hampton Hospital, and then comes back to the Naval Hospital several years later, that person would not be an incumbent, correct?
A Correct.
Q Okay. Now, there were some questions about the contract that had been marked in Exhibit No. 1. And then there were some contracts (sic) about a task order, correct?
A Correct.
Q And just so we're all clear, the task order that's at issue in this case is not contained within the 131 pages of Exhibit No. 1, correct?
A Correct.
Q I'll come back and ask you some questions in a minute about the contract. But for sake of today's proceedings, I'm going to mark as Exhibit No. 2 a multipage document that's been produced in this litigation that's MR-Miller 18 through 28, it was also identified as Exhibit No. 3 at the Rule 30(b)(6) deposition of CasePro, Inc.
Ma'am, I'm handing you that document. And take as much time as you need to flip through it and tell me if you've seen it before.
(Exhibit No. 2 is marked for identification.)
MR. BERLINSKY: Let me see when you're through, ma'am, please.
A (Document tendered to Mr. Berlinsky.)
MR. BERLINSKY: Okay (document tendered to the witness.)
BY MR. HOYLE
Q Ma'am, have you had an opportunity to look at the document that I've marked as Exhibit No. 2 to your deposition here today?
A Yes.
Q And this says on the face of the document that it is an order for supplies or services, correct?
A Correct.
Q And it has a date of order/call of October 1st, 2011, correct? In box No. 3 at the top of the page?
A Yes.
Q And for those of us who have never worked for the federal government, October 1st is

the beginning of the fiscal year, correct?
A Correct.
Q Is that when new contracts and new task orders typically begin with respect to persons or
00086:01 entities providing contractural services to the federal government?
A Yes.
Q Okay. And on this document which we've marked as Exhibit No. 2, can you tell us who the contractor is?
A CasePro.
Q Okay. And this is for supplies or services at the Naval Hospital here in Beaufort, correct?
A Correct.
Q Okay. And the very first page of this document bears a signature in block No. 24 on the very page of a contracting/ordering officer of the United States of America, correct?
A Correct.
Q Do you recognize whose signature that is?
A Yes.
Q Whose signature is that?
A Melanie Musgar, she's a contracting officer.
Q And do you believe she's authorized by the United States of America to sign contracts behalf of the government?
00087:01 A Yes, sir.
Q Okay. And this specific task order provides that certain payments will be made to CasePro, Inc. with respect to certain services being provided, correct?
A Correct.

34. PAGE 89:04 TO 93:16 (RUNNING 00:03:36.630)

Q All right. Turn with me to section C of this task order which begins on the page that is Bates stamp MR-Miller-000023. The services that are going to be provided under this task order are going to be in the emergency room at the Naval Hospital in Beaufort, correct?
A Correct.
Q And the contractor, that means CasePro, a company out in Texas, is going to provide personnel from three labor categories: Physician, registered nurse and licensed practical nurse, correct?
A Correct.
Q And we see further down this page in point number 4, hours of operation, that the contractor, that means CasePro, a company out of Texas, shall provide emergency room services on a 24-hour basis daily including holidays, correct?
A Correct.
Q So every hour of the day Monday through Friday, Saturday and Sunday there is going to be personnel in the emergency room from CasePro during
00090:01 this contract period?
A Yes.
Q Okay. And in fact, if you look at the next page of the document I've marked as Exhibit No. 2, we actually have a handy little chart that even shows that on Sunday, Monday, Tuesday, Wednesday, Thursday, Friday and Saturday there is going to be

one physician, two registered nurses and one licensed practical nurse on duty at all times, correct?
A Correct.
Q And those individuals who I just enumerated, the physician, the two registered nurses and the licensed practical nurse, are all going to be employees of CasePro, Inc., correct?
A Correct.
Q And if you look above that handy little grid that we have setting forth the days of the week and the personnel that CasePro is going to provide, we have language that says: The contractor, that means CasePro, is responsible for scheduling personnel to cover the schedule?
Did I read that correctly?
A Yes.
Q That's your understanding of what CasePro undertook to do, correct?
A Correct.
Q You didn't make this schedule for this doctor, the two nurses or the LPN, correct?
A Well, we -- we identified what we needed, what our needs were.
Q Okay. And the needs were set forth in this task order?
A Correct. Correct.
Q Was there any day of the week in which there would be two doctors instead of one?
A No.
Q Was there any day of the week in which there would be three registered nurses working instead of two?
A No.
Q Is there any day of the week in which there'd be two licensed practical nurses working instead of one?
A No.
Q What the government set for is set forth in the plain text on the page we were just looking at, that being the page Bates stamped MR-Miller-24 in document Exhibit No. 2 to your deposition, correct?
A Correct.
Q Okay .so the government said this is what we need. But it was up to CasePro, the folks from Texas, to actually schedule personnel to meet this schedule?
A Correct.
Q That's not something you did, correct?
A Correct.
Q All right. This task order also says: The contractor, that means CasePro, is responsible for providing the leave benefit for these personnel.
Is that correct?
A Correct.
Q This document also says: The contractor, that means CasePro, is responsible for approving leave for these personnel.
Is that correct?
A Correct.
Q This document also says: The contractor, meaning CasePro, is responsible for providing any holiday benefit.
Correct?
A Correct.

Q And in that same paragraph, that being paragraph section C, subpart 5, subpart B: The contractor, meaning CasePro, shall maintain sufficient backup personnel to ensure coverage of the schedule during periods of both scheduled and unscheduled absence.
Correct?
A Correct.
Q So the responsibility to make sure that at all times, whether you're talking about 2 o'clock in the morning or 2 o'clock in the afternoon, whether you're talking about a Monday, or whether or not you're talking about a Thursday, make sure there is one medical doctor, two registered nurses and one licensed practical nurse physically present during this time period in the Naval Hospital, Beaufort's Emergency Room fell to CasePro, correct?
A Correct.

35. PAGE 102:03 TO 103:14 (RUNNING 00:01:13.790)

Q Okay. Did you have understanding, going back to the task order I've marked as Exhibit 2, that the contractor, meaning CasePro, shall have an emergency-medicine-trained physician perform a peer review on the treatment on all emergent patients and not less than 10 percent of all urgent patients?
A What was that question again?
Q Sure. If you look at page 24 --
A Okay.
Q -- of Exhibit No. 2 to your deposition, where in paragraph 6 it says Duties. Do you see that?
A Yes.
Q And these are some additional duties that the contractor, in this case CasePro, has undertaken, correct?
A Uh-huh.
Q That's a yes?
A Yes.
Q Okay. And one of those additional duties is that an emergency-medicine-trained physician shall perform a peer review on the treatment of all emergent patients and not less than 10 percent of all urgent patients. Did I read that correctly?
A Yes.
Q Since you were the COR for this contract in this task order, can you tell the court and the jury which emergency-medicine-trained physician CasePro, Inc. designated to do that peer review?
A I don't know.
Q Did you ever know?
A No.
Q So that's not something you knew back in 2011 and 2012 and you forgot, you just never knew that?
A I wouldn't be involved in that.

36. PAGE 105:05 TO 115:03 (RUNNING 00:10:34.520)

Ma'am, we were looking at the schedule contained within the task order that's been marked as Exhibit No. 2, correct?
A Uh-huh.
Q That's a yes?
A Yes?
Q And that task order reflects that the

emergency room is going to be opened at the Naval Hospital in Beaufort 24 hours a day, 7 days a week, 52 weeks out of the year, correct?
A Yes.
Q Was Dr. Gina Jordan physically present 24 hours a day, 7 days a week, 52 weeks out of the year?
A I didn't supervise Dr. Jordan so I don't know for a fact.
Q Okay. Who did supervise Dr. Jordan?
A Her director, Dr. Their at the time.
Q Okay. She wasn't your direct report?
A Pardon?
Q You were not her direct supervisor, correct?
A No, I was no one's supervisor.
Q Same thing would be true with respect to Nurse Brannon, correct?
A Correct.
Q Who did Nurse Brannon work for?
A Her director, Dr. Their.
Q Okay. So both those individuals reported to -- I believe he held the rank of commander?
A Commander, uh-huh.
Q That's a yes?
A That's a yes.
Q Okay. So you don't know for sure whether or not Nurse Brannon or Dr. Jordan were physically there 24 hours a day, 7 days a week, 52 weeks out of the year; is that correct?
A I didn't know what their schedule was, no.
Q Okay. Other than Nurse Brannon or Dr. Jordan, are you aware of any other uniformed military personnel that actually would ever set foot in the emergency room at the Naval Hospital in Beaufort other than being a patient?
A I wouldn't know.
Q Not something you know?
A Not something that I was -- would be aware of, no.
Q Okay. Fair to say that you're not the best person to ask as to what actually went on on a day-to-day base in the ER?
A Correct.
Q There were some questions earlier about the supervision that either Dr. Jordan or Ms. Brannon provided to others. Do you recall that?
A Yes.
Q Okay. Do you actually have firsthand personal knowledge of what supervision, if any, either Dr. Jordan or Nurse Brannon provided to any employees of CasePro, Inc.?
A Do I have knowledge of their direct supervision?
Q Yes, ma'am.
A Yes.
Q Okay.
A Because they would come to me occasionally with issues on attendance, or what have you, minor issues.
Q Okay. And your understanding from those conversations was that that was dealing with things like time, attendance, punctuality, that kind of thing, minor issues, as you said?

A Yes.
Q Okay. Scheduling, perhaps?
A Uh-huh.
Q That's a yes?
A That's a yes.
Q Okay. Did either Nurse Brannon or Miss -- or Dr. Jordan ever come to you and talk to you about the actual way -- we'll start with the doctor -- one of the CasePro, Inc. employed doctors was utilizing his knowledge, expertise and skill to treat patients?
A Ask me that question again.
Q Sure. I'll ask it a little slower. During the time that you were the COR for the contract and task order that we were talking about here today, did either Nurse Brannon or Dr. Jordan come to you with a concern about how any CasePro, Inc. employed doctor was utilizing his or her education, training and experience to treat patients?
A Not that I could recollect, no.
Q Same question with respect to any CasePro, Inc. employed nurse?
00109:01 A How -- with a problem on how they were treating patients?
Q Yes, ma'am.
A Maybe occasionally on minor things, but nothing major that sticks out in my mind.
Q And that's specific to medical treatment?
A Yes.
Q Okay. When in 2010 did you begin doing work as a COR?
A January 2010.
Q Can you tell the court and jury who Amanda Rutten is?
A She was one of my points of contact at NMLC years ago when I first started working there.
Q This would be back in 2010?
A Uh-huh.
Q That's a yes?
A Yes, that's a yes.
Q What was her job title at NMLC?
A I don't recall. I don't know if she was a contracting officer or a contract specialist. I'm not sure.
Q We've talked a little bit today or danced around this concept of chain of command. Are
00110:01 you familiar with that concept?
A Yes, I am.
Q Okay. And certainly we have the civil command authority, the president of the United States at the top, and then we may have someone who just took the oath of enlistment 10 minutes ago at the bottom, is that fair kind of --
A Sure, that's fair.
Q Okay. Where within the chain of command was Ms. Rutten with respect to you? Was she your superior or your junior or your co-equal?
A Probably my superior.
Q Okay. Generally speaking, what, if anything, did Ms. Rutten have to do with peer review of physicians at the Naval Hospital in Beaufort?
A I would have no knowledge. She worked at NMLC. She didn't work at the Naval Hospital.
Q Okay. And for those persons who weren't

paying attention earlier, NMLC is located at Fort Detrick, Maryland?
A Correct.
Q Did you ever actually meet Ms. Rutten in person?
A Yes, I did.
Q How many times?
A Once.
Q Okay. And what was the circumstance that led you and Ms. Rutten to meet?
A She was down at the Naval Hospital on a -- I think it was a training session.
Q Was she conducting training that you yourself attended?
A Yes.
MR. HOYLE: I'm marking a two-page document that's been produced in this litigation as Defendant RRFP 333 and 334. Having previously marked the notice for today as Exhibit 3. This will be Exhibit 4, Counsel.
(Exhibit No. 4 is marked for identification.)
BY MR. HOYLE
Q And ma'am, I'm going to hand and I'll ask you a threshold question first after you've had a moment to look at it.
MR. BERLINSKY: This is Exhibit 4?
MR. HOYLE: Yes. The Notice is 3.
MR. MACKELCAN: Do you have copies of that?
MR. HOYLE: I do not.
MR. MACKELCAN: Okay. May I take a look that the, please?
MR. HOYLE: Sure (document tendered to Mr. Mackelcan).
MR. MACKELCAN: Thanks.
BY MR. HOYLE
Q Ma'am, I showed you a moment ago a two-page string of e-mails that's been marked as Exhibit No. 4 to your deposition. Let me just ask a foundational question. Have you ever seen these emails prior to today?
A No.
Q Okay. There's some information contained an email that Craig Martin sent Wednesday, April 28th, 2010?
MR. BERLINSKY: I just want to make a clarification? The witness testified to your question she hadn't seen those before today, the deposition. But she has seen them today, this morning. So I just want to make sure that the record's clear and we don't bind Ms. Meaut into inconsistent testimony.
BY MR. HOYLE
Q Okay. Let me try and straighten this out. Prior to this deposition starting, had you ever seen this email before?
A Yes.
Q Okay. Before Ms. Galuppo made you raise your right hand and swear an oath to tell the truth, you'd seen these two pieces of paper, correct?
A Today.
MR. BERLINSKY: Today.
BY MR. HOYLE
Q Okay. Without divulging to me any communications between and perhaps Mr. Berlinsky, I'm just going to ask you this question, did

Mr. Berlinsky show you these two pieces of paper?
A Yes.
Q Okay. Prior to Mr. Berlinsky showing you these two pieces of paper this morning prior to your deposition, had you ever seen this email exchange before?
A No.
Q And I appreciate Counsel cleaning that up.
Ma'am, there's some information contained in an email that Craig Martin sent Amanda Rutten back on April the 28th, 2010. And what is your understanding of who Craig Martin is?
A He was CasePro's project manager on that contract.
Q The contract that we've been talking about here today that's been marked Exhibit No. 1 and the task order that's marked as Exhibit No. 2?
A Yeah, uh-huh.
Q Is that yes?
A Uh-huh, yes. That's a yes.
Q And you used the term earlier in describing what you did as the COR as a liaison. Do you recall using that word?
A Yes.
Q Okay. Fair to say that with respect to the contract for the provision of personnel in the emergency department at the Naval Hospital, Beaufort that at some period of time Craig Martin was your liaison at CasePro?
A For some period of time, yes.
Q Okay. And then after he moved on to something else, Tracey Braswell took over that part?
A Yes, uh-huh.
Q He was, in essence, your counterpart?
A Yes.
Q Okay. How frequently would you communicate with Craig Martin? Is this somebody you'd send a Christmas card to in December and not hear from all year? Or would you be talking to him on, I don't know, a weekly basis?
A I wouldn't be talking to him. I was new to the job in January. I had very little dealing with Craig Martin at all until much later.

37. PAGE 118:16 TO 119:09 (RUNNING 00:00:59.770)

Q Okay. In the email that you first saw this morning from Amanda Rutten -- excuse me -- from Craig Martin to Amanda Rutten, there's a reference to a request made by the COR to CasePro, "To terminate Dr. Jansen immediately by direction of the CO."
Did you recall reading that in the email that you looked at here today?
A I read that, yes.
Q Okay. Prior to reading that in the email here today, did you yourself have any personal knowledge of that request made sometime in April of 2010?
A No.
Q That's not something that you and Ms. Smith ever discussed?
A No.
Q Okay. Let's go back to this concept, though. Who is the CO? Let's start there.

38. PAGE 119:14 TO 120:11 (RUNNING 00:00:45.180)

MR. BERLINSKY: Time period.
BY MR. HOYLE
Q Let me ask you the question this way then. We talked a little bit earlier today about a hierarchy or chain of command within the military, correct?
A Uh-huh.
Q Is that a yes?
A Yes, that's a yes?
Q Okay. If one were to set foot on the grounds of the Naval Hospital, Beaufort, South Carolina today, what is the significant of an individual being introduced as the CO, or commanding officer.
A Very significant?
Q How so?
A That's the commanding officer. You don't -- it doesn't get much higher than that on the post.
Q Is that the highest ranking military officer there on the grounds at the Naval Hospital in Beaufort?
A Yes.

39. PAGE 120:21 TO 121:17 (RUNNING 00:00:43.710)

A The CO is the commanding officer in the Naval Hospital. She's the commander of the ship, he or she.
Q Everybody on that post reports to him or her, correct?
A Yes.
Q In the civilian world, we'd call that the boss, correct?
A Correct.
Q How many persons back in, oh, let's just say, 2010 were physically present on a daily basis on the grounds of the Naval Hospital in Beaufort?
A Oh, I don't know.
Q Are we talking 10 people? 100 people? 1000 people? Give me an estimate.
A Probably between 500 to 1000.
Q And of those 500 to 1000 people, the CO, or the commanding officer, that's the top dog, correct?
A Yes.
Q That's the person in charge, correct?
A Yes.

40. PAGE 122:03 TO 123:21 (RUNNING 00:01:29.100)

Q As you sit here today, do you have any information or testamentary evidence that you can provide that disputes what's set forth in this email dated April 28th, 2010, that the commanding officer of the Naval Hospital, Beaufort, in April 2010, directed CasePro, Inc. to terminate Dr. Jansen immediately?
A Do I have any information that disputes that?
Q Yes, ma'am.
A I don't have any information that disputes it. That's the first I saw that email today.
Q Okay. If -- do you plan on going into the office today after you leave here?

A It depends.
Q Let's assume we finish in the next 15 minutes?
A Yes.
Q Okay. If you were to go back into the office today at the Naval Hospital in Beaufort and your telephone rang and it was the commanding office at the Naval Hospital in Beaufort, would you pick up the telephone?
A Yes.
Q Wouldn't let that call roll over to voicemail, would you?
A No.
Q And why is that?
A That's an important person to talk to.
Q All right. Probably the most important person on that post, correct?
A Yes.
Q Short of President Obama, or somebody from the Joints Chief of Staff showing up, that's the most important person that anyone on that post, whether military or civilian is going to listen to, correct?
A Correct.
Q If the commanding officer called you up on the telephone and told you that he wanted one of the contractors, on one of the contracts for which you are the COR, to terminate one of their employees, would you ignore the CO telling you that?

41. PAGE 123:24 TO 124:11 (RUNNING 00:00:21.560)

Q You can answer?
A I wouldn't ignore, but it's not the right course of action.
Q And why is that?
A Because it's not my place to do that. It's not my place to give an order to terminate an employee.
Q Particularly somebody who doesn't work for you, correct?
A Correct.
Q Particularly for somebody who doesn't work for the government of the United States, correct?

42. PAGE 124:13 TO 124:24 (RUNNING 00:00:35.160)

A Correct.
Q Who a contractor hires or doesn't hire, or conversely, who a contractor fires or doesn't fire, that's up to the contractor, correct?
A Correct.
Q And at the end of the day while persons on the post, whether they wear a uniform, whether they be civilian, while they've got to reason listen to the commanding officer of the United States Navy who has been dutifully assigned to that post, folks out in Texas at a private company, they don't have to listen to the commanding officer, do they?

43. PAGE 125:01 TO 125:05 (RUNNING 00:00:16.682)

A No. I mean, they would get their instruction from the contracting officer.
Q And under the contract, it's the contractor that has the right to hire and fire, correct?

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44. PAGE 125:07 TO 125:07 (RUNNING 00:00:01.044)

A Yes.

45. PAGE 130:05 TO 132:21 (RUNNING 00:02:44.290)

Q Ma'am, just a few brief questions in follow-up. You weren't the one actually making the schedule for the doctor, the two nurses and the LPN, correct?
A No.
Q That's something that a CasePro employee did and emailed to you?
A Correct.
Q That would typically, I would imagine, come from your liaison, either Craig Martin or Tracey Braswell, correct?
A Right.
Q That's a correct?
A Yes.
Q Okay. There were some questions a minute ago about what steps taken prior to privileges being granted. Do you recall that line of questioning?
A Uh-huh.
Q That's a yes?
A Yes.
Q Okay. With respect to a particular person, let's say a particular doctor, the doctor himself or herself would not submit a packet of materials concerning his or her credentials; is that fair?
A That's correct.
Q That package, instead, would actually come from the contractor in this case, CasePro, correct?
A Correct.
Q And did CasePro, with respect to a particular one of its employees, send things to you piece mill, meaning they'd send you a transcript from college and a board certification from a medical society another day? Or did they send it all in one nice, pretty packet?
A All in one packet.
Q And typically -- strike that.
And if you pull back out contract number -- I mean document No. 1, Exhibit No. 1 -- it's getting late in the day. I apologize. Use. This is the contract. Turn with me to the 28th page of that document, that's section 7.10.3.
A Uh-huh.
Q Is that correct?
A That's correct.
Q You look in the last sentence of that paragraph, does it provide that the contractor, in this case CasePro, shall discontinue the service of an individual who fails to maintain compliance with qualification and credentialing requirements?
MR. MACKELCAN: Object to the form.
A What's the question?
Q Is that -- I'll say it a little slower, okay?
A Uh-huh.
Q Look at 7.10.3.
A I am.
Q Okay. The last sentence.
A Yes, I am.

Miller Trial

Q Does the contract provide that the contractor, in this case CasePro, shall discontinue the service of an individual who fails to maintain compliance with qualification and credentialing requirements? Yes or no?
A Yes.

46. PAGE 133:01 TO 133:23 (RUNNING 00:00:43.590)

Q At one point in time, did they have contracts in addition to the one that we've been talking about here today for services in the ER?
A Yes.
Q How many contracts to do you think CasePro had to provide persons to do work at the Naval Hospital?
MR. MACKELCAN: Objection, calls for speculations.
Q Approximately, ma'am?
MR. MACKELCAN: Same objection.
A About 8 to 10.
Q And were you the COR for several of those contracts?
A Several of them, yes.
Q How many specific contracts with CasePro, Inc. were you the COR for, if you can recall?
A How many specific ones?
Q Yes, ma'am?
A I think approximately 10.
Q Have to use both hands to count them?
A Yeah.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 00:59:19.845)

PROOF OF SERVICE OF THE RECORD ON APPEAL

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM BEAUFORT COUNTY
Court of Common Pleas

Diane Schafer Goodstein, Circuit Court Judge

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SC Court of Appeals

Case No. 2012-CP-07-03782

Rebecca Delaney, as Personal Representative of the Estate of Justin Nicholas Miller, Appellant,

v.

CasePro, Inc., Respondent.

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR, I certify that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

I further certify that the Record on Appeal is in compliance with the Supreme Court Order of April 15, 2014 regarding "Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings."

June 10, 2016

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