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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

T. David Hoyle
South Carolina Bar # 74055
W. Christopher Swett
South Carolina Bar # 748251
Temitope O. Leyimu
South Carolina Bar # 101288
Motley Rice LLC
28 Bridgeside Blvd.
Mount Pleasant, SC 29464
(843) 216-9000
(843) 216-9440 (Facsimile)

Crystal Lynn Castleberry
South Carolina Bar # 78661
Castleberry Law Offices
3712 Swallowtail Dr.
Morgantown, WV 26508
(304) 594-2828
(304) 594-2899 (Facsimile)

Attorneys for Appellant

D. Gary Lovell, Jr.
South Carolina Bar # 69296
Douglas W. Mackelcan
South Carolina Bar # 76332
Carlock, Copeland & Stair, LLP
40 Calhoun Street, Suite 400
Charleston, South Carolina 29401
(843) 727-0307

Attorneys for Respondent

William J. Farley, III
S.C. Bar No.: 101033
CARLOCK COPELAND & STAIR, LLP
40 Calhoun Street, Suite 400
Charleston, SC 29401
Phone: (843) 727-0307

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) CASE NO. 12-CP-07-3782

Defendant.

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) CASE NO. 12-CV-07-5702

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

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

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) THE COURT OF COMMON PLEAS
) FOURTEENTH JUDICIAL CIRCUIT

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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).

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) MEDICAL⁵ AND FUNERAL EXPENSES.⁶

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

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

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

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.

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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).

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(Principal Liable for Acts of Agent, Servant or Employee Acting within the Scope of Employment)

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.

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

**REBECCA DELANEY, as the Personal
Representative of the Estate of JUSTIN
NICHOLAS MILLER,**

Plaintiff,

vs.

CASEPRO, INC.,

Defendant.

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 foreseeability 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. 143

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. 184

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. 165

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 in 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. **NR 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. **A18**
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. Rothstein, 281 S.C. 541, 316 S.E.2d 690, 701 n. 3 (Ct. App. 1984).

DEFENDANT'S REQUEST TO CHARGE NO. 1922
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.

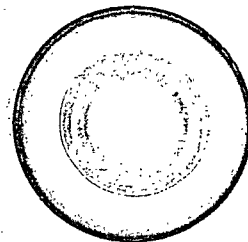
911 Recording Re-cut
PL1 version

911 Calls

WHR

10-7-15

Redacted



2012-CP-07-
037

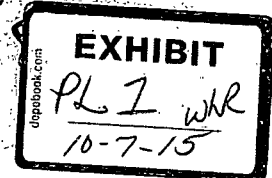


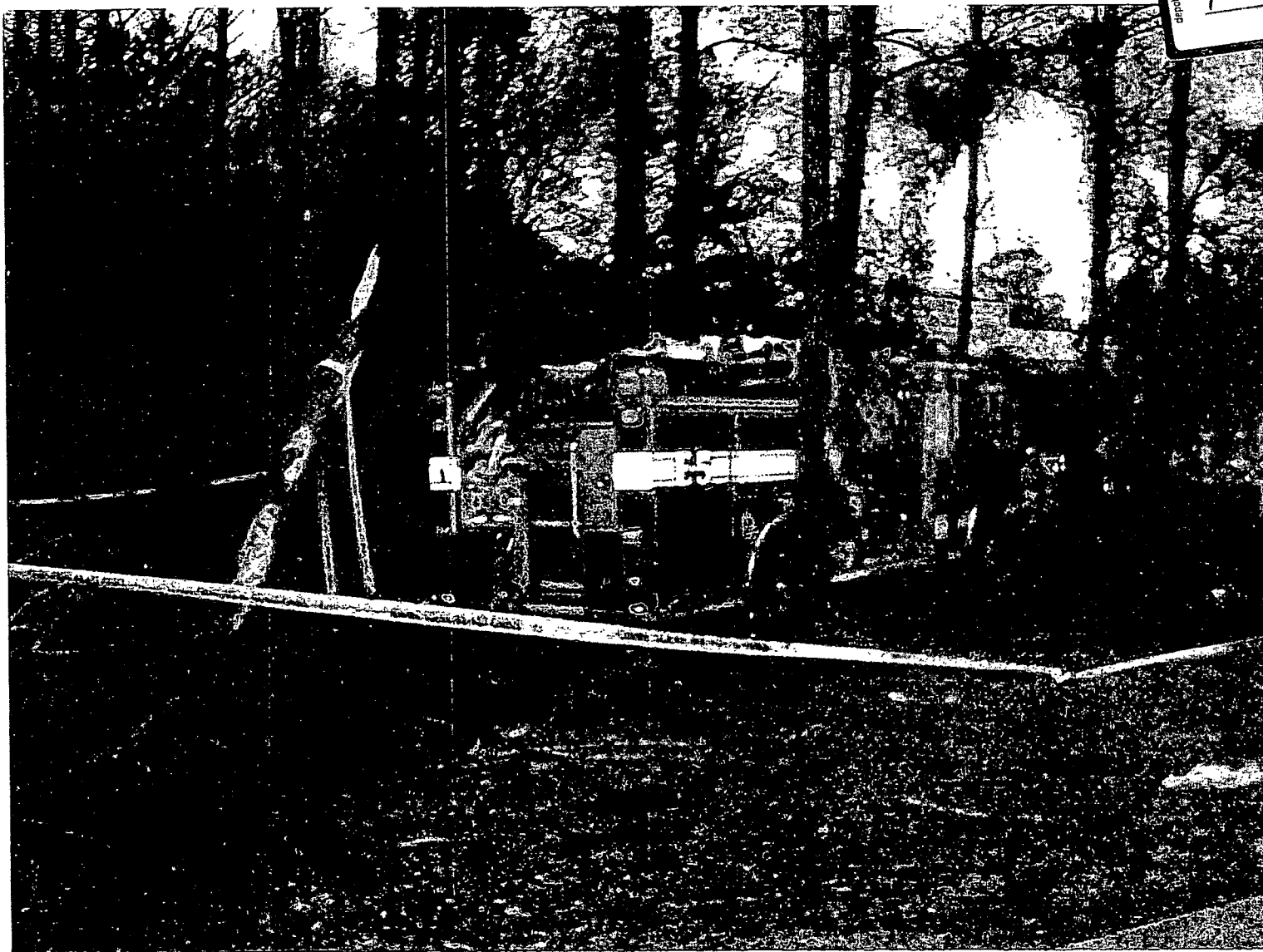
EXHIBIT
WHR
PL 3-A
10-7-15



MR-Miller-002189

Λ

EXHIBIT
PL3B

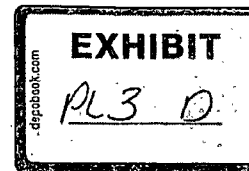


MR-Miller-002190

EXHIBIT
PL3 C



MR-Miller-002191



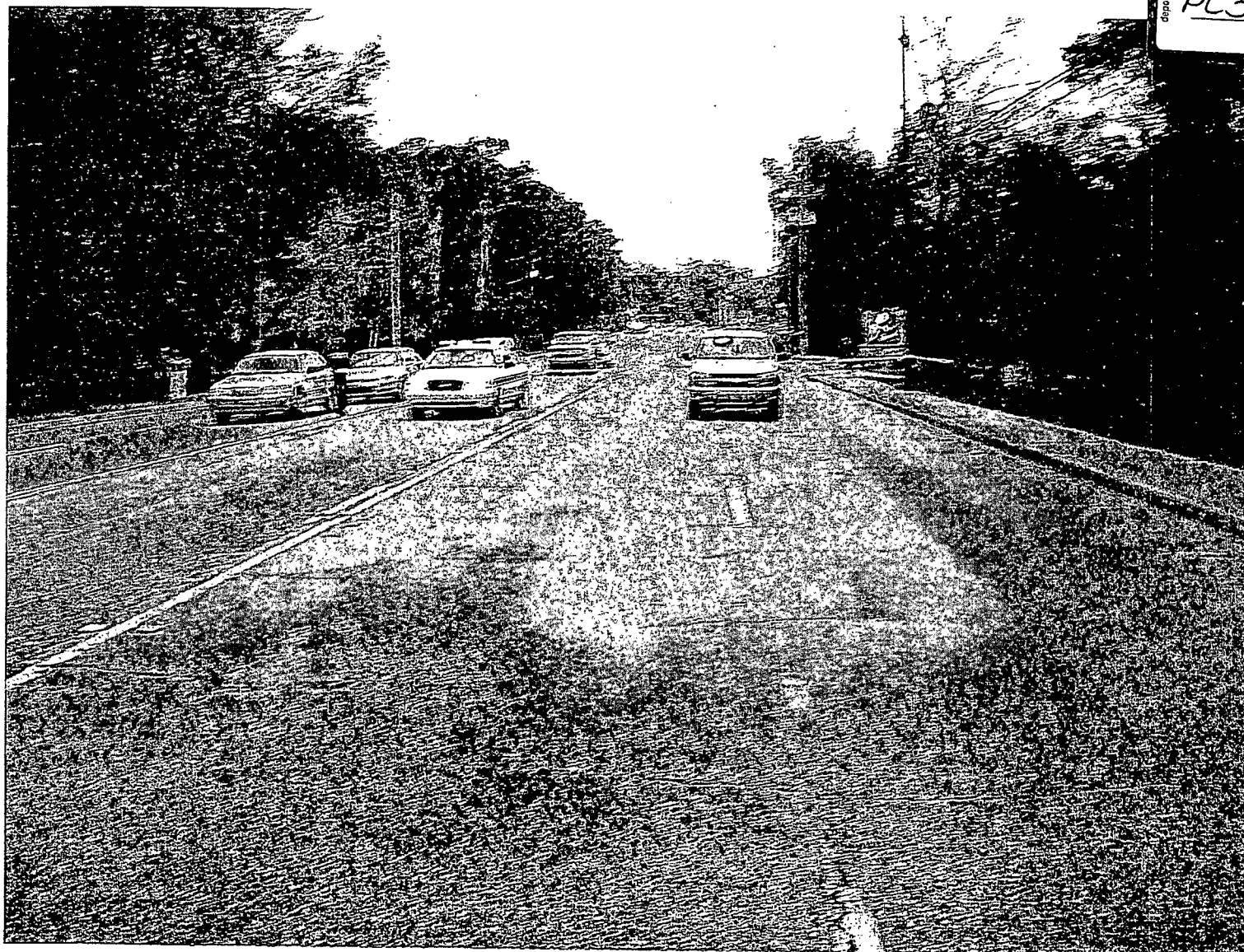
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EXHIBIT
PL 3 E



MR-Miller-002193

EXHIBIT
PL3 F



MR-Miller-002194

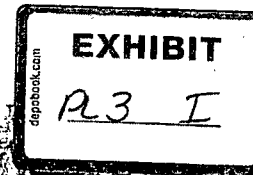
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PL 3 G



EXHIBIT
PL3 14



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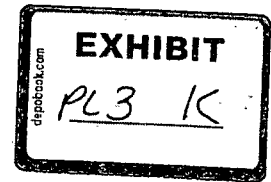


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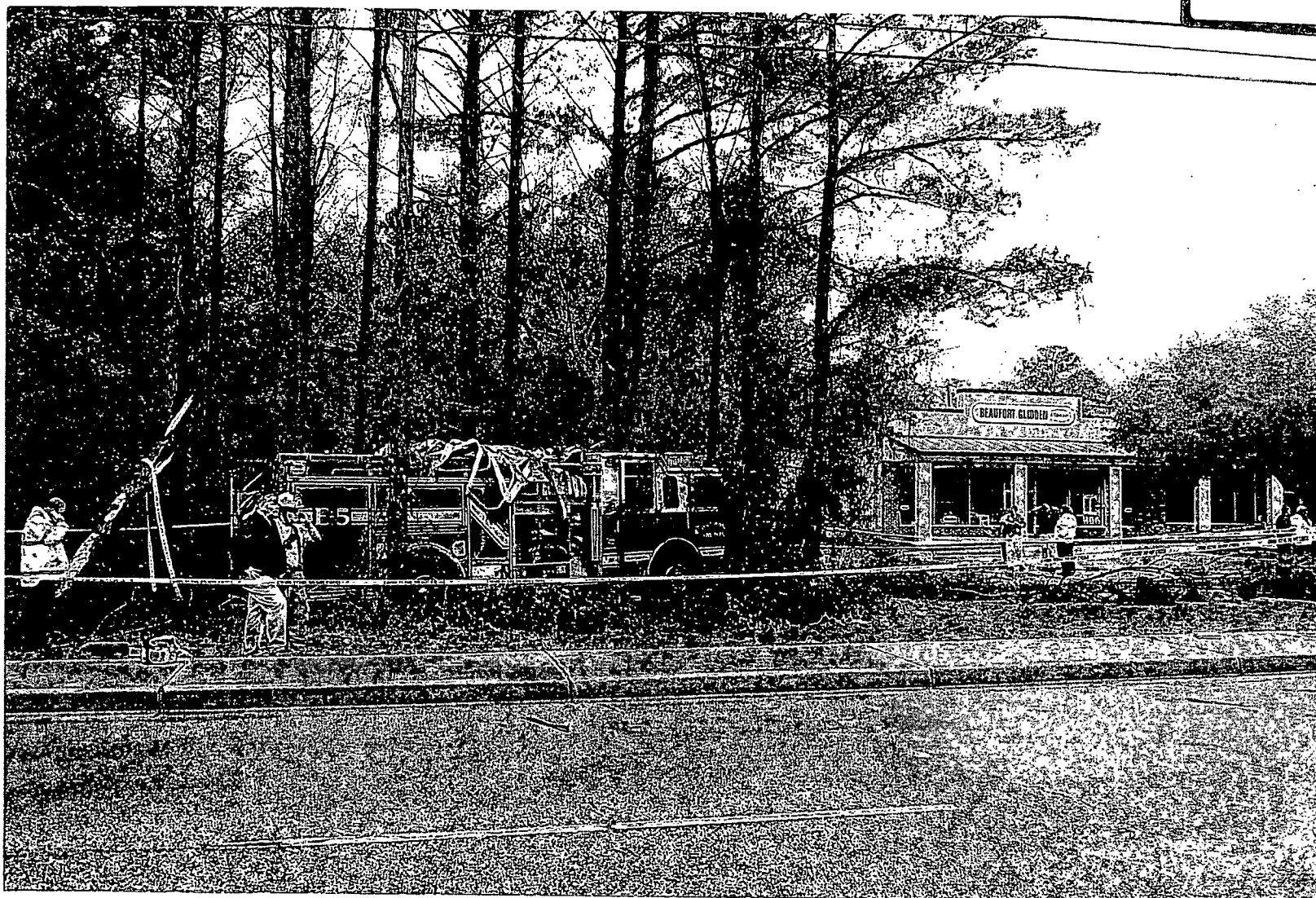


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MR-Miller-002203

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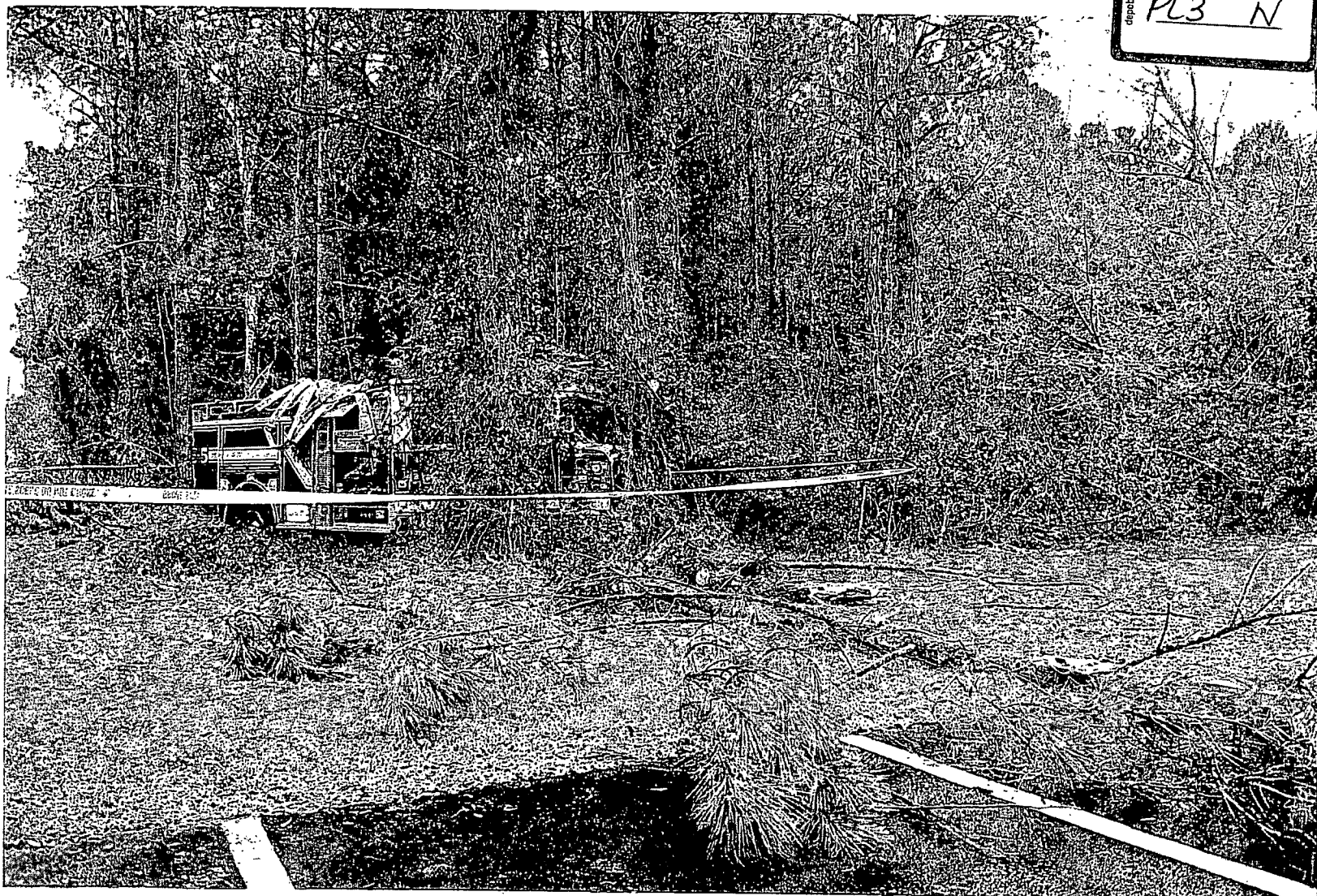
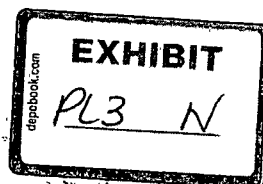


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EXHIBIT
PL 3 M



MR-Miller-002205



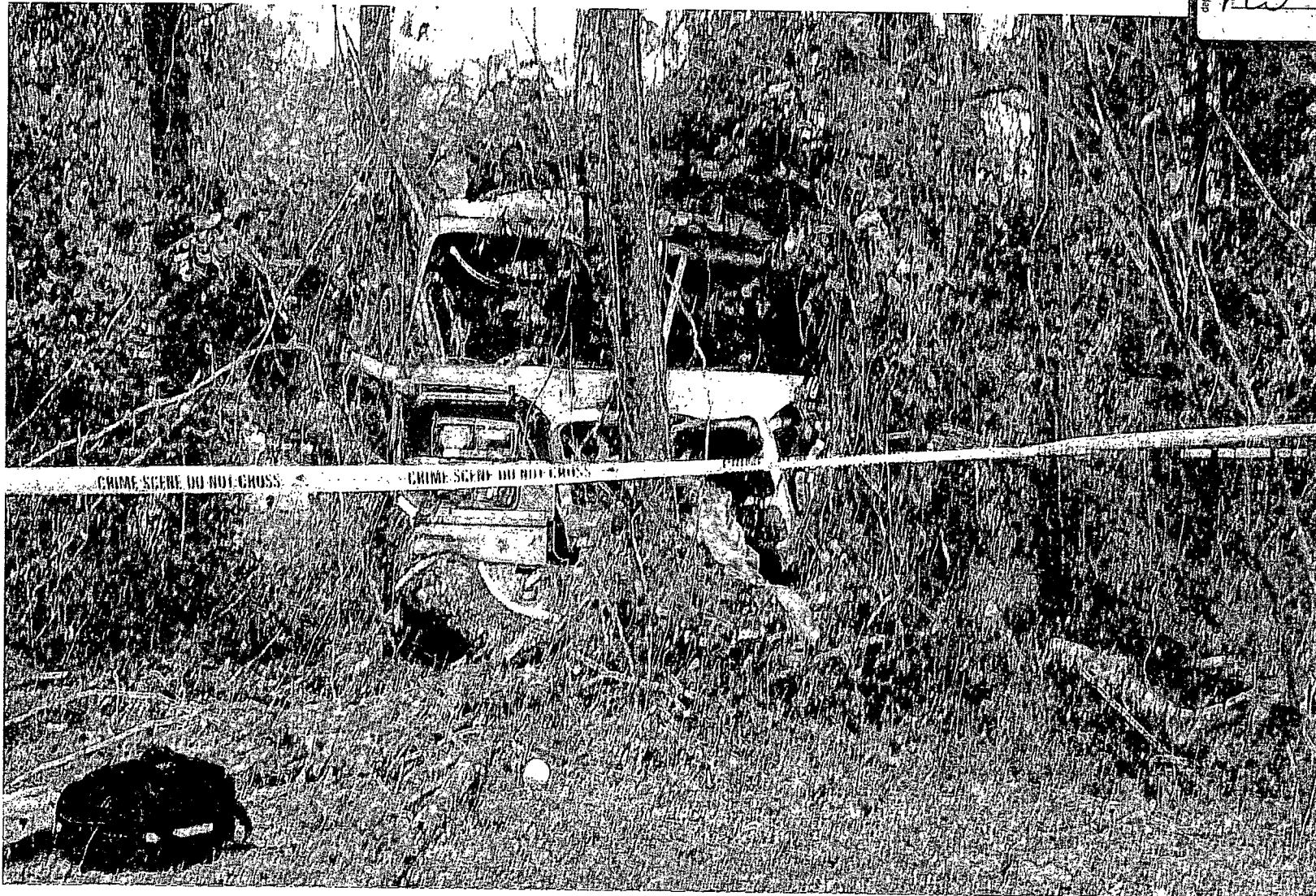
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EXHIBIT
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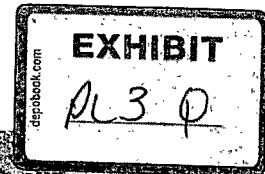


MR-Miller-002207

EXHIBIT
A3 P



MR-Miller-002208



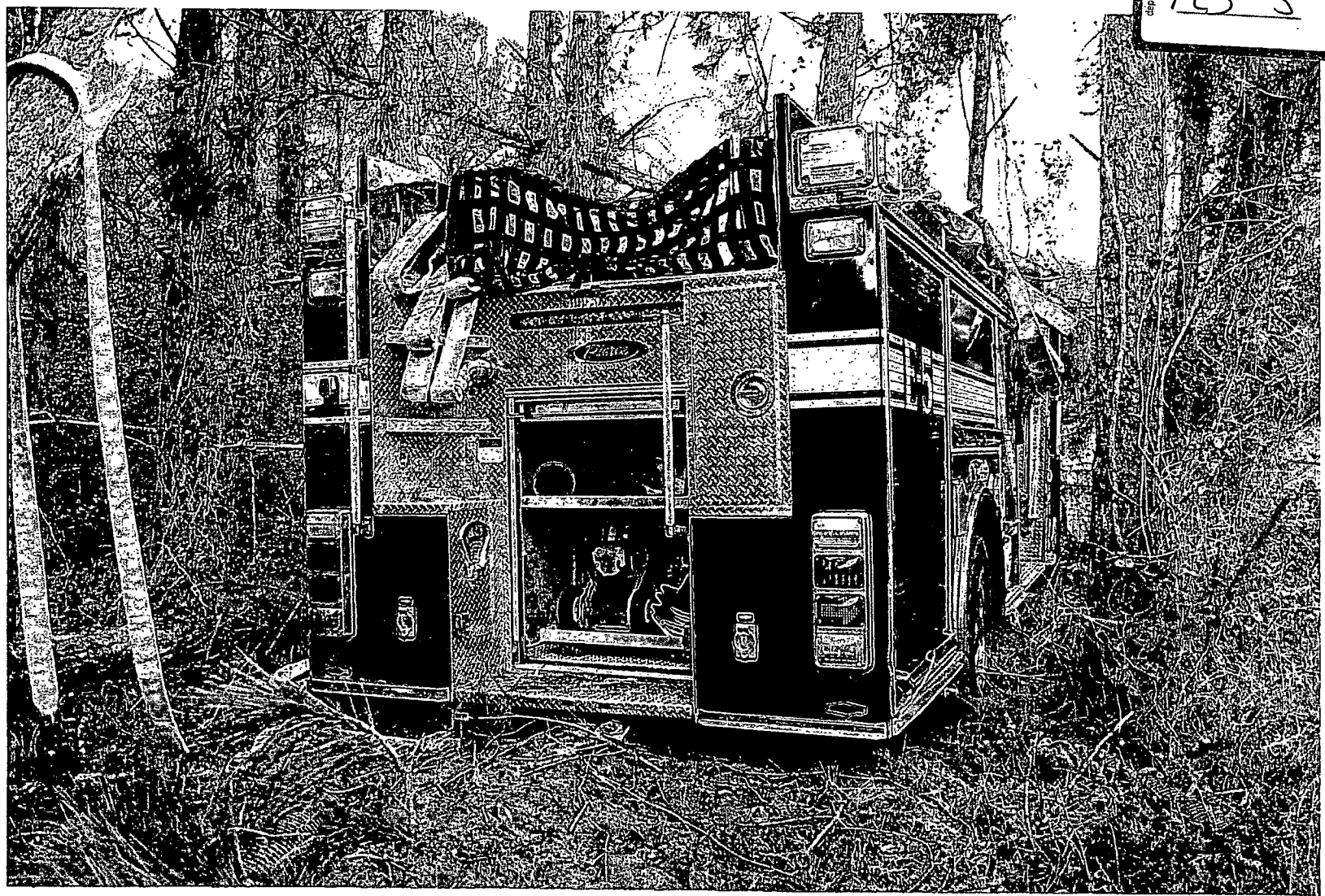
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PL3 R



MR-Miller-002210

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P3 S

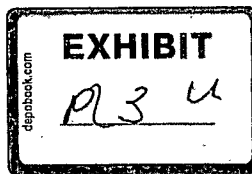


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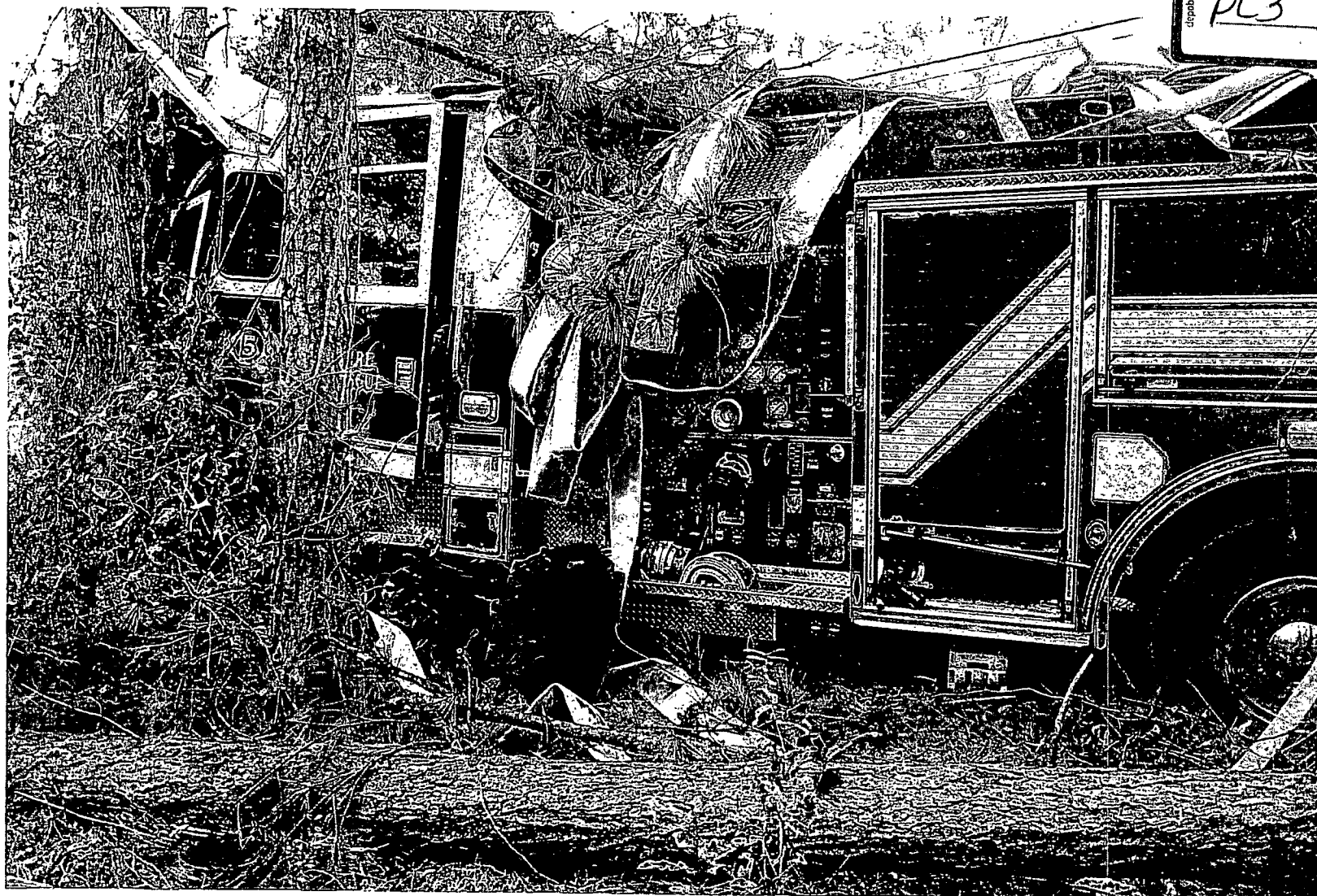


MR-Miller-002212



MR-Miller-002213

EXHIBIT
PL3 V



MR-Miller-002214

EXHIBIT
P3 W



MR-Miller-002215

EXHIBIT
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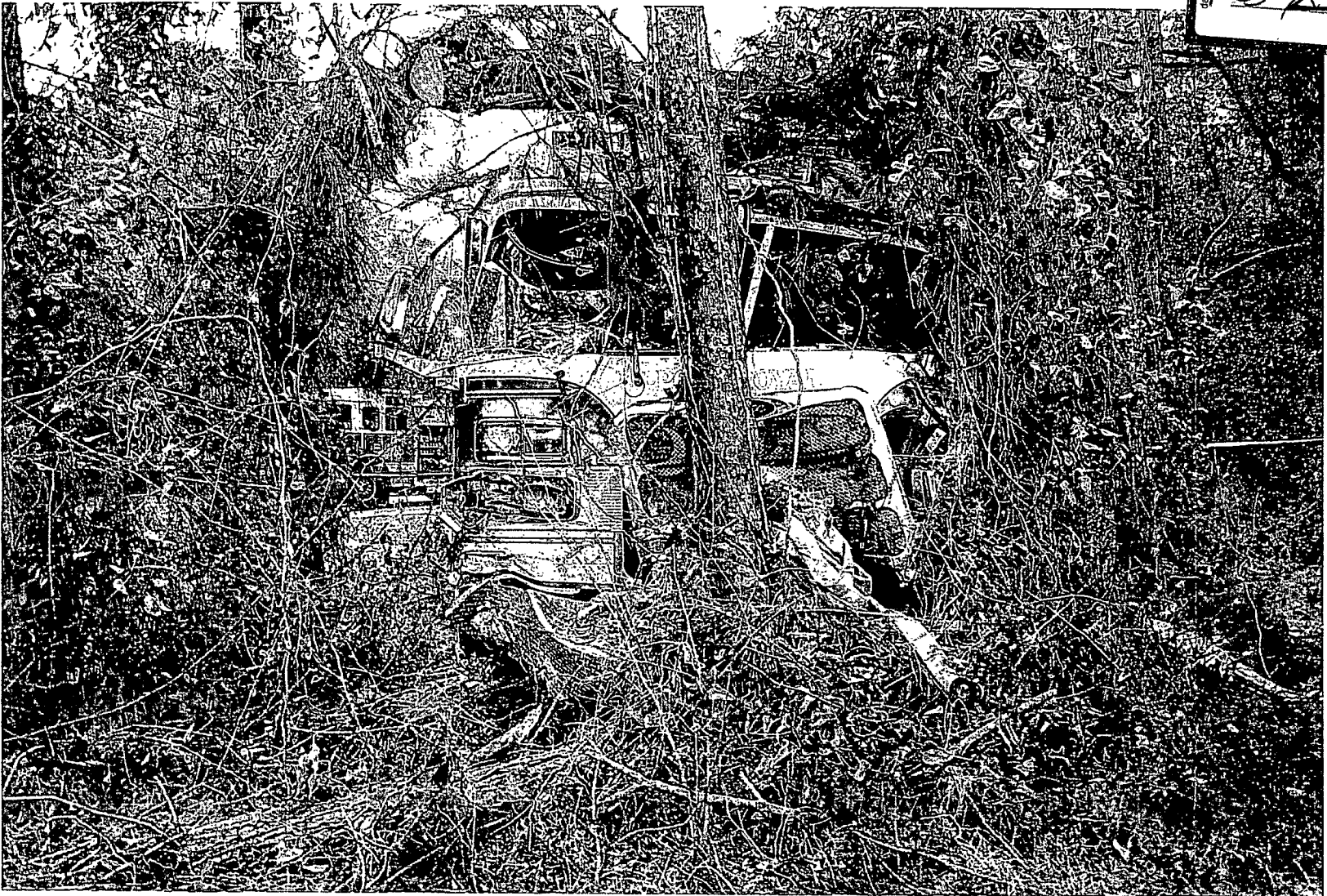
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EXHIBIT
P3 Y



NIR-Miller-002217

EXHIBIT
PL3 *X*



MR-Miller-002219

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

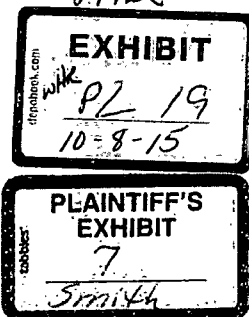
Appt Type: T-CON
Provider: SMITH, SAUNDRA L
Call Back Phone: (858)-360-0763

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)
• Malingerin
• 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 scoring
• 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



Name/SSN: HUNT, KALVIN DONTAY/

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

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

Page 1 of 2

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	
24 Feb 2012 1434	From: Health Clinic Charleston Clinic: BNH PCMH Tent	Provider: SMITH, SAUNDRA L

•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	Status	Sig	Refills Left	Last Filled
Active Medications 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

Name/SSN: HUNT, KALVIN DONTAY

FMP/SSN:	Scx: ni	Sponsor/SSN:	HUNT, KALVIN DONTAY
DOB: 1986	Tel H:	Rank:	PRIVATE
PCat: M13 USMC AD RECRUIT	Tel W:	Unit:	02031026
MC Status:	CS:	Outpt Rec. Rm:	RECRUIT HEALTH RECORDS
Insurance: No	Status:	PCM:	
		Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE
 THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS
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STANDARD FORM 600 (REV. 5)
 Prescribed by GSA and ICMR
 FIRM (41 CFR) 201-45.505

Page 2 of 2

Personal Data - Private 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) 1450

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 Inits 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:

HUNT, KALVIN

Others:

1986

Condition Upon Release:
Improved Unchanged
Deteriorated

Release Time: 1635

Signature of Provider/Stamp:

Instructions to Patient:

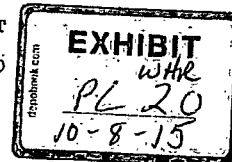
HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS *clanser*

HUNT, KALVIN DONTAY
1986 MALE
Loc: BNH EMERGENCY
Spon: HUNT, KALVIN DONTAY
Unit: 3D RECRUIT TRN BN

M13
W: INDIA CO H: 3072 PLT
Rank: PVT D: INDIA CO
RR: RECRUIT HEALTH RECORDS

558

N/A



Page 1

EMERGENCY DEPT TRIAGE RECORD		Informant: ☒ Pt ☐ Parent ☐ L/S/O ☐ Other: _____ Primary Care Provider: _____		Patient: <u>Mr. KALVIN DONTAY</u> FMP/ID: <u>311</u> DOB: <u>1986</u> Birthdate: <u>MALE</u> Age: <u>26</u>	
Date: <u>2/24/12</u> Arrival Time: <u>1417</u>		ESI TRIAGE CATEGORY: <u>1 2 3 4 5</u>		Contact Name/#: _____	
ASSESSMENT PERFORMED BY RN: <u>Debra McAnn 102 R</u> @ <u>1417</u>					
Barriers to communication: ☒ No ☐ Yes Action Taken: _____					
Arrival Via: ☐ POV ☒ Ambulatory ☐ Wheelchair ☐ Ambulance/EVOC ☐ Helicopter ☐ Other					
Pre-Hospital Care: ☒ None ☐ O2 ☐ Spinal Immobilization ☐ Dressing ☐ IV gauge NS/LR Lock ☐ Meds ☐ BGL ☐ See EMS Report					
CHIEF COMPLAINT: _____ Nursing Assessment: <u>suicidal ideation</u>					
<u>H/o alcohol + drug dependence + depression + PTSD</u>					
Allergies: ☐ NKDA ☐ Latex Fall Risk: ☐ No ☐ Yes Interventions: _____ Evaluated in last 72 hrs ☐ No ☐ Yes					
Pneumonia vaccine: ☐ Yes ☐ No ☐ Unk Immunizations: ☐ Up to date ☐ Not up to date					
VITAL SIGNS					
Temp: <u>99.5</u> HR: <u>103</u> RR: <u>18</u> SpO2: <u>100</u>		LMP: _____ Gravida: _____ Para: _____ Ab: _____ Pregnant: ☐ Yes ☐ No ☐ UNK		OD: <u>20</u> OS: <u>20</u> OU: <u>20</u> ☐ Corrected ☐ Uncorrected	
Infants: FLACC Score: _____		Pain is rated: _____/10 ☐ Constant ☐ Intermittent		☐ See attached	
Circle appropriate category: ☒ 0 ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐ 10		☐ Sharp ☐ Aching ☐ Dull ☐ Pressure ☐ Burning ☐ Throbbing Onset of Pain: _____ Location: _____ Radiates to: _____		<u>Citalopram</u> <u>Nicotine</u> <u>Verapamil</u> <u>Quetiapine</u>	
Past medical history: ☐ None ☐ Unknown ☐ Asthma ☐ COPD ☐ CHF ☐ DM ☐ HTN ☐ CVA ☐ Seizures ☐ Cancer ☐ GI/GU					
☐ Back injury ☐ Migraines ☐ Other: <u>Depression</u>					
Cigarettes: <u>7</u> packs per day <u>7</u> years Smokeless tobacco: ☐ Yes ☐ No ETOH: <u>2</u> day					
Surgical History: ☐ None ☐ Other: <u>Dent removed</u>					
☐ Patent ☐ Obstructed ☐ Stidor					
Breath Sounds: ☐ 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					
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: _____					
☐ Alert ☐ Verbal ☐ Pain ☐ Unresponsive Oriented: ☒ Person ☐ Place ☐ Time ☐ Event					
☐ 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 _____ mg PO @ _____ o Motrin _____ mg PO @ _____ o 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 @ _____					
Reassessment time: _____ By RN _____ Note: _____					
HR: _____ Respirations: _____ B/P: _____ SPO2 _____ Temp PO/PR _____ Pain: /10					

NHBFT 6320/112 (Rev 10/11)

PL - 3rd 20
Page 2

EMERGENCY DEPARTMENT NURSING RECORD Time in room: <u>1430 RM# 4</u> Provider @ bedside: <u>1430</u> Provider Name: <u>James</u>		HUNT, KALVIN DONTAY 20/4311 DOB: 1988 ALE Age: 26	
ESI Triage Category 1 2 3 4 5			
NURSING ASSESSMENT PERFORMED BY: (Name & Signature) <u>Prince, M. Medina (R)</u>			
Mental Status: ☒ Alert/Awake ☐ Agitated ☐ Combative ☐ Stuporous ☐ Unconscious ☐ Uncooperative ☐ BTOH odor		Orientation: ☒ Person ☒ Place ☒ Time ☐ Event ☒ Speech ☐ Clear ☐ Coherent ☐ Slurred ☐ Silent ☐ Other	
Parasthesia: ☐ LUE ☐ RUE ☐ LLE ☐ RLE Strength: ☐ Equal Bilaterally ☐ L ☐ R ☐ Weak ☐ Average ☐ Strong		Quality: ☐ Tachypneic ☐ Dyspneic ☐ Retractions ☐ Grunting ☐ Cough Prod/unprod ☐ Sputum: _____ ☐ Effort ☐ Unlabored ☐ Labored ☐ Shallow Breath Sounds: ☐ L, R ☐ Clear ☐ Crackles ☐ Wheezing ☐ Rhonchi ☐ Diminished ☐ Absent	
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		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 _____ in hrs ☐ Diarrhea _____ in hrs	
Visual Acuity: ☐ L ☐ R ☐ Dilated ☐ Pinpoint ☐ Redness ☐ Itching ☐ Pain ☐ Drainage		Color: ☒ Normal for race ☐ Pale ☐ Mottled ☐ Cyanotic ☐ Flushed ☐ Warm ☐ Jaundiced ☐ Cool ☐ Erythema ☐ Diaphoretic ☐ Hot ☐ See body map ☐ Dry	
Anterior ☐ Abrasions ☐ Abscess ☐ Burn ☐ Deformity ☐ Edema ☐ Gunshot ☐ Hematoma ☐ Laceration ☐ Puncture ☐ Pain ☐ Rash ☐ Swelling		Posterior ☐ Abrasions ☐ Abscess ☐ Burn ☐ Deformity ☐ Edema ☐ Gunshot ☐ Hematoma ☐ Laceration ☐ Puncture ☐ Pain ☐ Rash ☐ Swelling	
Body Map 		Pain: ☐ No ☐ Yes /10 Quality: _____ Radiation: _____ Extremity Pulse: _____ ROM: ☐ Full ☐ Limited Gait: ☐ Steady ☐ Unsteady ☐ Unable to ambulate Distal Sensation: ☐ WNL ☐ Abn	
☐ O2 L Via _____ ☐ Tele Monitoring ☐ NG Tube French _____ Foley Fr _____ ☐ Straight Catheter French _____ ☐ Consultant arrived @ _____ ☐ X-Ray: Departed _____ Returned _____ ☐ CT: Departed _____ Returned _____ ☐ US: Departed _____ Returned _____ ☐ Labs ☐ ABG ☐ UA UHCG ☐ EKG ☐ MD Notified ☐ Accu Check (#1) _____ (#2) _____ ☐ Other _____		Rectal: ☐ Soft ☐ Flat ☐ Bulging ☐ Closed Mucous Membranes: ☐ Moist ☐ Dry ☐ Tears ☐ No Tears ☐ Last wet diaper _____	
☐ 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		Hallucinations: ☐ Auditory ☐ Visual Identifications: ☒ Suicidal ☐ Homicidal ☐ Previous attempt ☐ Has plan Support System: ☐ Family ☐ Friends ☐ Sig other ☐ Lives alone ☐ In training	

PL - Sep 20
Page 3

Vital Signs										Time		Nursing Notes	
Time	BP	HR	RR	Temp	OX	O2	L/min	Pain	GCS	Initials	Time	Nursing Notes	
									10 15		1430	Rec'd report from triage	
									10 15			no eval pending	
									10 15		1500	Rep from V.C.T. Affairs	
									10 15			PT - cooperative	
									10 15			no eval in progress	
									10 15		1510	TIC to Bm H 2E to ingine	
									10 15			Bed availability - no spoke	
									10 15			in progress	
									10 15		1525	Psych treat nursing eval	
									10 15			in progress	
Start Time	Stop Time	Medication	Dose	Route	Initials								
Response Time:						Response:							
Response Time:						Response:							
HUNT, KALVIN													
1986													
R													
Response Time:						Response:							
Response Time:						Response:							
ID/DOB/DYAG						Exp Date							
Response Time:						Response:							
Time						Initials							
Additional Nursing Notes													
Time						Type							
Admission/Transfer						Disposition							
To: Room:						Vitals @ Discharge: Pain /10							
Dr.:						B/P HR R T O2							
Report To: @						Home Admit Transfer SIQ							
Phone #						Full duty Light Duty Morgue							
Transport w/o Monitor O2						F/U pcn other							
IV O H/M/R/N						Mode of release:							
See Transfer Sheet						Ambulatory Carried W/C							
Valuables w/ O PI O Family						Gurney Crutches To Drill Instructor							
Inventory						Shadow Watch							
Via: O ACLS O BLS O A/R						Discharge Time:							
						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:							
						Patient Parent Mother/Father Other							
						Discharge Instructions provided by:							

S/HUNT, KALVIN DONTAY/PVT
CCN: 27FEB12-CAP1-0013-7HMA

Back of 2

PL-9620
Page 4

Brought by VA worker from DSS

DATE 2/24/12 TIME 1:45 ROOM 4 EHS Antel
HISTORIAN: patient spouse paramedic Mr Ray
Hx/ EXAM LIMITED BY:

HPI

chief complaint:
suicidal thoughts depression agitated hallucinating
suicide attempt self-injury intentional drug overdose
accidental drug ingestion
medication ref 11

started / timing: several weeks
moderate
constant
gone now better continued in ED

severity:
mild moderate severe

context:

situational problems:
related to: spouse / parent / son / daughter / significant other
work / lost job / school / legal problems
A disturbance disturbance from HMC
and is apparently depression
a grandiose in Bannock St
all Mr Ray concerned about his depression

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

confused / hallucinating

suicidal thoughts / specific plan / history of attempt:
suicidal thoughts of jumping
off but no specific plan

ingestion (see list below):
suicide attempt: wanted to "escape" accidental will not answer

lacerated / abraded wrists (R/L)

LIST OF SUBSTANCES INGESTED (if applicable)			
name	strength	# taken	when taken
acetaminophen	Y/N		
aspirin	Y/N		
ethanol	Y/N		

HUNT: KALVIN DONTAY
DOB 1906
MALE Age: 26

© 1994-2004 T-Sprint, Inc. Circle or check affirmatives, backslash (V) negative

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

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

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

Recently seen / treated by doctor

ROS	NEURO / EYES
CVS / PULMONARY	headache
cough	visual disturbance
trouble breathing	GI / GU
chest pain	abdominal pain
	nausea
CONST	vomiting
toilet	diarrhea
chills	problems urinating
	SKIN / LYMPH / MS
	skin rash / swelling
	joint pain
	all systems OK except as marked

PAST HX negative
prior suicide attempt

psychiatric problems:
depression bipolar disorder
schizophrenia other

other problems: Alcohol / drug abuse
depression
suicide attempt

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

Surgeries:
tonsillectomy appendectomy
cholecystectomy hysterectomy

Medications: none (see nurse's note) Allergies: NKDA
penicillin (see nurse's note)

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

FAMILY HX mental illness

PL - Exl 20
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Nursing Assessment Reviewed: ☒ Vitals R: ☒ ed Temp: ☒
 V/S BP: HR 102 RR: 18
PHYSICAL EXAM
 General Appearance: no acute distress
alert
 ENT: normal
normal inspection
normal mucosa
normal gag reflex
 EYES: normal
normal pupils
normal EOM's intact
 NEURO / PSYCH: normal
normal status
normal mood / affect

slow / no response to commands
 withdrawn / no response to pain
 depressed affect
 fearful / hostile / non-communicative
 suicidal ideation

On direct query, patient ADMITS / DENIES
 continued consideration of suicide as an option
 If denies why? don't want to die

orientation: normal
normal x3
 day-of-week: normal
 month-year: normal
 place: normal
 person: normal

cranial nerves: normal
 sensory, motor: normal
 CN's intact as tested
 normal motor response
 normal sensory response
 normal reflexes
 normal gait

NECK / BACK: normal
 normal inspection
 neck supple
 RESPIRATORY: normal
 no resp. distress
 breath sounds normal

CVS: normal
 regular rate, rhythm
 heart sounds normal
 irregularly irregular rhythm
 extrasystoles (occasional / frequent)
 tachycardia / bradycardia
 JVD

ABDOMEN: normal
 non-tender
 normal bowel sounds
 no organomegaly
 SKIN: normal
 color normal, no rash
 warm, dry
 EXTREMITIES: normal
 non-tender
 normal ROM
 no signs of injury
 no pedal edema

guarding
 hepatomegaly / splenomegaly
 cyanosis / diaphoresis / pallor
 skin rash
 ulceration
 pedal edema

PROCEDURES: ☒ Restraints
☒ Incubated by ED physician: normal / oral normal ET tube
 breath sounds equal: normal tube position confirmed w/ CXR
☒ Gastric Lavage: normal fragments recovered
☒ Charcoal: normal gm given Sorbitol: normal oz given

Psych Disrupt: normal
 S/HUNT, KALVIN DONTAY/PVT
 CCN: 27FEB12-CAP1-0013-7HMA

LABS, EKG & X:
 CBC: normal except normal except normal except
 WBC: normal except normal except normal except
 Hgb: normal except normal except normal except
 Hct: normal except normal except normal except
 Platelets: normal except normal except normal except
 Trog: normal except normal except normal except
 bands: normal except normal except normal except
 lymphs: normal except normal except normal except
 monos: normal except normal except normal except
 EKG MONITOR STRIP: NSR Rate: normal

EKG: NSR ☒ Interpret by me ☒ Reviewed by me Rate: normal
NSR ☒ normal intervals ☒ normal axis ☒ normal QRS ☒ normal ST/T

not / changed from: normal
 CXR: ☒ Interpret by me ☒ Reviewed by me ☒ Discard w/ radiologist
normal / normal no infiltrates normal heart size normal mediastinum

not / changed from: normal
 Pulse Ox: normal on RA / normal % at (time)

PROGRESS:
 Time: 1500 unchanged improved re-examined
1500 unchanged improved re-examined
1520 unchanged improved re-examined
1540 unchanged improved re-examined
1600 unchanged improved re-examined

Discussed with Dr. normal Time: 1605
 Will see patient in: office / ED / hospital

INTERVIEW WITH OTHER RESPONSIBLE ADULT:
 Name: normal Relationship: normal
 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)
 Backwash in history (that depends on history based on H&P and, when needed, lab testing)
 • Toxics (CCP, Amphetamines, Hallucinogens, Acetaminophen, ASA, ETOH, Opioids)
 • Infectious (Meningitis, Encephalitis, Sepsis)
 • Metabolic (Hypoglycemia, Drug Withdrawal, Hypoxemia, Electrolytes)
 • CNS Vascular and Other (CVA, TIA, Seizure, Trauma)
 • Other Unstable Comorbidities: normal ☒ Cleared medically for psych referral
 Counseled patient / family regarding: normal CRIT CARE: normal min
 Lab results: normal need for follow-up: normal 75-104 min
 For given: normal Admit orders written: normal
 Prior records ordered: normal Additional history from: normal family caretaker paramedics

CLINICAL IMPRESSION:
 Ethanol Intoxication: normal Psychosis: normal Schizophrenia: normal acute exoc.
 Depression: normal Drug Overdose (Intentional / accidental): normal
 major manic: normal Suicide Attempt / Ideation: normal

DISPOSITION: ☒ home ☒ admitted ☒ transfer
 Time: 1600

CONDITION: ☒ unchanged ☒ improved ☒ stable
 CHRIS JANSEN MD
 PHYSICIAN SIGNATURE: normal
☒ Template Complete ☒ Addendum ☒ Add On Temp

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 Page 6

LABS TIME	STAND TIME	PANELS
☐ CBC	☐	Cardiac
☐ CBC & Diff.	☐	Liver
☐ CMP	☐	Thyroid
☐ BMP	☐	T ₁
☐ Lytes	☐	T ₂
☐ Myoglobin	☐	TSH
☐ CK	☐	
☐ Ma**	☐	
☐ UHCG	☐	
☐ SHCG	☐	
☐ Strep. Screen	☐	
☐ Amylase	☐	
☐ Lipase	☐	
☐ Troponin I	☐	
☐ PT / PTT	☐	
☐ Sed Rate	☐	
☐ H. Pylori	☐	
☐ UA	☐	
☐ Clean catch dip (ketones)	☐	
☐ CSF Protocol	☐	
☐ Toxin screen urine blood	☐	
☐ Drug Levels: digoxin, dilantin, ETOH, Tylenol	☐	
☐ ASA	☐	

PLEASE CALL DOCTOR
Time Ordered: _____ Doctor: _____ Returned Call: _____
1450: Psych. Text: _____

DEPARTMENT RECORD
Physician Order Sheet

Initial Nursing Orders

Time	Orders	Noted
	☐ Cardiac Monitor	
	☐ Pulse Oximeter	
	☐ Oxygen TNC	
	☐ Urine to keep SaO ₂ greater than 95%	
	☐ Fully Dressed / Gown	
	☐ Postural Vitals	
	☐ Neuro checks q	
	☐ IV saline lock mL / hr	
	☐ Rhenergan	
	☐ Toradol	
	☐ Tylenol	
	☐ Morphine sulfate	
	☐ Demerol	
	☐ Nubain	
	☐ Robaxin 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

RT LWCC 2 VA worker - 16
examined before was brought back
for ER

DISPOSITION

☐ ADMIT ☐ OBS ☐ DISCHARGE

☐ med / surg ☐ telemetry ☐ ICU ☐ L & D

☐ TRANSFER to: _____ Care of Dr. _____

Condition: ☐ Improved ☐ Stable ☐ Other

PHYSICIAN SIGNATURES

CHRIS JANZLA, MD
1999
EMERGENCY ROOM

HUNT, KALVIN DONTAY
DOB: 1986
Age: 26
MA

PL - Exh 20
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LABS TIME	STANDARD TIME	PANELS
☐ CBC	☐	☐ Cardio
☐ CBC & Diff.	☐	☐ Liver
☐ CMP	☐	☐ Thyroid
☐ BMP	☐	☐ T ₄
☐ Lyles	☐	☐ T ₃
☐ Myoglobin	☐	☐ TSH
☐ CK	☐	☐
☐ Mg	☐	☐
☐ UHCG	☐	☐
☐ SHCG	☐	☐
☐ Strep Screen	☐	☐
☐ Amylase	☐	☐
☐ Lipase	☐	☐
☐ Troponin I	☐	☐
☐ PT/INR	☐	☐
☐ Sed Rate	☐	☐
☐ H. Pylori	☐	☐
☐ UA	☐	☐
☐ clean catch dip (ketones)	☐	☐
☐ CSF Protocol	☐	☐
☐ Toxin screen: urine, blood	☐	☐
☐ Drug Levels: digoxin, dilantin, EPOCH, Tylenol	☐	☐
☐ ASA	☐	☐

PLEASE CALL DOCTOR

Time Ordered Doctor

1450 Psych Tech

Returned Call

Discharge Instructions

RT LWCC & VA workers Jan
repaired before was brought back
to ER

DEPARTMENT RECORD
Physician Order Sheet

Initial Nursing Orders

Time	Orders	Noted
☐	Cardiac Monitor	
☐	Pulse Oximeter	
☐	Oxygen LNC	
☐	Rate to keep SaO ₂ greater than 95%	
☐	Fully Dressed / Gown	
☐	Postural Vitals	
☐	Neuro checks q	
☐	IV saline lock mL / hr	
☐	Rhenergan	
☐	Toradol	
☐	Dylenol	
☐	Morphine sulfate	
☐	Demerol	
☐	Nubain	
☐	Roxaprin IM mix w/ 1% Lidocaine plain	
☐	Roxaprin IV	

Subsequent Nursing Orders

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

DISPOSITION

☐ ADMIT ☐ OBS ☐ DISCHARGE

☐ med / surg ☐ telemetry ☐ loc ☐ L & D

Dr. _____

☐ TRANSFER to: _____ Care of Dr. _____

Condition: ☐ Improved ☐ Stable ☐ Other: _____

PHYSICIAN SIGNATURES

CHRIS JAMES, MD

1969

EMERGENCY ROOM

HUNT, KALVIN DONTAY
DOB: 1966
Age: 26
MALE

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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
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***** HUNT, KALVIN DONTAY *****

PAGE 1

PDTS Cardholder ID:
Age: 26y Sex: MALE

PDTS Person Code: 24 Feb 2012 14:17
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
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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 - Ept 20
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1805 Duke St.
P.O. Drawer 1228
Beaufort, SC 29901

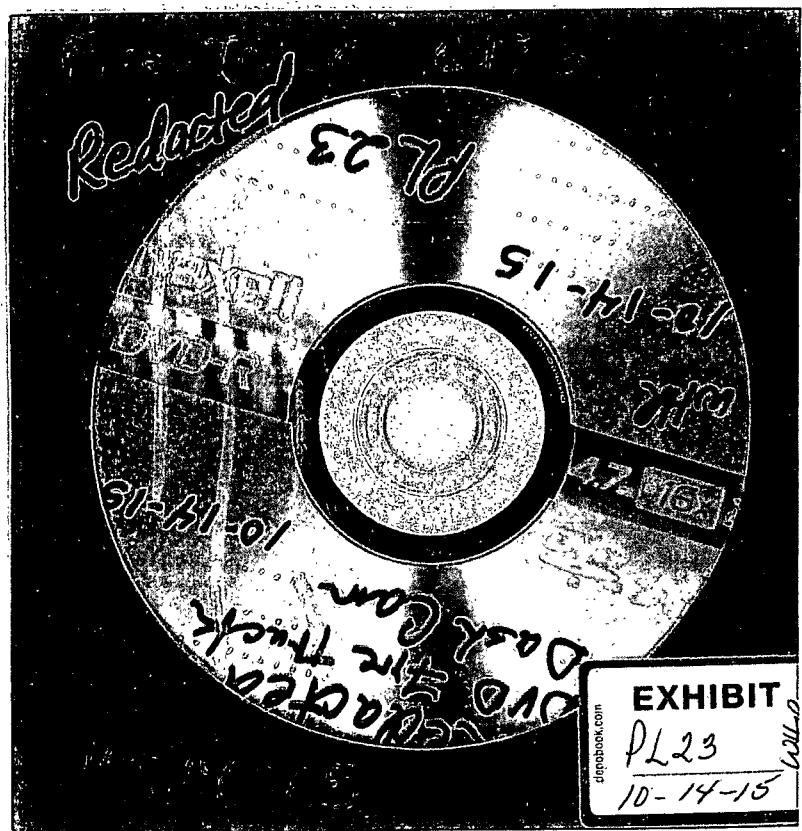
Edward Ray
Veterans Affairs Officer

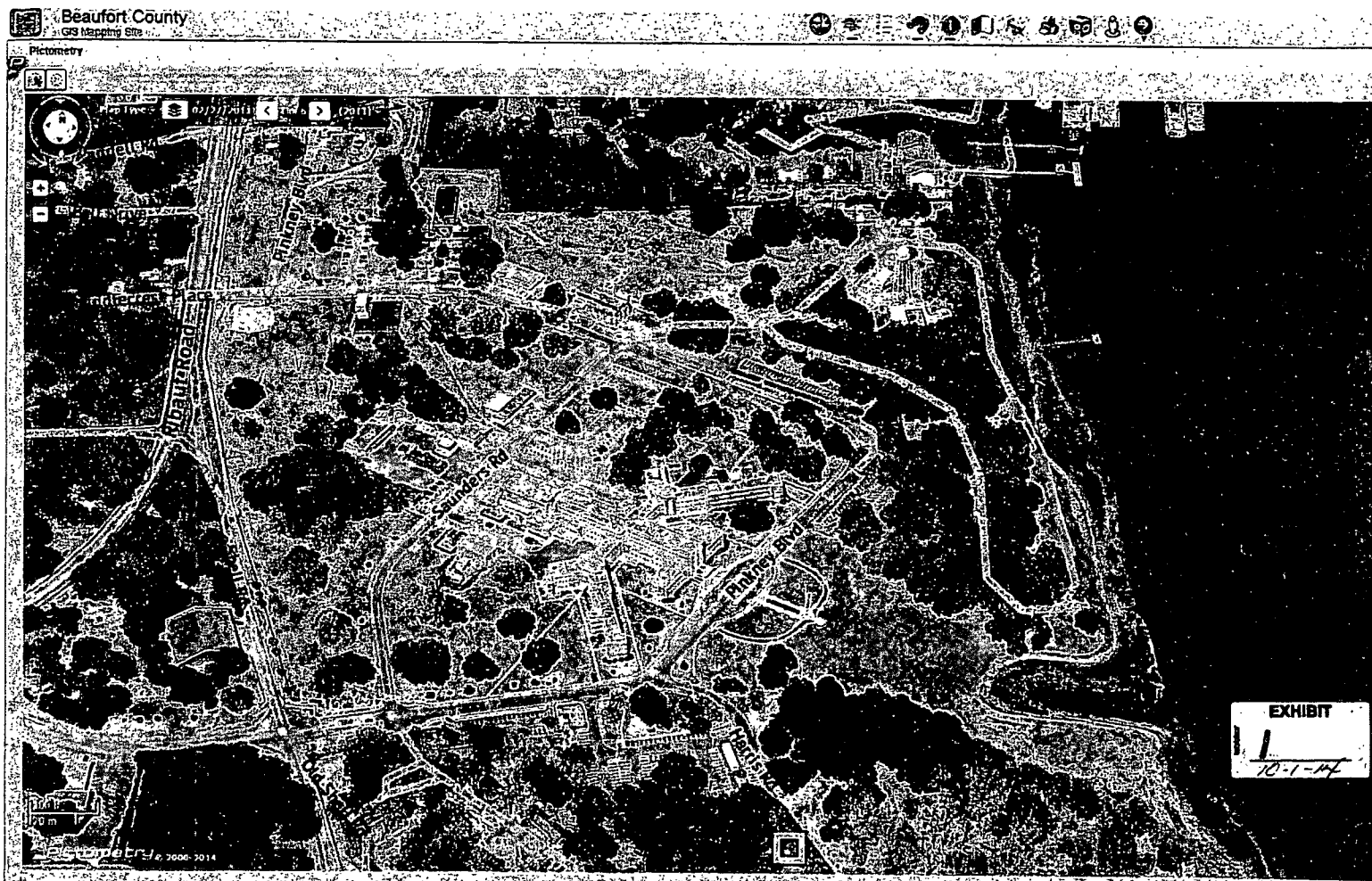
**BEAUFORT COUNTY
VETERANS AFFAIRS**
"Putting Veterans First"

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

HUNT, KALVIN DONTAY
DOB: 1986
MALE Age: 26

PL - Exh 20
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Trick

**DEFENDANT'S
EXHIBIT**
2 *WHR*
10-9-15

DEFENDANT'S EXHIBIT

3 WTR
10-12-15

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. 62645-07-D-5005		3. EFFECTIVE DATE 28 Sep 2007		4. REQUISITION/PURCHASE REQUEST/PROJECT NO.	
5. ISSUED BY NAVAL MEDICAL LOGISTICS COMMAND 1681 NELSON STREET FORT DETRICK MD 21702-9203		CODE N62645	6. ADMINISTERED BY (if other than Item 5) 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 See Schedule		CODE	12. PAYMENT WILL BE MADE BY DFAS-SAN DIEGO DFAS-OPLOC, CODE FPVAD, 4181 RUFFIN ROAD SAN DIEGO CA 92123-1819		
			CODE N69688		
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)	(X) SEC.	DESCRIPTION	PAGE(S)
PART I - THE SCHEDULE			PART II - CONTRACT CLAUSES		
X A	SOLICITATION/ CONTRACT FORM	1 - 2	X I	CONTRACT CLAUSES	87 - 92
X B	SUPPLIES OR SERVICES AND PRICES/ COSTS	3 - 20	PART III - LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACHMENTS		
X C	DESCRIPTION/ SPECS/ WORK STATEMENT	21 - 76	X J	LIST OF ATTACHMENTS	93 - 131
PART IV - REPRESENTATIONS AND INSTRUCTIONS					
X D	PACKAGING AND MARKING		K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	
X E	INSPECTION AND ACCEPTANCE	77	L	INSTRS, CONDS, AND NOTICES TO OFFERORS	
X F	DELIVERIES OR PERFORMANCE	78	M	EVALUATION FACTORS FOR AWARD	
X G	CONTRACT ADMINISTRATION DATA	79			
X H	SPECIAL CONTRACT REQUIREMENTS	80 - 86			
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) Hirley B. Hill, President			20A. NAME AND TITLE OF CONTRACTING OFFICER		
B. NAME OF CONTRACTOR Hirley B. Hill (Signature of person authorized to sign)			20B. UNITED STATES OF AMERICA		
19C. DATE SIGNED 7/26/07			20C. DATE SIGNED		
			BY (Signature of Contracting Officer)		

40-01-152-8069

26-107

STANDARD FORM 26 (REV. 4-85)

15 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	
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				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 See Schedule		CODE		12. PAYMENT WILL BE MADE BY DFAS-SAN DIEGO DFAS-OPLOC, CODE FPVAD, 4181 RUFFIN ROAD SAN DIEGO CA 92123-1819		CODE N68688	
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)	(X)	SEC.	DESCRIPTION	PAGE(S)
PART I - THE SCHEDULE				PART II - CONTRACT CLAUSES			
X	A	SOLICITATION/ CONTRACT FORM	1 - 2	X	I	CONTRACT CLAUSES	87 - 92
X	B	SUPPLIES OR SERVICES AND PRICES/ COSTS	3 - 20	PART III - LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACHMENTS			
X	C	DESCRIPTION/ SPECS/ WORK STATEMENT	21 - 76	X	J	LIST OF ATTACHMENTS	93 - 131
	D	PACKAGING AND MARKING		PART IV - REPRESENTATIONS AND INSTRUCTIONS			
X	E	INSPECTION AND ACCEPTANCE	77	K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS		
X	F	DELIVERIES OR PERFORMANCE	78				
X	G	CONTRACT ADMINISTRATION DATA	79	L	INSTRS, CONDS., AND NOTICES TO OFFERORS		
X	H	SPECIAL CONTRACT REQUIREMENTS	80 - 86	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 4 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		19C. DATE SIGNED		20B. UNITED STATES OF AMERICA		20C. DATE SIGNED	
BY _____ (Signature of person authorized to sign)				BY <u>Nancy L. LaVigne</u> (Signature of Contracting Officer)		27-Jul-2007	

NSN 7540-01-152-8069

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)

Def RRF 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	4,192	Hours	\$REDACTED	
	POP: 01 OCT 2007 – 30 SEP 2008				
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	

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

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	
	Chiropractor			\$REDACTED	
0002	POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours	\$REDACTED	
	Pharmacy Technicians			\$REDACTED	
0006	POP: 01 OCT 2007 - 30 SEP 2008	6,288	Hours		
	Chiropractic Assistant			\$REDACTED	
0007	POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours		

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	

	RN Utilization Managers			\$REDACTED	
0004AB	POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours		
	RN Family Practice			\$REDACTED	
0004AC	POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	\$REDACTED	
	RN Breast Care Coordinator			\$REDACTED	
0004AD	POP: 01 OCT 2007 - 30 SEP 2008	2,096	Hours		
	Travel, RN Breast Care Coordinator				
0008AB	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	
				\$REDACTED	
0004AA	LPNs - NHB Outpatient Clinics (Individuals)	6,304	Hours		

	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	
0003	Family Nurse Practitioners POP: 01 OCT 2007 - 30 SEP 2008	4,192	Hours	\$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	
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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	
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	
0006AB	Medical Laboratory Technicians POP: 28 SEP 2007 - 27 SEP 2008	4,176	Hours	\$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	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	\$REDACTED	Hours	UNDEFINED	UNDEFINED

MAX
NET AMT

UNDEFINED

ITEM NO	SUPPLIES/SERVICES	MAX QUANTITY	UNIT	UNIT PRICE	MAX AMOUNT
0003	Advanced Practice Nurse FFP Any specialty recognized by the American Nurses Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP).	\$REDACTED	Hours	UNDEFINED	UNDEFINED

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	Technician FFP	\$REDACTED	Hours	UNDEFINED	UNDEFINED

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	Assistant FFP	\$REDACTED	Hours	UNDEFINED	UNDEFINED

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 of 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 (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 of 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, Guam 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, laparoscopy, 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 physical 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 charts, 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 administering 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 patient 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.

10.10.2. 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 lumbar punctures, colonoscopies 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 suction, 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, endotracheal intubation, routine phlebotomy, arterial phlebotomy, percutaneous central venous line placement, umbilical line placement, lumbar puncture, suprapubic bladder taps, bladder catheterization, 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. OPTHALMIC 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 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 or 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 tissue 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 (sprains, strains, 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 O_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 O_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 its 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

<u>Employee Class</u>	<u>GS Equivalent</u>
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
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Attachment AH	Supplemental Pricing Worksheet sample
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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 RESPONSIBILITIES

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

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 ordnance, 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 ordnance, (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 ordnance, 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 ordnance, 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

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

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 20 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: 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) 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 ordnance, explosives, and incendiary materials. This includes work such as screening, blending, dying, mixing, and pressing of sensitive ordnance, 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 ordnance, (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 ordnance, 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 ordnance, 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 link 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 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	Dates of Shots: 1. 2. 3. Titer/Date:	Dates of Repeat Shots: 1. 2. 3. Titer/Date: Counseling provided:
	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		
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	2-Step TST dates:	BAMT date:
	One Blood Assay for Mycobacterium Tuberculosis (BAMT), OR	1st test: 1st result: 2nd test: 2nd result:	Result: Date/result of last annual eval:
	An annual evaluation if known TST reactor, including chest x-ray within 1 year if new hire	CXR Date: Pos: Neg:	
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 specified 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. Abeysance. 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

Enclosure (1)

Terrance L. Baker, M.D.

410-592-8464

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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

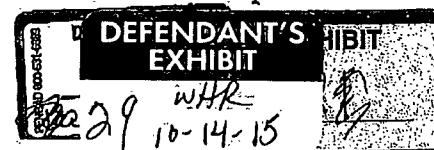
Dear Mr. Hoyle:

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 Kalvin 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 Kalvin 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 Kalvin 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 Kalvin 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 Kalvin 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 Kalvin 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:



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 Affairs 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 Affairs Officer, Edward Ray, departed from the duty of care required of

Terrance L. Baker, M.D.

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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 Affairs 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, Cleatha Hunt, regarding erratic behavior demonstrated by Mr. Hunt.

On 2/24/2012, 10:30, Veterans Affairs 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 Affairs 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 Jannsen, 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, Kelvin Hunt asked to get a quick breath of fresh air and with the permission of the emergency department staff as well as Edward Ray, exited the emergency department.

After exiting the facility, Kelvin 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 Kelvin Hunt jumped into the unoccupied fire truck and entered the highway from the apartment complex parking lot.

Subsequently, Kelvin 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 Kelvin Hunt opposed a threat of harm to himself and others.

Terrance L. Baker, M.D.

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- Entered into a special relationship with Calvin Hunt to provide necessary care and safety.
- Had the ability to monitor, supervise and control Calvin Hunt's suicidal and/or homicidal thoughts.
- Undertook a duty to ensure that Calvin Hunt was safe and secure during his medical treatment and throughout his entire visit to NHB. At all times Calvin 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 Affairs 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 Calvin Hunt and to ensure that he obtained medical care so as to prevent Calvin Hunt from harming himself or others.

Beaufort County, Beaufort County Office of Veterans Affairs and Edward Ray as the Veterans Affairs 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 Calvin 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.

09/25/2015 12:06 4103210272
Terrance L. Baker, M.D.

GORE BROTHERS
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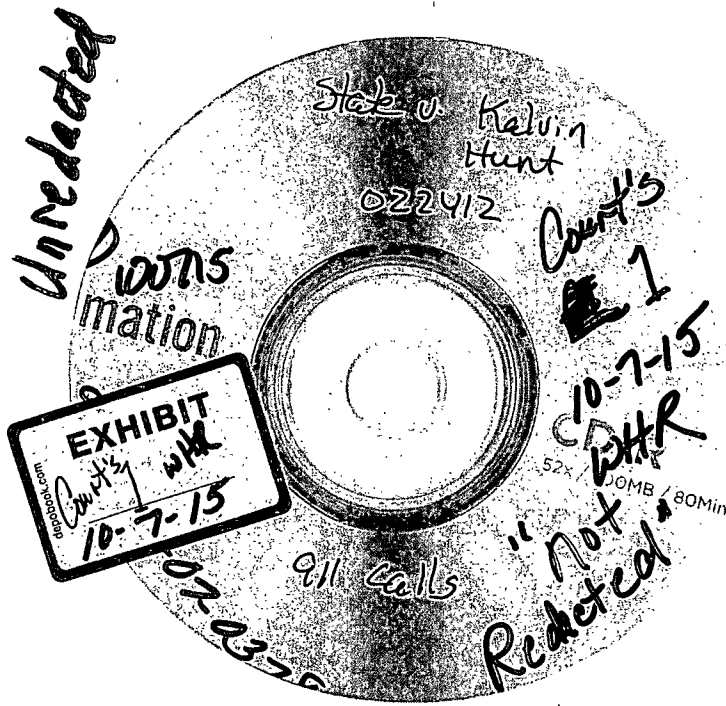
Failed to exercise adequate degree of care in escorting Calvin Hunt to the emergency department at NHB despite knowing that Mr. Hunt intended to injury himself and others.

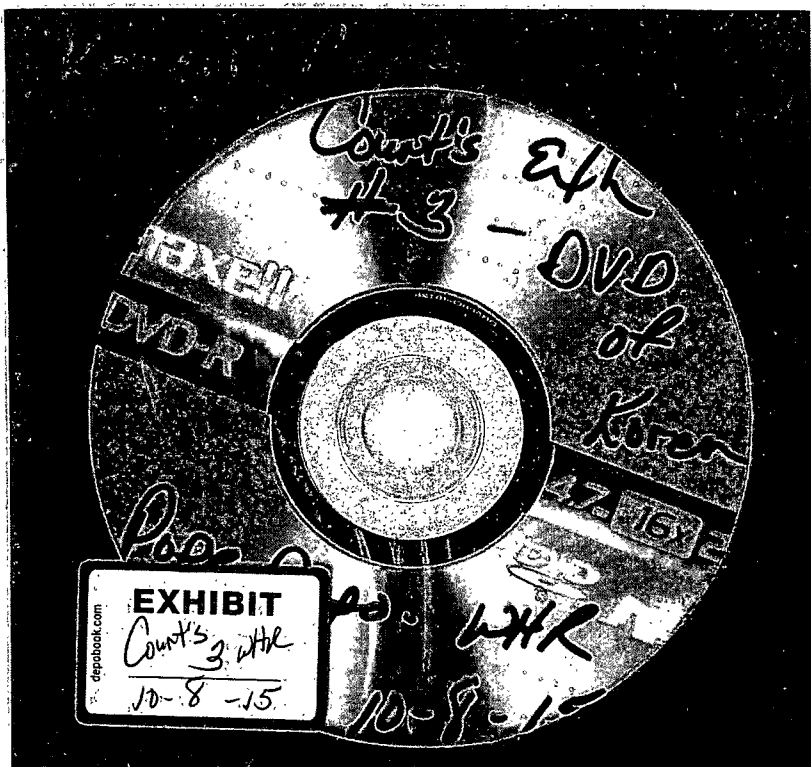
As a direct and proximal result of the grossly negligent, willful and careless acts and/or omissions of Beaufort County through Beaufort County Office of Veteran Affairs and Edward Ray as a Veteran Affairs Officer and employee of Beaufort County, Justin Nicholas Miller suffered injuries and death.

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.





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)

09 Q Good morning, ma'am.
10 A Good morning.
11 Q Can you state your full name for the
12 record?
13 A Koren Antoinette Pope.

2. PAGE 9:21 TO 10:16 (RUNNING 00:00:46.930)

21 Q And have you yourself ever served in the
22 military?
23 A Yes, I have.
24 Q When did you serve in the military, and
25 which branch?
00010:01 A The Navy, and I was in from '96 to 2001.
02 Q What's the highest rank that you
03 achieved in the United States Navy?
04 A E-3.
05 Q And what was your job classification in
06 the Navy?
07 A Corpsman.
08 Q And for those of us unfamiliar with how
09 the Navy works, what is a corpsman?
10 A Medical. So it's kind of the equivalent
11 of a medical assistant.
12 Q And during the five years or so that you
13 were in the United States Navy, what duty stations
14 were you assigned to?
15 A I was at Camp Lejeune, North Carolina
16 and Portsmouth, Virginia.

3. PAGE 10:17 TO 11:23 (RUNNING 00:01:11.840)

17 Q During your time as a corpsman in the
18 United States Navy, did you have a particular focus
19 within the medical field? Meaning, for example, you
20 were always assigned to primary care physicians, or
21 were you doing work with cardiologists, something
22 like that?
23 A It was varied. I started in the
24 surgical clinic. I went from there to the ICU, then
25 I went from there to family practice, and then to
00011:01 admin.
02 Q Okay. What training did the Navy
03 provide you in order to become a corpsman?
04 A You go -- well, you go to boot camp, of
05 course, and then --
06 Q Yes, ma'am.
07 A -- after boot camp you go to what is
08 called A school which is for, specifically for your
09 job. So it was -- I can't remember exactly how long
10 it was, but it's for -- it's medical assistant
11 school, basically.
12 Q Okay. And where did -- where physically
13 was your A school located?
14 A Great Lakes, Illinois.
15 Q And how long were you up there in

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16 Illinois for that?
17 A About eight months, and that's including
18 boot camp. So about eight months.
19 Q Okay. And was there classroom
20 instruction that went along with A school? Or tell
21 me how A school worked.
22 A Yes. It's classroom instruction plus
23 hands-on training.

4. PAGE 13:02 TO 13:23 (RUNNING 00:00:57.340)

02 Q Okay. And then you said the bulk of the
03 training was concerning patient care. What kind of
04 training did you receive with that?
05 A Bedside manner. Small things like how
06 to give baths, how to, you know, tend to patient's
07 needs while they're there. Nothing too detailed.
08 Because like I said, it's more of a medical
09 assistant, so you have to work one-on-one with an
10 RN. Anything detailed outside of that the nurse
11 would do, we wouldn't, so...
12 Q Okay. At any point in time did you
13 obtain any sort of license from any state agency as
14 a result of your corpsman?
15 A No.
16 Q Okay. Ever have any instruction when
17 you were in A school, I'm going to use this term
18 broadly, concerning mental health issues?
19 A No.
20 Q During the time that you served as a
21 corpsman in the United States Navy, was there
22 periodic refresher training that you had to undergo?
23 A No.

5. PAGE 14:03 TO 14:09 (RUNNING 00:00:18.450)

03 Q Okay. Where did you go work after you
04 left the Navy in 2001?
05 A I came back to Beaufort. I worked on
06 Hilton Head for a while at an investment company.
07 And then I worked at a cardiologist's office for a
08 couple years. And then I went to the Naval
09 Hospital.

6. PAGE 17:02 TO 17:10 (RUNNING 00:00:22.699)

02 Q Okay. All right. When you went to work
03 in May of 2006 at the Naval Hospital, were you going
04 in to work directly for the government?
05 A Yes.
06 Q Your employer beginning in May of 2006
07 was United States of America?
08 A Yes.
09 Q Is that who you're employed by today?
10 A Yes, Department of the Navy.

7. PAGE 25:13 TO 28:15 (RUNNING 00:03:45.596)

13 Q Ma'am, we're here today about an
14 incident that took place on February 24th, 2012.
15 Are you aware of that?
16 A Yes, I am.
17 Q And specifically we're here about an
18 incident that involves a gentleman by the name of
19 Calvin Hunt. Prior to February 24th, 2012, had you
20 ever met Mr. Hunt?
21 A No, I hadn't.
22 Q Where were -- strike that. Let me ask a
23 foundational question.

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24 Were you working at the Naval Hospital
25 on February 24th, 2012?
00026:01 A Yes, I was.
02 Q And on February 24th, 2012, what was
03 your job title at the hospital?
04 A Medical Support Assistant.
05 Q Okay. And at that point in time, you
06 were the medical support assistant in what
07 department?
08 A Medical Home Port Team 2 on the second
09 floor.
10 Q Okay. And what did the Medical Home
11 Port Team do?
12 A It's pediatrics and internal medicine.
13 It's -- so it's a mix of family practice, peds and
14 internal meds.
15 Q But in the olden days they would have
16 called it general practitioner?
17 A Yes.
18 Q Okay. And as in your role working for
19 that team, what were your job responsibilities?
20 A Check in, DEERS checks, which is
21 basically verifying insurance. Give directions to
22 the hospital, answer phones, take messages. That's
23 about it. It's very limited.
24 Q And would you have been the first point
25 of contact for someone coming into that department?
00027:01 A Yes.
02 Q Okay. Did anyone sit with you to also
03 serve as a first point of contact?
04 A No.
05 Q Back in February of 2012, approximately
06 how many people would have worked in this
07 department?
08 A I believe at the time -- I'm not exactly
09 sure. There might have been six or seven providers.
10 And corpsmen vary, so it could be between 10 to 12
11 corpsman, and they rotate out. So I'm not exactly
12 sure.
13 Q What were the typical hours that you
14 were working at the Naval Hospital back in February
15 of 2014?
16 A 7:30 to 4:00.
17 Q Those hours you work today?
18 A Yes.
19 Q And the Medical Home Port Team 2
20 department, what are the hours of that department?
21 A 7:30 to 4:00.
22 Q So this isn't a 24/7/52 type team?
23 A No, it's not.
24 Q Okay. What days of the week are
25 personnel present for Medical Home Port Team 2?
00028:01 A Monday through Friday.
02 Q 7:30 to 4:00?
03 A 7:30 to 4:00.
04 Q Do you recall what day of the week
05 February 24th was?
06 A Friday.
07 Q I asked you a moment ago about a
08 gentleman by the name of Calvin Hunt. Prior to
09 February 24th, 2012, had you ever met someone by the
10 name of Edward Ray?
11 A No.
12 Q On February 24th, 2012, how did you come
13 to have contact with Calvin Hunt?
14 A He came to the second floor with Mr. Ray

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15 to the desk.

8. PAGE 28:19 TO 30:01 (RUNNING 00:01:13.210)

19 when you say a desk, are you talking about a desk
20 that's out in a common room? Are you talking about
21 a window and a wall? Help me understand the Home
22 Port Team 2.
23 A It's a -- it's a waiting area and a
24 counter with an open area. So there's no window.
25 Q And you would have been sitting on one
00029:01 side of that counter?
02 A Yes.
03 Q Okay. And when Mr. Ray approached that
04 counter, was he with someone?
05 A Yes.
06 Q Okay. And who was he with?
07 A Mr. Hunt.
08 Q Okay. Who were the two gentlemen there?
09 A They were the only two there.
10 Q Okay. And it was Edward Ray and Calvin
11 Hunt?
12 A Yes.
13 Q Okay. When they -- these two gentlemen
14 approached the counter, who first spoke to you?
15 A Mr. Ray.
16 Q And did Mr. Ray identify himself?
17 A Yes, he did.
18 Q Okay. And did he tell you that he --
19 strike that.
20 Did he identify who he was employed by?
21 A Yes, he did.
22 Q And what was that information that he
23 gave you?
24 A He just said, "I'm Mr. Ray with the
25 Department of the VA and I want to know if you can
00030:01 help this young man."

9. PAGE 30:02 TO 30:23 (RUNNING 00:01:02.180)

02 Q Was Mr. Ray wearing some sort of name
03 tag or badge around his neck on a lanyard, if you
04 recall?
05 A I don't recall.
06 Q Don't know one way or the other?
07 A No.
08 Q Okay. But you had an understanding at
09 that point in time, on February 24th, 2012, that
10 Mr. Ray was there as some sort of Veterans' Affairs
11 officer; is that fair?
12 A Yes.
13 Q And he wanted to know whether or not you
14 could help this young man or not?
15 A Yes.
16 Q Did Mr. Ray tell you what kind of help
17 Mr. Hunt needed?
18 A That he needed to be seen by a provider.
19 Q Anything else? And we're going to walk
20 through this in kind of a slow, slow process.
21 Anything else that Mr. Ray initially told you other
22 than Mr. Hunt needed to be seen by a provider?
23 A No.

10. PAGE 30:24 TO 32:03 (RUNNING 00:00:55.245)

24 Q What did you do after learning that
25 Mr. Hunt needed to be seen by a provider?
00031:01 A I asked Mr. Hunt if he had ever been

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02 seen at the Naval Hospital before.
03 Q And what did Mr. Hunt tell you?
04 A No.
05 Q What did you do next?
06 A I asked him his name.
07 Q Did he tell you his name?
08 A Yes, he did.
09 Q Okay. He said he was Calvin Hunt?
10 A Yes.
11 Q Okay. And with the information that the
12 gentleman on the other side of the counter next to
13 Mr. Ray was Calvin Hunt, what did you do?
14 A I asked him his last four of his social.
15 Q Did he provide you that information?
16 A Yes, he did.
17 Q And what happened next?
18 A I looked him up in the system to verify
19 if he had ever been seen there before.
20 Q Okay. And the system, we're talking
21 about a computer?
22 A Yes.
23 Q Okay. And what happened next?
24 A And he didn't come up.
25 Q And what system specifically were you
00032:01 using on a computer?
02 A CHCS.
03 Q CHCS?

11. PAGE 32:04 TO 32:17 (RUNNING 00:00:39.025)

04 A Yes.
05 Q Okay. And do you know what CHCS stands
06 for?
07 A I have no idea.
08 Q Okay. CHCS, do you know if this is a
09 program that's used exclusively at the Naval
10 Hospital in Beaufort, or is it used elsewhere?
11 A It's nationwide.
12 Q Okay. So using CHCS, you put Mr. Hunt's
13 name and last four of his social in and nothing came
14 up. What did you do next?
15 A I said, "I'm not sure what we'll be able
16 to do for you." And then I called Ms. Smith in the
17 back.

12. PAGE 33:16 TO 33:21 (RUNNING 00:00:05.790)

16 know about the situation. How do you communicate
17 with Ms. Smith? Do you go tell her something? Do
18 you send her an email?
19 A I call her.
20 Q On the telephone?
21 A On the telephone.

13. PAGE 33:22 TO 35:07 (RUNNING 00:01:41.340)

22 Q Okay. And what information do you
23 provide Ms. Smith?
24 A I let Ms. Smith know that there was a
25 patient out there who wasn't registered here at the
00034:01 hospital, wanted to be seen by a provider, what
02 could we do. And she said, "I'll come out and talk
03 to him."
04 Q How soon after Mr. Hunt and Mr. Ray came
05 to the counter did you call Ms. Smith?
06 A I don't think it was five minutes.
07 Q Were they still standing at the counter
08 when you made that phone call?

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09 A No. I told them to have a seat.
10 Q Okay. Now, on a Friday afternoon in
11 this department, was the waiting room crowded or
12 empty, or do you remember?
13 A It was empty.
14 Q They were the only ones there?
15 A They were the only ones there.
16 Q And typically in the Medical Home Port
17 Team 2, are individuals seen who have appointments,
18 or are typically folks seen without appointments?
19 A Everyone has -- has to have an
20 appointment.
21 Q Okay. After you called Ms. Smith on the
22 telephone, did she come up to the front?
23 A Yes, she did.
24 Q How soon after you called her did she
25 come up to the front?
00035:01 A It wasn't very long, a few minutes.
02 Q Less than five minutes?
03 A Yes.
04 Q And when Ms. Smith came up to the front,
05 did she go out into the waiting room or did she
06 stand there at the counter where you sit?
07 A She went out to the waiting room.

14. PAGE 35:17 TO 35:20 (RUNNING 00:00:09.520)

17 Q Were you able to hear Ms. Smith's
18 conversation with Mr. Ray and Mr. Hunt?
19 A There wasn't conversation. She just
20 said, "Let's go back to my office."

15. PAGE 35:23 TO 36:02 (RUNNING 00:00:11.130)

23 Q Okay. So you see Ms. Smith go out into
24 the waiting room, talk with Mr. Ray and Mr. Hunt.
25 And the only thing that you heard her say was let's
00036:01 go back to my office?
02 A Yes.

16. PAGE 36:03 TO 38:09 (RUNNING 00:02:56.730)

03 Q Did Mr. Hunt or Mr. Ray say anything in
04 response to that, that you recall?
05 A No.
06 Q What happened next?
07 A They went back to her office.
08 Q Okay. And how far from the front desk
09 and the counter is Ms. Smith's office?
10 A It's a good little way. It's a very
11 long hallway.
12 Q Did you go with them back to Ms. Smith's
13 office?
14 A No.
15 Q You stayed at the counter?
16 A Yes.
17 Q When did you next see Mr. Hunt and
18 Mr. Ray again?
19 A Ms. -- about a few minutes later, I'll
20 say maybe five minutes later, Ms. Smith was
21 escorting them downstairs.
22 Q All right. This -- this is painful, I
23 know. But lawyers do this for a reason. So you see
24 Mr. Ray and Mr. Hunt and Ms. Smith go back down the
25 long hallway, then about five minutes later you see
00037:01 those three individuals come back?
02 A Yes.
03 Q Okay. Any doubt in your mind as you sit

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04 here today that it was Ms. Smith who was walking
05 Mr. Ray and Ms. Hunt into the waiting room at the
06 Medical Home Port Team 2?
07 A No, no doubt.
08 Q Can you describe for us what Ms. Smith
09 looks like?
10 A Ms. Smith is African-American, maybe
11 about 5-6, 5-7. I think at the time she had dark
12 hair, glasses. She always wears a white lab coat.
13 Q Did you see Mr. Hunt and Mr. Ray exit
14 the Medical Home Port Team 2 area with Ms. Smith?
15 A Yes, I did.
16 Q Okay. And at some point in time did
17 someone come back?
18 A Ms. Smith did.
19 Q How long had Ms. Smith been gone?
20 A Maybe 10 minutes.
21 Q Longer than the time that she'd spent
22 back in her office with Mr. Hunt and Mr. Ray?
23 A Yes.
24 Q Did Ms. Smith tell you where she had
25 gone with Mr. Hunt and Mr. Ray?
00038:01 A Yes, as she was walking out. She said,
02 "I'll be right back. I'm going to take them to the
03 ER."
04 Q This is as she's walking Mr. Hunt and
05 Mr. Ray out of the Medical Home Port Team 2 area?
06 A Yes.
07 Q And when Ms. Smith came back, did she
08 tell you any information?
09 A No.

17. PAGE 43:12 TO 46:22 (RUNNING 00:03:28.740)

12 Q Are you familiar with a database known
13 as AHLTA?
14 A Yes.
15 Q Tell us what AHLTA is.
16 A AHLTA is -- it's an electronic
17 recordkeeping system. So it has patients' medical
18 records, demographics. That's about it. And it's
19 nationwide so it holds a lot of information.
20 Q So it contained records of service
21 members from the East Coast to the West Coast from
22 the North to the South?
23 A Yes.
24 Q So for instance, somebody who's in the
25 Marine Corps out in California, his or her medical
00044:01 records would get entered into AHLTA?
02 A Yes.
03 Q And if they were back here in South
04 Carolina for some reason, their records from out in
05 California, would they be accessible through the
06 AHLTA?
07 A Yes.
08 Q Now this isn't a trick question. Do you
09 have access to the AHLTA?
10 A Yes.
11 Q Do you have an understanding as you sit
12 here today whether or not Ms. Sandra Smith has
13 access to AHLTA?
14 A Yes.
15 Q She does?
16 A Yes, she does.
17 Q Okay. Pretty much everybody at the
18 Naval Hospital who's working hands-on with patients
19 have access to AHLTA?

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20 A Yes.
21 Q And why is that, if you know?
22 A Because it's, it's patient care. So you
23 would need that information, depending on what it
24 is.
25 Q Is that something you were trained to do
00045:01 when you were in A school as a corpsman?
02 A No. AHLTA is fairly new. We didn't
03 have AHLTA when I was in the military. So I got
04 trained on AHLTA when I started working at the
05 medical -- at the Naval Hospital.
06 Q Tell me about that training. Was that a
07 classroom type training?
08 A Yes.
09 Q Okay. Is that something that everybody
10 who works at the Naval Hospital had to go to?
11 A If you have access you have to go to
12 training.
13 Q Okay. And how long does this training
14 last, or did it last?
15 A About two days.
16 Q Oh, wow. Two whole days?
17 A No. Couple hours out of the day for two
18 days.
19 Q But on two separate days?
20 A Two separate days.
21 Q Okay. And the training that you had on
22 AHLTA, was it somebody standing up in front of a
23 room explaining how it worked, or was there a
24 hands-on component? Help me understand.
25 A It's both. It's someone -- it's
00046:01 hands-on, because you're -- everyone is sitting at a
02 computer, but there is also an instructor.
03 Q Okay. Told me a lot of information
04 there. So everybody's sitting at a computer, and
05 there's an instructor, and so it's kind of guided
06 hands-on training?
07 A Yes.
08 Q Was it good training?
09 A It was okay.
10 Q Okay. Were you able to use the AHLTA
11 after you went through the two days of training?
12 A Yes.
13 Q Okay. Training wasn't so bad that you
14 couldn't figure out how to use AHLTA after you sat
15 through two days of training?
16 A No.
17 Q Okay. And the software itself,
18 particularly after you had two days of training, was
19 it fairly easy to use?
20 A Yes.
21 Q You had no trouble with it?
22 A No.

18. PAGE 46:23 TO 47:02 (RUNNING 00:00:13.800)

23 Q Who else was working on February 24th,
24 2012, in the Medical Home Port Team 2 department, if
25 you recall?
00047:01 A I can't remember who all was there that
02 day.

19. PAGE 47:06 TO 47:09 (RUNNING 00:00:09.540)

06 Q Okay. So at the time that Mr. Hunt and
07 Mr. Ray came in, was there a medical doctor present
08 in the Medical Home Port Team 2?
09 A No.

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20. PAGE 48:02 TO 48:05 (RUNNING 00:00:11.580)

02 Q How late in the day was it that Mr. Hunt
03 and Mr. Ray came into the Medical Home Port 2 Team
04 area, if you recall?
05 A I know it was after 3:30. It was very

21. PAGE 48:17 TO 50:25 (RUNNING 00:03:02.290)

17 Q Okay. When you spoke with Calvin Hunt
18 on February 24th, 2012, how would you describe his
19 appearance?
20 A He was neat, calm. I mean, normal, I
21 guess. He just...
22 Q You believe you interacted with him for
23 less than or more than a minute?
24 A Maybe right around a minute. The most I
25 asked him was his name and his last four.
00049:01 Q Did he know the last four of his social?
02 A Yes, he did.
03 Q Or he at least gave you four numbers?
04 A Yes.
05 Q Okay. Let me ask you this. If somebody
06 comes in to the -- your department at the Naval
07 Hospital and they give you a name. Let's say they
08 come in and say they're Paul Detrick.
09 A Okay.
10 Q And they -- you put in four digits of a
11 social security number that don't match up in the
12 computer.
13 A Okay.
14 Q Would Mr. Detrick's medical records show
15 up?
16 A No.
17 Q You'd have to have the combination of
18 both the last name and the correct last four of the
19 social?
20 A Yes.
21 Q And that would be true of whether or not
22 we're talking about Mr. Detrick or Mr. Berlinsky or
23 Calvin Hunt?
24 A Yes.
00050:01 Q Have you had any conversations with
02 Mr. Ray since February of 2012?
03 A No.
04 Q Okay. Do you know any of his family?
05 A No.
06 Q I'm just going to go through a list of
07 people, and it's going to be painful.
08 A Okay.
09 Q Do you know a lady by the name of Janice
10 McDonald?
11 A No.
12 Q Okay. What about her husband, Joe
13 McDonald?
14 A No.
15 Q Have you ever done any work with a
16 medical doctor by the name of Christian Jansen?
17 A No.
18 Q Did you know any of the people who were
19 working on February 24, 2012, in the emergency room
20 at the Naval Hospital in Beaufort?
21 A I don't know who was working that day,
22 so I don't know.
23 Q Okay. All right. Ma'am, I think those
24 are all the questions I have for you. Some of these
other lawyers around the room may have questions.

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25 A Okay.

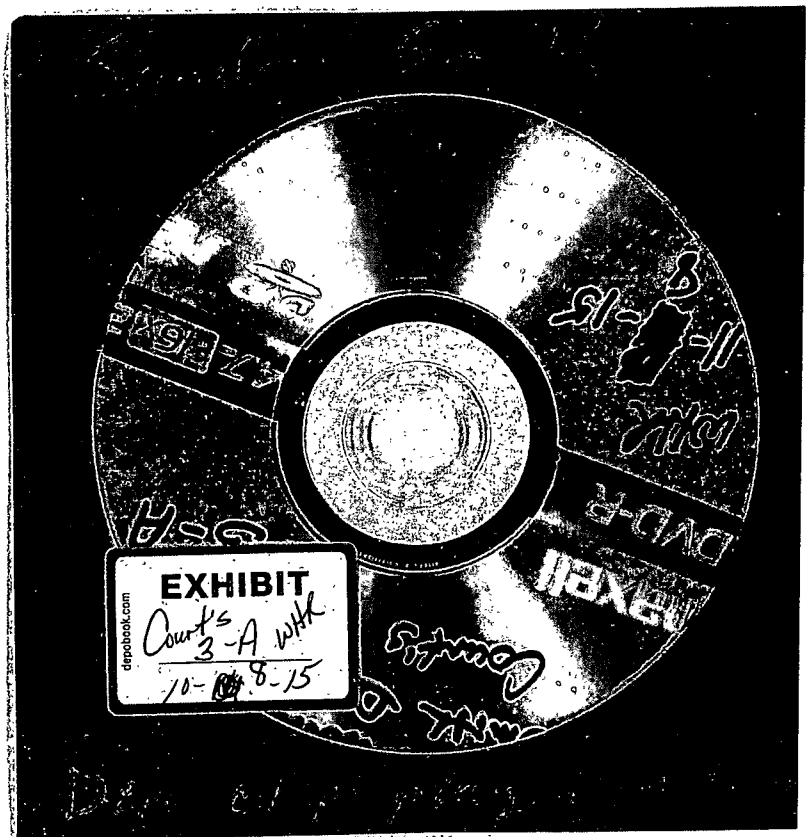
22. PAGE 63:23 TO 64:14 (RUNNING 00:00:25.040)

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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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)

05 Q Okay. Can you state your full name for
06 the record?
07 A My full name is Sandra Lorraine Green
08 Smith.
09 Q Thank you, ma'am. And where you current
10 reside?
11 A I live at 260 Story Teller Road on
12 St. Helena Island, South Carolina.
13 Q How long have you lived at the 260 Story
14 Teller residence?
15 A I've lived on Story Teller over 50
16 years.
17 Q Did you grow up out there?
18 A Yes, I did.
19 Q From St. Helena Island originally?
20 A Yes, sir.
21 Q Okay. Where did you go to school?
22 A I went to high school at Beaufort High.
23 I attended college at North Carolina A&T State
24 University in Greensboro, North Carolina.
25 Q And what year did you graduate from
00011:01 Beaufort High School?
02 A In '76.
03 Q And you went on to A&T in Greensboro?
04 A Yes, sir.
05 Q My mother-in-law used to teach at A&T?
06 A Oh.
07 Q Did you graduate from A&T?
08 A Yes, I did.
09 Q What year did you graduate?
10 A 1980.
11 Q Okay. And what degree did you obtain
12 from A&T?
13 A My bachelor's of science in nursing.
14 Q BSN?
15 A Yes, sir.
16 Q And you're a registered nurse?
17 A I am.

2. PAGE 11:18 TO 14:24 (RUNNING 00:03:09.770)

18 Q When did you became a registered nurse?
19 A Shortly after graduation I took the
20 State Board of Nursing.
21 Q When you took the State Board of Nursing
22 shortly after graduating from North Carolina A&T in
23 1980, did you take that up in North Carolina or did
24 you come home to take that test?
25 A I came home to take my boards.
00012:01 Q Okay. Have you continuously been
02 licensed as an RN in South Carolina since then?
03 A Yes, South Carolina and Virginia.
04 Q Any further graduate work or anything
05 like that after you finished at A&T?
06 A I do have a Master's in healthcare

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07 administration and a degree in Christian counseling.
08 Q All right. You said a Master's in
09 healthcare administration. Where is that degree
10 from?
11 A Central Michigan University.
12 Q Is that a program that you did online or
13 did you actually go up to Michigan?
14 A There was a program offered at the
15 hospital, here at Naval Hospital.
16 Q A distance learning type thing?
17 A Distance learning, yes, sir.
18 Q Okay. And when did you obtain or go
19 through that program through Central Michigan?
20 A That was 2001 I graduated.
21 Q And it's a Master's in healthcare
22 administration?
23 A Yes, sir.
24 Q Okay. I want to get that straight. And
25 then you have another graduate degree, that's in
00013:01 Christian counseling?
02 A Yes, sir.
03 Q And what's that degree through, which
04 institution?
05 A Cathedral Bible College, which is out of
06 Marion, South Carolina. And that was also a
07 distance learning program through the church.
08 Q Okay. And when did you obtain your
09 Master's degree in Christian counseling?
10 A I did not get a Master's in Christian
11 counseling, I got a doctorate.
12 Q Oh, I apologize, ma'am.
13 A That's okay. I'm sorry. I didn't say.
14 Q Okay. So is this a Ph.D. or a -- tell
15 me what the degree is.
16 A The degree is a doctorate in Christian
17 counseling.
18 Q Okay.
19 A It allows me to counsel through church
20 ministry.
21 Q I understand.
22 A Yes, sir.
23 Q And I mean no -- do you typically -- are
24 you typically called Dr. Smith, or I don't --
25 A I am not typically called. Most people
00014:01 don't even know that I have a doctorate.
02 Q Okay. Okay. So if I call you Ms. Smith
03 today, that's not going to offend you?
04 A That's not a problem at all.
05 Q Okay. I just wanted to make sure I
06 understand that. And that was through Cathedral
07 Bible College. And what year did you obtain the
08 doctorate?
09 A In 2012. 2011. I believe that was
10 2011.
11 Q Okay. And you said that this distance
12 learning program was through a church?
13 A Yes.
14 Q Okay. Which church was it through?
15 A It was through the Grace Hill Baptist
16 Church on Grace Hill, South Carolina.
17 Q Other than the registered nursing
18 license, do you hold any other licenses issued by
19 the State of South Carolina, other than that and a
20 driver's license?
21 A Not at this time, no.
22 Q Do you have plans to seek what's known

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23 as a Licensed Professional Counselor license?
24 A I do.

3. PAGE 16:06 TO 16:14 (RUNNING 00:00:31.840)

06 Q Okay. Where do you currently work?
07 A I work at Naval Hospital Beaufort.
08 Q And how long have you worked at the
09 Naval Hospital?
10 A I've been employed at the Naval Hospital
11 Beaufort twice during my career as a nurse.
12 Initially employed during 1988 to '93. Then again
13 from 1995 through '97 in inpatient nursing. And
14 then outpatient nursing from '97 to the present.

4. PAGE 18:05 TO 19:12 (RUNNING 00:01:16.290)

05 Q Certainly. Where did you work before
06 you went to the Naval Hospital in 1988?
07 A Oh, I worked at Bayview Nursing Center
08 from -- for a number of years, two years prior to --
09 from '80 to '84.
10 Q Okay.
11 A Yeah.
12 Q And where did you work after Bayview
13 Nursing?
14 A After Bayview, 1995 to 1988 (sic) I
15 worked at Kenner Army Hospital in Virginia.
16 Q Is that when you became licensed as an
17 RN up in Virginia, about that timeframe?
18 A Yes. Yes, professional nurse in
19 Virginia.
20 Q Okay. And then 1988, you started
21 working at the Naval Hospital here in Beaufort?
22 A Yes, sir.
23 Q Okay. When you started working for the
24 Naval Hospital in 1988, who was your employer, was
25 it the Department of the Navy or was it a
00019:01 contractor?
02 A I was working for the Department of the
03 Navy.
04 Q Have you continued -- strike that.
05 In the two separate timeframes that
06 you've worked for the -- at the Naval Hospital, has
07 that been employment with the Department of the
08 Navy?
09 A Yes.
10 Q You never worked for a contractor such
11 as CasePro or Sterling or anything like that?
12 A No, sir.

5. PAGE 20:09 TO 20:17 (RUNNING 00:00:24.000)

09 an immunization nurse. What other types of nursing
10 duties have you done for the Department of the Navy?
11 A I've done progressive care which is step
12 down from ICU.
13 Q Okay.
14 A Inpatient medical-surgical nursing, and
15 ambulatory care nursing, which is primary care
16 nursing dealing with pediatrics, family practice,
17 internal medicine patients.

6. PAGE 21:05 TO 21:13 (RUNNING 00:00:16.784)

05 Q Okay. Have you ever worked in an
06 emergency room setting?
07 A I have had some brief work in the
08 emergency room, but never assigned to the emergency

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09 room care.
10 Q The brief work that you've done in the
11 emergency room, was that ever at the Naval Hospital
12 here in Beaufort?
13 A No, it was not.

7. PAGE 24:19 TO 24:23 (RUNNING 00:00:11.960)

19 actually, that would be this year. Back in February
20 of 2012, which department were you working in at the
21 Naval Hospital?
22 A In the primary care, Medical Home
23 Department.

8. PAGE 25:08 TO 26:14 (RUNNING 00:01:51.300)

08 Q Okay. Tell me about that department.
09 How many people typically work in that department?
10 A Well, it's a very large department. And
11 currently we occupy two floors. I would say there
12 are close to maybe 60 people or more.
13 Q How many people on that team are RNs,
14 approximately?
15 A Approximately seven.
16 Q Okay. And how many medical doctors
17 staff that team?
18 A Oh, our providers come and go. But we
19 have currently ten, about ten providers.
20 Q And what's a typical shift for you on
21 this team as far as hours? When would you report to
22 work and when would you leave?
23 A I arrive at 7:30 a.m. and leave at 1600,
24 or 4 p.m..
25 Q Monday through Friday?
00026:01 A Monday through Friday.
02 Q Nobody's there working on Saturday or
03 Sunday; is that fair? In that department?
04 A In that department, no.
05 Q Okay. And what are your specific
06 responsibilities as a registered nurse for that
07 department?
08 A Currently, my responsibilities are to
09 the pod, which consists of pediatric care. So I
10 work with two, three doctors and one other nurse,
11 and our job is to ensure the scheduling is correct,
12 ensure patients are triaged correctly in person and
13 by phone. We administer medication when necessary.
14 We assist the providers in any way, and

9. PAGE 26:18 TO 27:06 (RUNNING 00:00:52.930)

18 Q Is that what you were doing in February
19 of 2012, working primarily with pediatric patients?
20 A In February of 2012 I was actually doing
21 a collateral duty which consisted of the support of
22 women's health.
23 Q Tell me about that. What did that
24 involve?
25 A That involved screening or assisting
00027:01 with the screening of women for cervical cancer. If
02 cervical cancer or any abnormal tests that could
03 lead to cervical cancer is noted, then I would
04 assist those women in getting further treatment and
05 scheduling within the team, or refer to the
06 Gynecology Department.

10. PAGE 28:16 TO 29:01 (RUNNING 00:00:28.980)

16 The events that bring us here today

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17 involve a gentleman by the name of Calvin Hunt.
18 A Uh-huh.
19 Q Is that a yes?
20 A Yes.
21 Q Okay. Prior to February 24th, 2012, had
22 you ever met Calvin Hunt?
23 A No, sir.
24 Q Prior to February 24th, 2012, had you
25 ever met a gentleman by the name of Edward Ray?
00029:01 A No, sir.

11. PAGE 29:10 TO 31:02 (RUNNING 00:02:21.390)

10 Q And how did you first encounter Calvin
11 Hunt that Friday?
12 A He was brought to the -- I was asked to
13 speak with him by Koren Pope.
14 Q And how did Ms. Pope ask you to do that?
15 Did she come talk to you? Did she call you on the
16 phone?
17 A She came to my office.
18 Q And what did Ms. Pope tell you?
19 A She said there was a gentleman that was
20 there who was requesting medication refills, and she
21 could not locate him in the system. And that he was
22 accompanied by someone from the VA.
23 Q Do you know why Ms. Pope came to you?
24 A I was the nurse on duty at the time.
25 Q Was there any other registered nurse
00030:01 present in that department at that point in time on
02 Friday afternoon?
03 A I don't recall any other nurses.
04 Q What did you do when Ms. Pope conveyed
05 that information to you?
06 A When she conveyed that information, she
07 also gave me some papers, which I looked at. And I
08 told her to give me a moment, let me review the
09 information and see what I could find out.
10 Q Could you describe the papers that she
11 handed you?
12 A I can't describe them in great detail.
13 I do recall that it mentioned he had been sent to
14 Beaufort from a base in California. And the papers
15 also mentioned that he was eligible to receive care
16 at the Naval Hospital Beaufort.
17 Q Okay. Do you know where these documents
18 came from?
19 A Mr. Hunt, I believe, had the documents
20 with him.
21 Q Now, when it said that he was eligible
22 to receive care, did it specifically state he was
23 eligible to receive care at Naval Hospital Beaufort?
24 A It said at the nearest MTF to his
25 location.
00031:01 Q And what does MTF stand for?
02 A Military treatment facility.

12. PAGE 31:03 TO 31:24 (RUNNING 00:01:02.870)

03 Q And the paperwork, or papers that you're
04 telling us about, did this bear the letterhead of
05 the Department of the Navy, if you recall?
06 A I don't recall exactly what letterhead
07 it bared (sic). They did look like official papers,
08 but I don't recall exactly what letterhead was on
09 the -- the papers.
10 Q Had you ever seen paperwork similar to
11 this previous to February of 2000 --

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12 A No, I had not.
13 Q Okay. That paperwork that Ms. Pope
14 handed you -- I want to make sure I understand the
15 timeline. Did she hand this paperwork prior to you
16 speaking with Mr. Hunt?
17 A Yes, she did.
18 Q Okay. And about how many pages do you
19 think this paperwork was?
20 A As I recall, there were approximately
21 three pages of paperwork.
22 Q It wasn't a big, thick binder like I
23 have in front of me?
24 A No, sir.

13. PAGE 32:16 TO 33:17 (RUNNING 00:01:31.880)

16 Q Okay. What did you do once you received
17 that paperwork?
18 A I attempted to access some information
19 from our system.
20 Q Now, I understand that there's a couple
21 of different acronyms out there at the Naval
22 Hospital, so just bear with me. When you're
23 referring to the system, are you referring to CHCS,
24 or to something known as AHLTA?
25 A They're both systems.
00033:01 Q And what did you find when you attempted
02 to locate Mr. Hunt?
03 A I noted that he was in the system, which
04 showed that he was an active duty person eligible
05 for care.
06 Q And what's the significance of that?
07 A That means that we can then care for him
08 at our hospital.
09 Q I know it was a long time ago, and it's
10 not a trick question. I can assure you there aren't
11 going to be any trick questions today. People
12 sometimes are just going to ask some
13 inartfully-worded questions to try to obtain
14 information.
15 As you sit here today, do you know if
16 you found Mr. Hunt in CHCS or AHLTA or both?
17 A I recall that he was in both systems.

14. PAGE 35:09 TO 36:08 (RUNNING 00:01:17.046)

09 Q So I want you to know that. With
10 respect to records that are in either AHLTA or
11 CHCS, do they contain information that would follow
12 the service member, whether or not he or she is
13 receiving treatment from the East Coast to the West
14 Coast, from the North to the South?
15 A That was the plan when, from my
16 understanding, when the systems were created to
17 ultimately connect them. So whether a member was on
18 ship or in the desert, or wherever they were, that
19 all of these records could be linked and travel with
20 them.
21 Q So a step further from my own question,
22 it wouldn't matter if they're deployed in some sort
23 of active theater or they're stationed at a base in
24 California or South Carolina, they should all be
25 there?
00036:01 A They're working on getting it all there.
02 It hasn't happened everywhere yet, but it is -- it's
03 happening with more Internet access and more
04 web-based programs.
05 Q Right. Might be some difficulties maybe

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06 on a ship in the middle of the ocean, but certainly
07 no difficulties here let's say in South Carolina
08 where we have good Internet.

15. PAGE 36:10 TO 36:12 (RUNNING 00:00:06.830)

10 Q Is that fair?
11 A Well, it's based on what's available and
12 what has been put in.

16. PAGE 36:24 TO 38:03 (RUNNING 00:01:29.517)

24 Q Before you talked with Mr. Hunt, you get
25 some paperwork from Ms. Pope and you look Mr. Hunt
00037:01 up in the computer, okay? What information are you
02 able to determine about Calvin Hunt from the
03 computer before you talked to him?
04 A That he was eligible for care because he
05 was found in the system as an active duty member.
06 Q Okay. Did you review any of his past
07 medical history at that point?
08 A No, sir.
09 Q And you understand what I mean by past
10 medical history?
11 A His prior records, and...
12 Q So you have the paperwork from Ms. Pope,
13 you look Calvin Hunt up in the computer and you
14 verify that he's in the computer, and don't look at
15 any of his records; is that correct?
16 A May I just look at this to make sure?
17 Q Certainly.
18 A To make sure I'm following your
19 timeline.
20 Q Sure.
21 A Okay. According to my statement for
22 recall, I was able to find his name and review his
23 last clinic encounter note which stated that he was
24 seen for shoulder pain.
25 Q And for the record, you're using a
00038:01 two-page document to refresh your recollection, the
02 state -- has your signature on the second page?
03 A Yes, sir.

17. PAGE 46:22 TO 47:04 (RUNNING 00:00:16.997)

22 the documents you've brought with you today, how
23 many Sandra Smith's work at the Naval Hospital?
24 A I am aware of one.
25 Q And that would be you?
00047:01 A And that would be me.
02 Q Okay. Not a dozen Sandra Smiths running
03 around the Naval Hospital?
04 A Not to my knowledge, no.

18. PAGE 48:14 TO 48:14 (RUNNING 00:00:01.440)

14 that follows, How long...?

19. PAGE 61:10 TO 62:11 (RUNNING 00:01:13.930)

10 voices down. Do you have no opinion if mental
11 health records are accessible, or is that something
12 that you were told?
13 A I have no opinion or ability to answer
14 your question based on what you're asking. I'm not
15 clear on your question.
16 Q All right. Well, you wrote down on this
17 piece of paper, "No opinion on if mental health
18 records are accessible," correct?

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19 A Right.
20 Q You wrote that?
21 A Yes, I did.
22 Q Why did you write that?
23 A I wrote that as a thought about the
24 possibility of having to review mental health
25 records.
00062:01 Q You weren't referring to February 24th,
02 2012, when you wrote that?
03 A Was I referring to February 24th?
04 Q Yes, ma'am.
05 A Yes.
06 Q Okay. And you made a note that you had
07 no opinion on if mental health records were
08 accessible, why?
09 A Because I don't have an opinion on
10 whether mental health records were accessible. I
11 don't have an opinion on that.

20. PAGE 69:16 TO 69:25 (RUNNING 00:00:29.648)

16 there. Let's try and flush that out. "Whether I
17 told them moaning and groaning," what does that
18 mean? Why did you write those words?
19 A That was something I was thinking about
20 as I read through this document.
21 Q All right. Are you -- were you
22 questioning whether or not you told somebody whether
23 or not Mr. Hunt was moaning and groaning?
24 A I thought about it as I was reading
25 through the document.

21. PAGE 71:10 TO 71:25 (RUNNING 00:00:45.170)

10 Q Earlier today when I started asking you
11 questions, you felt the need to consult papers that
12 you brought with you. And the real purpose of a
13 deposition is to obtain what information you have,
14 not informations written on a piece of paper or
15 otherwise.
16 A Okay.
17 Q So with respect to the notes that you
18 made, I'm just trying to get a sense, was this a
19 cheat sheet for your testimony, or what was this?
20 A This incident occurred two years ago.
21 So I don't know what you would call something to jog
22 your memory, but for me, that's what this was. Two
23 years was a long time for me to remember and go back
24 and think about all the things that happened, except
25 for this statement that I have.

22. PAGE 80:07 TO 80:15 (RUNNING 00:00:22.070)

07 Q All right. I know the answer you're
08 going to give me, but is that a memory from two
09 years ago that you're not qualified to answer a
10 question?
11 A No, that's a reminder to myself on who I
12 am and what kind of training I possess. I am not
13 qualified to answer anything that has to do with
14 mental health. I'm not a mental health doctor. I
15 am not an ER nurse.

23. PAGE 80:23 TO 81:09 (RUNNING 00:00:31.750)

23 Q All right. Back all those years ago at
24 A&T when you were enrolled in nursing school, did --
25 did you just opt out of learning anything about
00081:01 mental health?

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02 A I didn't opt out of learning anything
03 about mental health. But we have a protocol to
04 follow, and there are those that are more currently
05 trained in mental health who I have access to as a
06 resource, rather than me going back to my 20 years
07 of mental health training, trying to take care of a
08 patient that I know that I'm not qualified to take
09 care of.

24. PAGE 83:22 TO 84:11 (RUNNING 00:00:46.390)

22 Q All right. Over here there's a word or
23 some letters. Do you see that?
24 A "If."
25 Q If?
00084:01 A Uh-huh.
02 Q What word's following, "no access"?
03 A "To mental health records."
04 Q Why did you write that on this piece of
05 paper?
06 A Again, in preparation for this
07 deposition. It was a thought that I had. After all
08 of this occurred, and looking back knowing what I've
09 heard in the community, there might have been mental
10 health records. But I did not have access to those
11 records.

25. PAGE 114:06 TO 114:21 (RUNNING 00:00:53.520)

06 Q Okay. Do you recall actually on
07 February 24th, 2012, the day you first met Calvin
08 Hunt at the Naval Hospital in Beaufort, actually
09 inputting information into the computer about your
10 interactions with him?
11 A I do recall.
12 Q We'll use this as kind of a jumping off
13 point to get back where we were some three hours
14 ago, to a little bit of a chronology of that day. I
15 believe you told us earlier that Ms. Pope came to
16 see you back in your office?
17 A Yes, sir.
18 Q And that Ms. Pope had some papers with
19 her and that you used those papers to look Mr. Hunt
20 up in the computer; is that correct?
21 A Yes.

26. PAGE 115:01 TO 116:24 (RUNNING 00:02:20.300)

00115:01 Q Is that a yes?
02 A That is a yes.
03 Q Do you believe that would be the time
04 that Ms. Pope would have come back to your office
05 with the papers for Mr. Hunt?
06 A No.
07 Q Do you believe it would have been before
08 then or after that time?
09 A After.
10 Q Help me understand that. You believe
11 Ms. Pope would have come back to your office after
12 2:30 in the afternoon?
13 A Ms. Pope did not come back after 2:30.
14 I entered this documentation after I took Mr. Hunt
15 to the emergency room.
16 Q Okay. So you would have made entries at
17 1430, 1435, 1554, 1556; is that correct?
18 A Essentially, I would have made the
19 initial entry and the computer does some auto
20 citing. And then if I open and close the note or if

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21 I made any adjustments in the note, the final time
22 of that, whatever I wrote, would have been stamped
23 at the 1554. So the note can remain open as long as
24 it takes me to write it.
25 Q Okay. So you believe you would have
00116:01 began writing this note at 1430 or 2:30 in the
02 afternoon?
03 A Yes, sir.
04 Q And it took you to 1554 or 3:54 to
05 finish?
06 A I may have stopped to do something else.
07 I may have gotten a phone call. It's not uncommon
08 that the note is not closed immediately.
09 Q And there was a signature down there, it
10 says, "Signed by Smith, Sandra L., Registered
11 Clinical Nurse, NH Beaufort at 1556." Do you see
12 that?
13 A Yes, sir.
14 Q How does one sign electronically sign a
15 document using the computer system at the Naval
16 Hospital?
17 A This is automatically put into the
18 system. So this -- there was nothing special that I
19 needed to do except to type my code in to say I was
20 done with this note.
21 Q And once you were done at 1556 this
22 would have been a part of Mr. Hunt's permanent
23 medical record, correct?
24 A Yes, sir.

27. PAGE 120:03 TO 120:14 (RUNNING 00:00:38.220)

03 Ma'am, with respect to the document that
04 I've marked as Exhibit No. 7, it's your
05 understanding as you sit here today that any person
06 with the appropriate access to AHLTA and the
07 appropriate skill with how to use AHLTA, at least at
08 the Naval Hospital in Beaufort County, South
09 Carolina, could, beginning at 2:30 in the afternoon
10 on February the 24th, 2012, access the information
11 as you had input it at that time concerning your
12 encounter with Mr. Hunt, correct?
13 A Probably not in its entirety, but yes,
14 they could look at the note.

28. PAGE 123:08 TO 123:14 (RUNNING 00:00:21.432)

08 to make sure of. Okay. All right. So we know that
09 the last thing you did on February 24th, 2012, was
10 sign off on your note in the computer. And it looks
11 like that would have been done at about 3:56 in the
12 afternoon or four minutes before quitting time,
13 correct?
14 A Yes, sir.

29. PAGE 130:15 TO 131:06 (RUNNING 00:00:59.300)

15 Q Okay. At that point in time when you're
16 back there in the office with these two gentlemen,
17 do you pull anything up in the computer?
18 A I had already pulled up the visit that
19 showed his shoulder pain, and it also brought up his
20 medication, the two medications that I thought he
21 was requesting.
22 Q Okay. Other than the -- was it a
23 December 1st visit involving shoulder pain?
24 A I think it said December 11th, 2011.
25 Q The December 2011 shoulder incident, did

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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

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25 while momma and daddy are hopefully not getting sick
00127:01 themselves?
02 A Yes, sir.
03 Q Okay. I've been to plenty of those
04 myself. All right. So they're over there near the
05 pediatric playroom. And when you go out there, are
06 both gentlemen seated or are they standing up?
07 A Both gentlemen were seated.
08 Q This is South Carolina. I believe a man
09 should stand up when a woman approaches. Did they
10 do that?
11 A And they did.
12 Q Both of them?
13 A When I -- when I went into the room and
14 I called his name, they both stood up.
15 Q Okay. And what happened at -- what
16 happened at that point?
17 A And I called them back to my office.
18 Q All right. So you asked both Mr. Ray
19 and Mr. Hunt to come back to your office?
20 A Yes.
21 Q Okay. Were any -- other than you
22 inviting them to come back to your office, any type
23 of conversation or anything else discussed out there
24 in the waiting room?
25 A Only the, you know, the general
00128:01 courtesies of hello. And I introduced myself and
02 told them, you know, I would try to find out what he
03 needed and see if I could help him. And told him
04 that I had the papers and we could go back and
05 discuss what he needed.
06 Q Okay. And Mr. -- how was Mr. Hunt
07 dressed?
08 A Mr. Hunt was neatly dressed. I remember
09 some sort of striped white and yellow, maybe, shirt.
10 Q Okay.
11 A Like a Polo shirt that I bought for my
12 husband this weekend, it's a simple shirt. And some
13 slacks. But he was clean and well groomed.
14 Q Okay. Was he wearing shorts or long
15 pants?
16 A He had on long pants, I believe.
17 Q Okay. And what about Mr. Ray? How was
18 Mr. Ray attired?
19 A Mr. Ray was similarly dressed, but I
20 think he was wearing a darker shirt and slacks.
21 Q Did Mr. Ray have a lanyard or anything
22 like that around his neck with a name badge or
23 anything like that, that you recall?
24 A I don't recall.
25 Q Could have, just don't recall; is that
00129:01 fair?
02 A Could have, don't recall. I know he
03 introduced himself as the VA officer.
04 Q Did he give you a business card or
05 anything like that?
06 A No, he did not.
07 Q Okay. So the -- were either gentleman
08 carrying any type of file folder with them?
09 A Mr. Hunt had a file folder.
10 Q In his hands?
11 A Yes.
12 Q These two gentlemen, you invite them to
13 walk back with you. How long did the pleasantries
14 last out there in the waiting room? Are we talking
15 10 seconds, 10 minutes?

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16 A Probably only, you know, less than an
17 minute: Hello. How are you? I'm Ms. Smith. Would
18 you please come back to my office and we can discuss
19 your concerns.
20 Q So did both gentlemen follow you back to
21 your office?
22 A Yes, sir.
23 Q Okay. Once they got back to your
24 office, tell me what happened.
25 A I sat at my desk, and I offered them the
00130:01 two seats that were there.
02 Q Okay.
03 A Mr. Ray sat near the door, Mr. Hunt sat
04 near, closer to my desk at a small sink area. And
05 we discussed the papers that he had.
06 Q And by "papers," you're talking about
07 the papers that said "leave" on them?
08 A The papers that said he was eligible for
09 care.

31. PAGE 131:20 TO 135:04 (RUNNING 00:03:52.230)

20 Q Right. Let's use Paul Detrick as an
21 example, because I did that earlier today. Let's
22 say we wanted to find some of Mr. Detrick's records.
23 How would you go find Mr. Detrick's records in
24 the -- in AHLTA?
25 A Well, we would have to have some of
00132:01 Mr. Detrick's information. But once I had entered
02 the card, and if Mr. Detrick was able to give me
03 certain data on himself, then I would enter that.
04 Q Okay.
05 A And if he were eligible or actively
06 enrolled in the system, then his name would come up
07 along with address, phone number, doctor.
08 Q And assuming that Mr. Detrick was in the
09 system and that he had some records in there, are
10 these records that -- that a list comes up and you
11 click on, or do multiple screens pop up? Help me
12 understand what it looks like.
13 A Initially you're only getting the
14 demographic screen.
15 Q Okay.
16 A Which says that Mr. Detrick is in the
17 system, it tells us if he's an active duty member,
18 retired member. You don't have anything about
19 medical records, medications, anything at that
20 point. And there's a section at the bottom that
21 says whether he's enrolled or not enrolled. And
22 then you can go from there as to where you want to
23 go to look for more information on Mr. Detrick.
24 Q Well, let's assume Mr. Detrick's in the
25 system. He's currently enrolled. It says he's been
00133:01 in the United States Marine Corps, oh, let's say
02 from looking at Mr. Detrick, since he turned 18
03 years old. So a good 15 years ago. He's been in
04 the service for 15 years. How would you then go
05 through those 15 years of -- of medical records?
06 Does a -- does a chronological list come up? Or can
07 you go to some sort of search box. Help me
08 understand. Because, you know, he doesn't look like
09 he's a healthy guy. I mean, there might be a lot of
10 records in there. How do you narrow down what it is
11 you want to look at?
12 A Well, first of all, you may not get all
13 of Mr. Detrick's records.
14 Q Yes, ma'am.

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15 A And there may be only certain things
16 based on where Mr. Detrick has been stationed as to
17 what you will get.
18 Q Okay.
19 A I may get a small list of things. I may
20 get a lot. But it just depends on the patient and
21 where they have been stationed. As I said before,
22 people that are in California and on ships and other
23 places, while the system is trying to gather that
24 information, it doesn't make it readily accessible
25 for someone at my level of access always. So for --
00134:01 it just depends on what I would be able to pull up
02 on him.
03 Q Is there something in the AHLTA known as
04 a problem list?
05 A There is a problem list.
06 Q Okay. And tell -- tell us what a
07 problem list is?
08 A A problem list is a list of all the
09 diagnoses that have been generated on -- on a
10 patient. So -- and all of the things that they have
11 been seen for in the past. It would be keeping a
12 running list of all of the -- those concerns that a
13 patient has had medically.
14 Q Okay. Do you recall as you sit here
15 today one way or the other as to whether or not you
16 reviewed a problem list on February the 24th, 2012
17 for Calvin Hunt?
18 A A problem list did not come up until
19 after this note was generated -- until this note was
20 generated. So there was no problem list.
21 Q All right. You didn't see a problem
22 list until after the note was generated; is that
23 correct?
24 A Right.
25 Q Okay. After that note was generated,
00135:01 did you see a problem list?
02 A Yes.
03 Q Okay. Did you read it?
04 A Not really.

32. PAGE 136:07 TO 136:18 (RUNNING 00:00:36.860)

07 Q You -- as you sit here today, are you
08 able to tell us one way or the other as to whether
09 or not you knew on February 24th, 2012, as to
10 whether or not Mr. Hunt had a problem with anxiety?
11 A Did I look at this list before I took
12 Mr. Hunt to the emergency room?
13 Q No, no. I'm asking at any point in time
14 on February 24th, 2012, any time that day, with your
15 own two eyes, did you see listed as a problem with
16 Calvin Hunt, a problem of anxiety?
17 A I don't recall seeing that list. But
18 Mr. Hunt did say he was anxious, so...

33. PAGE 137:23 TO 138:07 (RUNNING 00:00:29.500)

23 Q Okay. And that's my question. Do you
24 know one way or the other whether or not you
25 reviewed this list on that day, on February 24th,
00138:01 2012?
02 A With the time that I spent with Mr. Hunt
03 and the fact that I took him down right after
04 talking with him, this list came up afterwards. I
05 signed it out at 1556. I went home sometimes maybe
06 10, 15 minutes later. I cannot tell you that I
07 reviewed all of these things on this list.

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34. PAGE 140:04 TO 140:20 (RUNNING 00:01:00.452)

04 Q Okay. What questions do you ask these
05 gentlemen while they're back there in your office?
06 A Well, the first question was how could I
07 help him today so that he could explain to me what
08 he, why he came to the clinic. And he showed me
09 some of the same papers, or the same note that I had
10 pulled up on him about his shoulder. And he said he
11 needed a medication refill. And I told him at that
12 time that these medications were issued back in
13 December 2011 and that they were no longer active,
14 and I wanted to know if he was trying to get refills
15 on these medications. And he said no. And then he
16 said -- and I said, well, what medications are you
17 trying to get refills on?
18 Q Yes, ma'am.
19 A And he said that I wanted something for
20 sleep. Sleep and anxiety, according to my note.

35. PAGE 140:21 TO 141:23 (RUNNING 00:01:02.598)

21 Q Okay. So when you asked him what kind
22 of medication he was -- sleeping, he made clear he
23 wasn't looking for medication dealing with some
24 shoulder pain; is that correct?
25 A No.
00141:01 Q He wanted something to help sleep better
02 and deal with some anxiety he was experiencing; is
03 that correct?
04 A Yes.
05 Q Okay. And he -- you mentioned that he
06 showed you some papers. Did I hear that correctly?
07 A Well, he had the same note about his
08 shoulder pain. He produced a document with the --
09 which is the exact same medical record, just that
10 one report from 2011.
11 Q Did you ask Mr. Hunt if he had any other
12 medical records?
13 A No, I didn't. But he didn't appear to
14 have any -- anything other than the note and the
15 forms that were given to me by Miss Koren.
16 Q Okay. Did you ever see him with a
17 manila folder?
18 A It was a folder. I don't recall what
19 color it was. But it was a very thin folder,
20 probably smaller than this.
21 Q It's your testimony as you sit here
22 today it was a thin folder?
23 A I was a thin folder, yes.

36. PAGE 142:01 TO 142:02 (RUNNING 00:00:05.620)

00142:01 A Mr. Ray did not appear to have a folder
02 with him. I don't recall a folder.

37. PAGE 142:07 TO 142:15 (RUNNING 00:00:21.910)

07 Q All right. Regardless of whether it was
08 a thin folder, a thick folder, or some folder of
09 some size in between, did you personally with your
10 own two eyes review every single piece of paper
11 within that folder?
12 A Between the three documents or the three
13 pages that were given to me and the one that he
14 pulled out, it appeared that I looked at most of
15 them, because, I mean, he took them out to show me.

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38. PAGE 142:23 TO 150:02 (RUNNING 00:08:36.670)

23 After Mr. Hunt tells you that he wants
24 some medication to help him sleep and to deal with
25 his anxiety, what do you do?
00143:01 A I told him again that these medications
02 were not on his list, and that we had two options
03 for getting him care today. Because of the late
04 hour, I did not have a doctor in the clinic, and I
05 offered to get him to the ER to maybe speak with one
06 of the doctors down there to get medications or the
07 requested medications that he wanted. Or we could
08 scheduled an appointment for the next working day in
09 the first available slot so that he could be seen by
10 one of our doctors and establish care and get the
11 medications that he needs from one of the Med Home
12 doctors.
13 Q Okay. Did Mr. Hunt specifically
14 identify for you any medication he was seeking?
15 A No.
16 Q Like by name?
17 A He did not.
18 Q He just generically wanted medication
19 for anxiety and -- and sleep?
20 A Yes.
21 Q Okay. When you told Mr. Hunt that those
22 were his two options, how did he -- how did he
23 respond?
24 A He seemed fine with it. And I asked him
25 which choice he wanted. And he said, "I would
00144:01 prefer to take the appointment for Monday."
02 Q Okay.
03 A And so I scheduled the appointment as he
04 requested.
05 Q And what time was he going to be seen
06 that Monday, if you recall?
07 A My best recollection was the first
08 available appointment, which would have been 7:00,
09 7:30, 7:40 in the morning.
10 Q Okay. All right.
11 A I think that -- it's on the sheet here,
12 if I could look at it.
13 Q All right.
14 A 7:40.
15 Q All right. Did something happen while
16 you were making that appointment for the following
17 Monday, the 27th?
18 A Well, while I was making the appointment
19 he became -- well, he just did one slight motion of
20 rocking back and forth. He just kind of sighed,
21 kind of moaned (indicating.)
22 Q Okay.
23 A So I asked him if he was okay. I didn't
24 want to ask him.
25 Q Why did you not want to ask him?
00145:01 A Because it didn't seem at the time
02 anything that you would want to question a patient
03 about. It was just more of an exasperated kind of
04 moan. But in the back of my mind I felt that I
05 should ask him if he was okay.
06 Q You had concern for him?
07 A I had a concern.
08 Q Okay. How -- how long was the moan?
09 A It wasn't really a moan. It was more
10 like -- like a sigh of exasperation (demonstrating).
11 Just -- just a simple sigh of exasperation and a --
12 a lean and a rock. Which as a nurse you feel the

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13 sympathy for people that, you know, seem to be...
14 Q Seem to be what?
15 A Just whatever the situation is, you want
16 to help. And so I wanted to know if he was okay.
17 Q He'd come there looking for help.
18 A For pills is what he came looking for.
19 And he agreed to take the appointment on Monday for
20 that.
21 Q Okay. And looking at your note from
22 that day, you documented that Kalvin Hunt did not
23 remember how long he'd been in Beaufort; is that
24 true?
00146:01 A When I asked him how long he had been
02 there, he wasn't able to give me an immediate
03 answer, no.
04 Q Did that give you a concern?
05 A That did. I thought it was odd that he
06 didn't remember.
07 Q Was this before or after you heard the
08 moan?
09 A I'm not sure. Did I write it down as a
10 sequence? That would have been before.
11 Q Okay. People typically know how long
12 they've been in a given city, that's fair?
13 A That's fair.
14 Q I didn't ask you your age a long time
15 ago. But you're able to tell me how long you'd been
16 in Beaufort County; is that fair?
17 A Yes, that's fair.
18 Q You're probably able to tell me how long
19 your family's been here, too?
20 A Yes.
21 Q If people have all their wits about
22 them, they know what's going on around them; is that
23 fair?
24 A Yes.
00147:01 Q But Mr. Hunt didn't know how long he'd
02 been in Beaufort; is that fair?
03 A Mr. Hunt said he didn't remember how
04 long he'd been in Beaufort.
05 Q And you had no reason to think he was
06 making that up, did you?
07 A No, I didn't have any reason to think he
08 was making it up.
09 Q Okay. And then some period of time
10 later you hear a moan, and what you describe in the
11 record, he rocks back and forth?
12 A Yes.
13 Q Okay. And you ask him if he's okay.
14 And how does he respond?
15 A He -- I asked him -- when he rocked back
16 and forth, I asked him if he was okay. And I told
17 him, you know, we could go down to the ER if he
18 wanted to try to get his medications this evening.
19 And I think, according to my note here, he declined.
20 Q Okay. Did -- was -- did that strike you
21 as -- as indicative of whether or not Mr. Hunt
22 wanted to go to the ER or not go to the ER?
23 A It struck me as a person saying I can
24 wait. I'm okay and I can wait.
00148:01 Q Okay. But after that, you asked him
02 whether or not he felt like hurting himself?
03 A Yes.
04 Q Why did you ask him that? Do you ask
05 all your patients that?
06 A I don't.

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04 Q I imagine particularly the pediatric
05 patients you don't ask that.
06 A No, I don't.
07 Q Or the women coming in for cervical
08 cancer screens?
09 A No, I don't. I don't ask them that
10 typically.
11 Q I'm going to ask you a question. How
12 many times in your career as a nurse do you think
13 you've asked a patient that, whether they felt like
14 hurting themselves?
15 A I've had to ask, unfortunately, a couple
16 times.
17 Q Less than 100?
18 A Oh, very much less than 100. Maybe
19 about three or four times during my career.
20 Q You've been a nurse for over 30 years?
21 A Yes, sir.
22 Q And in that 30 years you've only felt
23 the need to ask three or four patients whether or
24 not they feel like hurting themselves; is that fair?
25 A Yes.
00149:01 Q And Mr. Hunt was one of those folks?
02 A Yes.
03 Q Okay. His behavior in your presence and
04 the way he answered your questions, that motivated
05 you to ask; is that fair?
06 A No.
07 Q Why did you ask?
08 A I asked because I felt an inner instinct
09 to ask. Mr. Hunt was very calm. He wasn't acting
10 out in any way. And I just felt the nursing
11 instinct to ask him if he was okay.
12 Q Okay. And what did he say?
13 A At first he said he was okay and he
14 didn't want to go to the emergency room. But then
15 when I asked him if he wanted to hurt himself, he
16 said yes.
17 Q Okay. Did you ask him if he wanted to
18 hurt other people?
19 A No, I did not.
20 Q Did you ask him any other question after
21 you asked him the question "do you feel like hurting
22 yourself"?
23 A I didn't ask him any other questions at
24 that time.
25 Q Okay. At that point in time, you knew
00150:01 that this man needed to see a doctor?
02 A Yes.

39. PAGE 152:25 TO 153:06 (RUNNING 00:00:26.290)

25 Q Okay. All right. Back when Mr. Hunt
00153:01 and Mr. Ray were in your office, did Mr. Ray do any
02 talking?
03 A Mr. Ray, I think, informed me that
04 Mr. Hunt had come to his office at some point during
05 that day. And that I think he assisted him in
06 getting to Naval Hospital, but that's all I recall.

40. PAGE 153:11 TO 155:19 (RUNNING 00:02:20.800)

11 Q How soon after Mr. Hunt indicated that
12 he did have thoughts of wanting to hurt himself did
13 you begin the process of walking Mr. Ray and
14 Mr. Hunt down to the emergency room?
15 A It was immediate.
16 Q Okay.

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17 A Immediately I got up and we walked down
18 the stairs to the ER.
19 Q Okay. And you told -- did you tell
20 Mr. Hunt and Mr. Ray where you -- where y'all were
21 going?
22 A I said, let's go to the emergency room,
23 and follow me, please.
24 Q And did Mr. Hunt comply?
25 A Very cooperative. Calmly followed me
00154:01 down.
02 Q Now, you heard me reference earlier, and
03 perhaps maybe that was the last witness, I don't
04 know. There was a tour at some point at the
05 hospital.
06 A A tour?
07 Q At the Naval Hospital. Most of the
08 lawyers in this room got to go on it. I didn't. So
09 I haven't been. So I apologize that I may be asking
10 some questions that would seem kind of
11 commonsensical to somebody who's been over there.
12 How does one get from where you were of
13 the Medical Home Port Team to the ER?
14 A We would go back to the waiting area
15 where I initially met Mr. Ray and Mr. Hunt.
16 Q Yes, ma'am.
17 A Immediately outside of that waiting area
18 to the left there is a door, double doors that take
19 you up or down the stairs.
20 Q Okay.
21 A We took those stairs down to the first
22 floor.
23 Q Yes, ma'am.
24 A And we took an immediate right, and
25 after passing maybe two doors we were at the
00155:01 emergency room.
02 Q How long did that take?
03 A Probably no more than a minute or two,
04 maybe less than that. We didn't run, but I mean it
05 was briskly to the ER.
06 Q You weren't lollygagging around?
07 A No, sir.
08 Q Okay. It was a, not a trot or a run,
09 but a --
10 A Deliberate.
11 Q A deliberate pace?
12 A Yes. Yes, sir.
13 Q And why was that? Was that because you
14 wanted Mr. Hunt to be seen by a medical doctor?
15 A Well, once a patient has made that --
16 you know, once he had said that he wanted to hurt
17 himself, I wanted to make sure that he got there.
18 His condition was calm at the time, and I wanted him
19 to remain calm until he got to the emergency room.

41. PAGE 155:20 TO 156:01 (RUNNING 00:00:14.720)

20 Q And during the time that you went with
21 Mr. Hunt down to the emergency room, was Mr. Ray
22 with you every step of the way?
23 A Yes, he was.
24 Q He didn't peel off and go to the
25 bathroom or go outside or anything like that?
00156:01 A No, sir.

42. PAGE 157:10 TO 158:09 (RUNNING 00:01:14.410)

10 Q Okay. When you first met Mr. Hunt,
11 Mr. Ray was with him, correct?

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12 A Yes, sir.
13 Q When you brought Mr. Hunt back from a
14 public waiting room within the four walls of the
15 Naval Hospital to your office, Mr. Ray came with
16 him, correct?
17 A Yes, sir.
18 Q Okay. And again, having not been over
19 there to the Naval Hospital, I apologize if this is
20 a silly question, but people who aren't patients or
21 with the patient typically don't get to come back to
22 your office; is that fair?
23 A We do have some liberal leeway with
24 friends and -- and other acquaintances that want to
25 come with patients. So sometimes that's tolerated.
00158:01 And in this case, Mr. Ray presented himself as an
02 official. So it was okay for him to come back,
03 since he brought him to the -- brought him to my
04 office.
05 Q Mr. Ray never said anything along the
06 lines of "I'm just here because I'm a friend," or
07 "I'm just curious," or "I just wandered in off the
08 street." He was there because he thought he was
09 doing his job; is that fair?

43. PAGE 158:11 TO 158:14 (RUNNING 00:00:11.750)

11 Q You can answer.
12 A He said that he, Mr. Hunt, had been to
13 his office sometime during that day, and he assisted
14 him in coming to the Naval Hospital.

44. PAGE 158:15 TO 167:01 (RUNNING 00:09:42.750)

15 Q Now, when you and Mr. Ray walked
16 Mr. Hunt into the ER, were there people sitting in
17 the waiting room, or is it empty?
18 A We didn't go to the waiting room of the
19 ER.
20 Q Okay.
21 A We went to the glass enclosure first to
22 let them know that we were there.
23 Q Okay. And when you get to the glass
24 enclosure, is it a sliding glass window kind of
25 enclosure, or is it a window like you'd have at a
00159:01 gas station in a bad neighborhood where you got a
02 circular hole that you talk through, if you
03 remember?
04 A Well, it's been changed so I couldn't
05 tell you what's there, whether it's the circular or
06 the sliding, because we have had both. But I spoke
07 through the glass to the person sitting at the desk.
08 Q Okay. And what did you tell the person
09 sitting at the desk when you went down there?
10 A I told them who I was, where I had come
11 from, and that I had a patient that needed to be
12 seen, and I needed to see the nurse.
13 Q Okay. The person you spoke through to
14 the glass, do you know if that person was a nurse, a
15 clerk, a medical doctor, an x-ray tech?
16 A Usually there is a clerk or military
17 paraprofessional sitting there at the desk.
18 Q Do you know if this person was a clerk
19 or paraprofessional?
20 A I don't recall.
21 Q Okay. But you identified yourself as
22 Sandra Smith?
23 A Yes, sir.
24 Q Okay. Didn't use some other name?

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25 A No, sir.
00160:01 Q Okay. And nobody else was with you from
02 upstairs, it was just you, Mr. Hunt and Mr. Ray,
03 correct?
04 A Yes, sir.
05 Q Okay. And when you told this
06 information to the person on the other side of the
07 window, was it a male or a female?
08 A I honestly don't recall. I think it was
09 a male.
10 Q Okay.
11 A But I honestly don't recall.
12 Q Okay. Did somebody come out to assist
13 you?
14 A Yes, a nurse came out.
15 Q Okay. The person who came out to assist
16 you, who you said was a nurse, was it a man or a
17 woman?
18 A It was a female.
19 Q Okay. Had you ever seen this person
20 before?
21 A Yes, Ms. Janice.
22 MR. INFINGER: I'm sorry. Who?
23 THE DEPONENT: Ms. Janice.
24 Q You'd seen this lady before?
25 A Yes, sir.
00161:01 Q Knew she worked at the Naval Hospital?
02 A Yes, sir.
03 Q Knew her name was Janice. Did you know
04 her last name?
05 A I'm not very familiar with her last
06 name. But I knew it was McDoogal (sic). She had
07 her tag on, but I call her Janice all the time,
08 so...
09 Q Did you call her Janice that day?
10 A I don't know that we had any
11 pleasantries exchanged. I was more concerned about
12 getting Mr. Hunt seen.
13 Q Okay. And your goal when you're talking
14 with -- with Nurse Janice out there in the hallway
15 isn't to make some sort of social plan or social
16 arrangements, it's to make sure that Mr. Hunt gets
17 to a medical professional, a medical doctor, right?
18 A Yes, sir.
19 Q Okay. So what information do you tell
20 Nurse Janice when she comes out into the hallway?
21 A She said hello, and I said hello to her.
22 Q Okay.
23 A And I told her I have -- and the
24 details, you know, are not probably totally word for
25 word, but something to the effect of a 24-year-old
00162:01 male, Mr. Hunt, who came to my office with concerns,
02 looking for medication refill. He presented papers,
03 and at that time I gave them to her. And I told her
04 that, but upon further conversation with Mr. Hunt,
05 he expressed to me that he wanted to harm himself
06 and he needed to be seen by a doctor.
07 Q All right. You told us a lot of
08 information there. I just want to go through a few
09 things to make sure that I heard them correctly.
10 A Uh-huh.
11 Q Whatever papers Mr. Hunt had showed up
12 with, whether they were in a thin folder, a thick
13 folder or some sort of in between folder, you gave
14 that folder to Nurse Janice, correct?
15 A I didn't have the entire folder. Only

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16 the three pages that said he was eligible for care.
17 And I wanted her to be able to see that information
18 at the time.
19 Q Because if she had that information,
20 presumably she'd be able to access Mr. Hunt in
21 whatever system she had access to?
22 A Yes.
23 Q Okay. So you equip Nurse Janice with
24 the ability to find Mr. Hunt in the computer system
25 by giving her those -- those papers. And you told
00163:01 her that he expressed a desire to harm himself,
02 correct?
03 A Yes.
04 Q That's information you specifically told
05 her, correct?
06 A Yes.
07 Q And you specifically told Nurse Janice
08 that this young man, Mr. Hunt, needed to be seen by
09 a medical doctor, correct?
10 A Yes. That's why he was being brought
11 down. A doctor. I don't know if I said medical,
12 but doctor.
13 Q Okay. Could have been doctor of
14 osteopath?
15 A They know what's in the emergency room,
16 so...
17 Q Okay. Whether they're born in Poland or
18 Canada or South Carolina, correct, they know what's
19 down there?
20 A Yes, they know what's down there.
21 Q Okay. Now, how long did this
22 conversation between you and Nurse Janice last?
23 A It was very brief.
24 Q And I want to make sure -- and this is
25 going to sound silly. It's so silly that I tried to
00164:01 get my office this morning to print out a picture of
02 this lady. Can you describe for us what Nurse
03 Janice looks like?
04 A Ms. -- Nurse Janet (sic) is a Caucasian
05 female. At the time she had light colored hair, and
06 she was wearing scrubs. She maybe is about -- about
07 my height. And maybe around -- I wouldn't want to
08 guess her weight, but she's not a heavy female.
09 She's a slender woman.
10 Q She's proportionate?
11 A Yes.
12 Q Okay. How -- how -- and it's tricky
13 thing for a man to ask this. But which generation
14 would you put her in? It's a polite way of asking
15 how old do you think she is.
16 A Well, it would be my guess that she's
17 maybe a few years -- maybe a few years younger than
18 myself. I would say maybe mid to late -- or maybe
19 early 40s. Maybe early 40s. If not late 30s. I
20 don't really know her age.
21 Q Okay. She wasn't some 20-something?
22 A No.
23 Q And conversely, she wasn't some
24 80-year-old?
25 A No.
00165:01 Q Okay. And you said she was about your
02 height. That would make her approximately how tall?
03 A Five-three.
04 Q And she had a name tag on her scrubs?
05 A Well, we wear badges, so...
06 Q She had a badge on?

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07 A I believe she had her badge on that day.
08 Q And did the badge reflect her name?
09 A The badges do reflect your name, yes,
10 sir.
11 Q Okay. Have you had an occasion to
12 interact with this nurse since then?
13 A I'm thinking. Yes, I did.
14 Q Okay. Same lady?
15 A Same lady.
16 Q Nurse Janice?
17 A Yes.
18 Q Okay.
19 A But that was some time ago.
20 Q Okay. Do you know if Nurse Janice still
21 works at the Naval Hospital?
22 A I have not seen her at the Naval
23 Hospital lately.
24 Q Okay. What did you do -- strike that.
25 You relayed certain information on
00166:01 February 24th, 2012, that you told us about to Nurse
02 Janice McDonald. Did she say anything to you in
03 response to receiving that information that you
04 provided her?
05 A She essentially just said okay, and
06 we'll see him. And she ushered him into the
07 emergency room, and the door closed.
08 Q As far as you were concerned, at that
09 moment she -- Calvin Hunt was her responsibility?
10 A Well, not as far as I'm concerned. As
11 it is, it -- he has become her responsibility and a
12 patient of the emergency room.
13 Q Okay. Got a few -- after you -- did you
14 actually with your own two eyes see Nurse Janice,
15 Mr. Hunt and Mr. Ray go into the emergency room?
16 A Yes, sir.
17 Q And once you saw them go back into the
18 emergency room, what do you do?
19 A I left. Went back the way I came, back
20 to my office. And between interruptions and
21 whatever, I completed this document.
22 Q Okay. The record that we previously
23 talked about which is --
24 A A telephone consult.
25 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)

22 Q We looked earlier at some notes that you
23 yourself made. And I remember you went through and
24 looked up some terms, medical terms trying to define
25 them. Do you recall that?
00172:01 A Yes.
02 Q Okay. And we also earlier today, in
03 looking at Exhibit No. 7, the two-page medical
04 record that you prepared on February 24th, 2012,
05 concerning Mr. Hunt, had a list of problems on that?
06 A Yes.
07 Q Okay. What's your understanding of what
08 an adjustment disorder with anxious mood is?
09 A It is what I wrote on that paper.
10 Q Okay.
11 A And my understanding is very limited
12 when it comes to that. It's a patient that is
13 experiencing perhaps some anxiety related to life, a
14 change, a major change in a life event, whether it's
15 a death or a job loss or -- that would cause them to

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16 react negatively to certain situations.
17 Q What about delusional disorder, do you
18 have an understanding what delusional disorder is?
19 A That's the patient's that are -- have a
20 perception of things that are not in reality.
21 Q Is that a concern -- would you have a
22 concern as a registered nurse licensed to practice
23 nursing in this state if someone presented to you
24 and they had a past diagnosis of delusional
25 disorder?
00173:01 A Well, I could be concerned. You're
02 always concerned. But a list like Mr. Hunt's is not
03 uncommon. I mean, you could find this almost on
04 anyone.
05 Q But again, going back to our "almost
06 anyone," the example you've just given us, you told
07 us earlier that there's only been one or two, maybe
08 three times you've ever asked a patient in your
09 30-plus years of nursing as to whether or not he or
10 she intends to hurt himself, correct?
11 A Whether he or she intends to hurt
12 himself. But you were discussing the list, which is
13 again not uncommon. These diagnosis exist for many
14 people, and it doesn't mean that they want to hurt
15 themselves, it doesn't mean they want to hurt
16 others.
17 Q Is that information --
18 A Not always.
19 Q Strike that. I understand.
20 If you have someone who indicates that
21 he or she wants to hurt himself, is it important
22 information to have, to know past diagnoses such as
23 delusional disorder, personality disorder?
24 A As a part of the workup of that patient,
25 it would be good information. So once you've gotten
00174:01 that patient to a safe place where you know that the
02 actions cannot be carried out --
03 Q Yes, ma'am.
04 A -- then you begin to gather other
05 information on the patient that could be helpful in
06 your further assessment of that patient. So this
07 list would have been helpful for someone else.
08 Q And I believe you told us in your own
09 handwriting on Exhibit No. 3 that the more
10 information on a patient the better the treatment?
11 A Yes.
12 Q That's a general rule of nursing, isn't
13 it?
14 A Yes, sir.
15 Q That's a general rule that any licensed,
16 degreed medical practitioner should try and follow,
17 correct?
18 A If they are conscientious, it would be a
19 good rule to follow.
20 Q Okay. Somebody's having trouble getting
21 a history on a patient, should they just give up?
22 A It depends on the circumstances, because
23 there are other ways to obtain a history.
24 Q What are the ways one can obtain a
25 history from a patient?
00175:01 A Well, there may be a family member
02 present. There may be someone else that has
03 accompanied the patient that could help report the
04 history.
05 Q Can one consult past medical records to
06 determine a patient's history?

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07 A If -- yes, the past medical records
08 would give a patient's history.
09 Q For example, whether or not one has high
10 cholesterol or bad breath or hemorrhoids or some
11 sort of mental health disorder, correct?
12 A It could be found in the medical records
13 if it were documented.
14 Q But again, in order to determine whether
15 or not something is or is not documented in past
16 medical records, one would have to look, correct?
17 A Yes, you would have to look.
18 Q Ms. Smith, what did you expect was going
19 to happen to Mr. Hunt in the emergency room at the
20 Naval Hospital on February 24th, 2012?
21 A Well, everyone is an individual, so it's
22 difficult to say. I expected, however, that he
23 would be seen by the doctor.

46. PAGE 180:04 TO 180:10 (RUNNING 00:00:13.490)

04 Q Ma'am, I may have some question for you
05 a little bit later on. But I suspect anything that
06 I missed or forgot to ask you will be covered by
07 these fine lawyers. I'm just going to go ahead and
08 pass -- pass you at this time. I appreciate your
09 time and putting up with me. Thank you.
10 A Thank you, sir.

47. PAGE 183:04 TO 184:13 (RUNNING 00:01:22.020)

04 Q And I'm just looking at the entry for
05 Mr. Hunt.
06 A Yes, sir.
07 Q And I believe you testified earlier that
08 you made this appointment for him?
09 A Yes, sir.
10 Q All right. And my assumption, because
11 it's still on here, was that that was never
12 canceled; is that right?
13 A I am sure that some notation was put
14 there. It wouldn't have just remained. But at the
15 time that I printed it, it was not canceled. So
16 that would have been the 29th.
17 Q Well, it says, "status, no show."
18 A Okay.
19 Q All right. So if it says "no show" it
20 means that the appointment was never canceled; is
21 that right?
22 A It means that the patient did not arrive
23 for the appointment.
24 Q Okay. And so you -- you made the
25 appointment before you took Mr. Hunt to the
00184:01 emergency room; is that right?
02 A Yes.
03 Q Okay. And then when you went back to
04 work on your note, you just didn't cancel that
05 appointment; is that right?
06 A I don't believe I canceled it, no.
07 Q In the section next to where it says no
08 show, under the reason for visit, it shows, "Active
09 duty with sleep disturbance and anxiety."
10 A Uh-huh.
11 Q Is that -- did you write that in?
12 A Yes, sleep disturbance and anxiety,
13 that's what he reported.

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48. PAGE 204:18 TO 205:24 (RUNNING 00:01:25.060)

18 Q Now, you -- you had Mr. Ray and Mr. Hunt
19 accompany you back to your office. Once they got
20 into your office and you said that they sat down in
21 chairs across from you in your office, was there any
22 conversation between Mr. Hunt and Mr. Ray?
23 A The only time I can recall conversation
24 was when I asked about the appointment, and it seems
25 that they were both in agreement that they wanted
00205:01 the appointment.
02 Q All right. And this is the appointment
03 that -- that had been scheduled that is referred to
04 on Exhibit 8?
05 A Yes, sir.
06 Q All right. Did Mr. Ray answer any
07 questions on behalf of Mr. Hunt, that you posed to
08 Mr. Hunt?
09 A Not that I recall.
10 Q All right. Did Mr. Hunt have to refer
11 to Mr. Ray for the answers to any questions that you
12 asked him?
13 A Not that I recall.
14 Q When you asked Mr. Hunt for personal
15 information, did Mr. Hunt provide that to you, or
16 did Mr. Ray provide that to you?
17 A I don't recall asking for any personal
18 information that was not provided by Mr. Hunt. I
19 don't recall getting any answers from Mr. Ray.
20 Q Okay. Did Mr. Ray explain to you at any
21 point why he was there?
22 A Again, he said that Mr. Hunt had been at
23 his office that day and that he had brought him over
24 to assist him in getting his medication refill.

49. PAGE 222:05 TO 223:04 (RUNNING 00:01:07.340)

05 Q So you have somebody that reports to you
06 that is there for medication for anxiety, he does
07 not tell you what type of medication he's on, and
08 you do no further history to determine that; is that
09 correct?
10 A That is correct.
11 Q Okay. And why?
12 A Because I am not qualified to prescribe
13 medication for him. He needed to see a doctor. I
14 offered to take him to the ER to get the
15 prescriptions on that same day. He declined. He
16 preferred to have an appointment where he could
17 discuss his medication with a doctor. That was his
18 choice.
19 Q Did he ever refuse to discuss his
20 medication with you?
21 A He didn't refuse, but he didn't know.
22 Q Okay.
23 A He didn't know what his medications
24 were. He --
25 Q Okay. Sorry.
00223:01 A He gave me this.
02 Q Okay. Gave you what?
03 A The list of medications you see here is
04 what he -- he had.

50. PAGE 224:08 TO 224:11 (RUNNING 00:00:13.540)

08 Q As a nurse with a nursing background, is
09 that a concern to you that somebody is taking
10 anxiety medication and has not been on those

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11 medications for a long time?

51. PAGE 224:14 TO 225:02 (RUNNING 00:00:36.650)

14 Q Please answer the question?
15 A Patients go on and off anxiety
16 medications all of the time. So it's not like an
17 alarm bell that he was not taking medication, no,
18 sir.
19 Q Okay. So that's not an alarm to you
20 whatsoever at this time?
21 A Not at the time that I saw him, no.
22 Q No, no, no. So wait a minute. Not at
23 the time you saw him?
24 A Not at the time. I see patients
25 frequently that are on and off anxiety medications.
00225:01 It happens. I mean, they're not prescribed for long
02 term, always, not for long-term use.

52. PAGE 239:05 TO 240:08 (RUNNING 00:01:11.760)

05 Q Okay. When you -- you testified earlier
06 that you -- when you took him down to the ER, I
07 won't go through all the other stuff, you saw Janice
08 McDonald, correct?
09 A Yes, sir.
10 Q Now, you don't know what records were
11 either with Mr. Ray or completely with Mr. Hunt,
12 correct?
13 A Correct.
14 Q All right. But when you had the
15 conversation with Janice McDonald, you said to her
16 that you -- and I might be paraphrasing. You can
17 correct me on this.
18 A Yes, sir.
19 Q That he wanted to cause harm to himself?
20 A Yes, sir.
21 Q Okay. Is that a fair representation of
22 the paraphrase?
23 A Yes, sir.
24 Q Okay. Did you ever mention to her that
25 he was off anxiety medication?
00240:01 A I don't recall mentioning that.
02 Q Okay.
03 A I did mention he was there to get
04 medication.
05 Q Okay. Did -- do you recall ever
06 mentioning that he was off any medication?
07 A I mentioned he came to get medication,
08 so...

53. PAGE 241:06 TO 241:17 (RUNNING 00:00:37.550)

06 Q Did you -- did you mention to her that
07 he didn't know what medications he was taking?
08 A I don't recall.
09 Q Okay. Do you remember -- you do not
10 recall, or do you recall whether you mentioned moan
11 or groan or rocking back and forth?
12 A I don't recall mentioning that to her.
13 Q Okay. But you did put it in your note?
14 A And he was not rocking back and forth
15 when he went to the emergency room.
16 Q He was standing.
17 A He was standing. He was calm.

54. PAGE 242:02 TO 242:25 (RUNNING 00:01:10.380)

02 Q All right. Let me delve in that in just

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03 a little bit. I want to make sure about this.
04 First you were trying to set him up with just an
05 appointment to get medications, correct?
06 A Yes.
07 Q And then when he answered your question
08 about harming himself, you pretty much immediately
09 took him to the ER?
10 A Yes, sir.
11 Q Was there any discussion about why he
12 was going to the ER on the way down from your office
13 down to the ER?
14 A When he answered yes, I said, "Then we
15 need to go down to the emergency room and see a
16 doctor."
17 Q All right. And then in front of him, in
18 front of the nurse, you told them he had threatened
19 to harm himself and that he had been off medications
20 and he was -- he wanted to get medications, correct?
21 A I told her that he wanted to harm
22 himself. Initially he was in to see me because he
23 wanted medications. But I don't recall whether we
24 discussed that in any detail. The focus at that
25 point was him harming himself.

55. PAGE 255:06 TO 255:13 (RUNNING 00:00:23.740)

06 But I imagine there were some discussions about the
07 fact that Mr. Hunt had escaped from the Naval
08 Hospital and stolen a fire truck and killed
09 somebody. And I just want to know what you heard in
10 the hospital.
11 A Well, in any incidents of this
12 magnitude, people were surprised that it had
13 happened.

56. PAGE 259:09 TO 260:03 (RUNNING 00:01:09.660)

09 Q You also mentioned, too, but you didn't
10 mention it in -- you didn't mention it in your
11 report that was done on February 24th, 2012. But in
12 this particular, what's Exhibit No. 2, you mentioned
13 that he had, his eyes appeared to be troubled.
14 A Uh-huh.
15 Q Is that correct?
16 A Yes, that is correct.
17 Q Okay. You didn't put that in your note
18 of -- of February 24, 2012; is that right?
19 A That's right.
20 Q So when you asked him the question about
21 do you intend to harm yourself, is that when you
22 noticed his eyes appeared to be troubled? Or when
23 did you notice his eyes appeared to be troubled?
24 A When I walked into the waiting room, I
25 noticed his eyes. But while sitting there, he
00260:01 didn't appear to be troubled at that point. You
02 could just look at someone that looked like they
03 needed sleep.

57. PAGE 263:21 TO 263:25 (RUNNING 00:00:16.500)

21 go this way. There's obviously information that
22 you've stated here today that you did not orally
23 relay to Janice McDonald, which is the rocking back
24 and forth and the moan and groan, correct?
25 A Correct.

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58. PAGE 279:19 TO 280:10 (RUNNING 00:00:37.370)

19 Q Okay. Let me point out one other thing
20 on the first page of Exhibit 2 about the middle
21 paragraph. When I arrived at the waiting area, a
22 young handsome, decently dressed and neat appearing
23 black male patient was seated next to an older man
24 with a badge.
25 A I thought he had his badge.
00280:01 Q Because we earlier had talked about it,
02 and you couldn't remember.
03 A Yes.
04 Q But you say he had a badge, that Mr. Ray
05 had a badge?
06 A Yes.
07 Q Okay. And that badge probably meant
08 something that he has some -- some invitation to
09 come with Mr. Hunt and be with him?
10 A Yes.

59. PAGE 280:12 TO 280:22 (RUNNING 00:00:19.448)

12 A Yes.
13 Q The -- the -- any medications that
14 Mr. Hunt wanted would have to have been written,
15 prescriptions written by a doctor; is that correct?
16 A Yes, sir.
17 Q And you said there was not a -- a -- a
18 doctor's appointment left that day?
19 A Right.
20 Q And he would have to go to the emergency
21 room to get a prescription?
22 A Yes.

60. PAGE 302:20 TO 303:09 (RUNNING 00:00:48.300)

20 Q So that's a situation that we have on
21 February 24th, 2012. Based on that situation of all
22 those things that we just talked about, why did you
23 as a registered nurse, licensed to practice nursing
24 in this state, who holds a bachelor's degree, a
25 master's degree and a doctoral degree, not ask
00303:01 Calvin Hunt whether or not he intended to harm
02 others?
03 A Because I think the first question was
04 enough to get him where he needed to be. And I
05 didn't need to now any further information at the
06 time. He wasn't combative. He wasn't acting as if
07 he wanted to harm someone else at the time. And so
08 with the -- armed with the first information is the
09 reason that I took him to the emergency room.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 01:23:18.153)



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 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)

16 Can you please state your full name for the
17 record?
18 A Craig Martin.
19 Q And, Mr. Martin, where do you currently reside?
20 A I reside at 9741 Coppercreek in Converse, Texas.
21 Q And for those of us from South Carolina, where
22 generally is Converse, Texas located?
23 A It's on the northeast side of San Antonio. It's a
24 suburb.
25 Q And do you work here in the San Antonio area?
00007:01 A I do.
02 Q What do you do for a living, sir?
03 A I work for another Government contractor.
04 Q At one point in time were you employed by CasePro,
05 Incorporated?
06 A Yes, sir, I was.
07 Q How long were you employed by CasePro?
08 A Approximately four years.
09 Q During the four years that you were employed by
10 CasePro, Incorporated, what was your job title?
11 A Program manager.
12 Q What does a program manager do at CasePro,
13 Incorporated?
14 A A program manager is responsible for the day-to-day
15 operations of the contracts for which he is assigned. You are
16 the interface with the Government, you are the interface with
17 the employees, and are basically responsible for the financial
18 success of that contract.
19 As well as a smooth operation. Make sure the
20 deliverables of the contract are met, make sure all of the
21 contract requirements are followed, make sure that, you know,
22 those types of things are fulfilled so that you complete the
23 requirements of the contract success -- successfully.
24 Q What year did you begin working for CasePro,
25 Incorporated?
00008:01 A 2007 I believe.
02 Q You told us earlier that you worked for the company
03 for four years. So does that mean you left the company
04 sometime in 2011?
05 A I did, November 2011.
06 Q During that four year time frame, who did you direct
07 report to at CasePro?
08 A Well, I started with James Steele and then ended up
09 reporting to Mike McCabe.
10 Q And Mr. McCabe is here present in the room today?
11 A Yes, he is, uh-huh.
12 Q Who is James Steele?
13 A He at the time was the Executive Director of
14 contracting.
15 Q Did Mr. Steele leave the company?
16 A Not while I was there, no.
17 Q Okay. Why did you transition from direct reporting
18 to Mr. Steele to Mr. McCabe?
19 A That was Mr. McCabe's decision.
20 Q Okay. How many program managers did CasePro,

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21 Incorporated have on its payroll while you were working for
22 the company?
23 A There were two, possibly three. But two that I'm
24 familiar with, Mr. Steele and myself.
00009:01 25 Q Okay. And during the time frame that you worked for
26 the company, was there specific contracts or a specific
27 geographic region that you, yourself were responsible for?
28 A Yes.
29 Q Tell us about that.
30 A I had the Navy contracts. I started off with the
31 Carolina MATO, which was North and South Carolina. Then I had
32 Southeast MATO, which was Pensacola and Jacksonville. I had
33 Southwest, which was 29 Palms and Fresno and that area in
34 California. And then I had Portsmouth. There were two
35 contracts in Portsmouth. So it was a large number of Navy
36 contracts.
37 Q Okay. And how many employees of CasePro,
38 Incorporated were associated with those contracts that you
39 were responsible for?
40 A The contract personnel?
41 Q Yes, sir.
42 A All of those total? Around 800 I -- I believe,
43 somewhere in that neighborhood.
44 Q It sounds like a pretty big responsibility?
45 A Yes, sir.
46 Q What was your background before coming to work at
47 CasePro?
48 A Program manager for another Government contractor.
49 And I've also had experience in marketing and business
50 development, proposal writing and development.
00010:01 51 Q Can you give the court and jury the benefit of your
52 education?
53 A I have a Bachelor's Degree in Public Relations, and
54 that was my background in the Air Force as well.
55 Q So you're actually a Veteran, sir?
56 A Yes, sir.
57 Q How long did you serve this country through the
58 Armed Forces?
59 A Almost 18 years.
60 Q Thank you for your service, sir.
61 A Thank you.
62 Q And I understand that in addition to your private
63 sector employment as well as your service in the Armed Forces
64 that you've also served as the Mayor of your city --
65 A I have.
66 Q -- Converse, Texas?
67 A Yes, sir.
68 Q How many years were you the Mayor of Converse,
69 Texas?
70 A Eight years.
71 Q We are here today to primarily talk about a
72 gentleman by the name of Christian Jansen. Do you know
73 Dr. Jansen?
74 A I do.
00011:01 75 Q Have you met him personally?
76 A Yes, I have.
77 Q How many times do you think you've met Dr. Jansen?
78 A Oh, six, seven times at least.
79 Q When CasePro took over the contract for the
80 emergency room at the Naval Hospital in Beaufort, South
81 Carolina, were you involved in the hiring of Dr. Jansen to
82 work for CasePro?
83 A Yes, sir.
84 Q I have marked as Exhibit Number 2 to your deposition
85 here today a series of documents that has been produced by
86 CasePro in this litigation. And I'll represent to you that

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12 all of these documents have been deemed confidential pursuant
13 to a Consent to Confidentiality Order entered by the court in
14 Beaufort County.
15 So you did not have an opportunity to see these
16 documents prior to today, but I will tell you that these are
17 documents that came out of Dr. Jansen's personal file.
18 A Okay.
19 Q Okay. If you look at the first page of the document
20 that I've marked as Exhibit Number 2, can you tell us what
21 this appears to be, this Recruiting Activation Sheet?
22 A It is a Recruiting Activation Sheet that we use to
23 hire anyone for CasePro on any contract.
24 Q And there are some various check marks and initials
25 and those kind of things on this document. Is this something
00012:01 that you would have had a hand in filling out?
02 A Yes, sir.
03 Q Okay. And with respect to things like salary and
04 benefits, would you have been the person for CasePro,
05 Incorporated who would have negotiated those type items with
06 Dr. Jansen?
07 A Recruiting would have done that, as well as myself
08 in conjunction with Mr. McCabe.
09 Q So Mr. McCabe actually would have had a hand in
10 setting Dr. Jansen's salary?
11 A Yes.
12 Q And from reviewing the documents, it's my
13 understanding that Dr. Jansen originally started with the
14 company as an independent contractor and that he then
15 transitioned to a W-2 employee. Do you recall that?
16 A I don't recall that specifically for him, but I do
17 recall that we did that with those providers at Beaufort Navy
18 Hospital.
19 Q Okay. What's the significance of transitioning
20 someone from an independent contractor agreement to a W-2
21 employee?
22 A We -- we -- there was a requirement in the contract
23 for -- I -- as I recall, insurance purposes or coverage by
24 Title 10 U.S. Code that they needed to be employees of the
25 company.
00013:01 Q And as an employee of the company, would Dr. Jansen
02 have had to submit himself to certain policies and procedures
03 of CasePro, Incorporated?
04 A Yes.
05 Q Including a sexual harassment policy?
06 A Yes.
07 Q Including a drug and alcohol substance abuse policy?
08 A Yes.
09 Q Including a HIPAA privacy policy?
10 A Absolutely.
11 Q Okay. And just so we're all clear, Dr. Jansen's
12 paycheck would have actually come from CasePro, Incorporated
13 headquartered here in San Antonio, Texas?
14 A Correct.
15 Q Now, I know Dr. Jansen was doing his work on a
16 day-to-day basis in South Carolina and you were here in Texas.
17 Who was doing the scheduling of Dr. Jansen and the other
18 doctors in the emergency room at Naval Hospital Beaufort?
19 A I did the scheduling with assistance from two --
20 well, it started off with one doctor and ended up being two
21 doctors -- but I did the scheduling for the physicians,
22 scheduled their shifts.
23 Q So if Dr. Jansen was going to show up to work on
24 Monday instead of a Thursday, you were the person making that
25 decision?
00014:01 A Yes.
02 Q Turn with me midway through this stack of papers

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03 that we've marked as Exhibit Number 2 to page that's Bates
04 stamped in the lower right-hand corner 272. It's an e-mail
05 that you printed out bearing a date of June 26th, 2009.
06 A Okay. Can I take a moment to read it?
07 Q Absolutely. Take as much time as you need to look
08 at that page, and let me know when you're ready for some
09 questions about it, sir.
10 A Okay.
11 Q And does this reflect some negotiations between
12 Dr. Jansen and yourself about Dr. Jansen's compensation?
13 A Yes.
14 Q Okay. And it appears from my reading of this e-mail
15 that Dr. Jansen was seeking a rate of \$114.90 an hour with
16 benefits.
17 A Correct.
18 Q Okay. Would that have placed Dr. Jansen on the low
19 end or the high end of doctors that CasePro, Incorporated was
20 employing to work at Naval Hospital Beaufort?
21 A I don't recall.
22 Q Don't know one way or the other?
23 A Right.
24 Q Okay. In looking at this page, there are some
25 initials and dates on here. Do you know whose initials and
00015:01 dates those are?
02 A Yes, I do.
03 Q Whose are they?
04 A Mike McCabe.
05 Q And Mr. McCabe would have dated this document June
06 26th, 2009?
07 A Correct.
08 Q And the handwriting that says add corporate benefit,
09 whose handwriting is that?
10 A That is his.
11 Q Okay. And if you turn to the next page, sir, we
12 have some internal communications between Liz [sic] Keen and
13 Mike. Do you see that?
14 A I -- I do.
15 Q Who is Lin Keen?
16 A She is the contracts manager for CasePro or was at
17 the time.
18 Q She worked in the corporate office here in --
19 A Yes.
20 Q -- San Antonio?
21 A Yes.
22 Q Okay. And the Mike that is referenced Mike at
23 CaseProInc.com; is that Mr. McCabe?
24 A Yes.
25 Q Okay. And this is discussing Dr. Jansen's
00016:01 compensation and benefits, correct?
02 A Well, if you'd give me a moment to read it.
03 Q Certainly.
04 A Okay. And what was your question?
05 Q Certainly. Does this document reflect that
06 Mr. McCabe was involved in communications back in the 2009
07 time frame about Dr. Jansen's pay rate and benefits?
08 A Yes.
09 Q Okay. And Mr. McCabe writes: Do not offer any
10 leave. They have plenty of time off.
11 A Correct.
12 Q Turn with me to the next page, sir. And we have a
13 document that appears to be from the 2010 time frame.
14 A Yes.
15 Q Okay. And do you recognize the handwriting on this
16 page?
17 A I do.
18 Q Whose handwriting is that?

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19 A Mr. McCabe.
20 Q Okay. And is this adding a 401k and a continuing
21 medical education benefit as well as two weeks of vacation for
22 Dr. Jansen?
23 A Yes.
24 Q And who approved those changes?
25 A Mr. McCabe.
00017:01 Q If you'll turn with me to the next page, sir, we
02 have a page -- a letter dated April 12th, 2010. Do you see
03 that?
04 A I do.
05 Q Certainly take as much time as you need to read that
06 document, and let me know when you're ready for some
07 questions.
08 A Okay.
09 Q And does this appear to be a letter sent to
10 Dr. Jansen by Liz Keen on April 12th, 2010 reflecting the
11 changes that we've previously seen, the two weeks of vacation,
12 the continuing medical education allowance and 401k benefits?
13 A Yes.
14 Q Okay. So what we know from looking at the documents
15 so far is that as of early April 2010, Dr. Jansen is a W-2
16 employee of CasePro, Incorporated?
17 A Yes.
18 Q And CasePro, Incorporated has determined how much
19 he's going to get paid each paycheck?
20 A Yes.
21 Q Whether or not he's going to have vacation?
22 A Yes.
23 Q Whether or not he's going to get a continuing
24 medical education allowance?
25 A Yes.
00018:01 Q Whether or not he's going to have a 401k?
02 A Yes.
03 Q Okay. Turn with me, sir, to the next page of the
04 document I've marked as Exhibit Number 2 to your deposition.
05 And this document that I want to spend a good bit of time
06 talking with you about is actually a two-page document that's
07 been Bate's stamped in the lower right-hand corner as Def RREFP
08 333 through 334.
09 A Okay.
10 Q Do you see that document?
11 A I do.
12 Q Have you had an opportunity to review that document?
13 A I would like to review it now.
14 Q Take as much time as you need, sir.
15 A Okay. I've read the document.
16 Q Okay. I think I know the answer to this, but I just
17 want to ask you a threshold question.
18 Do you have a copy of this e-mail from April
19 29th, 2010 in your possession today?
20 A Right here, yes.
21 Q Okay. But not at home or somewhere --
22 A No.
23 Q -- else?
24 A No.
25 Q Fair to say that today is the first time you've seen
00019:01 this document since you left the employment of CasePro?
02 A Yes.
03 Q Back in April of 2010, were concerns about
04 Dr. Jansen brought to your attention?
05 A Yes.
06 Q Who brought those concerns to your attention?
07 A Dr. Scott Moore.
08 Q And who employed Dr. Scott Moore?
09 A CasePro.

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10 Q He was a employee of CasePro, Incorporated?
11 A Yes, he was.
12 Q And where did Dr. Scott Moore do his work?
13 A He worked for CasePro at Beaufort Navy Hospital in
14 the same emergency room.
15 Q Have you, yourself ever been in that emergency room
16 at Beaufort?
17 A Yes, I have.
18 Q Okay. How would you describe that emergency room;
19 is it big or ...
20 A It's a medium-sized. It started off with two bed,
21 and it was very busy depending on the time of year. Then they
22 expanded the emergency room as the mission expanded. Became
23 larger. They added additional requirements. But it was a
24 busy fairly fast-paced.
25 Q How did Dr. Moore bring certain concerns about
00020:01 Dr. Jansen to your attention?
02 A Called me on the phone.
03 Q Called you on the telephone?
04 A Yes, he did.
05 Q And at that time you were the program manager for
06 CasePro, Incorporated for CasePro's employees doing work in
07 Beaufort?
08 A Yes, I was.
09 Q Including Dr. Moore?
10 A Yes.
11 Q Okay. Was it unusual for Dr. Moore to pick up the
12 telephone and call you out here in Texas?
13 A He -- it -- it was not unusual, no.

2. PAGE 20:14 TO 21:11 (RUNNING 00:01:11.270)

14 Q What did Dr. Moore tell you on the telephone?
15 A That the standard of care was not followed in the
16 death of a Marine that was under the care of Dr. Jansen.
17 Q Was Dr. Moore concerned about that?
18 A He was.
19 Q Do you recall any other information that Dr. Moore
20 told you in that telephone call?
21 A He felt uncomfortable doing the peer reviews,
22 because he's a CasePro employee, Dr. Jansen is a CasePro
23 employee, I am a CasePro employee. It kind of puts us in an
24 awkward situation, because his job was to do the peer reviews
25 for the Navy. So we would never see the peer reviews. And in
00021:01 most cases he didn't tell us what was in it, because he
02 couldn't. It was for the Navy. So he did the peer reviews
03 for the Navy's purposes.
04 A And he was concerned that Dr. Jansen was not a
05 good doctor.
06 Q Okay. Did he tell you Dr. Jansen wasn't a good
07 doctor?
08 A He told -- he told me words to that effect.
09 Q Is that information that you, yourself took
10 seriously?
11 A Of course.

3. PAGE 21:19 TO 23:11 (RUNNING 00:02:32.810)

19 Q How long did your conversation with Dr. Moore on the
20 telephone last?
21 A I don't recall how long it last. I was in an
22 airport. He called me on his cell phone. So I was traveling
23 at the time, but we talked at length. If I -- I -- I can't
24 tell you how long the conversation occurred.
25 Q But this isn't a -- a casual comment?
00022:01 A No.
02 Q This was the point and purpose of him calling you?
03 A That was the only reason he called me.

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04 Q What did you do once you had the information that
05 Dr. Moore provided you on the telephone?
06 A I informed Mr. McCabe.
07 Q And how did you inform Mr. McCabe?
08 A Verbally.
09 Q Did you call him on the phone or did you physically
10 go see him?
11 A I -- as I recall, I waited until I got back to the
12 office and talked to him in person.
13 Q How much time had lapsed between the phone call from
14 Dr. Moore and you going in to see Mr. McCabe if you recall?
15 A I don't recall, but I was on my way back.
16 Q Okay.
17 A So it would have been the next day at the latest.
18 Q Not information that you sat on?
19 A No, absolutely not.
20 Q When you went to meet with Mr. McCabe, was anyone
21 else present for that meeting?
22 A I don't recall, but more than likely no.
23 Q What did you tell Mr. McCabe?
24 A The standard of care was not met.
25 Q What was Mr. McCabe's response?
00023:01 A I don't recall his exact response, but he wanted
02 proof.
03 Q What did you do as a result?
04 A I asked Dr. Moore for a copy of the peer review, but
05 I knew I wasn't going to get it.
06 Q Did Dr. Moore ever send you a copy of the peer
07 review?
08 A He did not. It belongs to the Navy.
09 Q Did Dr. Moore ever send you any records about the
10 care of the United States Marine who passed away?
11 A No.

4. PAGE 23:12 TO 23:15 (RUNNING 00:00:09.490)

12 Q But even without any documents from Dr. Moore, you
13 had Dr. Moore's verbal report that the standard of care was
14 not met?
15 A Yes.

5. PAGE 23:16 TO 23:22 (RUNNING 00:00:17.370)

16 Q Did you and Mr. McCabe have any conversation about
17 this incident subsequent to your request of Dr. Moore that he
18 forward the peer review?
19 A This same incident?
20 Q Yes, sir.
21 A I don't recall specifically. No.
22 Q Okay. That's a good question, sir.

6. PAGE 23:23 TO 30:09 (RUNNING 00:10:37.520)

23 Were there other incidents involving Dr. Jansen
24 that gave you concern?
25 A There were other allegations of his quality of care.
00024:01 Q Were these allegations concerning Dr. Jansen's
02 quality of care made before or after you learned in the April
03 2010 time frame about a dead United States Marine?
04 A As I recall, there were concerns before and after.
05 Q Let's talk about the concerns before.
06 A Okay.
07 Q We know that in looking at the document I've marked
08 as Exhibit Number 2 that Dr. Jansen started working for
09 CasePro back in the 2008 time frame.
10 A Okay.
11 Q All right. How soon after Dr. Jansen was hired in
12 2008 were your concerns about his quality of care brought to

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13 your attention?
14 A I don't recall.
15 Q Okay. What's the first incident that you recall
16 being brought to your attention?
17 A I recall that several of the nurses felt that
18 Dr. Jansen was taking too much time in sleeping on his shifts
19 as opposed to clearing out the emergency room, not spending
20 enough time with the patients.
21 Q Do you recall -- I know it was a long time ago -- do
22 you recall the names of any of the nurses who made those
23 complaints?
24 A I recall the name of one, yes.
25 Q And who was that?
00025:01 A That would be Nicole Gates.
02 Q Was Nicole Gates a CasePro employee?
03 A Yes, she was.
04 Q And how did Ms. Gates provide you that information
05 that Dr. Jansen was spending more time sleeping than he was
06 treating patients?
07 A She would call me on the phone.
08 Q And when you obtained that information that
09 Dr. Jansen was spending more time sleeping on his shift than
10 treating patients, what did you do with that information?
11 A I would have informed Mr. McCabe.
12 Q And what did Dr. McCabe do with that information?
13 A I have no knowledge of what he did with that
14 information.
15 Q He never told you -- strike that.
16 After you provided that information that you
17 had obtained from Nurse Nicole Gates about Dr. Jansen to
18 Mr. McCabe, did Mr. McCabe direct you as the program manager
19 for the CasePro employees at Naval Hospital Beaufort to do
20 anything?
21 A He would have wanted proof.
22 Q All right. What's the -- was there an incident
23 about Dr. Jansen after you received the report from Nurse
24 Nicole Gates about Dr. Jansen?
25 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
02 you sit here today under oath that prior to the concerns
03 expressed in April of 2010 about a dead United States Marine
04 that there had been concerns raised by Nurse Nicole Gates
05 about Dr. Jansen sleeping on the job instead of treating
06 patients?
07 A Yes.
08 Q That's information that not only you had, but
09 information that Mr. McCabe had for the company?
10 A Yes.
11 Q And even though CasePro, Incorporated had that
12 knowledge from Nurse Nicole Gates about Dr. Jansen sleeping on
13 the job instead of treating patients, Dr. Jansen was not
14 fired?
15 A He was not. But I would like to point out there
16 were beds there for the doctors to sleep in for the overnight
17 shifts.
18 Q You told us some information about the concerns that
19 you obtained from Dr. Moore in April of 2010. You also
20 indicated to me that there were concerns raised about
21 Dr. Jansen after April of 2010?
22 A Yes.
23 Q What was the first concern about Dr. Jansen brought
24 to your attention after April of 2010?
25 A That he may not have been diagnosing patients
00027:01 correctly.
02 Q Do you recall who brought that concern to your
03 attention?

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04 A Dr. Scott Moore.
05 Q How did Dr. Scott Moore bring that information to
06 your attention?
07 A Called me on the phone.
08 Q Did Dr. Scott Moore offer specific examples of how
09 Dr. Jansen was not correctly diagnosing patients?
10 A He did.
11 Q Do you recall what those specific examples were?
12 A I do not.
13 Q When Dr. Moore called you about those concerns, is
14 that something that you, yourself took seriously?
15 A Absolutely.
16 Q What did you do once Dr. Moore called you on the
17 telephone about Dr. Jansen not correctly diagnosing patients?
18 A I would have informed Mr. McCabe.
19 Q And did you call Mr. McCabe on the telephone, send
20 him an e-mail or did you go talk to him in person?
21 A Talked to him in person.
22 Q And would you have relayed to him all of the
23 information that Dr. Moore had provided you?
24 A Yes.
00028:01 Q And what was Mr. McCabe's response?
02 A He would have wanted proof.
03 Q Did you attempt to obtain any proof concerning
04 Dr. Moore's concern that Dr. Jansen was not correctly
05 diagnosing patients?
06 A Yes.
07 Q What did you do, sir?
08 A I asked for copies of the peer reviews.
09 Q Did you obtain them?
10 A No. They belong to the Navy.
11 Q Did you inform Mr. McCabe that you were unable to
12 obtain the peer reviews?
13 A Yes.
14 Q Did Mr. McCabe direct you to do anything further?
15 A No.
16 Q We now have three separate reports of concerns about
17 Dr. Jansen. First one being sleeping on the job instead of
18 treating patients; the second being the dead United States
19 Marine; and then the third concern about Dr. Jansen not
20 correctly diagnosing patients.
21 Did you talk to Dr. Jansen personally about any
22 of those three concerns?
23 A Yes.
24 Q Was Mr. McCabe aware of those conversations with
25 Dr. Jansen?
00029:01 A I would have told him I talked to Dr. Jansen, yes.
02 Q Okay. Did Mr. McCabe ever talk to Dr. Jansen?
03 A To my knowledge, no. He left that to the program
04 managers. That was my responsibility.
05 Q And you re -- you raise a very good word there, sir,
06 responsibility. As part of your job as a program manager for
07 CasePro, Incorporated, did you have the authority of the
08 company to terminate someone's employment?
09 A I did not.
10 Q Who at CasePro, Incorporated held that authority?
11 A Mike McCabe.
12 Q Do you have any recollections of your conversations
13 with Dr. Jansen about the three incidents we've talked about
14 today?
15 A I have some recollection.
16 Q Tell me what you remember, sir.
17 A Dr. Jansen said it's just another doctor's opinion.
18 He had his opinion; another doctor had his opinion.
19 Q Before you left the employment of CasePro,
Incorporated in 2011, were there any other concerns about

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20 Dr. Jansen other than the three you've told us about today?
21 A I don't recall.
22 Q How many years have you worked in this industry,
23 sir?
24 A Oh, boy. About 20 years.
25 Q Did you have more experience in this industry than
00030:01 Mr. McCabe?
02 A I think so.
03 Q Do you know what Mr. McCabe's background was before
04 he came to work at CasePro, Incorporated?
05 A I do.
06 Q Do you know?
07 A He ran Unilever plants.
08 Q Making things like butter and Ragu?
09 A Soup and canned tomatoes, things like that.

7. PAGE 30:10 TO 30:16 (RUNNING 00:00:25.020)

10 Q If it had been up to you to make a decision about
11 Dr. Jansen prior to your leaving the company -- so we'll just
12 say any point in time before November of 2011 --
13 A Uh-huh.
14 Q -- if the decision had been yours, would you have
15 fired Dr. Jansen?
16 A I would.

8. PAGE 30:18 TO 31:02 (RUNNING 00:00:33.056)

18 Q (By Mr. Hoyle) I'll ask the question a different
19 way.
20 A All right.
21 Q Based on your years of experience in the healthcare
22 industry and as the program manager for CasePro, Incorporated
23 with respect to the CasePro employees doing work at Naval
24 Hospital Beaufort, if the decision had been yours, would you
25 have terminated Dr. Jansen's employment from CasePro
00031:01 incorporated prior to November of 2011?
02 A Yes.

9. PAGE 31:04 TO 31:06 (RUNNING 00:00:16.108)

04 Q (By Mr. Hoyle) Why?
05 A Standard of care was not met. I'm a Veteran. He's
06 taking care of military people. Standard of care was not met.

10. PAGE 31:07 TO 31:18 (RUNNING 00:00:37.650)

07 Q Did Mr. McCabe ever serve in the military?
08 A No, sir.
09 Q Did anyone who owns the shares of CasePro,
10 Incorporated to your knowledge ever serve in the military?
11 A To my knowledge, no.
12 Q When you began working for the company, did you know
13 a lady by the name of Shirley Hill?
14 A I did.
15 Q And how was Ms. Hill related to Mr. McCabe?
16 A It's his mother.
17 Q And I understand Ms. Hill is no longer with us?
18 A Correct.

11. PAGE 34:08 TO 36:06 (RUNNING 00:01:52.790)

08 When you left CasePro, Incorporated, who
09 succeeded you as the program manager for the CasePro,
10 Incorporated employees working in the Beaufort area?
11 A I believe it was Tracie Braswell.
12 Q Did you work alongside Ms. Braswell for any period
13 of time?
14 A She worked there in the credentialing department

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15 while I was there.
16 Q And what's the difference between someone working in
17 the credentialing department and being a program manager?
18 A Credentialing department, they're pretty much
19 checking boxes, making sure documents have been returned,
20 doing verifications. That's what they do in the credentialing
21 department.
22 Q Sounds like a clerical type task?
23 A Shuffling papers and checking boxes and making sure
24 everything has been submitted and verified and make sure it's
25 correct, yes.
00035:01 Q Were you surprised that she succeeded you as the
02 program manager?
03 A I didn't give it much thought because I had gone by
04 then.
05 Q You had moved on?
06 A Yes.
07 Q Before I tell you that I have no further questions
08 and my friend Mr. MacKelcan conducts his examination, I just
09 want to make sure that this record is clear today.
10 When we began this deposition, the Court
11 Reporter was kind enough to administer you an oath.
12 A Uh-huh.
13 Q An oath to tell the truth, the whole truth and
14 nothing but the truth. Do you recall that?
15 A Yes, sir.
16 Q Okay. Have you given us truthful testimony here
17 today?
18 A I have.
19 Q And you understand that the testimony you've given
20 here today -- even though we're sitting in your lawyer's
21 office in San Antonio, Texas -- has the same full force and
22 effect as if you were testifying in front of a court and jury
23 in Beaufort, South Carolina?
24 A I do.
25 Q And are you on any medication or under the influence
00036:01 of any substance such as alcohol or otherwise that would
02 impair your ability to give us truthful testimony here today?
03 A No, sir.
04 MR. HOYLE: Sir, I very much appreciate your
05 time.
06 At this time I will pass the witness.

12. PAGE 36:13 TO 36:18 (RUNNING 00:00:25.920)

13 What is your understanding of this lawsuit?
14 A My understanding is that there was a patient of
15 Dr. Jansen's that somehow was released or got out of his care
16 in the hospital, got into a fire truck and ultimately killed
17 someone.
18 Q Okay. How did you obtain that information?

13. PAGE 36:22 TO 37:10 (RUNNING 00:00:31.590)

22 A When Mr. Hoyle initially called me and asked who I
23 was --
24 Q When did --
25 A -- he --
00037:01 Q When did he call you?
02 A Oh, geez. Three weeks ago maybe, four.
03 Q And the two of you spoke on the phone?
04 A Yes.
05 Q All right. What did -- what did you talk about?
06 A I told him what my job was at CasePro.
07 Q That was the extent of your conversation?
08 A Well, he -- he had asked a few questions about
09 Dr. Jansen or if there were any issues or concerns with
10 Dr. Jansen, and I told him yes.

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14. PAGE 38:08 TO 39:06 (RUNNING 00:01:03.360)

08 Q So now, you are not a medical doctor; is that
09 correct?
10 A That is correct.
11 Q Okay. So you were -- you're not qualified to
12 conduct a peer a peer review on a doctor in any State?
13 A You are correct.
14 Q All right. And you're not qualified to give a
15 standard of care opinion?
16 A I am not.
17 Q Okay. And that -- that would also be true of a
18 nurse; you're not a nurse, are you?
19 A No, I am not.
20 Q Okay. So you would -- you're not qualified to give
21 a standard of care opinion for the conduct of a nurse?
22 A Correct.
23 Q When you were at CasePro under the contract with the
24 Navy that we've been talking about today, could a CasePro
25 employee begin working at the Beaufort Naval Hospital without
00039:01 approval from the United States Navy?
02 A No.
03 Q Okay. So that -- approval from the Navy is a
04 requirement for any CasePro employee to set foot on the
05 Beaufort Naval Hospital and perform medical care?
06 A Yes.

15. PAGE 39:19 TO 39:23 (RUNNING 00:00:11.570)

19 Q Is it accurate to say that your responsibility in
20 the Navy's credentialing process is just to provide the
21 information required under the contract on the -- on the front
22 end?
23 A That is correct.

16. PAGE 40:04 TO 40:23 (RUNNING 00:00:42.190)

04 Q Once you have submitted that information to the
05 Navy --
06 A Uh-huh.
07 Q -- is that the end of your involvement with the
08 credentialing process?
09 A Yes.
10 Q The Navy has their own credentialing process?
11 A Correct.
12 Q Do you -- have you ever been involved in the Navy's
13 credentialing process for the healthcare workers?
14 A I have not.
15 Q Have you ever seen any of the documentation from a
16 Navy credentialing file?
17 A I have not.
18 Q Okay. So essentially what happens is you provide
19 this information, and at some point -- depending on the time
20 sounds like it can vary -- at some point the Navy will return
21 a decision to CasePro saying yes, this person can work at the
22 Naval Hospital Beaufort or no?
23 A That's correct.

17. PAGE 41:09 TO 41:25 (RUNNING 00:00:59.610)

09 Q Okay. So CasePro actually doesn't hire anyone until
10 the Navy is -- has approved that person for the particular
11 position at the particular hospital?
12 A That is correct.
13 Q Okay. And CasePro wouldn't hire someone if the Navy
14 denied that particular healthcare provider access to the
15 facility that they would be assigned to?
16 A That is correct. And that happened a number of

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17 times.
18 Q Okay. Were you ever involved -- well, while working
19 at CasePro -- with any performance reviews for the CasePro
20 employees at the Beaufort Naval Hospital?
21 A No.
22 Q And is that because the contract dictates that the
23 Navy is responsible for the medical performance reviews of the
24 CasePro employees at the Beaufort Naval Hospital?
25 A That's right.

18. PAGE 42:10 TO 42:13 (RUNNING 00:00:14.769)

10 Q (By Mr. MacKelcan) Mr. Martin, I've handed you
11 what's been marked Defense Exhibit 1 to your deposition. It
12 has the Bates label of Def RRFP 00949 and is also marked
13 confidential. As Mr. Hoyle mentioned earlier in the

19. PAGE 42:21 TO 43:02 (RUNNING 00:00:14.966)

21 Do you recall preparing and sending this letter
22 to Mr. Joe -- Joe McDonald?
23 A Not specifically this letter, but I -- I mean it's
24 my name on it. I would have prepared it.
25 Q You don't have any reason to believe that it's not
00043:01 from you?
02 A No.

20. PAGE 43:05 TO 45:03 (RUNNING 00:02:56.600)

05 Q And my question goes to something we talked about a
06 minute ago. If you look at the last sentence of the first
07 paragraph that states: This offer is contingent upon arrival
08 by the U.S. Navy to continue performing healthcare --
09 approval. I'm sorry. This offer is contingent upon approval
10 by the U.S. Navy to continue performing healthcare services as
11 an incumbent provider under the new contract.
12 A Yes.
13 Q All right. Is that what we were talking about
14 before that Mr. McDonald would not have been offered
15 employment unless the Navy approved him?
16 A That is correct.
17 Q In this particular case Mr. McDonald was already
18 working at the Beaufort Naval Hospital --
19 A That's correct.
20 Q -- prior to CasePro obtaining the contract?
21 A That's right.
22 Q And he was performing the same job that he performed
23 under the contract with CasePro?
24 A Yes.
25 Q Okay. Can you use Exhibit 2 that we've already been
00044:01 marked? That was the packet provided by Mr. Hoyle. And I'm
02 going to go back to page 333 that we looked at earlier.
03 A That was the e-mail?
04 Q That was the e-mail.
05 A Okay.
06 Q Who is Amanda Rutten?
07 A She was either the contracting officer or the
08 contracting specialist at Naval Medical Logistics Command. To
09 my recollection she was the contracting officer at this time.
10 Q For those of us that don't know much about this --
11 A Uh-huh.
12 Q -- unique area of Government contracting, what does
13 a contracting officer do?
14 A The contracting officer is responsible for making
15 sure that the contractors abide by the requirements of the
16 contract. She is the person who runs the contract for the
17 Navy on the Navy Government employee side of the house.
18 Q And then what would a contracting specialist do?

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19 A The specialist is a person that basically fields all
20 the information and then filters out what needs to go to the
21 contracting officer. So it's prob -- it's more the staff
22 person as opposed to going all the way to the top.
23 Q Okay. So they are in the same department, but it
24 sounds like the --
25 A Yes.
00045:01 Q -- specialist would report to the officer?
02 A Correct.
03 Q Okay.

21. PAGE 45:07 TO 46:07 (RUNNING 00:01:22.020)

07 Q Okay. If you look at number one, and this is an
08 e-mail that you sent to Amanda; is that correct?
09 A Yes, that is correct.
10 Q All right. So she was clearly aware of this
11 situation as well?
12 A Very clearly. She said thank you, Craig in her
13 response.
14 Q Okay. So in number one your statement says:
15 Dr. Moore, one of our ER physicians for DO#0103, was asked by
16 the Navy to conduct a peer review.
17 A Uh-huh.
18 Q Okay. Is that typically how peer reviews originated
19 while you were at CasePro?
20 A There was a requirement by the contract -- and I'm
21 sure you all have obtained a copy of the contract -- to
22 provide a certain number of peer reviews on emergency room
23 doctors over a period of time. Some occasions they were
24 random. Other occasions they were very specific. In the case
25 a death, they would automatically review that case.
00046:01 And a peer review is done by another -- for in
02 this case in the emergency room -- it would be done by an
03 emergency room doctor board certified in emergency medicine.
04 Q And but again in the question is that the Navy
05 dictated that this particular peer review was conducted; is
06 that correct?
07 A Absolutely.

22. PAGE 47:06 TO 48:16 (RUNNING 00:01:27.090)

06 Q But -- but that particular --
07 A Very clearly.
08 Q -- particular doctor was conducting the peer review
09 for the Navy, not for CasePro?
10 A That's correct.
11 Q Okay. And just to be clear -- and I think you've
12 already testified about this -- but you never saw any
13 documentation regarding this particular peer review or any
14 peer review?
15 A No peer reviews.
16 Q The only thing that you know about them is what
17 information may have been passed along to you by Dr. Moore or
18 a nurse?
19 A Correct.
20 Q Okay.
21 A Or other doctors.
22 Q But you never saw any documentation?
23 A No peer reviews were ever provided to CasePro.
24 Q Never participated in any interviews with the
25 providers or witnesses?
00048:01 A Regarding the peer reviews?
02 Q Regarding the peer review.
03 A No.
04 Q So you weren't involved in any way with any of
05 the --
06 A No.

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07 Q -- peer reviews?
08 A No.
09 Q All right.
10 A No one at CasePro was, other than other staff that
11 may have been involved at Beaufort Navy Hospital.
12 Q Okay. Did you personally ever receive documentation
13 from the Navy that indicated the standard of care had not been
14 met by Dr. Jansen?
15 A I -- I do not recall that I did, but it would have
16 been in his file if I'd have received notification.

23. PAGE 48:21 TO 49:10 (RUNNING 00:00:53.450)

21 Q Okay. Ult -- excuse me. Ultimately, the Navy
22 allowed Dr. Jansen to retain his privileges at the Beaufort
23 Naval Hospital; is that correct?
24 A That is correct.
25 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
02 have been able to have him work there?
03 A Correct.
04 Q All right. In number six you said: I requested
05 documentation in writing as to the CO's directions and reasons
06 for termination and have not received documentation to date.
07 In looking through all the records, I have not
08 seen any documentation that would be responsive to your
09 request, but I'll ask you do you recall receiving any
10 documentation responsive to your request?

24. PAGE 49:12 TO 49:24 (RUNNING 00:00:31.304)

12 A We did not receive documentation to my recollection.
13 Q (By Mr. MacKelcan) Okay. So you initially at some
14 point said Dr. Jansen was going to be terminated from the
15 Navy. That was a Naval decision; is that correct?
16 A If they wanted him terminated, that would be a Naval
17 directive.
18 Q Okay.
19 A To terminate.
20 Q And then at some point they changed their mind and
21 decided that he was still able to provide medical services at
22 the Beaufort Naval Hospital?
23 A To my knowledge while I was there we did not receive
24 any notification to remove him from the contract.

25. PAGE 51:02 TO 53:22 (RUNNING 00:04:22.560)

02 Q Is it also true that for Dr. Jansen to set foot at
03 the Beaufort Naval Hospital, it required approval from the
04 Navy?
05 A Well, he could set foot in it.
06 Q Provide medical services at the Beaufort Naval
07 Hospital?
08 A You are correct.
09 Q Okay. And that his job offer was contingent on
10 approval by the Navy?
11 A Yes.
12 Q All right. Okay. Would it be accurate to say that
13 your job responsibility at CasePro with respect to the
14 contract with the Navy involved in this case was to ensure
15 that CasePro complied with the terms of the contract?
16 A Yes.
17 Q Okay. And did the contract outline specific
18 requirements for CasePro to follow to meet that?
19 A Yes.
20 Q While you worked at CasePro, do you believe that you
21 did exactly that, that you met the terms of the contract with
22 the Navy?

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23 A Yes.
24 Q Okay. And you had Government contracting experience
25 before you came to work at CasePro; is that right?
00052:01 A Yes.
02 Q And you are working in this field right now?
03 A Yes.
04 Q Okay. Other than your conversation with Mr. Hoyle,
05 do you have any firsthand knowledge about the incidents on
06 February 24, 2012 that are involved in this case?
07 A No.
08 Q You weren't working at CasePro at that time?
09 A In 2012? No.
10 Q Right. Earlier you testified about -- we talked
11 about the three instances of concern regarding Dr. Jansen.
12 A Uh-huh.
13 Q And you recall -- I think you testified that you
14 would have spoken to Mr. McCabe about them?
15 A Yes.
16 Q All right. Do you recall specific conversations
17 with Mr. McCabe about them or were you just testifying as to
18 what would have been your standard practice?
19 A I recall telling Mr. McCabe that the standard of
20 care was not met, and I had very grave concerns about the
21 quality of care that he was providing in the incident where
22 the Marine died.
23 Q Okay. And you testified earlier that the Navy never
24 provided CasePro with any documentation as to a deviation from
25 the standard of care; is that correct?
00053:01 A That's correct.
02 Q The only information that you were basing this on
03 was the telephone call from Dr. Moore; is that right?
04 A That's correct.
05 Q Okay. And you said that Mr. McCabe -- well, and I
06 believe you testified that he would have wanted documentation.
07 Do you recall that he specifically asked for documentation
08 from the Navy?
09 A Yes.
10 Q All right. And you recall specifically trying to
11 get that documentation --
12 A Absolutely.
13 Q -- from the Navy?
14 A Uh-huh.
15 Q So there's no doubt in your mind that the Navy was
16 aware of these same concerns that you testified about today?
17 A There is no doubt in my mind.
18 Q Okay. But the Navy never provided you or CasePro
19 with any documentation or information that stated these
20 concerns are a deviation from the standard of care or anything
21 that would have supported the termination of Dr. Jansen by
22 CasePro?

26. PAGE 53:24 TO 53:24 (RUNNING 00:00:02.526)

24 A Not prior to --

27. PAGE 54:03 TO 54:08 (RUNNING 00:00:28.557)

03 A Not prior to my leaving, no, there was no
04 documentation about it.
05 Q (By Mr. MacKelcan) And you would agree that it was
06 reasonable for Mr. McCabe to want documentation on the basis
07 of firing an employee?
08 A Yes.

28. PAGE 55:23 TO 56:01 (RUNNING 00:00:08.330)

23 Q There have been some questions by my friend,
24 Mr. MacKelcan, about Dr. Scott Moore. Have you actually met

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25 Dr. Moore in person?
00056:01 A Absolutely.

29. PAGE 56:03 TO 56:13 (RUNNING 00:00:30.180)

03 There were some questions by my friend,
04 Mr. MacKelcan, about the whole peer review process and --
05 and -- and Dr. Moore's involvement with that. Did the Navy
06 actually say we want Dr. Moore to do the peer reviews or was
07 that CasePro's decision to say that Dr. Scott Moore should be
08 doing those?
09 A That was CasePro's decision, but Dr. Moore did it
10 with the previous contractor. So we wanted to keep that
11 continuity.
12 Q Okay. There --
13 A And they were pleased with his performance, so.

30. PAGE 56:14 TO 57:10 (RUNNING 00:00:58.190)

14 Q Did you ever have any concerns brought to your
15 attention about Dr. Scott Moore's abilities as a medical
16 doctor?
17 A No.
18 Q Never had nurses calling you up on your telephone
19 about Dr. Moore sleeping on the job?
20 A No.
21 Q Ever had any concerns about dead United States
22 Marines being treated by Dr. Moore?
23 A No.
24 Q When Dr. Moore called you on the telephone about
25 Dr. Jansen, I believe you've already told us you took his
00057:01 concerns seriously?
02 A I did.
03 Q Did you believe Dr. Moore was calling you with any
04 type of ulterior motive?
05 A No.
06 Q He didn't have an axe to grind with Dr. Jansen, did
07 he?
08 A No.
09 Q He was calling you because he wanted this brought to
10 your attention?

31. PAGE 57:12 TO 57:16 (RUNNING 00:00:11.609)

12 A Yes.
13 Q (By Mr. Hoyle) And I believe you testified in
14 response to questions by Mr. MacKelcan that you relayed to
15 Mr. McCabe that you had very grave concerns?
16 A Yes.

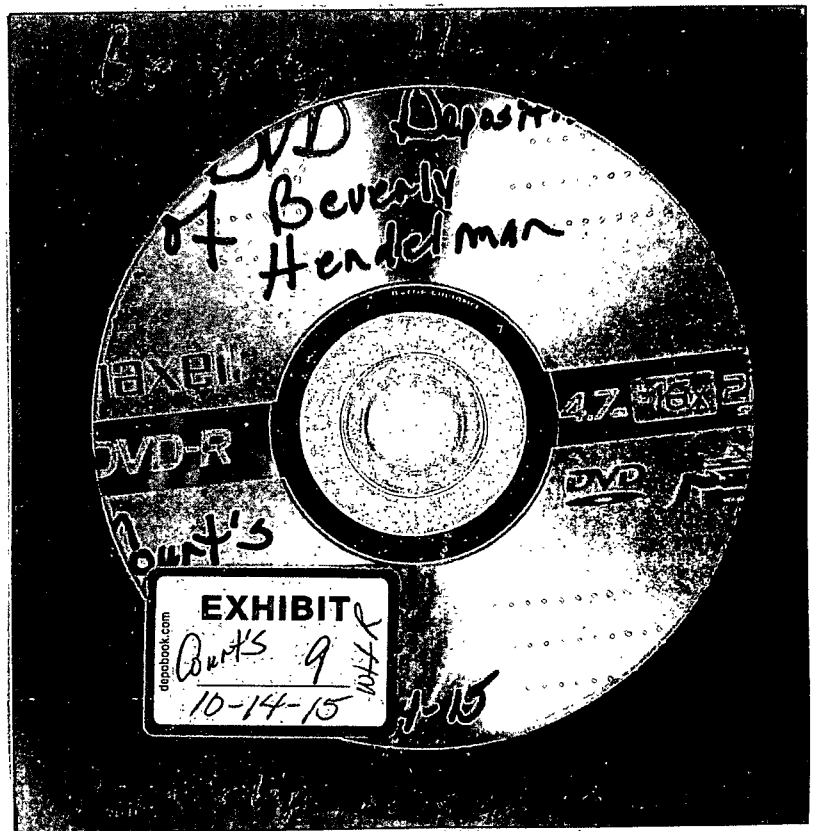
32. PAGE 57:17 TO 58:09 (RUNNING 00:00:50.920)

17 Q The answer may be obvious, but what were those very
18 grave concerns about Dr. Jansen?
19 A If the standard of care is not met in those
20 emergency situations, my grave concern is that there are other
21 people that could get misdiagnosed or could die or could have
22 serious injuries result of any substandard care that they may
23 receive. I would not want my spouse to be seen by Dr. Jansen.
24 I would not want to be seen by Dr. Jansen. I would not
25 Mr. McCabe seen by Dr. Jansen.
00058:01 Q And you certainly wouldn't want a uniformed member
02 of the United States military --
03 A I would --
04 Q -- seen by --
05 A -- not.
06 Q -- Dr. Jansen?
07 A I would not.
08 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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 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)

23 Q. Ma'am, would you please state your name
24 for the jury?
25 A. My name is Beverly Ilene Hendelman.
00019:01 Q. What's your occupation?
02 A. I'm a psychiatrist.
03 Q. Do you have a specific area of
04 specialization or concentration?
05 A. I work with children, disabled children,
06 particularly autistic and Asperger's and I work with
07 adults with PTSD and TBI.
08 Q. Dr. Hendelman, is it your understanding
09 that you are here testifying today regarding the
10 events that transpired involving Calvin Hunt on
11 February the 24th, 2012 at the Naval Hospital in
12 Beaufort County?
13 A. Yes.
14 Q. What was your job at the Naval Hospital on
15 February 24, 2012?
16 A. Staff psychiatrist.
17 Q. Do you recall a Dr. Jansen working at the
18 Naval Hospital?
19 A. Yes.
20 Q. Back on February 24, 2012, what was Dr.
21 Jansen's role at the Naval Hospital?
22 A. He worked in the emergency room.
23 Q. Dr. Jansen testified in this action that
24 you called him around 4:05 p.m. that day and you
25 told him that Calvin Hunt obviously needed to be
00020:01 admitted. Do you have a recollection of that
02 conversation with Dr. Jansen?
03 A. Briefly, yes.
04 Q. Let me ask you, is there a difference
05 between admitting a patient and committing a
06 patient?
07 A. Committing a patient means that you have
08 filed paperwork to say that that patient needs to be
09 held against his will. Admitting a patient states
10 that you are admitting a patient to a hospital and
11 that's a voluntary.
12 Q. After your conversation with Dr. Jansen on
13 February 24, 2012, what was your understanding as to
14 whether or not Mr. Hunt was going to be admitted or
15 committed?
16 A. My understanding is he was going to be
17 admitted.
18 Q. What's the process then after you tell Dr.
19 Jansen that Calvin Hunt obviously needed to be
20 admitted, what was supposed to happen next?
21 A. The techs would escort him to the hospital
22 by ambulance.
23 Q. When you say techs, who are you referring
24 to?
25 A. The two techs that were on duty that day,
00021:01 it was Manning, and I forget the other guy's name.
02 Q. Before the techs could get to Calvin Hunt,

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03 where was he located? Was he in the techs'
04 presence?
05 A. He was in the emergency room.
06 Q. Did you have an expectation that the staff
07 there in the emergency room would keep him there
08 until the techs could get to him to take him to the
09 hospital?
10 A. I have no control over that. I expect
11 that he would stay, but I don't have any control
12 over what goes on in the emergency room.
13 Q. I understand. Where was he being taken
14 to, was that Beaufort Memorial Hospital?
15 A. Yes.
16 Q. Dr. Hendelman, this isn't a trick question
17 so I'm not trying to trick you. But do you have an
18 understanding of what the word obvious means as it
19 is commonly used in the English language?
20 A. It means clearly.
21 Q. So if I were to ask you, what does the
22 word obvious mean to you, what would your answer be?
23 A. Clearly.
24 Q. What's the opposite of obvious?
25 A. Unobvious.

2. PAGE 22:12 TO 22:14 (RUNNING 00:00:07.470)

12 it again: Would you agree with me that it doesn't
13 necessarily require a medical school education to
14 recognize a condition that is obvious?

3. PAGE 22:16 TO 22:19 (RUNNING 00:00:13.021)

16 A. It depends. It depends on what you are
17 talking about. I mean, a limb being absent is one
18 thing. When you are talking about a mental health
19 condition, you are talking about something else.

4. PAGE 22:21 TO 23:09 (RUNNING 00:00:35.470)

21 Q. Ma'am, obvious means obvious, right?
22 Obvious is clear, correct?
23 A. No, that depends on who you are talking to
24 and what language you are talking with them about.
25 Q. I am talking about the commonly accepted
00023:01 definition as obvious is used in the English
02 language, okay? And you said that --
03 A. When Calvin Hunt obviously --
04 Q. -- when you said obviously -- let me
05 finish my question. You told Dr. Jansen that Calvin
06 Hunt obviously needed to be admitted. If something
07 is obvious, it's obvious, it's clear. That's what
08 you just testified to, correct?
09 A. That's correct.

5. PAGE 23:22 TO 24:03 (RUNNING 00:00:18.909)

22 Q. Based on your recollection of the events
23 of February 24, 2012, was it obvious to you that
24 Calvin Hunt needed to be admitted?
25 A. It was clear that he had a danger to self,
00024:01 therefore he needed to be admitted.
02 Q. It was also clear that he presented a
03 danger to others, correct?

6. PAGE 24:05 TO 24:08 (RUNNING 00:00:10.560)

05 A. I was aware of the danger to self. I had
06 not heard about the danger to others. But danger to
07 self, danger to others or gravely disabled, requires

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08 admission to the hospital.

7. PAGE 24:16 TO 26:13 (RUNNING 00:03:50.760)

16 Q. Let me ask you to take a look at what's
17 previously been marked as Exhibit 2 to this
18 deposition. It is a series of medical records.
19 Just let me know when you have had an opportunity to
20 look at it.
21 (Witness reviewing documents.)
22 BY MR. SWETT:
23 Q. Ma'am, have you seen those documents
24 before?
25 A. No.
00025:01 Q. Have you seen any of these documents
02 before?
03 A. No.
04 Q. On February 24, 2012, did anyone provide
05 these documents for your review?
06 A. No.
07 Q. Did you ask for any documents that were
08 completed or filled out on February 24, 2012?
09 A. No.
10 Q. Did you ask for any triage records?
11 A. No.
12 Q. Let me ask you to look at Page 112. On
13 the left-hand side, it is in handwriting, do you see
14 "suicidal thoughts" circled there, the left-hand
15 side?
16 A. Yes.
17 Q. I am going to read the handwriting there.
18 It says, "and thoughts of hurting others."
19 Do you see that written there?
20 A. Yes, and something other -- okay.
21 Q. But "no specific plan," right?
22 A. "And no specific plan," yes.
23 Q. But again, this document which was filled
24 out on, looks like February 24, 2012, states that
25 Calvin Hunt had thoughts of hurting others, correct?
00026:01 A. Yes.
02 Q. Based on this document alone, is it your
03 testimony that it was a requirement that Calvin Hunt
04 be admitted?
05 A. Yes, it was based on the fact that he was
06 a danger to self and a danger to others. He needed
07 to be admitted, yes.
08 Q. Why?
09 A. Because he is a danger to self and a
10 danger to others by his own admission.
11 Q. And that's pretty obvious, correct,
12 because it is by his own admission?
13 A. That makes him in need of hospitalization.

8. PAGE 29:12 TO 30:02 (RUNNING 00:00:42.830)

12 Q. Dr. Hendelman, if a patient says that they
13 have thoughts of hurting others, they have a history
14 of depression and PTSD and they have suicidal
15 ideations, is it obvious to you that that person
16 needs to be physically restrained?
17 A. No.
18 Q. Why is it that that person may not need to
19 be physically restrained?
20 A. Physical restraint is only used when a
21 person becomes agitated and is threatening at that
22 moment.
23 Q. So if someone comes in and says, hey, I
24 have thoughts of harming others, that person doesn't

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25 need to be restrained?
00030:01 A. No, they need to be talked to and
02 hospitalized.

9. PAGE 32:17 TO 37:07 (RUNNING 00:05:40.810)

17 Q. Let me back up a little bit and get some
18 basic information from you. Where do you currently
19 live?
20 A. I currently live here in Columbus,
21 Georgia.
22 Q. How long have you lived in Columbus,
23 Georgia?
24 A. About a year and three months.
25 Q. Where did you live prior to living in
00033:01 Columbus, Georgia?
02 A. Beaufort, South Carolina.
03 Q. How long were you in Beaufort?
04 A. About two years.
05 Q. Where did you live prior to Beaufort?
06 A. Dublin, Georgia.
07 Q. Are you married, Dr. Hendelman?
08 A. No.
09 Q. Do you have any kids?
10 A. I have a daughter.
11 Q. Is your daughter over the age of 17?
12 A. Yes.
13 Q. What is her name?
14 A. Elena Kemmerer.
15 Q. Where does she live?
16 A. With me.
17 Q. Where did you grow up?
18 A. I was born and raised in Detroit,
19 Michigan.
20 Q. Did you go to high school in Michigan or
21 somewhere else?
22 A. I went to high school in Detroit.
23 Q. If you could, how about just walk us
24 through your education after high school until you
25 had taken your first medical job.
00034:01 A. I completed high school. I taught school
02 for approximately four years; spent a year in
03 Israel, approximately a year in Israel; came back
04 from there, taught in inner city Detroit for another
05 year; did graduate work in physiology, biochemistry
06 and ed psych and was in the midst of obtaining a
07 master's, and decided to go to medical school.
08 I went to, then went to medical school at
09 Michigan State, completed medical school; did an
10 internship at Mount Zion and my first year
11 residency; finished my adult residency at Stanford;
12 and then did my child fellowship at McAuley
13 Institute in California, all in California.
14 MR. BERLINSKY: You left out
15 college.
16 A. Oh, I went to the University of Michigan
17 for college and then graduate work at Wayne State.
18 Q. Thank you, ma'am. Are you familiar with
19 the National Board of Medical Examiners?
20 A. Yes.
21 Q. My understanding is that there are three
22 parts of the test that laypeople like me commonly
23 call the medical boards. Are you familiar with that
24 test?
25 A. Yes.
00035:01 Q. Did you have to take that test?
02 A. Yes.

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03 Q. Did you pass all three parts of that test?
04 A. Yes.
05 Q. On the first try?
06 A. Yes.
07 Q. Are you licensed to practice in any state?
08 A. I'm licensed to practice in Indiana,
09 California and Alaska.
10 Q. Are you board certified in any area?
11 A. No.
12 Q. After you passed the boards, where was
13 your first medical job?
14 A. I had a private practice in California.
15 Q. About how long did you have that private
16 practice?
17 A. Ten years.
18 Q. Primarily, what were your, I guess you
19 were a psychiatrist at that time as well?
20 A. Yes.
21 Q. What were your primary duties or the
22 typical patients you would see in those ten years?
23 A. I saw mostly children with a few adults.
24 Q. What issues were those patients dealing
25 with?
00036:01 A. Soup to nuts, all kinds of issues.
02 Q. Just across the board?
03 A. Yes.
04 Q. How about your next job?
05 A. I became medical director of a facility in
06 Marin County. I worked there for a while and then
07 I, let's see, then I went to North Dakota.
08 I went to a variety of states and then I
09 went to New Zealand and spent a couple years there;
10 came back, went to Indiana. Then I went to Alaska,
11 spent some time there and then came back to
12 California. And then I came over to working at the
13 VA in Dublin.
14 Q. So you have been a psychiatrist all over
15 the world, sounds like.
16 A. I've had a good time, yes.
17 Q. How many years were you a practicing
18 psychiatrist before you made it to Beaufort County?
19 A. 35 years or so.
20 Q. What year did you first come to the Naval
21 Hospital in Beaufort County?
22 A. In Beaufort, that would have been what,
23 probably the year before all this, this was '12.
24 That would have been '11; is that right?
25 Q. At that time you had been practicing for
00037:01 about 36 years?
02 A. Yes.
03 Q. During those 36 years as a practicing
04 psychiatrist, did you gain experience assessing
05 individuals with a history of depression, thoughts
06 of suicide and a history of violence?
07 A. Absolutely, yes.

10. PAGE 37:08 TO 38:25 (RUNNING 00:02:06.500)

08 Q. As a practicing psychiatrist, how do you
09 typically evaluate an individual who has thoughts of
10 hurting others, a history of depression and suicidal
11 thoughts?
12 A. I do a complete psychiatric evaluation,
13 just learning about them from the time they were
14 born until the current time, evaluating their
15 thought process, evaluating their childhood,
16 substance abuse and all components related to those

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17 things.
18 Q. So you learn about everything you can
19 learn about them, correct?
20 A. That's correct.
21 Q. What makes up, you mentioned a complete
22 psychiatric evaluation. What is that composed of?
23 A. Just as I stated, learning about their
24 history, learning about what their thoughts are at
25 that time; evaluating whether they are thinking
00038:01 clearly; hallucinating, delusions; the whole mental
02 status; then doing their history; what's been going
03 on with them; where they are living; who they are;
04 then evaluating their history from their childhood
05 on up, their education, development; the problems
06 they have had; just a whole history of the person.
07 Q. How do you gather that information, do you
08 interview the patient?
09 A. Yes.
10 Q. I guess do you review the patient's prior
11 medical records?
12 A. If I have access to them, yes.
13 Q. What other techniques of
14 information-gathering do you use as a practicing
15 psychiatrist?
16 A. Well, with children, I interview parents,
17 interview teachers.
18 Q. So you may call a family member and ask
19 them for information to see what's going on,
20 correct?
21 A. Sometimes, yes.
22 Q. Do you put eyes on the patient physically,
23 you observe the patient to see how they are
24 behaving?
25 A. Yes.

11. PAGE 42:17 TO 46:25 (RUNNING 00:05:30.770)

17 Q. Let me go back and have you look at Dr.
18 Jansen's statement again, 118. The middle of that
19 first paragraph, five lines down, I'm going to read
20 it and ask you if I have read it correctly. It
21 says, "I called mental health about 1520 and asked
22 to have psych evaluate him in the ER."
23 Did I read that correctly?
24 A. Yes.
25 Q. That's at 3:20 p.m., right?
00043:01 A. That's correct.
02 Q. Do you know who in the mental health
03 department Dr. Jansen talked with?
04 A. I would expect he would have called to see
05 where the techs were and called the techs to have
06 the techs come. I don't know specifically who he
07 would have called.
08 Q. Do you have any way of knowing what was
09 said during that conversation?
10 A. No.
11 Q. Would there have been any notes or anybody
12 required to do a report or a little writeup about
13 what was said in that conversation?
14 A. No.
15 Q. So you testified that the first time you
16 knew Calvin Hunt was at the Naval Hospital was after
17 a tech had already spoken with him and came back to
18 your office; is that correct?
19 A. That's correct.
20 Q. Let me ask you to look at what's been
21 marked Exhibit 3.

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22 (Witness reviewing document.)
23 Q. I am just going to paraphrase this
24 document, but it basically says at 1555, that's
25 3:55, correct?
00044:01 A. Yes.
02 Q. "Petty Officer Manning comes up to our
03 office, staff patient, he had just been called in to
04 see in the ER." Okay?
05 A. Yes.
06 Q. So does it look like to you, the first
07 time -- is it your testimony that the first time you
08 knew Calvin Hunt was even at the Naval Hospital was
09 at 3:55 when Mr. Manning came up to your office?
10 A. That's correct.
11 Q. At that time, did Mr. Manning discuss what
12 he had learned from Calvin Hunt with you?
13 A. Yes.
14 Q. Can you tell me what was discussed?
15 A. I can't tell you the details because I no
16 longer remember the details, but I did make the
17 decision based on what I had heard from him that the
18 patient needed to be hospitalized. And the details
19 of that would have been at least that he is a danger
20 to self or a danger to others because those are the
21 criteria for hospitalization.
22 Q. So if you made the recommendation, if you
23 decided Calvin Hunt needs to be admitted, then you
24 had made the determination that he was either a
25 danger to self or a danger to others, correct?
00045:01 A. That's correct.
02 Q. You can't tell me, you don't recall
03 anything you discussed with Mr. Manning?
04 A. No.
05 Q. Nothing sticks out in your mind?
06 A. No.
07 Q. But based on your conversation with Mr.
08 Manning, you decided that Calvin Hunt obviously
09 needed to be admitted, correct?
10 A. That he needed to be admitted, yes.
11 Q. Do you recall what time -- strike that.
12 Did you then relay that recommendation to
13 Dr. Jansen?
14 A. Yes, the conversation, yes.
15 Q. Do you recall what time you notified Dr.
16 Jansen of that?
17 A. No. It's in your document somewhere.
18 Q. Let me ask you to look back at Exhibit 2,
19 118. Again, the first paragraph three lines up
20 says, "Dr. Hendelman called back around 1605 and
21 told me that patient obviously needed to be
22 admitted."
23 Do you see that?
24 A. (Indicating affirmatively.)
25 Q. Is that your recollection?
00046:01 A. Yes.
02 Q. So you made a recommendation to Dr. Jansen
03 at that time that Calvin Hunt obviously needed to be
04 admitted?
05 A. Yes.
06 Q. After your discussion with Dr. Jansen, was
07 it your understanding that Calvin Hunt was going to
08 be admitted?
09 A. Yes, but that is the emergency room's
10 decision on that matter because the emergency room
11 is an independent, functioning unit and they have
12 the right to take the recommendation of the

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13 psychiatrist or not take the recommendation of the
14 psychiatrist. They are in charge of the unit and
15 whatever decision they make is their decision. I
16 can make a recommendation, I cannot make the
17 decision for the doctor.
18 Q. I understand, ma'am.
19 A. Okay.
20 Q. But you as a medical doctor, this is what
21 you do, a psychiatrist, correct?
22 A. I'm a psychiatrist, yes.
23 Q. You as the psychiatrist recommended to Dr.
24 Jansen that Calvin Hunt needed to be admitted?
25 A. That's correct.

12. PAGE 47:01 TO 47:13 (RUNNING 00:00:33.357)

00047:01 Q. Let me ask you, how did you come to form
02 that recommendation?
03 A. Because he was a danger to self.
04 Q. And others?
05 A. He can be a danger to self and others, one
06 or the other, doesn't matter. Both are criteria for
07 admission, either one of them.
08 Q. Do you recall whether or not Mr. Manning
09 told you that Calvin Hunt was a danger to others?
10 A. I do not recall that, no.
11 Q. Do you recall whether or not he told you
12 Calvin Hunt was a danger to himself?
13 A. I know he told me he was a danger to self.

13. PAGE 48:11 TO 48:23 (RUNNING 00:00:27.780)

11 Q. What else did you take into consideration
12 in making your recommendation that Calvin Hunt
13 obviously needed to be admitted other than your
14 conversation with Mr. Manning?
15 A. Only my conversation with Mr. Manning, he
16 was a danger to self. That is a criteria for
17 hospitalization. That's the standard of practice.
18 Q. So you didn't have a face-to-face
19 interview with Calvin Hunt?
20 A. No.
21 Q. Did you review Calvin Hunt's prior medical
22 records?
23 A. No.

14. PAGE 49:08 TO 50:08 (RUNNING 00:01:02.911)

08 Q. What is AHLTA? How do you pronounce it?
09 A. "AHLTA," it is a computerized system of
10 recordkeeping.
11 Q. Was that in place at the Naval Hospital on
12 February 24, 2012?
13 A. Yes.
14 Q. Do medical doctors have access to that
15 system?
16 A. Yes.
17 Q. Did you have access to that system?
18 A. Yes.
19 Q. Did you review Calvin Hunt's prior medical
20 documents in that system on February 24, 2012?
21 A. No, nor did I need to. The point is that
22 he was a danger to self. Danger to self is criteria
23 for admission. That is the protocol. That is what
24 you do, you admit.
25 Later on when he came out, yes, I would
00050:01 have reviewed his records and interacted with him.
02 But when you are admitting a patient to the hospital

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03 at night, danger to self is criteria for admission.
04 Q. And danger to others is also a criteria
05 for admission, correct?
06 A. Yes, that's correct.
07 Q. And Calvin Hunt presented a danger to
08 others on that day, did he not?

15. PAGE 50:10 TO 50:12 (RUNNING 00:00:04.640)

10 A. According to the notes here, yes, he
11 presented as a danger to self and a danger to
12 others.

16. PAGE 50:20 TO 54:07 (RUNNING 00:04:27.010)

20 Q. Did you call in family members of Calvin
21 Hunt to inquire about what may be going on in his
22 life?
23 A. No, he is presenting as a danger to self,
24 danger to others. That is criteria for admission.
25 Q. But if medical records are available, does
00051:01 a medical doctor typically review those records?
02 A. No, not at that point. The point is that
03 he is going to the hospital. All of that can be
04 dealt with afterwards.
05 The point is that he is a danger to self,
06 he needs to go to the hospital. He needs to be
07 evaluated, he needs to be treated. The rest of it
08 comes later.
09 Q. Let me make sure I have your testimony
10 correct. Let me just ask you: On February 24,
11 2012, did you need to review any of Calvin Hunt's
12 prior medical records in order to make your
13 recommendation that he obviously needed to be
14 admitted?
15 A. No, the criteria he is a danger to self,
16 hearing that he is a danger to self is criteria
17 enough to admit a patient to the hospital.
18 Q. Again, criteria is that he was a danger to
19 others as well, correct?
20 A. Yes.
21 Q. Ma'am, do you recall Nurse Janice
22 McDonald?
23 A. I don't really remember her, no.
24 Q. So do you know back on February 24, 2012
25 what Nurse McDonald's role at the Naval Hospital
00052:01 was?
02 A. No, not really.
03 Q. I will represent to you that Nurse Janice
04 McDonald has given testimony in this case that you
05 should have conducted a face-to-face interview with
06 Calvin Hunt. In fact, I believe she testified that
07 the reason you didn't was because it was Friday
08 afternoon and you were ready to go home.
09 A. Well, the -- go ahead.
10 Q. Can you tell me, is that in fact the
11 reason you didn't conduct a face-to-face interview
12 with Calvin Hunt?
13 A. No, that is not the reason. Between the
14 hours of eight and three o'clock, a doctor will come
15 down and do a face-to-face examination. Technically
16 we take call as of four but we cut it off at three.
17 We do not do face-to-face.
18 Then the on-call doctor, regardless of
19 whether the doctor is at Parris Island Air Station
20 or at the hospital, they take over. And you do not
21 do face-to-face examinations when you are on call.
22 Q. Do you believe that you should have

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23 proceeded differently or done more before making
24 your recommendation with respect to Calvin Hunt on
25 that day?
00053:01 A. No. My decision was appropriate for what
02 was going on. He was a danger to self, danger to
03 others. That's the criteria for admission. I
04 wanted him admitted. All this other information
05 would have been just supportive evidence that he
06 needed to be admitted.
07 Q. You concluded that Calvin Hunt needed to
08 be admitted because you were concerned that he might
09 actually hurt himself or others, correct?
10 A. He was saying that, yes.
11 Q. Let me ask you this: Does the fact that
12 someone has prior training as a United States Marine
13 concerning when that person has thoughts of harming
14 others?
15 A. He has skills to take care of it, yes.
16 Q. Because Dr. Jansen testified that enlisted
17 men in the United States Marine Corps are trained
18 killing machines. Do you agree with Dr. Jansen?
19 A. They are trained. I would hope they are
20 not killing machines.
21 Q. He stated they were trained to kill. Do
22 you agree with that?
23 A. They are trained to use weaponry to defend
24 this country, yes.
25 Q. So it is concerning when a Marine, someone
00054:01 who has lethal training, has thoughts of harming
02 others, correct?
03 A. If he is having thoughts of harming
04 himself -- it doesn't matter if he is a Marine or if
05 he stands five foot or whatever. If he is a danger
06 to self and a danger to others, he has met the
07 criteria for admission to the hospital.

17. PAGE 54:15 TO 55:07 (RUNNING 00:00:46.130)

15 Q. Were you aware that Calvin Hunt's medical
16 records indicated major depression as an active
17 problem?
18 A. No.
19 Q. When someone has thoughts of harming
20 others, what's the significance of the fact that
21 they have a history of major depression?
22 A. The problem here is that you are confusing
23 admission to the hospital with medical history. You
24 can have a psychiatric history, you can be actively
25 hallucinating.
00055:01 You cannot be admitted to the hospital for
02 being depressed or hallucinating, delusional or any
03 of those things. That is not criteria for admission
04 to a hospital.
05 The criteria for admission to a hospital
06 is very clear: Danger to self, danger to others and
07 gravely disabled, any of those criteria.

18. PAGE 55:08 TO 55:12 (RUNNING 00:00:17.216)

08 Q. I understand, ma'am. I am trying to ask
09 you as a medical doctor, what significance those
10 prior problems indicated in medical records have on
11 the fact of someone who does present a danger to
12 others. Does that not go into the equation?

19. PAGE 55:14 TO 55:15 (RUNNING 00:00:03.220)

14 A. Not at the time you are making that

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15 decision, no.

20. PAGE 56:24 TO 58:17 (RUNNING 00:01:39.910)

24 Q. Were you aware that Calvin 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 Calvin 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, Calvin Hunt should have
07 been admitted?
08 A. At that point, the recommendation was to
09 admit.
10 Q. At that point, Calvin 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 Calvin 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 Calvin 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.

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00062:01 Q. Were you aware that Calvin 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 Calvin 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

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07 Calvin 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. Calvin 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 Calvin 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 Calvin 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 Calvin 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,

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21 homicidal, if he can designate which person he might
22 want to hurt, if he is having delusions,
23 hallucinations, if he is paranoid. They ask the
24 basic mental status kind of questions.
25 Q. If the patient, or if he brings someone
00095:01 with him, has his medical records with him, should
02 the psych tech look at those records in order to get
03 as good a history of that patient as they should to
04 be getting and doing their evaluation?
05 A. Once he's done an initial eval if he feels
06 that he needs more clarification, which clearly he
07 didn't need at that point, he can go ahead and look
08 at the records, but it was very clear that this man
09 had met criteria for admission and that is when he
10 comes up and presents it to me.
11 Q. Mr. Manning came to your office, correct?
12 A. Yes.
13 Q. If you would, tell us everything you
14 remember about the conversation between you and Mr.
15 Manning.
16 A. He just presented the patient, information
17 about the patient. I said he meets criteria for
18 admission, and we'll admit him to the hospital and
19 to go ahead and get that process underway.

35. PAGE 139:18 TO 140:04 (RUNNING 00:00:42.570)

18 Q. So if you testified earlier today in this
19 deposition that you would not have allowed a person
20 like Mr. Hunt who had suicidal ideations and
21 threatening to harm other people to leave the
22 hospital, that would be incorrect?
23 A. As I testified earlier today, I would not
24 allow them to leave my office on their own. My
25 office currently is not in a hospital.
00140:01 At Beaufort, I would have escorted him
02 down from my office on the fourth floor to the
03 emergency room on the first floor because that was
04 the standard protocol in Beaufort.

36. PAGE 140:05 TO 140:18 (RUNNING 00:00:32.880)

05 Q. What would you have done to make sure that
06 he did not leave the hospital when you escorted him
07 down to the ER?
08 A. I would have turned him over to the care
09 of the ER and gone ahead and recommended that he be
10 transported and called for a tech.
11 Q. You would have also informed them that you
12 would not want, for example, Mr. Hunt to leave the
13 hospital, correct?
14 A. Yes.
15 Q. You would have had to have told that to
16 the doctor in the ER because he wouldn't have done
17 any evaluation, correct?
18 A. That's correct.

37. PAGE 157:03 TO 157:14 (RUNNING 00:00:49.270)

03 Q. So if Dr. Jansen had informed you that he
04 was angry in the ER, would that have made a
05 difference on any of your recommendations to Dr.
06 Jansen?
07 A. He did not inform me that he was angry in
08 the ER. He did not inform me --
09 Q. If he had informed you or Psych Tech
10 Manning had informed you that he was angry in the
11 ER, would that in any way have added to your

Miller Trial

12 recommendations?
13 A. If he was not acting up, he can be angry
14 all he wants. We have lots of angry patients.

38. PAGE 157:24 TO 158:12 (RUNNING 00:01:02.190)

24 Q. If you had had the knowledge that he was
25 psychotic or delusional on top of the fact that he
00158:01 was angry, and on top of the fact that you were
02 giving a recommendation of admitting or
03 involuntarily admitting, would you have given
04 additional recommendations to the fact that, not to
05 let him leave the hospital?
06 A. Patients are able to sit there and remain
07 there voluntarily until they do something. And
08 that's the status quo. They will stay there and
09 wait until they are going to go to the hospital.
10 Some patients can explode and act up and
11 some will not. If they explode and act up, then you
12 have to do something to restrain them.

39. PAGE 201:24 TO 202:06 (RUNNING 00:00:31.950)

24 Q. If Manning had been concerned for his own
25 safety when he was interviewing Mr. Hunt in the ER,
00202:01 what options were available to him in terms of
02 action that he could have taken at that time with
03 respect to Mr. Hunt?
04 A. He could have called another tech down to
05 sit with him or he could have called hospital
06 security to come in and watch him.

40. PAGE 211:02 TO 211:04 (RUNNING 00:00:08.840)

02 Q. In this case, on February 24, 2012, did
03 the staff in the ER manage Calvin Hunt safely on
04 that day?

41. PAGE 211:06 TO 211:12 (RUNNING 00:00:14.460)

06 A. Looking in retrospect?
07 BY MR. SWETT:
08 Q. Sure.
09 A. Clearly, since he eloped, no.
10 Q. Should Calvin Hunt have been allowed to
11 leave the facility that day prior to being admitted
12 at Beaufort Memorial?

42. PAGE 211:14 TO 211:15 (RUNNING 00:00:02.714)

14 A. No, he shouldn't have been allowed to
15 leave.

TOTAL: 1 CLIP FROM 1 DEPOSITION (RUNNING 00:44:00.778)

Page 2	Page 4
1 THE SOUTH CAROLINA) 2 DIVISION OF VETERANS) 3 AFFAIRS,) 4) 5 Defendants.) 6) 7) 8) 9) 10) 11) 12) 13) 14) 15) 16) 17) 18) 19) 20) 21) 22) 23) 24) 25) 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. <u> </u> = Defendants ? designated <u> </u> = Plaintiff ? designated <u> </u> Manning " " <u> </u> both Δ & Π designated	1 APPEARANCES (Cont'd): 2 For The Estate of Justin Miller (a separate action): 3 (Via Telephone) 4 5 W. CHRISTOPHER SWETT, ESQ. 6 Motley Rice, LLC 7 28 Bridgeside Boulevard 8 Mt. Pleasant, SC 29464 9 (843) 216-9149 10 cswett@motleyrice.com 11 For Calvin Hunt (a separate action): (Via Telephone) 12 CORY H. FLEMING, ESQ. 13 Moss, Kuhn & Fleming 14 1501 North Street 15 Beaufort, SC 29902 16 (843) 524-3374 17 cory@mossandkuhn.com 18 19 For First Acceptance Insurance Co. (a separate action): 20 (Via Telephone) 21 WESLEY SAWYER, ESQ. 22 Murphy & Grantland, P.A. 23 Post Office Box 6648 24 Columbia, SC 29260 25 (803) 782-4100 wsawyer@murphygrantland.com REPORTED BY: Laura Savo, CSR No. 347 State of Hawaii -o-o-
Page 3	Page 5
1 APPEARANCES: 2 For Plaintiffs: (Via Telephone) 3 J. PAUL DETRICK, ESQ. 4 Peters, Murdaugh, Parker, Eltzroth & Detrick 5 101 Mulberry Street East 6 Post Office Box 457 7 Hampton, SC 29924 8 (803) 943-2111 9 pdetricksmped.com 10 For Defendant Case Pro, Incorporated: (Via Telephone) 11 DOUGLAS W. MACKELCAN, ESQ. 12 Carlock, Copeland & Stair, LLP 13 40 Calhoun Street, Suite 400 14 Charleston, SC 29401 15 (843) 266-8228 16 dmackelcan@carlockcopeland.com 17 For Defendant United States Naval Hospital and The 18 United States of America: 19 LEE E. BERLINSKY, ESQ. 20 U.S. Attorney's Office 21 151 Meeting Street, Suite 200 22 Charleston, SC 29401-2238 23 (843) 727-4381 24 For Defendant South Carolina Division of Veterans 25 Affairs: (Via Telephone) MICHAEL D. FREEMAN, ESQ. Griffith, Sadler & Sharp, PA 600 Monson Street Beaufort, SC 29902 (843) 521-4242 mfreeman@griffithsadlerssharp.com For Jonas Armstrong (a separate action): (Via Telephone) PAUL H. INFINGER, ESQ. Law Office of Paul H. Infinger, LLC 1105 Bay Street Beaufort, SC 29901 (843) 521-5015 paulinfinger@hargray.com	1 INDEX 2 EXAMINATION: PAGE 3 By Mr. Detrick 6, 103 4 By Mr. Infinger 67, 152 5 By Mr. Swett 91 6 By Mr. Mackelcan 130 7 By Mr. Berlinsky 145 8 9 EXHIBITS FOR IDENTIFICATION: 10 Exhibit 1 6 11 (18-page emergency room record for 12 Calvin Hunt) 13 Exhibit 2 103 14 (1-page typewritten statement of 15 Arthur Manning) 16 17 18 19 20 21 22 23 24 25 EXHIBIT Count 10 10-14-15

= Plaintiff

= Defendants

Page 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

BEAUFORT DIVISION

Manning

" " both A & N designated

CHRISTOPHER D. MILLER,) Civil Action No. 9:13-3395-DCN

Plaintiff,)

v.)

) DEPOSITION OF ARTHUR MANNING

CASE PRO, INCORPORATED;) TAKEN ON: MAY 22, 2014
THE UNITED STATES NAVAL)
HOSPITAL; THE UNITED)
STATES OF AMERICA; AND)
THE SOUTH CAROLINA)
DIVISION OF VETERANS)
AFFAIRS,)

Defendants.)

LATTANNISHA ROBERTS,) Civil Action No. 9:13-3394-DCN

Plaintiff,)

v.)

CASE PRO, INCORPORATED;)
THE UNITED STATES NAVAL)
HOSPITAL; THE UNITED)
STATES OF AMERICA; AND)
THE SOUTH CAROLINA)
DIVISION OF VETERANS)
AFFAIRS,)

Defendants.)

KELLI R. FRANKLIN,) Civil Action No. 9:14-cv-00289-
DCN

Plaintiff,)

v.)

CASE PRO, INCORPORATED;)
THE UNITED STATES NAVAL)
HOSPITAL; THE UNITED)

Page 6

1 (Pursuant to Rule 14 of the Rules Governing Court
2 Reporting in Hawaii, the reporter's disclosure was made
3 and is attached hereto.)
4 (Exhibit 1 is marked for identification.)
5 ARTHUR MANNING,
6 having been called as a witness and being first duly
7 sworn to tell the truth, the whole truth and nothing but
8 the truth, was examined and testified as follows:
9 EXAMINATION
10 BY MR. DETRICK:
11 Q Mr. Manning, this is Paul Detrick. Would
12 you please give us your full name, please, sir. "
13 A Arthur Gerard Manning.
14 Q And, Mr. Manning, according to the rules of
15 our depositions, if you don't understand my question or
16 the other attorneys who are asking questions after me,
17 you should direct to them and tell them you don't
18 understand the question, and they'll rephrase the
19 question or I'll rephrase the question. Is that okay?
20 A Okay.
21 Q And since the deposition has started, you're
22 not allowed to communicate either verbally or with hand
23 motions or anything with the lawyer for the United
24 States. Is that fair?
25 A Yes.

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1 Q Okay. Could you tell us --
2 "You're in the military; is that correct?"
3 A Yes.
4 Q And what is your present rank?"
5 A E-5.
6 Q What does that mean to someone who doesn't
7 know anything about the military, thank God?
8 A Shoot. I guess I don't understand that
9 question. E-5 is like -- that's the E-1 through E-9.
10 I'm enlisted, I'm on the enlisted side. When you first
11 initially enlist, you usually start at E-1. So I've
12 made it to E-5, and highest rank would be an E-9. Does
13 that make sense, I guess?
14 Q I guess so. Where are you presently "
15 stationed?
16 A 3rd Marine Regiment with 3rd Marine
17 Division.
18 Q Where at?"
19 A In Kaneohe Bay, Hawaii.
20 Q Is that where we're taking this deposition
21 today?
22 A Yes.
23 Q We were given, it says, HM-3 before for
24 Arthur Manning. Can you explain what HM-3 means?
25 A Yes. That's -- HM is the rate that I am in

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1 the Navy, which is a hospital corpsman. And the HM-3 is
2 just an E-4, but I'm E-5 now. So it's HM-2.
3 Q When you were -- where were you stationed
4 prior to being in Hawaii?
5 A I was in Parris Island, South Carolina.
6 Q Did you have duties at the Beaufort Naval
7 Hospital?
8 A Yes.
9 Q What were those duties?
10 A I mean, we were a detachment of the naval
11 hospital.
12 Q How long were you detached there?
13 A Four years.
14 Q Okay. And that would be during the period
15 of February 24, 2012; correct?
16 A Yes.
17 Q Did you have any particular duties in the
18 hospital?
19 A Just with -- I work in psychiatry. So the
20 only duty I had with the hospital was being the
21 psychiatric technician on duty.
22 Q Psychiatric technician on duty? Is that
23 what you said?
24 A Yes.
25 Q Now tell me about what is a psychiatric "

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1 technician."
2 A We basically -- we work with -- within a
3 psychiatric unit. So where I was at Parris Island, we
4 were the mental health unit. It's an outpatient clinic.
5 When patients come in, we would do the initial intakes.
6 We would do evaluations on patients, and then we would
7 staff the doctor with the information that we get,
8 whether it's the demographics, the current issues going
9 on with the patient, and our opinion of what's going on.
10 Then the doctor would go on to do their evaluation for
11 diagnosis and treatment, and then if -- when the
12 treatment was made, we would also carry out whatever
13 treatment plan that the provider has laid down for the
14 patient.
15 Q Okay. What kind of training did you have to "
16 have in order to be a psychiatry technician?"
17 A Just a -- first we go to A school, which is
18 where you get your basic -- your hospital corpsman rate.
19 After you get your hospital corpsman rate, you would go
20 to C school, which C school stands for career school,
21 and that's where we would get training for to become a
22 psychiatric technician, and it's like directed towards
23 psychiatry/psychology.
24 Q Now at the Beaufort Hospital, who would you "
25 work with? Who were your supervisors?

1 A Who were my supervisors?

2 Q Yes, sir. At Beaufort Naval Hospital during
3 this period of time we're referring to.

4 A I don't understand that question because, I
5 mean, like the naval hospital was over us, but I was --
6 my supervisors would have been at Parris Island. So
7 like, I mean, the director -- the director of mental
8 health was Dr. Cowan, but, I mean, he was just our
9 director. So he was just who we fell under at the naval
10 hospital administratively. So that's why I don't
11 understand.

12 Q Who would be your direct boss, in other
13 words?

14 A Okay. The psychologist that was the
15 department head --

16 Well, do you want just for the time period
17 in February?

18 Q Yes, sir. That's fine. Unless I say,
19 otherwise in the questions, the time period is February
20 12th or 2012, 24th, 2012.

21 A Okay. It was a Lieutenant Rose, but I think
22 her name is like Lieutenant Hiers now.

23 Q R-o-s-s?

24 A No. Rose, R-o-s-e.

25 Q R-o-s-e?

1 A Right. And I think she's gotten married.
2 So I think she's Lieutenant Hiers, H-i-e-r-s, now or
3 Rose-Hiers. I'm not sure.

4 Q How do you spell that again, please?

5 A H-i-e-r-s.

6 Q Oh, Hiers. What was her capacity?

7 A She was the department head and she was a
8 clinical psychologist.

9 Q She was at the Beaufort Naval Hospital?

10 A No. She was in Parris Island.

11 Q How about whenever -- now, tell me like in a
12 regular day, would you report to the Beaufort Naval
13 Hospital every day or how did that work?

14 A No. I was only at Parris Island, and if
15 need be, if the naval hospital needed help, they would
16 call us, but we did not report to the naval hospital at
17 all.

18 Q So on a regular basis, you all would not
19 report to Beaufort Naval Hospital?

20 A No.

21 Q How is it that you happened to be, if you
22 were, at the Beaufort Naval Hospital on February 24,
23 2012?

24 A I was the psychiatric technician on duty.
25 So on the day that that -- well, the day of the event, I

1 was called into the naval hospital.

2 Q Who would have called you?

3 A The ER.

4 Q Okay. The ER meaning who?

5 A Who is the ER?

6 Q Who from ER called you and said to report?

7 A I'm not sure. It would just be a nurse at
8 the front desk. It was a pager duty. So they would
9 page the pager, and then we just call the ER. So it's
10 not a specific name we will call for.

11 Q That nurse who would do the pager duty?

12 would that be an employee of Case-Pro?

13 A I'm not sure. I don't know.

14 Q Okay. All right. How often would you be
15 paged to be a psychiatry technician at Beaufort Naval
16 Hospital?

17 A How often?

18 Q Yes. I'm trying to get an idea how often
19 you were there.

20 A It just depends -- I mean, you can't guess
21 what's going to happen in psychiatry. So, you know,
22 whenever there was a patient, whether it was alleged
23 psychosis or suicidal ideations, anything like that,
24 they would call us in, and this is for the naval
25 hospital, Parris Island, wherever it was.

1 Q On February 24, 2012, were you there all
2 day, or did they page you because of a situation with
3 Mr. Hunt?

4 A I was paged then. I was at Parris Island
5 when they paged.

6 Q I gotcha. Do you remember who paged you?

7 A No. I don't know who would have paged me.

8 Like I said, the number comes through for the ER number
9 and I called it.

10 Q Okay. And it's not very -- it doesn't take
11 you very long then to get to the naval hospital from
12 where you're at at Parris Island?

13 A Not long.

14 Q About how long?

15 A Shoot, I mean, it could have been -- I'm not
16 exactly sure how long it took, but, I mean, it's like a
17 15-minute drive to get from Parris Island to the naval
18 hospital if, you know, all goes well.

19 Q Okay. Is there -- in situations such as

20 Mr. Hunt, would they just page you to come to the naval
21 hospital, or would they page a psychiatrist or other
22 personnel?

23 A It would just be -- it's not a specific
24 person they would page. They would just page -- they
25 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 right. 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

1 with. <Page 18>	Page 20
2 Q All right. I do some writing. So that 3 takes me a little bit of time here. 4 Okay. Now, so that we can both be talking 5 the same and I'll know somewhat about what went on, have 6 you had a chance to review what has been marked Exhibit 7 No. 1 before the deposition? 8 A Yes. 9 Q Okay. If you don't mind, if you would take 10 that and let's go through it just a little bit. 11 Hopefully, you can read some of the writing I couldn't 12 read. 13 A Okay. 14 Q If you got it in front of you -- 15 MR. INFINGER: Paul, what page number are 16 you on? 17 MR. DETRICK: I'm not on any yet. 18 THE REPORTER: Who is speaking, please? 19 MR. DETRICK: That was Paul Infinger. I'm 20 Paul Detrick. 21 Q (By Mr. Detrick) Let's go to -- it would 22 be -- I think I can read everything up until No. 01549. 23 Mr. Manning, could you turn to that page, please? 24 MR. BERLINSKY: There's a little number on 25 the bottom corner.	1 A "Report from Veteran Affairs with patient." 2 I don't know what that next word is to the "ER." I 3 don't know what the rest of that is. 4 Q Okay. And the next would be 1510, it looks 5 like to me, is that correct, next entry? 6 A Yes. 7 Q What does that say? 8 A They -- he -- he contacted or I don't know 9 what the first -- that first thing is, but it says, 10 "Beaufort Memorial." I guess they called Beaufort 11 Memorial to inquire bed availability. 12 Q Do you have any remembrance of why at 1510, 13 they would be calling Beaufort Memorial to determine 14 whether a bed was available? 15 A Say that again. 16 Q Do you know or do you remember, since you 17 were there some of this, why at time 1510, they were 18 calling Beaufort Memorial to determine if there was bed 19 availability? 20 MR. BERLINSKY: I'm going to object to the 21 form of the question. 22 MR. DETRICK: That's okay. 23 MR. BERLINSKY: But you can still answer the 24 question, Mr. Manning, if you know it. 25 Q (By Mr. Detrick) You can still answer if you
Page 19	Page 21
1 THE WITNESS: Okay. 2 Q (By Mr. Detrick) Do you know whose writing 3 this is? My guess is it would be Nurse -- a male -- 4 McDonald, Joe McDonald, I guess his name is? 5 A I'm not sure whose writing this is. 6 Q You don't know whose writing that is? 7 A No. 8 Q Are you able to read the writing on the 9 right-hand corner, right-hand side of the page for me, 10 or you're no better than me? 11 A Yeah, for the most part, I can see some of 12 it. 13 Q I just thought you might be more familiar 14 with it in your practice. 15 A Okay. 16 Q I assume on the right-hand side there would 17 be the time 1430. Is that up at the top looks like? 18 A Yes. 19 Q And that looks like a trial was done at that 20 time, an evaluation pending? 21 A A triage. 22 Q Triage. I'm sorry. Correct? 23 A Yes. 24 Q And at 1500, it looks like -- can you read 25 that for me?	1 know. 2 A I can only assume that they're calling -- 3 they're calling Beaufort Memorial for bed availability 4 because they're looking to do inpatient -- to have them 5 admitted to inpatient. 6 Q Okay. Do you know whether this already 7 would be the psychiatric ward at Beaufort Memorial at 8 Maryland? 9 A Yeah. That's the only place you would 10 inquire about a bed availability. 11 Q Okay. So at 1510, they already have 12 somebody -- Nurse McDonald or someone is inquiring 13 whether there's a bed availability for Mr. Hunt in the 14 psychiatric ward; is that correct? 15 MR. MACKELCAN: Objection. This is Doug 16 Mackelcan. 17 Q (By Mr. Detrick) That's okay. Go ahead, 18 Mr. Manning. 19 A What's the question? 20 Q Well, let me ask you this. Do you remember 21 that time that's set forth in this exhibit, 1510, 22 whether at that time there was -- someone was already 23 checking to see if there was bed availability in the 24 psychiatric ward for Mr. Hunt? 25 A I'm not sure. I just see that in the note

Page 22	Page 24
1 that it says that. 2 Q Okay. And I see the next entry is 1525. 3 Could you read that for me? 4 A Yes. "Psych Tech Manning, eval in 5 progress." 6 Q And from your memory, is that the 7 approximate time you would have been doing an evaluation 8 for Mr. Hunt? 9 A I only know that because it says it there. 10 I don't remember what time it was. 11 Q All right. And just so -- if you would just 12 to get your help on reading this, would you please go 13 and read the remaining entries for me on 01549? 14 A So at 1612? 15 Q Yes. 16 A It says, "Patient --" 17 I don't know what the next word is. 18 "-- to bathroom returned. Veteran Affairs 19 rep," something, "Ray states, 'We're getting some air.'" 20 And then at 1625, "Mr. Ray returns to ER 21 stating, 'He took off through the gate.' Psych tech 22 returned 10 ago." I don't know. "Has been looking for 23 patient and Mr. Ray." 24 I don't know what that Q -- it's a Q. I 25 don't know what it says after that. "Security gate." I	1 Q You hadn't seen this similar record before? 2 A No, I wouldn't do this. So this isn't 3 something I would fill out. 4 Q Okay. I assumed not, but a chance to clear 5 this out. 6 Have you read Mr. Jansen's writing before? 7 A No. 8 Q You're not much help. 9 A No, not at all. 10 Q Reading most of it, it says, "suicidal 11 thoughts." You see that circled? 12 A Yes. 13 Q Can you read what that says? 14 A It just says, "medication refill." 15 Q No. I'm talking about -- I don't see where 16 you're at. 17 A Under where you said it's circled "suicidal 18 thoughts," it says, "medication refill." 19 Q Some writing there, it says, "and thoughts," 20 it looks like to me. 21 A Huh? "And thoughts"? Oh, okay, I see. 22 "And thoughts of hurting --" 23 Shoot. I don't know. 24 "-- bad disrespect." I'm not sure what that 25 says.
Page 23	Page 25
1 don't know what the rest of this says. 2 And then 1635, "OOD, PMO, ER medical 3 doctor," or "ER MD," something, "director," and I don't 4 know what the rest of it says. 5 Q All right. Do you know what OOD stands for? 6 A Officer of the day. 7 Q And PMD? 8 A PMO is -- 9 Q Oh, PMO. I'm sorry. 10 A Yeah. It's military police. I don't 11 remember what PMO exactly stands for, but it's military 12 police. 13 Q Looks like to me it says, "Notified of AMA." 14 Do you know what AMA stands for? 15 A No. AMA? 16 Q If you would, could you next go to 01551, 17 please? 18 A Okay. 19 Q This looks like an Emergency Physician 20 Record; correct? 21 A Correct. 22 Q And it says, "Psych Disorder, Suicide 23 Attempt, Overdose." Is that a record that's filled out 24 by the doctor with those conditions of the patient? 25 A I'm guessing so.	1 Q Looks like, "others, but no specific plans"? 2 A Oh, Okay. Yeah, okay. "Thoughts of hurting 3 others with no specific plans." 4 Q -- Was those "thoughts of hurting others, but 5 no specific plans" ever communicated to you by Mr. Hunt? 6 A I don't remember the specifics of what we 7 talked about. 8 Q We'll go into that. If you would just go to 9 the next page, 01552. 10 A Okay. 11 Q And over here on the times on "Progress" -- 12 A Uh-huh. 13 Q -- can you help me with some of the writing 14 there of 1510, 1520, 1440 and 1510? 15 A All right. 1510, "Called mental health. 16 Asked for psych tech." 17 1520, I don't know. Looks like -- 18 Q "Called mental health again," maybe? 19 A Yeah. And then it says, "tech coming." The 20 last two words are "tech coming." 21 And then 1540, "Mr. Manning present." I 22 don't know the next word. 23 And then 1610, "Call," something. Looks 24 like the last word is my name. I think the last word is 25 "Manning" or I don't know.

1 Q And then something about, "Discussed with
2 Dr. Hendelman at 1605"?
3 MR. BERLINSKY: Mr. Detrick, can you speak a
4 little bit louder for us, Paul?
5 MR. DETRICK: Yeah, I sure will. I'm sorry.
6 Q (By Mr. Detrick) It says, "Discussed with
7 Dr. Hendelman, 1605"?
8 A Oh, yes, yes.
9 Q All right. Well, I thought you could do
10 better than that. You're not much better than me, but
11 we'll get Dr. Jansen and the other nurses to help us.
12 Okay?
13 A All right.
14 Q Now, as far as you're concerned,
15 Mr. Manning, it's my understanding that there's nothing
16 in writing of anything you did or your opinions,
17 et cetera, on February 24th, 2012, regarding Mr. Hunt,
18 is that correct?
19 A Right.
20 Q You never made any notes, any memos, no
21 reports?
22 A No.
23 Q Do you know of any such that Dr. Hendelman
24 may have completed?
25 A She never got a chance to see the patient.

1 Q She never got a chance. Okay. Well, we'll
2 go into that.
3 All right. If you would, why don't we go
4 kind of from the beginning, Mr. Manning. You were paged
5 to come to the Beaufort Hospital regarding Mr. Hunt;
6 correct?
7 A Yes.
8 Q And you don't remember who, but it would
9 have been a nurse in the ER; is that correct?
10 A Yes.
11 Q What specifically do you remember was told
12 to you by the nurse as the reason you needed to come to
13 the naval hospital regarding Mr. Hunt?
14 A You mean on the initial contact when they
15 first called or paged?
16 Q They just page you and you go, correct, and
17 then you don't know what your purpose is?
18 A Right.
19 Q Okay. All right. And then you got there,
20 and I think the first thing you said is you would report
21 to the nurse?
22 A Right. To the nurses' station.
23 Q All right. And what do you remember, if you
24 would tell us about when you reported to the nurses'
25 station, who you talked to and what they may have told

1 you?
2 A I remember -- I remember I got there. I
3 talked to the nurses' station. There was the doctor --
4 Dr. Jansen. Dr. Jansen was there, and he told me that
5 he had tried to talk to the patient, but he wasn't -- he
6 didn't open up very much to him, and that's all I
7 remember. And then I went in and started talking to
8 him.
9 Q What was Dr. Jansen talking to him about
10 that would require you to come to the naval hospital?
11 A Well, it would be suicidal thoughts and
12 depression. I mean, that's what the note says anyway.
13 Q That's what what note says?
14 A The note where he circled "suicidal
15 thoughts" and "depression."
16 Q Didn't it also say that he had thoughts of
17 hurting others and himself?
18 A Right. Yeah, that page.
19 Q So that was -- did you discuss that part
20 with Dr. Jansen if he was present when you got there?
21 A It would have been a part of the
22 conversation, but I don't remember specific like him --
23 the specifics of the conversation. I just remember --
24 the one thing I remember, Dr. Jansen saying was the guy
25 wasn't -- he wasn't opening up to him. So he wouldn't

1 talk to him much.
2 Q But there was a mention by Dr. Jansen that
3 Mr. Hunt had thoughts at least of hurting himself and
4 others?
5 A Like I said, I don't remember specifics --
6 MR. MACKELCAN: Objection.
7 THE WITNESS: -- of the conversation.
8 Q (By Mr. Detrick) I'm sorry. He was
9 objecting. I didn't hear your answer.
10 MR. MACKELCAN: I tried it about two
11 questions prior as well.
12 THE REPORTER: Who is objecting?
13 MR. MACKELCAN: Doug.
14 MR. DETRICK: Okay. Doug. Doug was
15 objecting. This is Paul Detrick again.
16 MR. BERLINSKY: Paul, hold on for a minute.
17 MR. DETRICK: Yeah.
18 MR. BERLINSKY: Let's try to help the court
19 reporter by remembering to identify who you are before
20 you speak unless it's an objection, and then state who
21 it is that's objecting, and also let's try to make sure
22 that we don't cross-communicate so that she can make an
23 accurate record.
24 MR. DETRICK: We'll do the best we can,
25 Madam Court Reporter. We apologize when we make your

1 job difficult.

2 Q (By Mr. Detrick) Mr. Manning, what do you
3 remember regarding the conversations with Mr. -- I mean,
4 with Dr. Jansen involving any suicidal inclinations or
5 thoughts of hurting others, if anything?

6 A I don't remember anything. Like I said, the
7 only specific thing I remember is he said the guy
8 wouldn't talk to him.

9 Q Well, what was the purpose -- did Dr. Jansen
10 tell you what the purpose was that he called you, a
11 psychiatry tech, to come to the naval hospital for
12 Mr. Hunt?

13 A Did he tell me in our conversation? Is that
14 what you're asking?

15 Q In some way or another, how did you find out
16 why you went there?

17 A When I like got there, that's when they told
18 me.

19 Q Well, what did they tell you?

20 A I don't remember any specifics of that
21 conversation.

22 Q What were the generalities for the purpose
23 for you to be there as a psychiatry technician?

24 A I mean, if I'm getting a page on the pager,
25 I can only assume it's either a psychosis, somebody

1 wants to kill themselves or hurt themselves, and that
2 I'm going to be doing like a transport possibly.

3 Q All right. Have you told us -- I understand
4 you didn't make any notes. You didn't make any reports.

5 A No.

6 Q We don't have any idea what exactly happened --
7 as a result of that, but can you please tell us what you
8 remember specifically that anyone told you, nurses or
9 doctors, when you arrived at the Beaufort Memorial
10 Beaufort Naval Hospital regarding Mr. Hunt?

11 A I don't remember any specifics. I mean, I
12 can -- I remember them telling me where he was. That's
13 about it.

14 Q Where was he?

15 A In the third bed of ER.

16 Q And that's all you remember?

17 A Yes.

18 Q Okay. All right. Well, then what did you
19 do, Mr. Manning?

20 A After they told me where he was, I went into
21 the little section that he was in and I started talking
22 to him.

23 Q Can you tell us what you talked about, what
24 questions and what his responses were?

25 A I don't remember like details of the

1 conversation, but I know that I went through my
2 normal -- the standard mental status exam and the --

3 I don't remember any specific answers he
4 gave me. I remember his body language. Like I can see
5 him sitting in front of me right now, but I don't
6 remember any like detailed conversation we had.

7 Q Would you have been doing what I've seen in
8 the records would be an emergency mental health
9 evaluation?

10 A Would I be doing --

11 Q Is that what you would have been doing?

12 Your questions and answers would have been an emergency
13 mental health evaluation?

14 A Is that like a paper you're looking at?

15 Q Yes.

16 A No, I don't know what you're talking about.

17 Q You don't call it that?

18 A No.

19 Q You call it a standard mental status exam?

20 A Right. It would be a mental status exam.

21 Q What's the purpose of that mental status
22 exam as far as Mr. Hunt's concerned? Why are you doing
23 it?

24 A It's basically like a safety evaluation.

25 I'm looking for -- I'm looking for any kind of altered

1 thought process, any thoughts of like a right here,
2 right now, are they oriented to where they are, who he
3 is, a time frame; is he thinking about killing himself
4 or is he thinking about killing himself right now, those
5 kinds of things. That will be a part of the mental
6 status exam.

7 Q Would a part of the mental status exam be
8 whether he had thoughts of injuring other persons?

9 A Yes.

10 Q Did you ask Mr. Hunt that?

11 A I can only assume that I did.

12 Q And what was his response?

13 A I don't remember.

14 Q Would it have been that he did, or you
15 wouldn't have done the recommendations you made later?

16 A Ask that question again.

17 Q I know you didn't do any notes. Okay?

18 That's giving us a problem, but we'll deal with it.

19 A Right.

20 Q But you said you would have assumed you
21 asked him that?

22 A Right.

23 Q Well, can you give me -- based on what your
24 actions were after that, can you give me what you assume
25 his answer was?

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1 A No, I couldn't, actually. But the only
2 thing that I could say is that according to my actions,
3 there -- there was not a concern of him like hurting
4 someone right then and right there. Like there was
5 no -- because if there was some kind of specifics to him
6 hurting someone, then it would have been a different
7 situation.

8 Q What you were doing was a safety evaluation;
9 correct?

10 A Yes.

11 Q What does that mean?

12 A It's a safety -- like I'm evaluating for
13 safety.

14 Q Safety of him and others; correct?

15 A Right.

16 Q Now, the purpose of the safety evaluation
17 would be to determine what kind of recommended treatment
18 you would have for Mr. Manning -- I mean, Mr. Hunt?

19 A That and, you know, what needs to be done as
20 far as like making sure the patient is safe and those
21 around are safe.

22 Q If you were concerned about his safety or
23 those around him, what would have been your
24 recommendation?

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25 A Basically, the same thing. I'd have let the
1 doctor know my concerns and gotten a treatment plan from
2 the doctor. I'm a technician. I can't -- I can't like
3 make --

4 The only thing I can do is if the patient
5 was an immediate threat to himself or someone else while
6 I was there, then I can make an on-spot decision, but if
7 there's nothing, then it is my job to let the doctor
8 make that decision of what's going to happen next.

9 Q Okay. So your -- well, what were your
10 concerns as you told the doctor?

11 A My concerns, I do remember that he -- he was
12 not -- it did not seem that he was oriented to like what
13 was going on right then and there. I remember that
14 his -- the way he was talking to me, it was very
15 disorganized. It didn't seem like he had a grasp of
16 like time right then and there, and I also felt that the
17 way that he was talking and his -- the demeanor and body
18 language was -- it was very aggressive.

19 Q What do you mean by his demeanor and body
20 language was very aggressive?

21 A The way he was talking. The way he was
22 sitting. I mean, it's like little things that we're
23 taught to look for. It's kind of like -- it's called
24 psychomotor agitation. Just the same way you would read
25 a person that you're talking to, you know, body language

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1 tells a lot about a person regardless of what their
2 words are. So like little simple things, you know,
3 common communication, I guess you could say.

4 Q Very aggressive; meaning he was very angry?

5 A Yes. He was very agitated. I wouldn't say
6 angry. I would say agitated.

7 Q And being agitated, did he indicate during
8 your conversation that he had any thoughts of suicide?

9 A I don't remember any like details of our
10 conversation.

11 Q And you don't remember whether he expressed
12 those thoughts to any of the other staff, doctors and
13 nurses?

14 A No, not other than what's in the notes. No,
15 I don't remember.

16 Q But you do remember what was in the notes?

17 A What's that?

18 Q You do remember those in the notes?

19 A I mean, I see what's in the notes because
20 it's in front of me.

21 Q Right. I'm talking about the time of
22 February 24, 2012. You knew those were in the notes
23 that they had been communicated to --

24 A No. I have nothing to do with what the ER
25 notes are. I don't -- I don't do anything with them.

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1 Q Okay. You did your safety evaluation;
2 correct?

3 A Yes.

4 Q And you said you asked the standard mental
5 status examination questions?

6 A Right.

7 Q Is that something in writing or is that
8 something you just got memorized?

9 A Right. That's something I memorized.

10 Q What are those questions?

11 A First, I would ask about if they're having
12 thoughts of suicide. I would ask them about if they're
13 having any thoughts of hurting themselves. I would
14 ask -- if it's right here, right now, so like if I ask
15 about suicide, I would say, "Are you thinking about
16 suicide right here, right now? Do you want to kill
17 yourself right here and right now? Do you want to harm
18 yourself? Have you had these thoughts in the past?
19 Have you had them in the last week? Did you have them
20 yesterday? Did you have them this morning," that kind
21 of line of questions.

22 And then I would ask the same thing about
23 hurting themselves. I would ask the same thing about
24 killing someone. I would ask the same thing about
25 hurting someone. I would also ask, "Do you know where

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?

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.

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?

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 of --

A No. I called -- first I called her, and she said she was still upstairs. So I went upstairs to find

1 her

2 Q Okay. So you went upstairs to personally

3 talk with her?

4 A Yes.

5 Q All right. If you would, tell us what you

6 told Dr. Hendelman.

7 A Well, I relayed the message or I relayed
8 whatever the information was that I talked about with
9 the patient, and I do remember telling her like my
10 concerns that, you know, like I felt like he needed to
11 be admitted to an inpatient ward and that he was very
12 aggressive in how he was speaking, and I told her that
13 me and -- and I grabbed another psych tech who was still
14 at work and told him like, "Hey, we're going to go down
15 with her when she talks to him."

16 Q Why?

17 A Because I felt -- like I said, I felt he was
18 agitated and he was aggressive. So, you know, it was
19 just a concern that I had.

20 Q You were concerned for the safety of

21 Dr. Hendelman?

22 A And the patient.

23 Q Okay. All right. You recommended he be

24 admitted as an inpatient in the psychiatric ward,

25 correct?

1 A Yes.

2 Q And would this have been an involuntary
3 admission; in other words, you didn't go down and ask
4 him, "Mr. Hunt, you've got a choice"? It wasn't any
5 choice at all. He was being admitted, right?

6 A No. I didn't ask him if he wanted a choice.

7 Q He didn't have a choice, did he?

8 A He wouldn't have had a choice if the
9 doctor -- well, if it would have went through.

10 Q Okay. All right. Well, tell us -- now, you
11 told Dr. Hendelman that. You asked another psychiatry
12 technician for your safety and his safety. What else
13 happened with Dr. Hendelman --

14 A What else --

15 Q -- when you went to see her, if anything?

16 A What do you mean?

17 Q What did she say?

18 A She just agreed with what I was saying and
19 said that she would come down so we can start to get the
20 patient admitted.

21 Q Okay. Would you have told her about if

22 he -- you told me you don't remember, but if you did

23 would you have told her about any thoughts of suicide,

24 hurting himself, killing other people, hurting someone

25 else, hearing voices such as that? Would you have told

1 her those facts?

2 A Yes.

3 Q Okay. Now, you told me everything you
4 remember Dr. Hendelman would have said in response to
5 your facts and opinions and recommendations?

6 A Yes.

7 Q Tell me what happened after that.

8 A After that, we -- along with Clifton or this
9 other psych tech, I went downstairs.

10 Q What is the other psych tech's name? I'm
11 sorry.

12 A It was Clifton.

13 Q Clifton?

14 A Yes.

15 Q Clifton who?

16 A That's his last name. I don't know his
17 first name.

18 Q Oh, I'm sorry. Where is Clifton at now, do
19 you know?

20 A I have no clue.

21 Q Okay. All right. I'm sorry to interrupt
22 you. Go ahead.

23 A All right. We went back downstairs. When
24 we got to the ER, he -- Calvin Hunt was gone.

25 Q Let me ask you this. Was there any

1 communication -- there are some notes somewhere about
2 Dr. Hendelman speaking with Dr. Jansen. Was that done
3 in your presence or do you remember anything about that?

4 A No, I don't -- I don't remember anything
5 about that.

6 Q It may have been done after you left or you
7 just don't know?

8 A Yeah. I mean, I just don't remember.

9 Q Just what you know is --

10 One other thing. Did Dr. Hendelman go with
11 you and Mr. Clifton down to the ER? Did you all leave
12 her, or how did that work?

13 A From what I remember, she came downstairs.

14 Q She came with you?

15 A Yes.

16 Q In your presence, do you remember her

17 calling anybody or someone calling her. Like Dr.

18 Jansen?

19 A No, I don't remember that.

20 Q Do you remember one way or the other or is
21 that just --

22 A I just don't remember if she like -- I mean,
23 I know it's common practice, but I don't remember if it
24 happened in front of me or what -- when it happened. I
25 don't know.

←Page=46 1 Q What is common practice then? 2 A That the doctors would talk. 3 Q Would it be common practice after your 4 recommendation for Dr. Hunt (sic) to then speak to the 5 treating doctor? 6 A Who's Dr. Hunt? 7 MR. BERLINSKY: Object to the form. 8 Q (By Mr. Detrick) I mean Doctor -- 9 I'm sorry. 10 Hendelman to speak to the treating 11 doctor, Dr. Jansen, about recommendations? 12 A I mean, yeah, the doctors would talk. 13 Q All right. That's normal practice, correct? 14 A Yep. 15 Q All right. Dr. Hendelman did agree, though, 16 with your recommendation? 17 A Yes, she did. 18 Q And so you all were going down to the ER in 19 order to involuntarily admit Mr. Hunt to the Beaufort 20 Memorial psychiatric ward? 21 A Right. 22 Q Would Dr. Hendelman have done anything else, 23 or would she already have made her choice -- you know, 24 she's already made her treatment plan before going to 25 the ER?	Page 48 1 Q What would be the normal policy and 2 procedure who would make those arrangements? 3 A The nursing station. 4 Q You wouldn't have nothing to do with that 5 though? 6 A No. I would only be -- once the decision 7 has been made for him to be transported to or go 8 inpatient, I would do the transport or I would be the 9 escort. 10 Q I'm sorry. Say that one more time. 11 A I said after the decision had been made for 12 him to go inpatient, I would do the transport. I would 13 be his escort. 14 Q Okay. So you would have basically taken him 15 into custody and taken him to the Beaufort Memorial 16 Hospital for admission? 17 MR. BERLINSKY: Object to the form of the 18 question. 19 Q (By Mr. Detrick) You would have escorted him 20 to Beaufort Hospital if he had been in your custody; is 21 that correct? 22 A Not in like my custody. I would just be his 23 like -- I would be kind of like the representative, you 24 know, like a -- like the pass-off. A continuance of 25 care is what you could call it.
←Page=47 1 A That -- hold on. Say that again. Would 2 she -- 3 Q She already decided on what she was going to 4 do, and she didn't need to see Mr. Hunt? Is that the 5 way you remember it? 6 A I mean, I know she made her decision on what 7 was going to happen, but, I mean, that's all I know. 8 Q Okay. So decision was already made to 9 involuntary admission of Mr. Hunt to Beaufort Memorial 10 psychiatric ward prior to you all arriving in the ER? 11 MR. BERLINSKY: Object to the form of the 12 question. 13 Q (By Mr. Detrick) Correct? 14 A I don't -- can you repeat the question 15 again? I just want to hear it one more time. 16 Q Okay. The question then would be did 17 Dr. Hendelman already arrive at her decision when you 18 all were talking to admit Mr. Hunt to the Beaufort 19 Memorial psychiatric ward? 20 A Yes. When she was talking to me, yeah, she 21 had already decided that that was going to happen. 22 Q Do you know anything about the arrangements 23 for admission to the psychiatric ward for Mr. Hunt, who 24 made them, if they were even made? 25 A No, I don't know.	Page 49 1 Q Once he got -- you know, once you were his 2 escort and taking him in the process of transporting 3 him, you weren't about to let him escape, were you? 4 A No. 5 Q Why is that? That's because he was a 6 danger? 7 A No. It's more -- 8 MR. MACKELCAN: Object to the form. Doug 9 Mackelcan. 10 Q (By Mr. Detrick) Why is that? 11 A I mean, it's my job to make sure the patient 12 is safely transported, but I mean, I have no control 13 over if he -- I mean, I don't know. I have no control 14 over what the patient decides to do after that, but I 15 will make sure that he's safely transported. 16 Q If he was to try to escape during your 17 escort or in any part when you were starting your 18 escort, what would you have done? 19 MR. BERLINSKY: Object to the form of the 20 question. No. I withdraw the objection. Sorry. 21 MR. DETRICK: And that was Doug, but thank 22 you. 23 MR. MACKELCAN: No. That was Lee. 24 MR. DETRICK: Oh, I'm sorry. I apologize. 25 You all sound alike.

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1 THE WITNESS: Can you repeat the question
 2 again?
 3 Q (By Mr. Detrick) Okay. Whenever -- you
 4 know, what I'm saying is you were going down to the ER;
 5 correct?
 6 A Right.
 7 Q And the reason you were going down to the ER
 8 is an arrangement was going to be made to escort
 9 Mr. Hunt to the psychiatric ward for admission to
 10 Beaufort Memorial Hospital; correct?
 11 A Right.
 12 Q And could you tell us now how he would
 13 get -- how you would actually go about escorting him?
 14 How would you take control of that process?
 15 A The hospital has a -- what is the truck
 16 called? Damn it. What's the truck called? The
 17 paramedic rig. So they have like the paramedic-type
 18 truck or we call it a rig. I don't know. So we
 19 would -- the hospital actually has two duty drivers.
 20 The two duty drivers would be -- they would drive the
 21 truck, and I would sit in the back of the rig with the
 22 patient, and then they would drive us to the hospital.
 23 Q I'm not familiar with this truck --
 24 A It's --
 25 Q -- Mr. Manning. Could you describe it,

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1 please?
 2 A You know the paramedic truck?
 3 Q Yeah.
 4 A You know the paramedic, it's the same truck.
 5 Same thing.
 6 Q You're talking about a regular paramedic
 7 truck?
 8 A Yes.
 9 Q Okay.
 10 A The thing with the lights and sirens and all
 11 that.
 12 Q I gotcha.
 13 A Yeah, that thing.
 14 Q And there would be two duty drivers in order
 15 to escort along with you --
 16 A Yes, and then --
 17 Q -- and Mr. Hunt?
 18 A And then Clifton was going to ride along
 19 with me.
 20 Q You all were going to have four people to
 21 make sure he didn't escape?
 22 A No.
 23 Q You were going to have four people in the
 24 truck?
 25 A Right.

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1 Q Mr. Clifton was going to also sit in the
 2 back?
 3 A Yes.
 4 Q Do you know -- I don't assume you knew who
 5 the drivers were supposed to be?
 6 A No, I don't.
 7 Q They're on duty at all times?
 8 A Yes.
 9 Q And then, of course, by the time you got to
 10 the ER, Mr. Hunt had already escaped?
 11 MR. MACKELCAN: Object to the form. Doug
 12 Mackelcan.
 13 Q (By Mr. Detrick) Tell us what happened to
 14 Mr. Hunt.
 15 A I don't know what happened to Mr. Hunt. I
 16 came to the ER and he was gone.
 17 Q If you all had gotten Mr. Hunt in the
 18 paramedic truck with the two duty drivers and you and
 19 Mr. Clifton, and he had attempted to leave, what would
 20 you have done?
 21 MR. BERLINSKY: Object to the form of the
 22 question.
 23 MR. DETRICK: Who was that?
 24 MR. BERLINSKY: Berlinsky.
 25 MR. MACKELCAN: Can we agree going forward

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1 that one objection will be an objection for all?
 2 MR. DETRICK: That's fine. I agree to that.
 3 Q (By Mr. Detrick) What is your answer,
 4 Mr. Manning?
 5 A Honestly, I mean, we would do -- we would do
 6 everything we can to make sure the patient is safe, but
 7 if the patient tries to escape, that's -- I mean, the
 8 best we can do is try to keep them safe, but if they get
 9 away, we're not -- we are not allowed to do anything.
 10 Q Would you have called any authorities?
 11 A Excuse me?
 12 Q Would you have called any kind of legal
 13 authorities?
 14 A Yes.
 15 Q Would you have made sure he didn't get away
 16 and kept within your sight?
 17 A We can -- if we can do that, we can try, but
 18 it's not something that is required. We just have to --
 19 we can watch where they're going and, you know, report
 20 to whoever, whether it's PMO or the naval hospital ER,
 21 the doctors, everything like that, but --
 22 Q I mean, this is an involuntarily --
 23 A -- I'm not going to --
 24 Q I'm sorry.
 25 A I'm not going to chase him down. I'm not

Page 54 1 going to do that. 2 Q But it's involuntary admission. So he 3 doesn't have any choice and he's a service member; 4 correct? 5 MR. BERLINSKY: Objection to the form of the 6 question. 7 Q (By Mr. Detrick) This is an involuntary 8 admission; correct? 9 A There was no admission. So I don't know 10 what you're talking about. 11 Q It would have been an involuntary admission? 12 A It would have been. 13 Q Okay. All right. If you would now, as you 14 got down to the ER, tell me what happened as far as you 15 were concerned after that on this February 24, 2012. 16 A After -- after I got to the ER, the -- and 17 he was gone, all I remember is I went to the quarterdeck 18 of the hospital and I called for a code for missing 19 patient. 20 Q Quarterdeck, explain to me why you went 21 there and where that's at. 22 A Quarterdeck, it's like -- it's where like 23 the main -- the PA system is and everything like that. 24 So it would be a person on duty at the quarterdeck. 25 It's like the information desk at a normal hospital, but	Page 56 1 A No. 2 Q At any time that day, did you ever talk with 3 Edward Ray? 4 A I mean, he was there. I didn't have like a 5 direct conversation. He was just a part of the 6 conversations I had. 7 Q What part of the conversations you had? 8 A He was in the ER when I arrived. 9 Q Was he present during your safety 10 evaluation? 11 A No. 12 Q Just so we'll have it, what do you remember 13 about any conversations you may have had with Edward 14 Ray? 15 A I didn't have a conversation with him. 16 Q All right. He never said anything to you. 17 You never said anything to him. He just may have been 18 present some? 19 A Right. 20 Q Okay. Now, you yourself, did you have any 21 conversations with any of the guards or the persons at 22 the front gate? 23 A No, I didn't. 24 Q After you arrived at ER and found out that 25 Captain Hunt had escaped, did you have any conversations
Page 55 1 it's a quarterdeck for the, you know, Navy. We try to 2 keep things like across the board the same thing. 3 Q I gotcha. And someone would announce a code 4 for missing patients; correct? 5 A Yes. 6 Q Who would actually receive that? I mean -- 7 A It would go through the whole hospital, and 8 then they alerted the front gate where the 9 master-at-arms are. 10 Q Who would have alerted the front gate? 11 A The quarterdeck. 12 Q Do you remember who -- was it someone 13 assigned to the quarterdeck to do this? 14 A It was, but I don't know. It's the same 15 just like a duty. So, you know, it changes. 16 Q What else did you do, if anything? 17 A Really, that's all I remember other than I 18 know me and -- me and Clifton, we drove around the 19 campus or the base to see if we could find him and that 20 was it. 21 Q Did you see him or any evidence of where 22 he'd been when you drove around the base? 23 A No. 24 Q Did you talk with Mr. Edward Ray, who was a 25 Veterans Affairs officer?	Page 57 1 with Dr. Jansen? 2 MR. MACKELCAN: Object to the form. Doug 3 Mackelcan. 4 Q (By Mr. Detrick) Did you have any 5 conversations with Dr. Jansen after you arrived at the 6 ER and found that Mr. Hunt was gone? 7 A I mean, I don't exactly remember, but I 8 mean, I'm pretty sure I did talk to him, but I don't 9 remember what we would have talked about other than, 10 "Hey, he's gone." I don't know. 11 Q Do you remember the specifics of any 12 conversation? 13 A No, I don't. 14 Q I think there were two nurses there, the 15 McDonalds, is that correct, or do you know? 16 A I mean, according to the note, it says they 17 were there. 18 Q Right. Well, did you have any specific 19 conversations with the McDonalds after Mr. Hunt had left 20 that you remember? 21 A I don't remember any conversations with 22 them. 23 Q Okay. Do you remember any conversations 24 with anyone with Case Pro and/or the Navy after you 25 found out Mr. Hunt had left?

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1 A I don't know the difference between -- I 2 don't even know what the Case Pro thing is. All I know 3 is there was nurses and doctors and me. 4 Q Well, let's just put it this way. Do you 5 remember any specific conversations with anyone after 6 you found out that Mr. Hunt had left? 7 A No, I don't remember any specific 8 conversations. 9 Q Other than meetings with the attorney for 10 the United States, afterwards, were there any meetings 11 with any of the personnel to discuss Mr. Hunt's leaving 12 or anything that occurred at the naval hospital on 13 February 24, 2012, regarding Mr. -- Mr. Hunt? 14 A Can you ask that question again? 15 Q Yeah. I'm interested in any gatherings or 16 meetings, anybody getting together talking about 17 Mr. Hunt leaving or his condition on February 24th, 18 2012, after February 24, 2012. 19 A I mean, other than Commander -- oh, God -- 20 Commander Watson, he talked to me, but that was it. 21 Q Okay. When did you talk to Commander 22 Watson? 23 A I don't remember. 24 Q Who's Commander Watson? 25 A I don't even know who he was either. I just	1 may not be. It probably is as a matter of fact. 2 MR. INFINGER: This is Paul Infinger. It 3 was on the disk. 4 MR. DETRICK: Yeah, I don't know whether 5 Mr. Manning has it, though. 6 Do you all have that, Lee? 7 MR. BERLINSKY: I don't have anything 8 like -- 9 Q (By Mr. Detrick) That's okay. No big deal. 10 Let me read what it says to you, 11 Mr. Manning. It says this is from -- apparently, from 12 the guards. It's at 1616. 13 MR. BERLINSKY: Hold on one second. Paul, 14 you're fading away. 15 MR. DETRICK: I'm sorry. Can you all hear 16 me? 17 MR. BERLINSKY: Yes. 18 Q (By Mr. Detrick) Okay. Mr. Manning, you can 19 hear me? I apologize if I fade away. 20 MR. BERLINSKY: What is the document that 21 you're referring to? 22 MR. DETRICK: 01513. 23 MR. BERLINSKY: I don't know what that is. 24 MR. DETRICK: Apparently, it's the notes of 25 the guard shack or the watch or person on duty or
Page 59	Page 61
1 remember him. Little short guy. 2 Q When did this conversation occur? 3 A I don't remember. 4 Q What transpired? What was said? 5 A I mean, I don't remember. I don't remember 6 any specifics of the conversation. I just -- you know, 7 he was like one of the officers there. 8 Q I'm sorry? 9 A He was just one of the officers at the 10 hospital. I just remember him asking about what 11 happened. 12 Q When did this meeting occur? 13 A I don't remember. 14 Q What was the purpose of the meeting? 15 A I guess he was asking about what happened. 16 That's all. 17 Q Any report or file regarding this meeting or 18 do you know? 19 A I don't know. 20 Q You don't remember anything about the 21 meeting? 22 A No, I don't. 23 Q There's a note which we have been provided. 24 It is Bates stamped 01513. Have you got that? I think 25 that's -- is that part of what's in front of you? It	1 whatever. It's just stated at the top, "24 February 2 2012." 3 MR. BERLINSKY: I don't know what it is. So 4 you can ask Mr. Manning if he knows what it is. 5 Q (By Mr. Detrick) Well, I was going to ask 6 it -- I think it speaks for itself kind of. 7 Mr. Manning, it says in here -- take me at 8 my word this is what it says. It says, "Psych tech 9 notified watch of missing patient. Code Pink initiated. 10 OOD, COD, security front gate notified." 11 Is that what you were talking about when you 12 said you went to the quarterdeck? 13 A Yeah. It's like -- yeah, it's talking about 14 what I would have done at the quarterdeck, I guess. 15 Q And that Code Pink, I assume, is the missing 16 person code? 17 A Yes. 18 Q Okay. Mr. Manning, did you at any time look 19 around and find any clothing of Mr. Hunt or someone else 20 do that? 21 A No. That was not me. 22 Q Do you have any information as to how 23 Mr. Hunt left the Beaufort Naval Base? 24 A No, I don't. 25 Q Okay. Do you have any information, any

Page 62 1 knowledge about -- 2 In the notes, it said something about they 3 were going outside for some air is what Mr. Ray had 4 said. Do you have any knowledge where we're talking 5 about, what door he would have used, what location they 6 would have been in when he did this? 7 A I know the door that they're talking about, 8 but I don't -- 9 What are you trying to ask about it? 10 Q I want to know the door they're talking 11 about, could you tell me where that door is located, 12 please, sir? 13 A Right across from the ER. 14 Q Right across from what? 15 A The ER. 16 Q All right. I'm not real familiar with the 17 naval base there. Can you kind of tell me -- you know, 18 I've seen the gate. Okay? 19 A Right. 20 Q Can you tell me if I'm entering the gate, 21 where would the ER be and then where this door would be 22 as I go in the ER? 23 A That would be really -- 24 Q If you can tell me. 25 A That's like really difficult. I don't --	Page 64 1 ER where it has a whole section to itself. It's like 2 right in the middle of the hospital is the ER. 3 Q Okay. And I know it's a little bit 4 difficult because you said it's weird, but can you do 5 the best you can to tell me if I went through the front 6 door of the ER, how I would get to the door where 7 Mr. Hunt went out of? 8 A Can you ask the question again? 9 Q If I'm going like I would go in the ER 10 doors, you know, if I'm a patient or someone taking a 11 patient, I'm walking in the door, how would I get to 12 this door he went out of? 13 A That's what I'm saying. It's weird. Like 14 in the middle of the hospital is the ER. So the door 15 was like there's the ER. There's the waiting room for 16 the ER that's just right across the hallway from the 17 entrance to the ER and then that door. It's all like 18 right there. It's hard to explain. 19 Q Is it to the right, to the left or -- 20 A To the right or to the left? 21 Q When you're talking, do I keep going 22 straight? Do I go right, left or -- 23 A That's what I'm telling you. It's so I 24 don't even know how to explain that because of how the 25 location of the ER in the hospital.
Page 63 1 you couldn't see this door from the gate. You couldn't 2 even drive up to it. It was like -- it's like an 3 interior yard to the hospital. So like you wouldn't be 4 able to see it from the -- driving around the hospital, 5 you wouldn't be able to see that door. 6 Q Would you be able to see the ER from the 7 gate? 8 A No. No, you couldn't see the ER from the 9 gate. 10 Q Where is the ER located? Can you kind of 11 tell me? 12 A If you go through the gate, there's a little 13 road. Once you go through the gate, you turn left, and 14 then the ER is like the first parking lot that you pull 15 up to. 16 Q I assume they got signs of that, huh? 17 A I'm hoping. I don't remember. 18 Q And then I go through into the ER -- let's 19 say, through the normal doors, a person would go through 20 the ER. Now, where would this door be? How would I get 21 to this door that Mr. Hunt went out of once I entered 22 the ER? 23 A It's like right there. I don't -- I don't 24 know. There's like -- it's weird because where the ER 25 is in the hospital, it's like -- it's not like a normal	Page 65 1 Q All right. If you would exit that door that 2 he went through -- 3 A Right. 4 Q -- where would you be going to? What would 5 you see? 6 A If you exit the door, I guess it would take 7 you -- if you kept walking the little sidewalk, it takes 8 you back to the quarterdeck which was -- the quarterdeck 9 is once you go through the front gate and you drive 10 straight where the flagpole is, that's the quarterdeck. 11 Q How far from that door would the quarterdeck 12 be? 13 A I mean it's -- 14 Q Approximately. 15 A I don't know. 16 Q I want an estimate, please. 17 A I am not good with numbers. I don't know. 18 I don't know. 19 Q Are we talking about a pretty good walk or 20 small walk? 21 A I mean, yeah, it's a little short walk, 22 but -- 23 Q Now, when do you -- if someone exited that 24 gate -- 25 I'm trying to get some ideas.

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1 -- and walked in the direction of the gate
2 or the gates, when would that person be seen? What
3 keeps him from being seen or --
4 A I mean, just trees and a gazebo. That's why
5 you couldn't see the door, but like once you walk out
6 down the sidewalk, I mean, eventually, you'll get seen
7 because it leads --
8 Q How far is that -- where you would be seen,
9 how far is that from the gates, approximately?
10 A I don't know.
11 Q A fairly good distance? Is it 10 yards? 10
12 feet? 100 yards? 200 --
13 A Oh, heck no. It's a hell of a lot longer
14 than 10 yards or 10 feet.
15 Q How about football fields, can you tell
16 that?
17 A Probably -- I mean, football fields,
18 probably like --
19 It's a good distance if you measured in
20 football-field length.
21 Q I guess it's still like that. So we can
22 see. I was just trying to get an idea where it's
23 located.
24 Mr. Manning, right now, I think that's all
25 the questions I have. These gentlemen can ask the

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1 questions after me, please.
2 MR. INFINGER: You all ready to start now?
3 MR. DETRICK: Yeah.
4 EXAMINATION
5 BY MR. INFINGER:
6 Q Mr. Manning, my name is Paul Infinger. I
7 represent Jonas Armstrong. He was one of the people
8 involved in the wreck with the fire truck.
9 A Okay.
10 Q The day after -- I mean, the day after that
11 you saw Mr. Hunt in the naval hospital, did you read
12 about the incident with the stolen fire truck in the
13 paper?
14 A No, I didn't.
15 Q When did you first learn, if you ever
16 learned, that there was an incident with a stolen fire
17 truck and some people hurt, one killed?
18 A The same time we were looking for him in the
19 hospital.
20 Q I can barely hear you.
21 A I said the same time we were looking for him
22 in the hospital, I heard that there was a fire truck
23 that was stolen.
24 Q Did you know it was Calvin Hunt that you had
25 just interviewed?

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1 A No, I did not.
2 Q When did you learn it was Calvin Hunt?
3 A I think like the next week.
4 Q When you learned that Mr. Hunt was driving
5 that truck, did you decide you needed to report your
6 involvement with him to anybody at the naval hospital?
7 A Did I decide that? No.
8 Q Yes. Did you decide you needed to go in and
9 make a report about him being at the hospital and
10 running away?
11 A No.
12 Q So you never made any kind of written report
13 of any kind to anybody regarding Calvin Hunt?
14 A Who are you referring to?
15 Q I'm referring to you making any kind of
16 report to anybody, a written report regarding your
17 involvement with Calvin Hunt at the naval hospital
18 before he ran away.
19 A The naval hospital already knew my
20 involvement. So --
21 Q Nothing was in writing, though, was it?
22 A Not on a clinical standpoint, no.
23 Q What kind of standpoint was there a writing?
24 A Like I said, I talked to Commander Watson.
25 That was the report that was given to the commanding

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1 officer, I'm guessing.
2 Q You wrote a report and gave it to him?
3 A No, I did not.
4 Q So that's what I'm trying to find out. You
5 never wrote anything down --
6 A No.
7 Q -- at all?
8 Okay. Prior to when you -- how long were
9 you in service before you became an HM, hospital
10 corpsman, involved in psychiatry?
11 A I was in for boot camp before I became a
12 corpsman, and then right after I became a corpsman, I
13 became a psych tech. So, let's see, I was in for two
14 months. Then I became a corpsman. Then six months
15 later, I was a psych tech.
16 Q During your training, did you actually come
17 in contact with people who needed psychiatric care?
18 A That's my job.
19 Q So you did come into contact with people
20 with psychiatric disabilities?
21 A Yep.
22 Q And were those in the emergency room, or
23 those were people who were already in custody or
24 treatment of some kind?
25 A No. Not everybody who has a psychiatric

Page 70a 1 problem is emergent. So anybody with stress, 2 depression, anxiety, any of those realms. I mean, I've 3 gone from major to minor. So, you know, just needing 4 sleep therapy or relaxation therapy. It's all around. 5 Q What would you have characterized the 6 situation with Calvin Hunt? 7 A What do you mean? 8 Q Well, I mean, anxiety, the kind of things 9 you were just talking about. 10 A I'm not a doctor. I don't diagnosis people. 11 So I don't know. 12 Q Well, how would you know what to discuss 13 with the doctor after you evaluated him? 14 A Just from what I've been taught. 15 Q But you didn't characterize it one way or 16 the other whether he needed a holiday anxiety or some 17 other kind of anxiety? 18 A Right. I'm not a doctor. I don't diagnose 19 people. 20 Q Okay. Do you make recommendations to the 21 doctors? 22 A Right. 23 Q Okay. And then you are out of it after you 24 make a recommendation? 25 A Yes. Once I make my recommendation, it's	Page 72 1 maybe Mr. Berlinsky has with him -- 2 A Yes. 3 Q -- regarding the emergency room intake and 4 notes on those documents? 5 A Yes. 6 Q All right. And those documents, and I'm 7 referring to Bates stamp 01551, 01552, 01549, 01560, 8 01559, those particular documents make reference to him 9 when he was there that morning? 10 A Yes. 11 Q Wait a minute. Yeah, let me get the page I 12 want to here that he had -- that he had or he had 13 discussed with those people who wrote those records. 14 Specifically starting with 01551 at the top is a form 15 that's called "Emergency Physician Record, Psych 16 Disorder, Suicide Attempt, Overdose." Now, was that 17 typed onto this, this particular document, or does this 18 document come with that already typed onto it? 19 A I don't know. This isn't a document I would 20 use. 21 Q But, I mean, a psych disorder, suicide 22 attempt, overdose, would that fit Calvin Hunt? 23 MR. MACKELCAN: Object to the form. Doug 24 Mackelcan. 25 Q (By Mr. Infinger) Does that fit Calvin Hunt?
Page 71 1 the doctor's decision on, you know, what happens. I 2 just can make a recommendation. 3 Q On the day that you were called or texted -- 4 not texted. 5 A Paged? 6 Q What do you call it? 7 A Paged. 8 Q How do they get in touch with you? 9 A Page. A pager. 10 Q They paged you? 11 A Right. 12 Q You said you went to the hospital, Beaufort 13 Naval Hospital -- 14 A Right. 15 Q -- correct? 16 You went to the emergency room? 17 A Yes. 18 Q Is that correct? 19 A Yes. 20 Q And you did not see any papers or documents 21 or intakes anyone else had done -- 22 A No. 23 Q -- prior to meeting with Calvin Hunt? 24 A No. 25 Q And have you since seen those documents that	Page 73 1 A I don't understand your question. 2 Q Those -- 3 A Does the title of this paper fit Calvin? I 4 don't understand that. What does that mean? 5 Q What I mean is does it reflect the condition 6 that he had? I'm looking at the stamp. It looks like a 7 stamped or typed logo on the top of 01551. Do you have 8 that with you? 9 A Yes. 10 Q Okay. It says, "Psych Disorder, Suicide 11 Attempt, Overdose." Does that apply to Calvin Hunt or 12 did it apply on that day, February 24? 13 MR. BERLINSKY: Object to the form of the 14 question. 15 THE WITNESS: I really don't know how to 16 answer this question because, I mean, like the title of 17 the paper and the evaluation, I don't understand what 18 you're asking. I really don't. 19 Q (By Mr. Infinger) Okay. We'll stick to the 20 left-hand side. 21 A All right. 22 Q That particular document, whoever completed 23 it, it looks like a time at the top of that page. It 24 says, "14." Is that 1400, you think? 25 A I don't know what they're trying to say

Page 74	Page 76
1 right there. It actually looks like something's cut off 2 of it. 3 Q It looks like somebody maybe had a hole in 4 it or something -- 5 A Yeah. 6 Q -- but I don't know. But it says, "Chief 7 Complaint: Suicidal thoughts --" 8 A Right. 9 Q "-- depression," and he came for a 10 medication refill; is that correct? 11 A That's what it says. 12 Q And it says, "Situational problems. Patient 13 dishonorably discharged from USMC and is appealing 14 decision. Visiting with grandmother in Beaufort. She 15 called Mr. Ray concerning a concern about his 16 depression." 17 So he's got suicidal thoughts and 18 depression. Then it says, "Suicidal thoughts: Only 19 thought of hurting others, but no specific plans." Do 20 you agree with that? 21 MR. BERLINSKY: Objection to the form of the 22 question. 23 Q (By Mr. Infinger) Do you agree it says that? 24 A That's what it looks like it says. 25 Q And on the right-hand column, it says,	1 Q (By Mr. Infinger) But I mean, do you agree 2 that that's what this record says? 3 A That's what's written down on the paper. 4 Q And then on page 01552, "Physical Exam: 5 Patient doesn't deny nor confirm ideations," and they're 6 talking about suicide; is that correct? 7 MR. MACKELCAN: Object to the form. Doug 8 Mackelcan. 9 Q (By Mr. Infinger) Is that what it appears to 10 say, Mr. Manning? 11 A No, I don't know what that says. It just 12 says, "ideations." So there's many ideations that we 13 have. 14 Q Right, but the question says, "On direct 15 query, patient admits/denies continued consideration of 16 suicide as an option," and right above that, it says, 17 "Suicidal ideation," which is typed. 18 A Oh, okay. 19 Q I can't read what's in there. It's 20 something. 21 A It does say, "For suicide attempt." So, 22 yeah. All right. I'm guessing they're talking about he 23 doesn't confirm -- I don't know. He doesn't deny nor 24 confirm ideations. It does say that in the box. Yes, 25 it does. I'm sorry. I didn't understand your question.
Page 75	Page 77
1 "Other problems: Alcohol, drug abuse, depression." 2 A Oh, wait a minute. I'm sorry. You said, 3 "only thoughts of hurting --" 4 It says, "and thoughts," but not "only 5 thoughts." 6 Q Okay. All right. And thoughts. That's 7 fine with me. 8 A Okay. I didn't mean to cut you off. Go 9 ahead. What were you doing? 10 Q "And thoughts of hurting others, but no 11 specific plans?" 12 A Right. 13 Q Then in the right-hand column -- 14 A Right-hand problem. 15 Q -- it says, "Other problems: Alcohol, drug 16 abuse, depression, prior suicide --" 17 I don't know what that word is. "Gestures" 18 or something. I don't know. 19 MR. BERLINSKY: Objection. 20 THE WITNESS: Right. Okay. 21 Q (By Mr. Infinger) Do you agree with that? 22 MR. BERLINSKY: There's no question there, 23 is there? 24 THE WITNESS: Yeah, I don't know what you're 25 saying.	1 Q So if you have seen these records prior to 2 the time you did an evaluation of Mr. Hunt, would it 3 have changed your decision and made him more 4 consideration -- there had been more consideration for 5 safety of others? 6 MR. BERLINSKY: Object to the form of the 7 question. 8 THE WITNESS: If I would have seen this 9 evaluation? 10 Q (By Mr. Infinger) If you had seen all these 11 things involving dishonorably discharged, depression, 12 anger, suicide thoughts, thoughts of hurting others, 13 alcohol and drug abuse, would that have been a pretty 14 serious problem patient? 15 MR. MACKELCAN: Objection to the form. Doug 16 Mackelcan. 17 THE WITNESS: Would that have been a 18 serious -- your question is weird too. I don't 19 understand what you're asking me. 20 Q (By Mr. Infinger) What I'm asking you is 21 would you have made any recommendation any different to 22 Dr. Hendelman than you did make? 23 A I would have still done my -- regardless of 24 this information, I would have still done my evaluation 25 and made my own recommendation.

Page 78 1 Q Regardless of what has already been said 2 just before you got there? 3 A Right. Well, no. You're saying if I had 4 these papers, would I have changed my recommendation? I 5 would have done my own evaluation, my own safety 6 evaluation. I mean, this would have been collateral 7 information, but, I mean, I don't think it would have 8 affected -- 9 Just because they talked to them, like I 10 said, before I even -- 11 If before I would have done my evaluation 12 had this paperwork, I would have still done the same 13 thing. I'd have done my own evaluation and asked the 14 same questions that I asked. 15 Q One thing I haven't heard you talk about is 16 Bates stamp 01560, which is the chronological record of 17 medical here. Do you have that? 18 MR. BERLINSKY: I'm not sure that 19 Mr. Manning has seen that document. 20 Q (By Mr. Infinger) Well, this document, 21 Mr. Manning, it has a paragraph written in it by Sandra 22 Smith, and it says, "While appointment was being 23 scheduled for Monday, 27 February 2012, patient began to 24 moan and rock back and forth. I informed him that he 25 could be seen in the ER if needed, but he declined. As	Page 80 1 A No. 2 Q Does anybody follow behind you after you've 3 done an evaluation? 4 A The doctor. 5 Q Pardon me? 6 A The doctor. 7 Q The doctor? 8 A Yeah. 9 Q That was Hendelman? 10 A No. Whichever doctor -- you said an 11 evaluation. It would be after -- see, after a 12 technician sees a patient, the doctor follows it. 13 Q That would have been Dr. Hendelman? 14 A In this certain situation, yes. 15 Q Okay. And did you have any conversations 16 with Hendelman? 17 A Yes, I did. 18 Q And what was your conversation with him? 19 A Dr. Hendelman is a female. 20 Q Oh, okay. Her. 21 A I don't remember any details. 22 Q Would those have helped you remember what 23 you did and what you said and what you thought? 24 A Notes of what? 25 Q Notes of your involvement with Calvin Hunt
Page 79 1 the behavior continued, I asked the patient if he felt 2 like hurting himself and he said, 'Yes.' Patient 3 escorted to ER and turned over to ER nurse following a 4 brief report. Will leave pending appointment in 5 schedule for possible follow-up care with a PCM in this 6 area if needed." 7 Were you aware of that report before you saw 8 Calvin Hunt? 9 A No, I wasn't. 10 Q Did you have any information that he had 11 been in the intake room rocking back and forth and 12 moaning? 13 A What intake room? 14 Q I can't hear you. 15 A I said, "What intake room?" 16 Q Well, I don't know. Wherever this was 17 taken. The written note written by Sandra Smith on 18 February 24, 2012, at 1554, do you know where this was 19 written, Mr. Manning? 20 A No. Do you know where it was written? 21 Q It just has a chronological record of 22 medical care, and it's talking about that day. Well, 23 it's talking about other medications, but it's talking 24 specifically about that day. You are not familiar with 25 that?	Page 81 1 that day at the naval hospital. 2 A Like if I had what notes? What are you 3 talking about? 4 Q Would it have refreshed your memory more 5 about what went on that day? You don't remember much of 6 anything, do you? 7 A I mean, not with details of conversations. 8 I see -- I mean, I see like -- when I was at Parris 9 Island, I was seeing like 500 patients a year. So I'm 10 not going to remember every detail of what I talked 11 about with a patient. 12 Q How many patients of that 500 killed 13 somebody? 14 A I'm not sure. I don't know. 15 Q You never heard of any one of your patients 16 having killed somebody else? 17 A No. I mean, I don't understand your 18 question. Of the patients that I saw -- 19 Q Have you ever been told or read or seen any 20 information that one of your 500 patients may have 21 killed somebody? 22 A No. 23 Q Well, you know one, don't you? You know 24 Calvin Hunt. 25 MR. BERLINSKY: Object to the form of the

Page 82 1 question. 2 Q (By Mr. Infinger) You did know Calvin Hunt, 3 didn't you? 4 A I do not know Calvin Hunt other than seeing 5 him in the ER. 6 Q That's what I'm talking about. I'm talking 7 about all your patients that would have been seen in the 8 hospital setting or ER or wherever. 9 A Okay. 10 Q Okay. So none of those other 500 -- can you 11 think of any of them that killed somebody? 12 A No, I don't. 13 Q Okay. I'm just hesitating because I think 14 Paul Detrick has already asked a lot of questions that I 15 wanted to ask. 16 MR. DETRICK: Let me interrupt a minute. Do 17 you all got a fax number there, Lee, that I can fax 18 something to you? 19 MR. BERLINSKY: I wouldn't have any idea. 20 We're stuck in a conference room. 21 MR. DETRICK: Can anyone make that 22 determination for me? I need to fax something to 23 Mr. Manning. 24 MR. INFINGER: Do you want to step outside 25 and ask somebody, Lee?	Page 84 1 MR. INFINGER: He won't be able to print it, 2 though, right away. 3 MR. BERLINSKY: If you want to take a 4 five-minute break, I'll call over to the legal contact. 5 They might be in the same building. I just don't know 6 where they are. They've met me in lobbies. 7 MR. DETRICK: At the very least, if we have 8 to, we can email it and he can at least look at it and 9 see if it's his signature and we can deal with it in 10 that manner. 11 MR. BERLINSKY: Okay. 12 MR. INFINGER: Would you like a five-minute 13 break? 14 MR. BERLINSKY: Okay. 15 MR. DETRICK: That sounds good. I'm not 16 going to hang up, though. 17 MR. BERLINSKY: Just remember that 18 everybody's on a live call. 19 (Recess taken from 10:19 a.m. until 10:39 20 a.m.) 21 MR. BERLINSKY: So I think it's pursuant to 22 local Rule 30 that there was an off-the-record 23 discussion between Mr. Berlinsky and Mr. Manning 24 regarding a document that was just sent by email. We 25 have not received a fax yet. But according to
Page 83 1 MR. BERLINSKY: I don't even know where 2 these folks are. I can make a couple of phone calls. 3 Is it something that I may have here? 4 MR. DETRICK: Apparently not. I didn't have 5 it myself. It's a statement that, apparently, 6 Mr. Manning gave that we were provided, but you may not 7 have had it either. I'm not sure. 8 MR. BERLINSKY: Well, I sure would like to 9 know if Mr. Manning has given a statement because I 10 haven't seen one. 11 MR. DETRICK: I hadn't either, but I've got 12 it now. That's the reason I want to fax it to 13 Mr. Manning so he could look at it. 14 MR. BERLINSKY: Let me think of how I can 15 find these folks. I know I can. Do you want to go off 16 the record? Do we want to go off the record? 17 MR. SWETT: Do you want to come back to it, 18 Paul, I mean, after we -- 19 MR. DETRICK: That's fine. Why don't you 20 ask him to go -- let him go ahead and get a fax on, if 21 he can. If he can do that, I'll fax it immediately. 22 MR. MACKELCAN: You can email it. 23 MR. DETRICK: I can email it. That's fine. 24 MR. BERLINSKY: Well, that's not going to 25 be --	Page 85 1 Mr. Manning, he recognizes his signature on the document 2 and indicates that it is a statement that he produced 3 and had made a mention of this to me, and I hadn't had a 4 chance to confirm it. So this is a confirmation that 5 that is a document that he prepared. 6 MR. DETRICK: We agree with that statement, 7 and we have no problem with Mr. Berlinsky conferring 8 with Mr. Manning about the document. 9 MR. BERLINSKY: When the document gets here, 10 we'll mark it as an exhibit. 11 MR. DETRICK: Okay. Cheryl says she can't 12 get confirmation on this first fax number. What was the 13 other fax number? 14 MR. BERLINSKY: Well, it's (808) 257-1829. 15 Do you know where that goes to upstairs or 16 no? 17 THE WITNESS: No. 18 MR. BERLINSKY: So we'll just have to track 19 it down. 20 MR. DETRICK: If she gets confirmation, I'll 21 let you all know whichever number it is. 22 MR. BERLINSKY: Okay. But in the meanwhile, 23 we can pull it up on my BlackBerry. I can't make the 24 screen any bigger. 25 MR. INFINGER: Let me mention one thing to

Page 86 1 you, Lee. This is Paul Infinger. The documents I 2 referred to with the Bates numbers, I'd like to offer 3 those as exhibits, the Bates numbers I gave Mr. Manning. 4 MR. BERLINSKY: I think it's already been 5 admitted collectively as Exhibit 1. 6 MR. INFINGER: Oh, okay. All right. I may 7 have missed that. 8 MR. BERLINSKY: Okay. 9 MR. INFINGER: Paul Detrick, I'm just going 10 to let you do anything else that's needed with your 11 exhibit. So we're waiting right now to -- 12 MR. SWETT: Well, we can go ahead and then 13 come back to Paul Detrick. 14 MR. INFINGER: Does he got Manning there? 15 MR. BERLINSKY: Was that Mr. Swett? 16 MR. SWETT: Yes. 17 MR. BERLINSKY: Okay. 18 MR. SWETT: Is everybody present? 19 MR. BERLINSKY: Yes. 20 MR. SWETT: I guess the question is if 21 everybody's ready. 22 MR. BERLINSKY: Everybody's here. That was 23 Mr. Swett. 24 Q (By Mr. Infinger) All right. This is Paul 25 Infinger again resuming the deposition. I've just got a	Page 88 1 Q Is it common procedure not to take notes, 2 written notes, on a psych tech evaluation? 3 A No. I was saying that earlier in a clinical 4 environment where we're in our offices, yes, we take 5 notes, but in situations where it's in the ER, no. 6 Q And what's the reason for that? 7 A That's beyond my pay grade. I don't know. 8 Q That's beyond your pay grade. So you could 9 have taken notes if you wanted to, but it's just not 10 common procedure to do that? 11 A There was no resources for us to take notes. 12 I mean, unless you bring your own pen and paper. 13 Q Okay. So you were missing a pen and paper? 14 A No, no, no. That's not what I said. That's 15 not what I'm saying. 16 Q Tell me what you said so I get it right. 17 A I mean, it's not a common thing that we 18 would take notes for an ER visit because we're already 19 in the ER, and the ER are the ones that have taken 20 notes. 21 Q Okay. But you hadn't seen their notes or 22 read their notes? 23 A No. I have nothing to do with their notes. 24 Q Do you recall that Calvin Hunt came in for a 25 medication refill or did you know that?
Page 87 1 few questions. 2 Mr. Manning, when you came down and you were 3 paged to come back to the hospital as a psych tech for 4 the evaluation of Hunt, you did not talk to anyone about 5 his condition or their opinions of his condition; is 6 that correct? 7 A What are you talking about? At what time? 8 Q When he was paged to come back -- to come 9 over to the Beaufort Naval Hospital to do an evaluation 10 of Hunt -- 11 A When I was paged? 12 Q -- you did not talk to anyone about Calvin 13 Hunt's conditions or what their opinions of his 14 conditions were? 15 A I mean, I talked to -- I would have talked 16 to the nurses' station and the doctor then. I just 17 don't remember what the details of the conversation -- 18 Q You don't remember what they might have said 19 about his condition or what their opinion of his 20 condition was? 21 A No. 22 Q Okay. Is it common procedure not to take 23 notes of a psych tech evaluation for people who they're 24 called in to evaluate? 25 A Is it not common practice?	Page 89 1 A No, I didn't know that. 2 Q You're just learning this as I tell you? 3 A Oh, no. I thought you were talking about 4 when I came to the ER. 5 Q No. When Calvin Hunt came in to the 6 Beaufort Naval Hospital that day, he was coming in 7 for he was coming in, in his mind, for a medication 8 refill? 9 A Right. 10 Q Okay. And when was he told he was going to 11 be admitted? 12 A I don't know. 13 Q You didn't tell him? 14 A No. I didn't say anything to him about 15 being admitted. 16 Q During your conversation with him, you 17 didn't say, "You should be admitted and treated and" 18 A No. I'm not a doctor. So I don't make 19 those kind of decisions. 20 Q Okay. Did you hear any doctor tell him 21 that? 22 A Did I hear a doctor tell him that? No. 23 Q Right. You weren't present when any doctor 24 said, "Rather than filling your prescriptions, we're 25 going to admit you and give you medications," or --

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1 A Is that what a doctor said?
2 Q -- something to that effect; is that
3 correct?
4 A Are you saying that a doctor said that? I
5 don't understand what you're saying.
6 Q I mean, did you hear a doctor tell him
7 that --
8 A No, I didn't hear a doctor say that.
9 Q -- tell him, "Mr. Hunt," a doctor,
10 "Mr. Hunt, you came in for medications and we're going
11 to admit you today?"
12 A No, I didn't hear that.
13 MR. INFINGER: Okay. All right. I think
14 that's all I have, and Paul Detrick wants to put his
15 document -- exhibit in.
16 MR. DETRICK: Chris, you want to go ahead
17 and --
18 MR. SWETT: Yes. Let me --
19 MR. DETRICK: Before you do that, Cheryl
20 said that the second number did go through, that
21 (808) 257-1829, if somebody wants to go check and see
22 that.
23 MR. BERLINSKY: Okay. Do you want to go
24 forward now, or do you want me to take a break and go
25 look for that?

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1 MR. DETRICK: It's up to you all. I don't
2 care.
3 MR. SWETT: I've only got about maybe a
4 dozen questions. I won't be long at all.
5 MR. DETRICK: That's fine. However you all
6 want to proceed.
7 MR. INFINGER: Chris, who do you represent?
8 MR. SWETT: I represent --
9 MR. DETRICK: Excuse me, Chris. She said
10 that both of them ended up going through.
11 MR. SWETT: I represent the Estate of Justin
12 Miller, the deceased.
13 EXAMINATION
14 BY MR. SWETT:
15 Q Mr. Manning, how are you, sir?
16 A All right.
17 Q Good. Good. First, I just want to say
18 thank you for your service and let you know I'm not
19 going to try and trick you or anything. Some of my
20 questions may sound similar, but they're a little
21 different. So I just don't want you to think I'm trying
22 to trick you when I ask you and it may sound like some
23 questions you already heard, but I assure you I'm asking
24 them for a reason. Okay?
25 A Got it.

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1 Q I couldn't tell from your earlier testimony,
2 after you performed your mental status exam on Mr. Hunt,
3 were you concerned at that time that he may harm
4 himself?
5 A Was I concerned that he might harm himself?
6 Q Yes, sir.
7 A I don't quite remember. I mean, I had a
8 concern, but I don't remember my concern was that he was
9 going to harm himself.
10 Q Okay. But you had a concern; correct?
11 A Right.
12 Q And that concern was such that you actually
13 went and talked with Dr. Hendelman, and your
14 recommendation was that he be admitted; correct?
15 A Right.
16 Q Okay. Do you recall whether you had a
17 concern after your initial mental status exam that he
18 may harm someone else?
19 A Like I say, I don't remember details of the
20 conversation I had with him. I just remember having
21 those -- like my concern was that he needed to go
22 inpatient.
23 Q And I understand that and that's what I'm
24 trying to get to. I'm not really asking you the
25 conversation, but you tell me you had a concern. So I'm

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1 just trying to figure out if you recall what your
2 concern may have been. Basically, if you can tell me
3 why was it that you thought he needed to be admitted?
4 A Like I said, it was the demeanor -- like I
5 said, he wasn't really -- he wasn't talking in an
6 organized manner to me. Like I said, his body language
7 and everything like that, that was my concern because of
8 him not being -- like within my mental status, he had a
9 lot of red flags as far as the cognitive part of it.
10 Q Okay. Do you recall whether you had any
11 concern of any imminent action he might take; any
12 immediate action he might take?
13 A No. Like I said, if it was an immediate
14 thing like right then, right there and there was some
15 threat or danger, the situation would have been totally
16 different.
17 Q Okay. When you say the situation would have
18 been totally different, what would have happened
19 differently than what actually happened?
20 A The police would have been involved.
21 Q Okay. Who would have called the police?
22 A I would have.
23 Q Okay. Now, let's see here. I want you to
24 take a look -- you've already looked at a document. I
25 think it's Bates stamped 01549. Tell me when you find

Page 94 1 that. 2 A Yes. 3 Q Is that a document, it looks like, by a 4 Nurse McDonald, and it starts at the top with a time of 5 1430? 6 A Yes. 7 Q Okay. And I just want to try and establish 8 a time frame here, a rough time frame if you can just 9 help me with this. If you look at the 1525 -- 10 A Uh-huh. 11 Q -- would you agree with me that this 12 document reflects that you -- your evaluation of 13 Mr. Hunt was in progress at 1525? 14 A Right. 15 Q Okay. Do you recall about how long your 16 mental status exam of Mr. Hunt lasted? 17 A No, I don't remember exactly a time frame. 18 Q Okay. You don't have a rough estimate as 19 you sit here right now? 20 A I mean, in a -- in a normal situation, it 21 would probably be about 20 minutes. 22 Q Okay. Fair enough. Let me ask you to look 23 at the next entry. It looks like 1612. It says -- at 24 the beginning, it says, "Patient ambulates to the 25 bathroom." This is basically when they said they were	Page 96 1 A You mean 1625? 2 Q Yes, 1625 entry. 3 A That's what the entry says, "Mr. Ray 4 returned to ER." 5 Q Okay. And then right after that, would you 6 agree with me that it says, "Psych tech returned 7 approximately 10 minutes ago"? 8 A Yeah, I see that. 9 Q Okay. So let me just run through the time 10 frame again and tell me whether or not you agree with me 11 on this. So at 1525, you were examining Mr. Hunt. At 12 some point, your examination ended. It ended maybe 13 around 1545. At that time you went up to speak with 14 Dr. Hendelman, and while you were upstairs around 1612, 15 Mr. Hunt left the ER. Are you with me so far? You 16 agree with that? 17 A Okay. 18 Q And then about 1615 was when you returned 19 from upstairs back downstairs. Would you agree with me 20 on that? 21 A I mean, I don't know if that's the exact 22 time, but -- 23 Q I understand, but would you agree with 24 me that -- 25 A The paper, yes.
Page 95 1 going to go out and get some fresh air. 2 A Right. 3 Q Do you agree with me? Okay. 4 MR. MACKELCAN: Object to the form. Doug 5 Mackelcan. 6 MR. SWETT: I'm sorry. Was there an 7 objection there? 8 MR. MACKELCAN: Yes. Doug Mackelcan. 9 Objection. 10 Q (By Mr. Swett) Okay. Let me ask you 11 whenever Mr. Hunt left the ER, were you still present or 12 had you already gone up to speak with Dr. Hendelman? 13 A When he left the ER, yeah, I was -- I 14 wasn't -- I was still upstairs or on my way, whichever 15 one. 16 Q Okay. Okay. So just to get a rough 17 outline, your evaluation was going on about 1525. It 18 lasted about 20 minutes or so. And by 1612, it was 19 over. It had been over because you weren't there 20 whenever Mr. Hunt left, correct? 21 A Correct. 22 Q Okay. Now, if you look at the 1525 entry 23 next, this is sort of when -- would you agree with me 24 that this is when Mr. Ray returned and stated that 25 Mr. Hunt took off through the gate?	Page 97 1 Q -- that's basically what this document 2 reflects? 3 A Right. Right. 4 Q Do you have any information to indicate to 5 you that that time frame would not be accurate? 6 A No, I don't. 7 Q Okay. Fair enough. So let me ask you this. 8 Do you recall -- there was some testimony about this 9 earlier. When you were upstairs talking with 10 Dr. Hendelman, as we've sort of gone through this 11 deposition, now do you recall whether or not she came 12 back downstairs with you or whether or not it was just 13 you and Clifton that came downstairs? 14 A What do you mean? 15 Q Well, earlier there was a little bit of 16 confusion. I don't think you recall. After you talked 17 with her, you gave her your recommendation and she 18 agreed with your recommendation that he should be 19 admitted. You basically said that you came back down 20 with Clifton, but there was some confusion on my part 21 whether or not Dr. Hendelman actually walked back 22 downstairs with you or not, and my question is would you 23 agree with me that she didn't? It was just you and 24 Clifton that went back down to the ER? 25 A Yeah. I think it might have been just me

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1 and Clifton. I mean --

2 Q Okay.

3 A -- I don't remember that. I mean, it could

4 be -- I think it was just me and Clifton.

5 Q And if you've given any statements or if any

6 records reflect that you and Clifton walked back

7 downstairs and there's no mention of Dr. Hendelman

8 coming back downstairs, would you dispute those

9 documents?

10 A Say that again.

11 Q If documents indicated it was just you and

12 Clifton, would you have any reason to question the

13 accuracy of those documents?

14 A No. I mean, if it says -- yeah. No.

15 Q And I guess the whole point I'm trying to

16 get to with all this is if there is another record

17 somewhere in these piles of records that we have that

18 says that after speaking with you, Dr. Hendelman called

19 Dr. Jansen at 1605 and told him that the patient

20 obviously needed to be admitted, would you have any

21 reason to dispute that that happened?

22 A No.

23 Q All right. So you see where that falls on

24 on our time line? All right. So, basically, you

25 finished your examination. You'd gone upstairs to talk

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1 to Dr. Hendelman. Dr. Hendelman calls Dr. Jansen at

2 about 1605, tells him that Mr. Hunt needs to be

3 admitted, and then at 1612, document 01549 indicates

4 that Dr. Jansen allowed Mr. Hunt to leave the ER. Would

5 you agree with me?

6 MR. MACKELCAN: Object to the form. Doug

7 Mackelcan.

8 THE WITNESS: I don't see where it says

9 Dr. Jansen allowed him to leave the ER.

10 Q (By Mr. Swett) Okay. Well, would you agree

11 with me that at 1612, those present in the ER with

12 Mr. Hunt allowed him to leave their presence?

13 A Yes.

14 Q Is it common practice -- I mean, do you have

15 procedures that you have to follow as a tech? Is there

16 any --

17 Well, let me ask you that first. Is there

18 any procedures that you have to follow as a tech,

19 written procedures?

20 A Yes.

21 Q Okay. What are those? Are those codified

22 or can you explain those to me?

23 A I mean, I don't remember the exact

24 procedures that like from Parris Island or anything like

25 that, but -- well, I mean, it would depend on --

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1 What are you like looking for here?

2 Q Well, I wasn't asking for the specifics. I

3 just didn't know if you all had a book that you all

4 received or --

5 A Yeah. It's like a standard procedure for

6 each clinic and all that kind of stuff.

7 Q Okay. Is that something individual -- would

8 you have any reason to know if that is something

9 individual to what you do or are other employees --

10 A No. It's individual -- it's individual for

11 each section. So I mean, like, you know, just I guess

12 the same thing for, you know, with you guys. Like your

13 office might have a standard procedure how you want

14 things, while Paul or one of the Pauls has a different

15 procedure for their office. So, you know, you do the

16 same job, but you have different procedures. So it

17 depends on where you're at.

18 Q Sure. And so for Beaufort Naval with what

19 you're doing, would the nurses or any of the doctors

20 have the same procedures that you had?

21 A I don't know. I don't know their

22 procedures. I didn't work in the ER.

23 Q Bear with me one moment. I don't want to

24 duplicate any questions.

25 Sort of switching gears just a little bit,

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1 prior to you starting your testimony today when we first

2 got started, in the past month before that, had you

3 spoken with anyone about the subject of your testimony

4 today?

5 A So you're talking this past month?

6 Q Yes. Just in the previous month up to --

7 from last month all the way up to the moment you started

8 your testimony today, had you had any conversation with

9 anyone about your testimony today?

10 A No.

11 Q Okay. I mean, did you meet with

12 Mr. Berlinsky yesterday to talk about your deposition

13 today?

14 A Oh, yes. Yeah.

15 Q Okay. Who was --

16 Yes?

17 A Huh? Who was yes?

18 Q Oh, I'm sorry. I thought someone said

19 something. I got some feedback on the phone. I

20 apologize.

21 Who was present for that conversation?

22 A Myself and Mr. Berlinsky.

23 Q Okay. Was anyone conferenced in on a

24 conference call or anything like that?

25 A Not for our talk. I mean, we checked the

Page 102 1 phone if you're -- I don't know what you're -- 2 Q Okay. Other than speaking with 3 Mr. Berlinsky, have you spoken with anyone else in the 4 past, let's say, six months about the subject matter of 5 this testimony? 6 A No. I mean, other than like let my command 7 know about what's going on? Is that what you're saying? 8 Q Not really. I understand that. That's 9 okay. No, that wasn't really what I was referring to. 10 I understand what you're saying. 11 Who's present in the room with you right 12 now? I don't know if we ever got who all is there. 13 A It's Mr. Berlinsky and the court reporter. 14 Q And yourself? 15 A And myself, yes. 16 Q Okay. I believe that may be all the 17 questions I have, Mr. Manning. I appreciate your time, 18 sir. 19 A All right. 20 MR. MACKELCAN: Paul Detrick, do you want to 21 go and then I go after you, or do you want me to go 22 ahead? 23 MR. DETRICK: That's totally up to you all. 24 You just tell me how you want to proceed. You want me 25 to go ahead?	Page 104 1 Q Tell me the circumstances regarding the 2 giving of this statement, if you remember. 3 MR. BERLINSKY: Before we go forward, Paul, 4 this is Lee Berlinsky. I just wanted to make a quick 5 note. Seeing it for the first time, it looks like it's 6 dated February 23rd of 2011; is that correct? 7 MR. DETRICK: I was going to ask him that. 8 MR. BERLINSKY: Okay. Well, then let's 9 proceed until he can identify the date of when it was 10 written because it might be that this is a protected 11 document, and we'll just have to ask under what 12 circumstances he was asked to write that document, but 13 it looks like it might have been under the direction of 14 the JAG investigation in anticipation of litigation. 15 MR. DETRICK: Well -- 16 MR. BERLINSKY: So I'll let him look at that 17 and see when it was written. 18 MR. FLEMING: Well, I can chime in on that. 19 MR. DETRICK: I'm sorry? 20 MR. FLEMING: I can chime in on that. 21 MR. BERLINSKY: Who's talking? 22 MR. FLEMING: This is Cory Fleming. 23 MR. DETRICK: Cory, if you don't mind, state 24 for the record how this document is contained. 25 MR. FLEMING: This document is contained in
Page 103 1 MR. MACKELCAN: Yeah, go ahead. 2 MR. BERLINSKY: We do not have that form 3 yet. Do you want me to go look for it? 4 MR. DETRICK: It's supposed to be at both 5 places. So, yeah, why don't you go look for it. 6 MR. BERLINSKY: It will take me about two 7 minutes. 8 MR. DETRICK: That will be fine. I'll take 9 a quick bathroom. 10 (Recess taken from 10:59 a.m. until 11:04 11 a.m., and Exhibit 2 is marked for identification.) 12 EXAMINATION 13 BY MR. DETRICK: 14 Q This is Paul Detrick, Mr. Manning. Since we 15 obtained, apparently, a statement from you, the other 16 parties wanted me to question you regarding that 17 statement, and I think that you've been handed Exhibit 18 No. 2; correct? 19 A Yes. 20 Q And have you had an opportunity to review 21 that exhibit? 22 A Yes. 23 Q Is that a statement by you given shortly 24 after this February 24, 2012, incident? 25 A Yes.	Page 105 1 the criminal investigation file produced to me from the 2 Port Royal Police Department in the criminal case, not 3 in any civil matter. 4 MR. DETRICK: All right. Are we ready to 5 proceed with the questions, Mr. Lee? 6 MR. BERLINSKY: Yeah. I just want to know 7 when it was written, you know. 8 MR. DETRICK: All right. Well, I'll ask him 9 that. There's no privilege here. 10 Q (By Mr. Detrick) Mr. Manning, as your lawyer 11 was talking or said, the top of it says February 23rd, 12 2011. Do you see that? 13 A Yes. 14 Q And, obviously, it wasn't written then; 15 correct? 16 A I don't know. What day was the -- 17 Q The incident was February 24, 2012. 18 A Yeah. So I guess I just put the wrong date 19 on there. 20 Q Is that your handwriting? 21 A Yes, that is. 22 Q Okay. At the bottom, apparently, it was 23 faxed to someone from the naval hospital, apparently, on 24 February 27th, 2012. 25 A Right.

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1 Q Do you see that?

2 A Yes.

3 Q Did you fax this to someone?

4 A No.

5 Q Okay. But you read it. Does it contain an

6 accurate statement of the facts of February 24, 2012,

7 regarding Mr. Hunt?

8 A Yes.

9 Q And it has your signature at the bottom?

10 A Yes.

11 Q And given that it was faxed -- well, do you

12 remember when you gave this statement?

13 A I think it was the same night that it

14 happened. That's when I typed it up.

15 Q Was this statement given to Port Royal

16 Police Department?

17 A I gave it to my command. I was asked by my

18 command to type it up.

19 Q Okay. Let's go through it some, if that

20 suits you. The first sentence there says, "I was called

21 to talk to said named member due to possible need of

22 inpatient admission"; correct?

23 MR. BERLINSKY: Mr. Detrick, you have to

24 speak a lot louder for the court reporter's benefit,

25 please.

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1 Q (By Mr. Detrick) I apologize.

2 The first sentence in this statement says,

3 "I was called in to talk to said named member due to

4 possible need of inpatient admission." Do you read

5 that? Did I correctly read the first sentence?

6 A Yes.

7 Q And does that refresh your memory now that

8 the first call, there was concern for inpatient

9 admission?

10 A Yes.

11 Q Does it refresh your memory there was

12 concern about whether Mr. Hunt was a danger to himself

13 or others --

14 A No, it doesn't.

15 Q -- therefore, needing inpatient admission?

16 A No.

17 Q You remember that now?

18 A No. I mean, that sentence doesn't say that

19 he was going to hurt himself or others.

20 Q I wanted to -- see, sometimes statements

21 such as this given shortly thereafter will refresh

22 memories, and that's the reason I was asking that

23 question.

24 A All right.

25 Q It says you spoke to the patient who did not

Page 108

1 seem to be able to respond in a normal manner and seemed

2 to be in an altered mental state; correct?

3 A Yeah, altered mental status.

4 Q Mental status. I'm sorry. And you already

5 testified to that; correct?

6 A Yeah. That's what the paper says.

7 Q And that was a part of your safety

8 evaluation?

9 A Right.

10 Q All right. You made your safety evaluation,

11 and you said what you basically considered regarding

12 that safety evaluation. Had you at that point in time,

13 after making that safety evaluation, knew that you were

14 going to make a recommendation to Dr. Hendelman for

15 inpatient admission of Mr. Hunt?

16 A Yes. After my evaluation, I did know I was

17 going to make that recommendation.

18 Q Okay. And you have Mr. Hunt in the room you

19 talked about; correct?

20 A Say what?

21 Q In your evaluation, what room did you have

22 him in?

23 A We were in the ER in the third bed.

24 Q Third bed in the ER?

25 A Right.

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1 Q Where was Mr. Ray at that time?

2 A I don't know.

3 Q Were other personnel of the naval base or

4 Case Pro present in the room or close there by?

5 A I mean, they were close, but they weren't

6 with me and Mr. Hunt when I was doing my evaluation.

7 Q Okay. After you made your evaluation, did

8 you just leave Mr. Hunt to take care of himself, or did

9 you give any instructions to any persons regarding

10 Mr. Hunt?

11 A After I got done with my evaluation, I told

12 Dr. Jansen and the -- well, I just told Dr. Jansen that

13 I would be going upstairs because I called Dr. Hendelman

14 and she said she was upstairs.

15 Q Did you tell Dr. Jansen what your

16 recommendation was going to be to Dr. Hendelman?

17 A Yes.

18 Q Who all was present to hear what your -- who

19 did you communicate this recommendation to before you

20 went to see Dr. Hendelman?

21 A Nobody.

22 Q Just Dr. Jansen?

23 A Dr. Jansen.

24 Q Is that correct?

25 A Right.

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1 Q Was Mr. Ray present? Did he hear you?

2 A I don't remember.

3 ~~Q Okay. Did you give any precautions to~~

4 ~~Dr. Jansen or any of the personnel regarding making sure~~

5 ~~Mr. Hunt did not leave?~~

6 A No. I didn't -- I didn't give any kind of

7 specific type of thing like that.

8 Q Did you assume when you left and they knew

9 what your recommendations were regarding involuntary

10 admission that precautions were going to be made to make

11 sure that Mr. Hunt did not leave?

12 A Can you ask that again?

13 Q Did you assume, after you told Dr. Jansen

14 and Mr. Ray about your recommendations regarding

15 involuntary admission of Mr. Hunt, that they were going

16 to take some sort of precaution to ensure that Mr. Hunt

17 did not leave before you got back?

18 MR. BERLINSKY: I'm going to object.

19 MR. FREEMAN: This is Mike Freeman. I

20 object to the form.

21 MR. BERLINSKY: Exactly.

22 MR. SWETT: The same.

23 Q (By Mr. Detrick) You can answer it.

24 A Yes, I guess I made that assumption.

25 Q What did you think, Mr. Manning, that was

Page 111

1 going to be done between -- from the time you told them

2 of your recommendation and you were going up to see

3 Dr. Hendelman, what did you think was going to be done

4 to make sure that Mr. Ray was going to be there when you

5 got back?

6 A Mr. Ray?

7 MR. FREEMAN: This is Mike Freeman. I

8 object to the form of the question.

9 Q (By Mr. Detrick) If anything. Go ahead.

10 A Why would I expect Mr. Ray to be there?

11 Q Okay. You didn't expect Mr. Ray. What did

12 you expect as far as Mr. Hunt?

13 A That he was going to be in Bed 3.

14 Q How did you figure he was going to be in Bed

15 3? Why did you figure he was going to be in Bed 3 when

16 you returned?

17 A That's where he was when I left.

18 Q Well, did you assume that someone, either

19 Dr. Jansen or someone down there, was going to take

20 precautions to make sure that Mr. Hunt was in Bed 3 when

21 you returned?

22 A Did I assume that someone was going to make

23 sure he was in the bed? I mean, I don't understand. I

24 don't know.

25 Q Well, they knew about what recommendations

Page 112

1 were going to be -- that you were going to recommend he

2 be involuntarily admitted to the psychiatric ward of the

3 Beaufort Memorial Hospital --

4 A Right.

5 Q -- correct?

6 A Yes.

7 Q Okay. And given that they knew what your

8 recommendations were going to be, what precautions did

9 you expect them to take to make sure he was going to be

10 present after you talked to Dr. Hendelman?

11 MR. MACKELCAN: Doug Mackelcan. Objection.

12 THE WITNESS: I'm not sure. Like I said,

13 I'm not a doctor. So my recommendation is just a

14 recommendation. If Dr. Hendelman would have said a

15 totally different thing, that's what was going to

16 happen.

17 Q (By Mr. Detrick) But you did expect

18 precautions to be taken by someone to make sure that

19 Mr. Hunt was going to be present when you returned after

20 your recommendations were given to Dr. Hendelman;

21 correct?

22 A I don't know. I mean, I can't really say

23 'cause this is -- I mean, it was a weird situation. I

24 don't know. I can't really say.

25 ~~Q Well, you did expect Mr. Hunt to be in the~~

Page 113

1 ~~ER in the bed~~

2 A When I came back.

3 ~~Q -- after you returned; correct?~~

4 A Yes.

5 Q All right. Now, you left to go see

6 Dr. Hendelman and make your recommendations to her;

7 correct?

8 A Yes.

9 Q Okay. And Mr. Swett was going into some of

10 the time line. So we can have the time line even a

11 little better, how long does it take for you to go from

12 the ER to wherever Dr. Hendelman was to make your -- to

13 see her and make your recommendation, approximately?

14 A Less than two minutes.

15 Q Okay. And then you went up and saw

16 Dr. Hendelman. How long did it take you to make your

17 recommendation to her that he be involuntarily admitted?

18 A I'm not exactly sure.

19 Q Approximately.

20 A It could have taken 10 minutes. It depends

21 on -- I mean, I don't remember. It could have been

22 about 10 minutes.

23 Q So we're talking about approximately, give

24 or take a few minutes, 10 minutes for you to make your

25 recommendation to Dr. Hendelman and her accept your

Page 114 1 recommendation; correct? 2 A Yes. 3 Q And then another two minutes for you and 4 Mr. Clifton to go back to the ER? 5 A Right. 6 Q Is that approximately right? 7 A Right. 8 Q Okay. All right. She's told you, as you 9 set forth in Exhibit No. 2, that she was going to 10 recommend that the patient be sent inpatient to either 11 Beaufort Memorial Hospital or Fort Stewart; correct? 12 A Yes. 13 Q And you would assume, since the 14 recommendation was made to go to Beaufort Memorial 15 Hospital, that she must have communicated that to 16 someone before you even got to the ER; correct? 17 A Well, she was making arrangements while I -- 18 you know, that kind of thing. 19 Q She was making arrangements while you left 20 and proceeded downstairs, correct -- 21 A Right. 22 Q -- to the ER? 23 A Right. 24 Q The next sentence in this Exhibit No. 2 25 says, "When I returned to the ER accompanied by HM --"	Page 116 1 A Right. 2 Q What do you mean by the word "eloped"? 3 A It means that he left or he -- yeah, he 4 left. 5 Q He ran away somewhat. 6 MR. BERLINSKY: Object to the form of the 7 statement. 8 Q (By Mr. Detrick) Okay. I'll withdraw that. 9 But that was before you had these concerns 10 about -- why? 11 A Say what? I'm sorry. 12 Q Why did you have those concerns -- that 13 someone in the ER said that he and the VA officer just 14 left for a walk, why did you have concerns about the 15 patient eloping? 16 A I mean, I'm guessing in the time line, it 17 was after he had not come back for a while. 18 Q Okay. Were you informed by people in the ER 19 that Mr. Hunt -- it had been a while since he had left 20 the ER? 21 A I don't remember any kind of details of 22 someone telling me like that. 23 Q But you had those concerns as a result of 24 that; correct? 25 A Correct. Yeah. I had that concern.
Page 115 1 Excuse me. Let me back up. The sentence -- 2 I missed a sentence. I apologize. 3 The next sentence, "I also asked HM Clifton 4 to assist me as I was not comfortable with the patient's 5 mental state and his somewhat unpredictable demeanor"; 6 correct? 7 A Correct. 8 Q And you already testified that you were 9 concerned about danger to himself or danger to you and 10 possibly Mr. Clifton as the reason you asked Mr. Clifton 11 to accompany you; correct? 12 A Yes. 13 Q And then the next sentence says, "When I 14 returned to the ER accompanied by HM Clifton, the ER 15 staff reported that he had left with VA officer for a 16 walk, but no one had seen them return." And then it 17 says, "HM Clifton and I walked to the quarterdeck and 18 HM1 Ballinger, the COD, to report that it was possible 19 patient eloped from the ER." 20 A Right. 21 Q Did I read that correct? Is that a true 22 statement? 23 A Yes. 24 Q And so at that time, you had concerns about 25 whether Mr. Hunt had eloped from the ER; correct?	Page 117 1 Q And this is before the VA Officer Ray had 2 come back and said he had gone -- 3 A Right. 4 Q -- correct? 5 A Right. 6 Q You already -- and then next sentence says 7 you went to the quarterdeck and you asked them to call 8 the code right then; correct? 9 A Right. 10 Q And that was before -- again, before Mr. Ray 11 had even told anybody that Mr. Hunt had run? 12 A Right. 13 Q And then at that time before Mr. Ray even 14 told anybody that Mr. Hunt had run, you started your 15 search outside on the hospital grounds; correct? 16 A Yes. 17 Q You and Mr. Clifton? 18 A Yes. 19 Q Tell me about that search. What did you 20 find? 21 A Nothing. We drove around. We didn't see 22 anything. 23 Q You didn't see the clothing or anything? I 24 think you already testified to that; correct? 25 A Right.

Page 118 1 Q And then when it says, "When we returned 2 from searching the immediate area, that's when the VA 3 officer was back in the ER and reported that the member 4 did run from him when they were outside and he could not 5 keep up"; correct? 6 A Right. 7 Q We got a correct time line now. You already 8 knew he or thought he had run or eloped before 9 Mr. Hunt -- I mean, before the VA officer had stated to 10 you that he had actually did run; correct? 11 A Correct. 12 Q And then it says, "I reported the situation 13 to DFA Commander Bristol and Chief Geter who were 14 walking down the hall." 15 A Right. 16 Q Who are they? 17 A The DFA, he's one of the directors. I can't 18 remember what FA stands for. Dang it. What is FA? And 19 Chief Geter was just my chief. 20 Q Next sentence refers to a Captain Simmer. 21 Who is that? 22 A Captain Simmer, he was the executive 23 officer. He's also a psychiatrist. 24 Q Okay. All right. We have this report which 25 now you've testified to. Are there any other reports	Page 120 1 Q On No. 3 of that, doesn't it require that 2 any evaluation and assessment that you make under those 3 subject matter that you said you agree with me on will 4 be made on an SF 600 in the patient's medical record? 5 A Which is what -- which is what the ER would 6 do. 7 Q Doesn't it require you to do that? 8 A No. Like I said, in this situation, it's 9 the ER. In my office, I would -- if he was seen in 10 mental health, then that would be my note, but this was 11 the ER's patient and it's the ER that does that. 12 Q Then let me ask you this. It says here -- 13 I'll read it for you. Tell me if I'm reading what is 14 required policy under 6520.1F for Mr. Hunt's evaluation. 15 No. 3 says, "Upon completion of the mental 16 health evaluation," first it says, "the member's command 17 will be notified of the finding, typically by telephone 18 contact with his supervisor or division officer," 19 period. "Documentation of the evaluation and assessment 20 will be made on SF 600 in the patient's medical record 21 and, when necessary and appropriate, in official 22 correspondence to the command." 23 A Who is that command? 24 Q Did I correctly read what is required on the 25 evaluation you did with Mr. Hunt?
Page 119 1 that you made that you haven't told us about? 2 A No. This -- no. 3 Q Now, Mr. Manning, whenever -- would you 4 consider this, whenever Mr. Hunt came to see you or was 5 sent to you or you went to him really, an evaluation and 6 disposition of a person with suicidal inclinations or 7 behavior? Would it come under that standard or subject? 8 A Can you repeat the question again? 9 Q All right. Would the subject of your 10 evaluation come under an evaluation disposition of 11 persons presenting with suicidal -- 12 I can't pronounce it. 13 A Ideations? 14 Q -- inclinations or behavior? 15 A Suicidal ideations, yeah. 16 Q Yeah, ideations. Yes, sir. 17 A Right. 18 Q Would you agree that's what Mr. Hunt was 19 when you evaluated -- that's what kind of evaluation 20 this was? 21 A Yes. 22 Q And are you familiar with Naval Hospital 23 Directive 6520.1F? 24 A I mean, I heard it. I don't know it word 25 for word or anything like that.	Page 121 1 MR. BERLINSKY: Mr. Detrick, I pulled out my 2 copy of that so that Mr. Manning could read along, but 3 since you're not in the room, and I just wanted the 4 record to indicate that I pulled this instruction out. 5 MR. DETRICK: I do appreciate that. I'm 6 glad you did that. I wasn't aware that you had it with 7 you. I'm sorry. Maybe I should have asked before I 8 started the question. 9 You got that in front of you? 10 MR. BERLINSKY: He's got my copy of it. 11 MR. DETRICK: Yes. 12 THE WITNESS: Okay. 13 Q (By Mr. Detrick) Did I correctly read No. 3 14 of that -- 15 A Yes, you did. 16 Q -- policy? 17 MR. INFINGER: Paul. Paul Detrick, is that 18 part of the Bates stamped documents? 19 MR. DETRICK: No, it's not. I'm sorry. 20 MR. INFINGER: Okay. All right. Go ahead. 21 I'm sorry. 22 Q (By Mr. Detrick) I correctly read that 23 policy; correct? 24 A Yes, you read No. 3 correctly. 25 Q And that policy should have been followed in

Page 122 1 the mental health evaluation of Mr. Hunt, shouldn't it? 2 A No. 3 Q Why is that? 4 A One, he wasn't active duty at the time. 5 Q He was considered a service member, and he 6 appealed his decision as set forth; correct? 7 A I mean, at that time, I don't think so. I 8 don't think we were treating him as active duty, though. 9 Q Okay. This applies to service members; 10 correct? 11 A Yeah, number -- 12 Q What you have in front of you, 6520.1F? 13 A No. 3, yeah, you're reading under "Active 14 Duty Personnel." 15 Q Right. I mean, it applies to service 16 members; correct? 17 A To active duty personnel. 18 Q I'm saying it applies to marine recruits 19 too. What classification do you consider him that -- 20 He was entitled to benefit as a military 21 personnel, as a service member. So what classification 22 did you consider him to where he would not come under 23 this standard? 24 A From what I understand, he wasn't -- he was 25 like on appellate leave for discharge or something like	Page=124 1 because it is their patient. 2 Q Isn't it your responsibility to see that the 3 ER documented your evaluation and assessment? 4 A No. 5 Q Well, how are they going to know what to 6 document on SF Form 600 about your evaluation and 7 assessment if you don't tell them? 8 A My evaluation goes to the psychiatrist. 9 Q Did you expect after your evaluation or 10 assessment, did you expect that a Form SF 600 should 11 have been completed by the ER? 12 A My evaluation has nothing to do with the ER. 13 It goes to the psychiatrist, and then the psychiatrist 14 off of that, off of my evaluation and recommendation, 15 she will make her own if she's going to see the patient 16 or -- 17 Dr. Hendelman we're talking about. 18 -- would make her recommendation from there, 19 which would be recorded in the notes of the ER. We 20 didn't even make it that far. 21 Q You did make it that far, Mr. Manning, 22 because you knew that Dr. Hendelman had already 23 recommended inpatient admission of Mr. Hunt and, as a 24 matter of fact, was in the process in front of you of 25 making arrangements for that admission; correct?
Page 123 1 that. 2 Q So you disagree that you were supposed 3 to -- 4 Wait a second. Was an SF 600 supposed to 5 have been filled out? 6 A From what I see, it was, though. That's 7 what you have in like this -- 8 Q Okay. If the SF 600 was supposed to be 9 filled out, and I think it was filled out by the first 10 nurse that saw him; correct? 11 A The first nurse who saw -- 12 Q That's what you're referring to is 01559 and 13 01560; correct? 14 A Yes. 15 Q And that is an SF 61; right? I mean 600. 16 A This is a version -- that's the electronic 17 SF 600, yeah. 18 Q Okay. Well, it was required to be filled 19 out by her. So, apparently, Standard Form 600 applied 20 to Mr. Manning -- I mean, Mr. Hunt; correct? 21 A Excuse me? You're talking about the ER, 22 though. I think that's where the confusion is coming 23 in. Like the instruction, yes, it says that, but we 24 were in the ER at the time. So it was the ER's 25 responsibility is the one to record what's going on	Page 125 1 A Right. 2 Q And so either you or Dr. Hendelman, someone 3 by the rules and standards and policies, should have put 4 something in writing because that recommendation had 5 been made, arrangements had been already entered into, 6 and there should have been something in writing 7 regarding either your evaluation and admission and 8 assessment and Dr. Hendelman's recommendation for 9 admission, shouldn't it? It should have been in 10 writing, should it not? 11 MR. BERLINSKY: Object to the form of the 12 question. 13 Q (By Mr. Detrick) Should it not have been in 14 writing, Mr. Manning, in some manner? 15 A But it's in the ER note that we were -- of 16 what was happening. Everything that we did was in the 17 ER note, and then after that, he was gone. 18 Q Where is there anywhere that you could point 19 to me in the ER note which you have before you in 20 Exhibit No. 1 that sets forth your evaluation and 21 assessment? Could you please point that out to me and 22 Bates stamp number? 23 A "Psych Tech Manning, Eval in Progress." 24 Q Okay. What else? 25 A That's me doing my evaluation.

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1 Q Yes, sir. Where is it in your assessment? 2 A What are you asking? 3 Q Well, should your assessment have been in 4 writing -- 5 A No. 6 Q -- like what the standard requires? 7 A Like I said, my assessment, it's not a part 8 of that. My assessment is for the psychiatrist. 9 Q What about the assessment of the 10 psychiatrist, whenever she recommends, as a matter of 11 fact, and makes arrangements for involuntarily 12 committal, shouldn't that have been in writing? 13 MR. BERLINSKY: Object to the form of the 14 question. 15 THE WITNESS: What assessment did the 16 psychiatrist make? 17 Q (By Mr. Detrick) She made an assessment of 18 his involuntarily admission of Mr. Manning (sic) for 19 some reason which we don't have because we don't have 20 the writing. 21 A Dr. Hendelman made a recommendation for him 22 to be put inpatient. She didn't make an assessment. 23 Q Doesn't she have to make some sort of 24 assessment before she could involuntarily admit a 25 military serviceman?	1 that he talked to Dr. Hendelman. 2 Q Specifically read that and tell me -- I know 3 that's in there. Tell me what you see specifically 4 regarding Dr. Jansen's notes. 5 A Dr. Jansen says, "Discussed with 6 Dr. Hendelman. Time 1605." 7 Q That's 01552? 8 A Yep. 01552. 9 Q And read where that is and tell me where 10 it's at. 11 A Progress -- in his progress notes, he said, 12 "Discussed with Dr. Hendelman 1605." 13 Q That's all there is as far as anything in 14 the records regarding any kind of assessment or 15 evaluation? 16 A Then in his clinical impression, it says, 17 "Patient left ER --" 18 Well, whatever the rest he says right there, 19 that's basically what happened. 20 Q (Inaudible.) 21 A Huh? 22 Q You're talking about the part that says at 23 the bottom, "Clinical Impression --" 24 A Right. 25 Q "-- patient left ER and escaped from Case,"
Page 127	Page 129
1 A Dr. Jansen and Dr. Hendelman spoke, and she 2 also got my collateral information from me talking to 3 the patient and she made a recommendation. That's not 4 an assessment. 5 Q So you disagree with me that should have 6 been in writing by Dr. Hendelman for you, or do you 7 disagree with that? 8 A I'm saying that it was documented. That's 9 what I'm saying. 10 Q Again, I'll back up and we'll get off this 11 line of questioning. Where is this assessment of 12 Mr. Hunt anywhere in the documentation that I can look 13 at? 14 A It says, "Psych Tech Manning, Eval in 15 Progress." 16 Q Is there any specifics in the record 17 regarding what you found on your evaluation or even what 18 kind of evaluation you did? 19 MR. BERLINSKY: Object to the form of the 20 question. 21 THE WITNESS: That's where the 22 recommendation for him to go inpatient. 23 Q (By Mr. Detrick) Where is that? If you 24 would point that out to me and -- 25 A That's what Dr. Jansen -- Dr. Jansen said	1 I guess, "case of Mr. Ray -- care of Mr. Ray?" 2 A Oh, is that what that says? 3 Q Is that what you're referring to? 4 A Yes. That's his clinical impression. 5 Q Do you consider that a documentation of your 6 assessment and evaluation -- 7 A My assessment -- 8 Q -- what you just said in the record? 9 A What I did for -- with Mr. Hunt only went to 10 the psychiatrist. That was only for the purpose of the 11 psychiatrist. 12 Q I meant to ask you, and I'll leave you alone 13 about that, 01554, it says something about LWCC. Do you 14 know what that means? 15 A Hold on. Where are you at again? 16 Q It's on 01554. At the very bottom, 17 "Discharge Instructions," do you know what those letters 18 mean, LWCC? 19 A I mean, I'm not like perfect, but I'm pretty 20 sure that means left without being seen. 21 Q You had mentioned something about a report 22 to your Commander Watson. Are you referring to what we 23 now have as Exhibit No. 2, or is there something else? 24 A No. Talking to Commander Watson, I don't 25 know. I think that was just something for the CO. I

1 don't know what that was. He just sat down and was like
2 asking questions.

3 Q What is Commander --
4 Is it Watson, W-a-t-s-o-n?

5 A Right.

6 Q What's his name, do you know?

7 A No, I don't.

8 Q What is his -- do you know where he is? Was
9 he at Beaufort Naval Base?

10 A Yes, he was.

11 Q Do you know was he there when you left?

12 A I don't know.

13 MR. DETRICK: All right. That's all I have.

14 EXAMINATION

15 BY MR. MACKELCAN:

16 Q Mr. Manning, my name is Doug Mackelcan, I
17 represent a company called Case Pro in these lawsuits,
18 and I've got a few questions for you as well.

19 A Okay.

20 Q Do you need to take a break for any reason
21 or should we just keep going?

22 A No, go ahead. Sorry I told you.

23 MR. BERLINSKY: The court reporter has
24 indicated the need to rest her fingers.

25 MR. MACKELCAN: Okay. Let's take five

1 minutes then. If people need to use the restroom or
2 whatever, we can do that and start up in five.

3 (Recess taken from 11:37 a.m. until 11:42
4 a.m.)

5 Q (By Mr. Mackelcan): Mr. Manning, when were
6 you born?

7 A February 1st, 1987.

8 Q Where did you grow up?

9 A Tampa, Florida.

10 Q What year did you enter the military?

11 A 2007.

12 Q Did you graduate from high school?

13 A Yes.

14 Q Where did you go to high school?

15 A Blake High School in Tampa.

16 Q What year did you graduate?

17 A 2005.

18 Q What did you do between 2005 and 2007?

19 A Work.

20 Q Where did you work?

21 A So many places, it's ridiculous. I just
22 jumped around jobs.

23 Q Why did you decide to join the military?

24 A Excuse me?

25 Q Why did you decide to join the military?

1 A I wanted a job I couldn't quit.

2 Q Where did you go to boot camp?

3 A Great Lakes.

4 Q Where is that?

5 A Chicago or Illinois.

6 Q And then were you stationed in Parris Island

7 immediately out of boot camp?

8 A No. I went to Virginia for training.

9 Q Where in Virginia?

10 A Portsmouth.

11 Q How long were you there?

12 A About eight, nine months.

13 Q And then how long at boot camp?

14 A Boot camp is like two months.

15 Q Then after Virginia, you went to Parris

16 Island?

17 A Yes.

18 Q Do you remember generally when you started

19 at Parris Island?

20 A In like August. August, September. It was

21 September maybe.

22 Q What year?

23 A 2008.

24 Q And were you a psych tech right from the

25 start at Parris Island?

1 A Yes.

2 Q You had already done your training for psych

3 tech?

4 A That's where I came from. I went from

5 training as a psych tech to Parris Island.

6 Q Do you have any family in South Carolina?

7 A No. Not that I know of, anyway.

8 Q Did you go to Hawaii from Parris Island?

9 A Yes.

10 Q So in your -- are you currently still a

11 psych tech?

12 A Yes.

13 Q Okay. All right. Starting in August of '08

14 through February 24, 2012, I believe you said you saw

15 approximately 500 patients a year, is that right?

16 A Just about.

17 Q You saw over 1,500 patients probably in the

18 time you were at Parris Island before you saw Mr. Hunt?

19 A Yes.

20 Q Okay. Had you dealt with patients that had

21 anxiety?

22 A Had I dealt with them? Yes.

23 Q Had you evaluated patients with depression?

24 A Yes.

25 Q Had you evaluated patients with PTSD?

1 A Yes.
 2 Q Had you evaluated patients with suicidal
 3 ideations?
 4 A Yes.
 5 Q How would you define suicidal ideation?
 6 A Suicidal ideation is just -- how would I
 7 define it? Okay.
 8 Q Well, what is your understanding of what
 9 suicidal ideation is?
 10 A It's basically a person with a thought that
 11 they would take their own life.
 12 Q Is there any time frame for suicidal
 13 ideation?
 14 A Is there a time frame? What does that mean?
 15 Q Well, what I mean by that is in order for
 16 that to be the diagnosis or the evaluation, does the
 17 thoughts of suicide need to have happened within the
 18 last 12 hours, 24 hours, week, you know, month? I mean,
 19 how is that part of the evaluation?
 20 A No. I mean, if a person had a thought of
 21 killing himself a year ago, that's still considered a
 22 suicidal ideation.
 23 Q So that doesn't mean that somebody is
 24 thinking of killing himself right now?
 25 A No.

1 Q Have you ever evaluated a patient prior to
 2 seeing Mr. Hunt who had suicidal plans?
 3 A Suicidal plans? Yes.
 4 Q Okay. And have you had any experience with
 5 patients that had suicide attempts?
 6 A Yes.
 7 Q And I'm going to jump around a little bit.
 8 I heard a lot of questions. So I apologize if I shift
 9 gears quickly on you, but when you were at Parris
 10 Island, had you ever heard of a company called Case Pro?
 11 A No.
 12 Q In this deposition, you have referred to
 13 your recommendation and I believe -- or Dr. Hendelman's
 14 recommendation that Mr. Hunt would be inpatient at
 15 Beaufort Memorial Hospital; is that correct? You used
 16 the word "inpatient"?
 17 A Right.
 18 Q Some of the lawyers that have asked you
 19 questions have been using the term "involuntary
 20 admission."
 21 A Yes.
 22 Q You heard them use that?
 23 A Yes.
 24 Q Okay. Those two terms, "inpatient" and
 25 "involuntary admission," are not the same thing?

1 necessarily, are they?
 2 A No.
 3 Q Okay. Is it possible that a patient
 4 could -- well, let's say is it possible that you could
 5 have come down to the ER and Mr. Hunt was seated in Bed
 6 3, and you could have said to him, "Mr. Hunt, we think
 7 you need to be admitted at Beaufort Memorial Hospital.
 8 We'd be happy to give you a ride over there," and then
 9 he would just go and be admitted? Is that possible that
 10 it could work out that way?
 11 A Yes.
 12 Q Okay. So in that circumstance that I just
 13 described, that would not have been an involuntary
 14 admission; right?
 15 A No.
 16 Q So we don't really know if he was going to
 17 be involuntary -- involuntarily admitted or not, do we?
 18 A At the time, yes, we did.
 19 Q Why is that?
 20 A Because once the recommendation was made,
 21 there was going to be -- it wasn't a question. He was
 22 going to go.
 23 Q But you just answered my question to say
 24 that he could have agreed with the plan, in which case
 25 it would not have been involuntary; it would have been

1 voluntary; right?
 2 MR. DETRICK: I object to the form of that
 3 question. It misstates your question.
 4 THE WITNESS: You were saying -- you're
 5 saying in a situation, can a patient be in the ER and
 6 they say, "Hey, I want to be admitted"? Then, yes,
 7 that's a voluntary admission. But when the
 8 recommendation came from the doctor, if he was like,
 9 "No, I don't want to go to the hospital," there is no,
 10 "No, I won't go." It's, "You're going to the hospital.
 11 You're going to be admitted."
 12 Q (By Mr. Mackelcan) I understand that.
 13 A So that's involuntarily admitted.
 14 Q I believe you testified that you never told
 15 Mr. Hunt one way or the other what was going to happen
 16 to him; is that correct?
 17 A Right.
 18 Q You never said to him, "You're going to be
 19 admitted"; right?
 20 A No, I didn't.
 21 Q And you're not aware of anyone that ever
 22 said to him he was going to be admitted?
 23 A Right.
 24 Q Okay. So my question is do you know whether
 25 or not he would have agreed for admission?

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1 A Do I know if he would have agreed? No, I
2 don't.

3 Q I understand that your testimony was that
4 one way or the other, he was going to go over there, and
5 I understand that. But my question is you really -- you
6 really don't know whether it was involuntary or not
7 because it could have been voluntary?

8 MR. DETRICK: Object to the form of this
9 question. It was already asked and answered.

10 THE REPORTER: Who else is objecting?

11 MR. MACKELCAN: You can answer the question.

12 MR. DETRICK: This is Paul Detrick. I'm
13 sorry.

14 MR. BERLINSKY: It was echoed.

15 THE WITNESS: What's the question again?

16 Q (By Mr. Mackelcan) The question was are you
17 aware of Mr. Hunt's being given the option of admission
18 or not?

19 A No.

20 Q Okay. So the question was so we don't
21 really know one way or the other whether it was going to
22 be voluntary or involuntary because he was never given
23 the option; is that correct?

24 A No.

25 MR. DETRICK: I'll object to the form of

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1 that question as already asked and answered. This is
2 Paul Detrick.

3 THE WITNESS: There was no -- there was no
4 option. The recommendation was made.

5 Q (By Mr. Mackelcan) So the recommendation was
6 for him to be inpatient at Beaufort Memorial Hospital?

7 A Right.

8 Q Okay. If you felt that after your safety
9 evaluation of Mr. Hunt that he needed to be restrained,
10 what would you have done?

11 A If I felt what? There was never an
12 evaluation that you're going to feel that a patient
13 needs to be restrained. I don't get -- that didn't make
14 sense. I don't get your question.

15 Q If you were conducting a safety evaluation
16 of a patient that you feel presents an immediate risk to
17 himself or others around him, what action do you take?

18 A You call the police.

19 Q But you do not feel that was necessary in
20 this circumstance?

21 A No.

22 Q Could patients have been -- this is a
23 general question. Could patients be sent to Beaufort
24 Memorial Hospital for psychiatry without being evaluated
25 by a psychologist?

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1 A Not on my call. So like you're saying if a
2 person wants to go to Beaufort Memorial?

3 Q Yes.

4 A Yes. I mean, if you're just some Joe Schmo
5 walking down the street and you want to go to Beaufort
6 Memorial, then that's your choice.

7 Q How about in an involuntary situation?

8 A What do you mean?

9 Q If you were going to have a patient
10 involuntarily admitted to Beaufort Memorial, does a
11 psychiatrist need to evaluate the patient?

12 A Yes. Well, not really that a psychiatrist
13 needs to evaluate the patient, but the psychiatrist or
14 psychologist has to make that recommendation. They have
15 to be consulted with at least.

16 Q So is it common practice for a psychologist
17 or psychiatrist to make recommendations without actually
18 seeing the patient?

19 A Is it common practice for them to make the
20 recommendation without them seeing the patient?

21 Q Well, was it common practice at that time is
22 the question.

23 A Yes.

24 Q What is the distinction between
25 Dr. Hendelman giving a recommendation and issuing an

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1 order?

2 A Giving a recommendation or issuing an order?

3 Q You had clarified one of the questions that
4 was asked earlier and said that she had given a
5 recommendation. She hadn't given an evaluation or she
6 hadn't given some sort of -- now I'm trying to look for
7 the word that you used. You specifically said that she
8 made a recommendation that he be admitted, and I'm
9 wondering what's the distinction? What's the
10 difference?

11 A Well, doctors don't give orders. Like if
12 your doctor ordered you to get a surgery, would you just
13 do it? Like it's a recommendation. But her
14 recommendation was to -- the patient was in the ER. So
15 it's Dr. Jansen's patient. So when Dr. Hendelman was
16 consulted basically through me, she gave the
17 recommendation this person needs to be inpatient, and
18 then the recommendation is put to Dr. Jansen in which we
19 would do the escort for the inpatient, but the patient
20 has no choice in that.

21 Q I guess who makes the final decision of what
22 happens with the patient?

23 A That would have been -- that would have been
24 Dr. Jansen. But I mean, it's not like Dr. Jansen going
25 to be like, "I disagree with you, Psychiatrist, because,

1 you know, I don't trust your word," or something like
2 that. That's not going to happen.

3 Q So, typically, the doctor would follow the
4 recommendation of the psychiatrist?

5 A Right. And this was a concern for safety.
6 So he had no choice.

7 Q You testified that you had not reviewed any
8 of Mr. Hunt's medical records. Would you typically
9 review a patient's medical records before doing your
10 safety evaluation?

11 A No.

12 Q Do you recall when you first found out why
13 Mr. Hunt was at the naval hospital?

14 A Do I recall first finding out?

15 Q Yes.

16 A Not any details, but what are you -- like
17 when I first walked in the door?

18 Q Well, the record we discussed earlier said
19 that he was there for a prescription refill.

20 A Okay.

21 Q And I was just wondering when you first
22 found out that that's why he was there.

23 A I don't know. I don't know. I don't think
24 I ever found out that he was there for a prescription
25 refill. That's not what I was there for.

1 Q When you were speaking with Dr. Hendelman
2 and making your recommendations, was Dr. Jansen present
3 for that conversation?

4 A No. He was in the ER.

5 Q Okay. How about either of the ER nurses,
6 were they present for your conversation with
7 Dr. Hendelman?

8 A No.

9 Q When you left the ER to go speak with

10 Dr. Hendelman, did you give any specific instructions to
11 either of the nurses or Dr. Jansen?

12 A No.

13 Q I'm a little unclear as to whether
14 Dr. Hendelman was planning to come to the ER or not with
15 you and Clifton. Do you know if she intended to
16 evaluate Mr. Hunt or not?

17 A No, I don't.

18 Q Are you aware of any naval hospital policy
19 that was broken by either of the ER nurses or
20 Dr. Jansen?

21 A Say that again.

22 Q Are you aware of any naval hospital policies
23 or procedures that were broken by or not followed by
24 either of the ER nurses or Dr. Jansen?

25 A No.

1 Q Had you worked with either of the ER nurses
2 or Dr. Jansen in the past?

3 A Possibly. I mean --

4 Q You didn't know them personally, though?

5 A No, I don't know them personally.

6 Q Was there anyone else in psychiatry other
7 than Dr. Hendelman who had any involvement in deciding
8 how to treat Calvin Hunt?

9 A Not that I know of.

10 Q Did you speak with anyone else other than

11 Dr. Hendelman about Calvin Hunt?

12 A No.

13 Q I asked you before of your experience with
14 psychiatric patients while you were stationed at Parris
15 Island. Did you have as of February 24, 2012,

16 experience with patients with homicidal ideation?

17 A Yes.

18 Q How about homicidal plans, did you have
19 experience with that?

20 A Yes.

21 Q Is it fair to say that Calvin Hunt did not
22 present you with a situation that you had not been in
23 before or experienced?

24 A Yes.

25 Q That's all I have. Thank you for your time,

1 Mr. Manning. Appreciate it.

2 A All right.

3 MR. BERLINSKY: The only person left is me.
4 This is Lee Berlinsky. Is there anybody on the other
5 end of the phone that may have questions for
6 Mr. Manning?

7 MR. FREEMAN: This is Mike Freeman. I don't
8 have any questions.

9 MR. FLEMING: Cory Fleming. I don't have
10 any questions.

11 MR. SAWYER: Wesley Sawyer. I don't have
12 any questions.

13 MR. BERLINSKY: Just give me one or two
14 minutes. I just want to correct a couple of things for
15 the record if I can.

EXAMINATION

16 BY MR. BERLINSKY:

17 Q Mr. Manning, if you look at Exhibit No. 1
18 and just flip through a couple of the nurses' progress
19 notes up in the top pages, there's been a reference that
20 you made to Mr. Manning (sic) being in Bed 3 or Room 3,
21 and I just wondered if you could look at any of those
22 documents and see if you needed to correct the record.
23 Specifically, you can look at 1547 at the top or --

24 MR. DETRICK: Object to the form.
25

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1 MR. BERLINSKY: I'm just trying to muscle
2 through.
3 MR. DETRICK: This is Paul Detrick.
4 MR. BERLINSKY: I don't want to lead too
5 much. I just want to save the memory of the court
6 reporter's stenography equipment.
7 THE WITNESS: Oh, right here?
8 Q (By Mr. Berlinsky) Correct.
9 A All right.
10 Q Does that give you a better indication that
11 the records may have accurately depicted what room
12 Mr. Manning was -- Mr. Ray was in versus your memory
13 going back a couple of years?
14 A Yeah. Well, I mean, yeah. There are
15 four -- there are four beds in ER, but one room is like
16 off to the back and it's for like -- it's a separate
17 room, and then there are three beds that are in the
18 front. So Room 1 is the back room, and then 2, 3, 4,
19 but that's why I said Bed 3 because there's numbers 1, 2
20 and 3. But, yeah, it was Bed 4.
21 Q Okay. And you were describing for
22 Mr. Detrick a truck or you called it a rig that has
23 lights and a siren. Are you talking about an ambulance
24 that would transport Mr. Ray to the hospital?
25 A Mr. Hunt?

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1 Q Mr. Hunt.
2 A Yeah.
3 Q Is that a typical ambulance that would be at
4 the access for the Beaufort Naval Hospital or the
5 Beaufort Memorial Hospital?
6 A The naval hospital.
7 Q And so are you tasked with transportation of
8 Mr. -- would you have been tasked with transportation of
9 Mr. Hunt, or are you there as a person that sits in the
10 back?
11 A No. I will be the person to transport him.
12 Q You're driving the ambulance?
13 A No. No, no, no. The duty drivers would
14 drive, but I am responsible for him. Like I'm the
15 pass-off.
16 Q Well, I want you to think about the question
17 I just asked you. I'm asking you are you driving the
18 ambulance with Mr. Hunt?
19 A No.
20 Q Okay. Are you in the back with Mr. Hunt?
21 A Yes.
22 Q Are you an escort?
23 A Yes.
24 Q Okay. When Mr. Detrick asked you that
25 question, you made it sound like you were driving an

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1 ambulance, and I just want to make sure that you are
2 clear on your answer.
3 A Okay.
4 Q Okay? And Mr. Mackelcan was asking you a
5 question to distinguish between an involuntary admission
6 and an inpatient admission. Do you remember those
7 questions just recently?
8 A Yes.
9 Q In this case, you agree with the testimony
10 that you provided earlier that this discusses an
11 inpatient admission of Mr. Hunt, does it not, the
12 medical records?
13 A The medical records?
14 Q The medical records that are Exhibit No. 1,
15 those discuss --
16 A An inpatient.
17 Q -- inpatient admission?
18 A Right.
19 Q Other than Mr. Detrick and maybe
20 Mr. Infinger using the word "involuntary admission," did
21 you see anything in those medical records that discuss
22 an involuntary admission?
23 A No.
24 Q Okay. Now, there was questions regarding
25 the medical records about Mr. Hunt having a suicidal

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1 ideation and also thoughts of hurting others, but no
2 specific plan, and that was on page 1551. Do you
3 remember those questions?
4 A Yes.
5 Q And do you have that record in front of you?
6 A Right.
7 ~~Q During your evaluation, did Mr. Hunt make~~
8 ~~any specific threat to any identifiable person or~~
9 ~~readily identifiable third party?~~
10 A I don't remember any details of the
11 conversation we had, but in my actions, I can say that
12 he wouldn't have made that statement to me because it
13 would have went a different direction.
14 ~~Q Well, I don't understand what that means --~~
15 ~~A Like if he would have made direct threats to~~
16 ~~a third-party person, then it would have been like -- it~~
17 ~~would have been a legal issue instead of just a mental~~
18 ~~health issue.~~
19 ~~Q If he would have made a statement that~~
20 ~~specifically threatened a third party or a readily~~
21 ~~identifiable third party, are you indicating that that~~
22 ~~statement would have triggered a response by you to have~~
23 ~~called law enforcement?~~
24 A Well, not law enforcement, but it would have
25 been a legal issue because I would have had to have

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1 identified the third party and then get the chain of
 2 command involved, in which that's when PMO would have
 3 been involved.

4 Q Did you get the chain of command or the PMO
 5 involved?

6 A No.

7 Q Okay. Does that lead you to believe that he
 8 did not make a readily identifiable threat or specific
 9 plan to hurt someone else?

10 A Yes.

11 Q And if you look at the bottom of
 12 Dr. Jansen's note that Mr. Detrick was asking you about
 13 on page 1552, do you see Dr. Jansen's signature on the
 14 bottom of that page?

15 A Yes.

16 Q And do you see a time stamp just above that?

17 A Yes.

18 Q And what time stamp is that?

19 A 1620.

20 Q Okay. And if you look back at his notes of
 21 progress, do you see the note that's time stamped at
 22 1540?

23 A Yes.

24 Q And I think it's been read into the record.
 25 "Mr. Manning present. Evaluating patient," is that what

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1 that says, or the best that we can determine since
 2 Dr. Jansen is not here to testify to his writing?

3 A Correct.

4 Q And I believe you testified that after that
 5 evaluation, you went up to talk to Dr. Hendelman;
 6 correct?

7 A Right.

8 Q And do you see on this document your
 9 indication that -- an indication that Dr. Jansen
 10 discussed with Dr. Hendelman at 1605 Mr. Hunt's patient
 11 progress?

12 A Yes.

13 Q Okay. Would you have seen Dr. Jansen's
 14 medical records that he wrote at 1620?

15 A No.

16 Q So you didn't know what's in this record
 17 until you saw it here today at the deposition?

18 A Right.

19 Q And when Mr. Detrick asked you if you were
 20 familiar with these documents earlier, when did you
 21 first see these medical records?

22 A Yesterday.

23 Q And did you specifically look at each and
 24 every page and try to identify what these writings were
 25 yesterday?

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1 A I tried. I couldn't read any -- I couldn't
 2 read most of it.

3 Q Okay. All right. If Dr. Jansen wrote an
 4 addendum to this 1552, which means a supplemental
 5 report, you don't have any indication as to what he did
 6 after this report, do you?

7 A No.

8 Q And if it's in the record, then it's in the
 9 record; right? You wouldn't have seen it --

10 A Right.

11 Q -- other than maybe in preparation for a
 12 deposition?

13 A Right.

14 MR. BERLINSKY: Okay. I don't have any
 15 other questions of Mr. Manning at this time.

16 MR. DETRICK: I don't have any further
 17 questions. This is Paul Detrick.

18 MR. INFINGER: Paul Infinger. I do have one
 19 or two questions. You ready?

20 THE WITNESS: Yes.

21 EXAMINATION

22 BY MR. INFINGER:

23 Q Mr. Manning, when you went into the -- after
 24 being paged and you went from Parris Island over to the
 25 Beaufort Naval Hospital and you understood you were to

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1 do a safety evaluation, could you have asked emergency
 2 room personnel to let you look at whatever records they
 3 had that they had just gotten for Mr. Hunt?

4 A Could I have asked?

5 Q Yes. Could you have asked them -- is there
 6 any reason they would not have let you look at the
 7 records they had?

8 A I'm not sure. That's not something that's a
 9 procedure that we would follow.

10 Q But if you wanted to look at the records
 11 because you had somebody there for a psychiatric
 12 evaluation, you could have asked for those records,
 13 whatever they had, a couple of pages, whatever they had
 14 that morning and looked at them; is that right?

15 A Well, it was in the afternoon. It wasn't
 16 morning.

17 Q Afternoon then.

18 A Like I said, I'm not sure. That's not a
 19 procedure that a technician would follow. If I was a
 20 doctor, that might be something, but I'm not a doctor.
 21 I'm a technician.

22 Q Well, they aren't doctors either, the ones
 23 who took the initial -- the notes, the intake notes.

24 A Right.

25 Q There's no reason, no legal reason you know

1 of that you couldn't have looked at those if you wanted
2 to, is there?

3 A Like I said, I'm not sure. That's not a
4 procedure that a technician will follow.

5 Q In all your time as a psych tech, you've
6 never asked to look at notes or records or anything when
7 you went in to evaluate somebody?

8 A In an ER? No.

9 Q So if they had threatened somebody in the
10 ER, you wouldn't know about it?

11 A If he had threatened somebody before I got
12 there, that -- he would have been in handcuffs. They
13 would have called the police.

14 Q Well, I mean, it depends on how the threat
15 was, wouldn't it?

16 A If he's directly -- if he immediately
17 threatened somebody right there while they're waiting
18 for me to get there.

19 Q What if he said, "I might hurt some other
20 people"?

21 A But that's not a direct threat. He's
22 saying, "I might hurt some other people."

23 Q You don't view that as a threat?

24 A No. It is a threat, but I mean, there's no
25 direct threat. It's just that's the same as somebody

1 saying, "I'm going to kill myself."

2 Q I understand that, but since he had already
3 made a statement to that effect before you got there,
4 Mr. Hunt had --

5 MR. BERLINSKY: Objection.

6 Q (By Mr. Infinger) -- that he might hurt
7 himself or others, you weren't interested in knowing
8 that, were you?

9 MR. BERLINSKY: Objection to the form of the
10 question.

11 THE WITNESS: I was interested. That's why
12 I went in and did my evaluation, and I would have asked
13 him questions.

14 Q (By Mr. Infinger) I know, but it would have
15 been helpful if you had known that before you did your
16 evaluation, wouldn't it?

17 A Not really.

18 Q Not really? It wouldn't have helped you
19 any?

20 A Not really.

21 MR. INFINGER: Okay. I don't have any other
22 questions.

23 MR. DETRICK: Anybody have any questions?

24 MR. FLEMING: Nope.

25 MR. DETRICK: I want to know when Lee's

1 coming back.

2 MR. BERLINSKY: We're off the record?

3 MR. DETRICK: Yeah, we're off the record.

4 (Whereupon the proceedings were adjourned at
5 12:15 p.m.)
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1 I, the undersigned, ARTHUR MANNING, being
2 first duly sworn say:

3 I have read and/or had translated the
4 foregoing deposition and know the contents thereof, and
5 I certify that the same is true of my own knowledge,
6 except as to those matters which are therein stated upon
7 my information and belief, and as to those matters, I
8 believe it to be true.

9 I declare under penalty of perjury that the
10 foregoing is true and correct.

11 Executed on _____, 2014,
12 at _____
13 _____
14 _____
15 _____
16 _____
17 _____

18 ARTHUR MANNING
19 _____

20 Signed before me this _____ day
21 of _____, 2014.

22 Witness to Deponent's Signature
23 _____
24 _____
25 _____

Miller, et al., vs. Case Pro, et al.
Civil Action No. 9:13-3395-DCN, etc., May 22, 2014
by Laura Savo, RPR, CSR

1 C E R T I F I C A T E
2 STATE OF HAWAII)
3) ss.
4 CITY AND COUNTY OF HONOLULU)
5 I, LAURA SAVO, a Court Reporter in and for
6 the State of Hawaii, do hereby certify:
7 That prior to being examined, the witness
8 herein, ARTHUR MANNING, was sworn by me to testify to
9 the truth, the whole truth and nothing but the truth;
10 That the foregoing deposition was taken down
11 by me in machine shorthand at the time and place herein
12 stated, and was thereafter reduced to typewriting under
13 my supervision;
14 That the foregoing is a full, true
15 and correct transcript of said deposition;
16 That pursuant to Rule 30(e), if signature
17 was requested by the witness or by counsel, the witness
18 was notified through counsel, by mail, or by telephone
19 to appear and sign; that a signed copy of the changes
20 made will be appended hereto; that if the transcript is
21 filed without signature, either the reading and signing
22 were waived by the witness and all parties, or the
23 witness has failed to appear and the original has been
24 sealed unsigned.
25 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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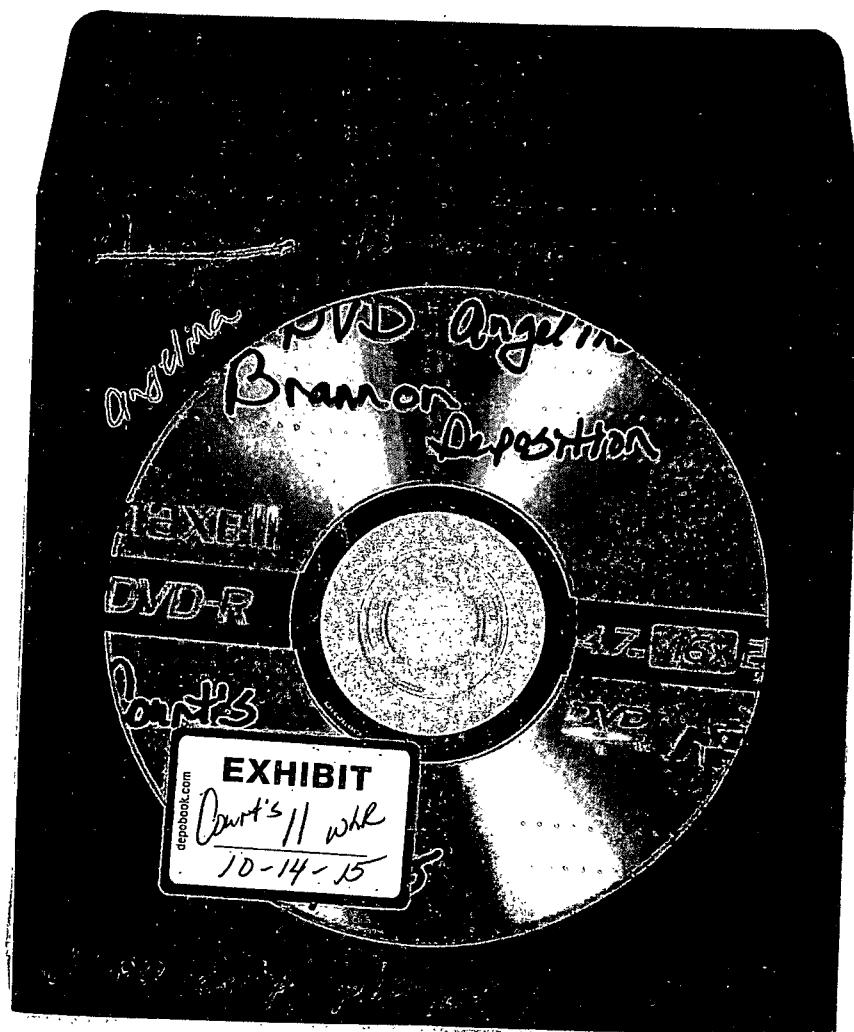
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 Brannon, Angela (Vol. 01) - 09/27/2015

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)

10 Q. Okay. Lieutenant Brannon, what is your full
11 legal name?
12 A. Angelina Delores Brannon.
13 Q. Are you currently a member of the United States
14 Military?
15 A. Yes, I am.
16 Q. What branch are you a member of?
17 A. The United States Navy.
18 Q. What is your rank in the Navy?
19 A. I'm a lieutenant, which is an O3. And I have
20 been selected for promotion, so I'm O4 select,
21 lieutenant commander select.
22 Q. Congratulations.
23 A. Thank you.
24 Q. How long have you been in the Navy?
25 A. On January 13th it will be 18 years.
00010:01 Q. So 1998?
02 A. Yes. I enlisted first in the Navy on
03 January 13th, 1998.
04 Q. How old were you when you enlisted?
05 A. 20.
06 Q. Were you stationed at the Naval Hospital
07 Beaufort in Beaufort, South Carolina, on February 24,
08 2012?
09 A. Yes, I was.
10 Q. Are you generally familiar with the incident
11 that is the subject of -- of the case that you are here
12 to testify about?
13 A. Yes, I am.
14 Q. Are you also a licensed medical provider?
15 A. No, I'm not a licensed medical provider. I'm a
16 licensed registered nurse.
17 Q. When did you first obtain your RN license?
18 A. In 2007.
19 Q. Where did you do that?
20 A. In Virginia.
21 Q. Beginning with your first assignment in the
22 Navy, can you walk us through your employment history in
23 the Navy?
24 A. Well, when I first enlisted in the United
25 States Navy, I come in as an E3, because I had prior
00011:01 college credits so they promoted me to the rank of E3.
02 I went to recruit training command in Great
03 Lakes, Illinois, and that was roughly about nine weeks
04 of training followed by basic hospital corpsman school,
05 which is -- for civilians, it's basically being a medic.
06 After graduating from that training, I went to
07 Pensacola, Florida, where I was stationed at the Naval
08 Hospital for two years. And I worked in the OBGYN
09 department and with the anesthesia providers.
10 Upon completing my tour of duty at Naval
11 Hospital Pensacola, I was selected for training to go
12 for field medical service school training, which is to
13 be a combat medic, and that was in Camp Johnson, North
14 Carolina. Roughly five weeks of training.

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15 Upon completing that training, I went to
16 surgical technologist training school. And that was in
17 Portsmouth, Virginia, and that training was
18 approximately six months.

19 Upon graduating from surgical technologist
20 training school, I proceeded to my following duty
21 station, which was Naval Medical Center, Bethesda,
22 Maryland, which has now been changed. It's no longer
23 existing, because they have merged with other branches.

24 I was there a year. I elected to leave early,
25 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.

03 At that point, I was stationed at Naval Medical
04 Center, Portsmouth, Virginia, for approximately three
05 years, where I worked in the operating room department.
06 And I was one of the education and training petty
07 officers or the individual who helped with orientating
08 new technologists and managing training records.

09 At that point, I was selected for a very
10 competitive program called the Medical Enlisted
11 Commissioning Program, in which I was selected and
12 allowed to attend the -- a four-year university to
13 obtain my Bachelor's Degree in nursing.

14 I began my studies at Hampton University in
15 2005, and I graduated in 2007. Upon graduating Hampton
16 University, I proceeded to my former duty station, Naval
17 Medical Center, Portsmouth, where I had a three-month
18 orientation to the command, just experience in the
19 different departments. Command orientation, any nursing
20 training that was required at that time. And my first
21 assignment was in one of our complicated, high-risk OB
22 departments, labor delivery, where I worked for
23 approximately one year, nine months.

24 Labor and delivery, when you are a brand new
25 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.

05 I was working in the Emergency Department of
06 Naval Medical Center, Portsmouth, from approximately
07 January 2009 until I left in July 2011. The emergency
08 department there were 42 bed, ER. We had a patient
09 volume of approximately 60,000 patients per year.

10 And I started off as one of -- just regular
11 floor nurses. I was selected for charge nurse, and I
12 was later selected for team leader, in which I was in
13 charge of approximately ten registered nurses and
14 roughly nine to ten hospital corpsmen, which is medics.

15 And I -- at that point, called my detailer,
16 which is the individual who we call in order to select a
17 future duty station and Beaufort Naval Hospital was one
18 of the options that I had available, and so I selected
19 it.

20 And then I proceeded to Naval Hospital
21 Beaufort. I checked on board July 29th, 2011. And I
22 left Naval Hospital Beaufort pretty recently, in August
23 of this year.

24 While I was working in -- at Naval Hospital
25 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.

05 I was there from July 2011 until I deployed.

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06 As I have mentioned before, I have been on -- in the
07 Navy almost 18 years. My career was not operational. I
08 wanted to do something big. I wanted to contribute. I
09 didn't want to spend 20 years of my career and never
10 have experienced a deployment. So I spoke to my
11 director of nursing and requested if a deployment did
12 happen to come up that I would like to get selected.
13 And that's where I went. In 2013, I was
14 selected to a deploy with the Marine unit. And I
15 deployed to Camp Leatherneck in Afghanistan for roughly
16 ten months, where I was a medical regulator responsible
17 for working in the combat operation center, providing
18 med/evac assistance, which is evacuation of casualties
19 from the battlefield to the next level of care, whether
20 it be an actual treatment facility or another unit.
21 Upon returning from deployment, the ER
22 department had now been closed. So the only other place
23 where I could work and actually engage in clinical
24 practice as a nurse would be the post-anesthesia care
25 unit, which is a recovery room where I was a recovery
00015:01 room nurse. And I also worked in the ambulatory care
02 unit, which is the unit in which patients first check on
03 board in order to get checked in for surgery and for
04 surgical prescreening where we screen patients for
05 surgeries.
06 And now, while I was deployed I applied for
07 another very competitive program called Duty Under
08 Instruction by the Navy Nurse Core. And with my love of
09 emergency nursing, the only way that I could stay in
10 emergency nursing was to specialize as a clinical nurse
11 specialist. I applied. There was only two billets.
12 There was seven of us applying, and I was selected.
13 So right now I have just began my studies at
14 the University of California, San Francisco, where I am
15 studying for a Critical Care Trauma Clinical Nurse
16 Specialist program with the hopes of graduating in June
17 2017.
18 And I don't know where I will be stationed
19 next. That's all upon, you know, the Navy and where the
20 needs are.
21 Q. Okay. Thank you for that. That was a lot
22 of -- that was a lot.

2. PAGE 16:02 TO 16:12 (RUNNING 00:00:37.197)

02 risumi quite that well, so I'm impressed. I want to
03 focus on your time at the Naval Hospital Beaufort.
04 Could you repeat for me what your title was when you
05 began there in July of 2011?
06 A. Yes. Department head.
07 Q. Did you also say that you were a supervisor?
08 A. It's kind of difficult to kind of switch the
09 military terminology to civilian, but essentially that's
10 what it is. A supervisor. When we are in charge or
11 responsible for overseeing contractors, we are in a
12 supervisory role.

3. PAGE 16:17 TO 17:24 (RUNNING 00:02:05.825)

17 Q. Who does the department -- who did you report
18 to as the department head?
19 A. The director of medical services, who at the
20 time was Commander Thier, who is now Captain Thier.
21 Q. Who did you supervise while you were in the
22 department head of the ER?
23 A. I supervised CasePro employees, which included
24 physicians, nurse practitioners, PAs, and LPNs. Did I
25 say registered nurses already? No? Registered nurses.

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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

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19 in 2007. I have a Masters of -- Master of Arts in
20 Management and Leadership that I obtained in 2012. And
21 I'm working on my second Master's Degree in nursing
22 right now. That's more of the formal training.
23 I have non-formal training that includes
24 leadership training, officer training. When I first
25 became a naval officer, I went to Rhode Island where I
00021:01 went to officer training school and we had leadership
02 training courses. I have had ongoing leadership

7. PAGE 21:25 TO 22:16 (RUNNING 00:01:02.261)

25 question, so that -- that's good. When you are talking
00022:01 about the committee, you mentioned patient safety,
02 quality management. Were there other committees that
03 you participated on while at the Naval Hospital
04 Beaufort?
05 A. Yes. But I don't recall all of them. I was
06 very involved within the command and the department.
07 Q. Were contract workers involved in -- in those
08 committees that you referenced?
09 A. In those specific committees that I referenced,
10 no.
11 Q. Were those hospital management-type committees?
12 A. They're usually -- in order to participate in a
13 hospital-wide committee, you have to be active duty or
14 you'd have to be a federal employee, because contract
15 employees cannot go outside the scope of their contract.
16 So a committee would be outside.

8. PAGE 22:20 TO 23:04 (RUNNING 00:00:35.672)

20 Q. As of -- as of February 2012, what was, at the
21 time, Commander Thier's job?
22 A. He was the director of medical services. I'm
23 trying to make it more simple, because I know you are
24 not familiar with the military system. He's essentially
25 the executive who is in charge of Medical Home Port,
00023:01 which you may know it as family practice and internal
02 medicine and the emergency department and the urgent
03 care. He answers to the executive officer and to the
04 commanding officer.

9. PAGE 23:13 TO 23:23 (RUNNING 00:00:37.163)

13 Q. Recognizing that you did not serve in either of
14 these roles, what is the -- what are the duties or
15 responsibilities, generally, of the commanding officer
16 versus the executive officer?
17 A. I can't speak to the extent of the
18 responsibilities and duties, because I'm not thoroughly
19 familiar with them. But I know in order to better
20 simplify it for you, it would be the equivalent to a CEO
21 of a hospital, and the XO would be the second person in
22 line. I don't know if there's an assistant CEO or what
23 their -- the terminology is.

10. PAGE 23:25 TO 25:18 (RUNNING 00:03:08.547)

25 So -- so the CEO or the commanding officer was the
00024:01 person in charge of the hospital?
02 A. Yes, that's correct.
03 Q. And the XO worked for the commanding officer?
04 A. Yes.
05 Q. Okay.
06 A. They're the two most senior people inside the
07 command -- of any command.
08 Q. Did at the time Commander Thier report to the
09 CO and the XO?

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10 A. Yes, that's correct.
11 Q. And you reported directly to Commander Thier?
12 A. Yes.
13 Q. Did -- did I hear you say that you treat --
14 also treated patients at the Emergency Room at Naval
15 Hospital Beaufort on occasion?
16 A. It was on occasion. We were a small
17 department, so there were times when the nurses would
18 need assistance. And I, as a fellow registered nurse
19 and an ER nurse, I would assist when -- when needed.
20 Q. Were you physically present at the Naval
21 Hospital Beaufort on February 24, 2012?
22 A. I was present. I had left for the day when the
23 incident happened.
24 Q. Do you recall when you were there?
25 A. Roughly from 7 in the morning until, I don't
00025:01 know, after working hours. Sometime after 15:30.
02 Q. So you were -- 15:30 is 3:30 in the afternoon,
03 for those of us non-military?
04 A. Yes, roughly. But I don't recall the exact
05 time. I just remember I had already left for the day
06 when I received the phone call.
07 Q. Is 3:30 the time that you would typically --
08 would have typically left for the day?
09 A. No, not typically. My days were pretty long.
10 I'd get there at 7 in the mornings. Sometimes I was
11 there until about 18:00, which is 6 p.m., depending.
12 Q. How many days a week would you work at the
13 Naval Hospital Beaufort?
14 A. Five days a week.
15 Q. Monday through Friday?
16 A. Yes, that's correct. But the hours that I told
17 you were not set in stone. It's all depending on what
18 was going on.

11. PAGE 25:25 TO 26:15 (RUNNING 00:00:39.295)

25 Q. Were you there at the Naval Hospital at
00026:01 14:00 hours?
02 A. Yes.
03 Q. Okay. Were you there at 15:00 hours?
04 A. Yes.
05 Q. Were you there at 15:30?
06 A. I believe I was, but I can't say exactly.
07 Q. Okay. So beyond 15:30 that you are not exactly
08 sure if -- that you were there?
09 A. That's correct.
10 Q. Did you have an office at the Naval Hospital
11 Beaufort?
12 A. Yes, I did.
13 Q. Where was your office located?
14 A. It was around the corner from the emergency
15 department. I had two offices. The initial office that

12. PAGE 26:24 TO 27:06 (RUNNING 00:00:27.750)

24 Q. How long would it take for you to walk from
25 your office to the emergency department?
00027:01 A. Seconds. Less than 30 seconds.
02 Q. On a typical day, recognizing that every day is
03 different, but on a typical day, how many times would
04 you physically set foot in the emergency department at
05 the Naval Hospital Beaufort?
06 A. Approximately three, four times, give or take.

13. PAGE 27:13 TO 27:17 (RUNNING 00:00:21.747)

13 Q. Do you recall whether you were physically

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14 present in the emergency department on February 24,
15 2012?
16 A. In the department? I don't recall. That's a
17 long time ago. I was at the hospital, and everyday --

14. PAGE 27:22 TO 28:21 (RUNNING 00:01:03.885)

22 A. Oh. Every day, part of the -- the normal
23 routine that I do, I come into the department. You
24 know, I check on the staff, see what the patient volume
25 is. See if there's any pressing issues, and I collect
00028:01 the ER medical records.
02 And I get prepared for morning report, which
03 starts at 07:30, where I go -- it's myself, usually
04 inpatient ward, and other pertinent parties and the
05 executive officer, commanding officer or directors are
06 all there. And we go over, you know, how many patients
07 we are seeing. And if there's anything which is a
08 command interest patient.
09 Say, for instance, an active duty member was
10 admitted to the hospital, then that would be something
11 relevant that the commanding officer and director should
12 know. So at that time I would let them know there's a
13 command interest patient or if there's something that's
14 pressing or concerning that would be the time to report
15 it.
16 So every day I made my rounds to the
17 department. Now on that day I can't recall how many
18 times I did.
19 Q. Did I hear you say that you collected the
20 records each day?
21 A. Yes.

15. PAGE 30:17 TO 31:07 (RUNNING 00:00:55.757)

17 Q. Did you personally review medical records from
18 the emergency room?
19 A. What do you mean by review?
20 Q. Well, you, I believe, testified that you
21 collected the records and brought them to the morning
22 report and various hospital executives would discuss the
23 treatment that had been rendered in the emergency room.
24 The -- my question is in -- either prior to that meeting
25 or really, at any time, did you personally look through
00031:01 the records to review them?
02 A. Yes.
03 Q. How frequently did you review emergency room
04 medical records?
05 A. I don't recall the frequency.
06 Q. Was it a daily, weekly?
07 A. More so weekly. On -- I have to explain to you

16. PAGE 32:14 TO 33:06 (RUNNING 00:01:06.674)

14 Q. I -- I don't -- I'm not asking you about a
15 specific peer review, meaning a specific medical
16 provider's peer review. But I'm just asking, generally,
17 were you involved in peer reviews and performance
18 evaluations?
19 A. I was not directly involved in the peer review
20 of the providers, which is the physicians, the physician
21 assistants, or the nurse practitioners. We didn't have
22 a formal peer review type process for the nurses.
23 But I would review periodically charts just to
24 make sure that there are certain things that, you know,
25 are relevant, such as certain stop times for certain IV
00033:01 push medications, certain start and stop times of
02 fluids, piggyback medications, reassessment of a

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03 patient, vital signs frequency.
04 Q. Did you conduct performance reviews for the
05 contract workers who performed services in the emergency
06 department that reported to you?

17. PAGE 34:06 TO 35:21 (RUNNING 00:02:07.588)

06 A. Okay. For the nurses, there is something
07 called the ACPA. I don't remember what the actual
08 acronym stands for. It's a credentialing form. It's
09 like two pages, and it's done every year. And it's due
10 in December. And that goes over the individual's time
11 that they've worked there, the period.
12 Have they completed any type of training or
13 have they conducted any type of training with other
14 personnel. It also asks more personal questions. Have
15 they -- gosh, I can't even remember, been convicted
16 of -- of anything, they would have to address those
17 there. It all goes to credentialing.
18 Certifications they may have obtained. The
19 length of stay of the average patient, the patient
20 population. And then on the back, there's a small part
21 for narrative, in which the supervisor would then, you
22 know, write a brief description of is the individual a
23 competent nurse or not. And that's per the
24 credentialing department.
25 And then the member would sign, the supervisor
00035:01 signs, the director of nursing signs. And it goes to
02 the credentialing department. And the -- I'm sorry.
03 The director of medical services would actually review
04 the part of the chain of command.
05 For the physicians, there's something
06 different. I believe it's called an OPPE, but I don't
07 remember the exact terminology. It does require
08 supervisor signature. And if I recall correctly, that
09 also -- you have to document number of peer reviews
10 done.
11 But I wouldn't do the peer reviews for the
12 physicians or any of the providers, because I'm not a
13 physician. It would have to be another physician
14 conducting those peer reviews.
15 Q. When you -- you referenced the credentialing
16 department. Is that a department at the Naval Hospital
17 Beaufort?
18 A. Yes, it is.
19 Q. Who was in that department while you were there
20 in 2011 and 2012?
21 A. Ms. Kirkwood was. There was a new employee. I

18. PAGE 35:24 TO 36:03 (RUNNING 00:00:20.036)

24 Q. Was Ms. Kirkwood the person who actually issued
25 the -- the credentials or privileges?
00036:01 A. Yes.
02 Q. Was Ms. Kirkwood a GS worker?
03 A. Yes, she is.

19. PAGE 36:12 TO 38:20 (RUNNING 00:03:40.955)

12 Q. Lieutenant Brannon, there's been some testimony
13 in this case that the emergency department did not use
14 AHLTA, the electronic medical records system. Is that
15 your recollection as well?
16 A. Do you know what AHLTA is at all? Do you know
17 the extent of it? I'm just trying to understand just
18 what your knowledge base is, so I can explain.
19 Q. I think it's -- I think it's fair to say that I
20 don't know --

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21 A. Okay.
22 Q. -- a whole lot about it.
23 A. Okay.
24 Q. If you could describe what AHLTA is for us,
25 that would be helpful.
00037:01 A. Okay. AHLTA is an electronic medical record.
02 It's primarily used like in Medical Home Port as if --
03 like you would go to your -- your primary care manager
04 now. The physician would document an AHLTA, and that's
05 only at a military treatment facility.
06 Also like on Parris Island, the recruits, all
07 documentation is done in AHLTA. AHLTA has access to
08 CHCS, which is our oldest computer system. CHCS, it's
09 an old program, and that's where we enter all of our lab
10 orders, radiology records, if we are going to check in
11 or check out a patient say for an appointment, that's
12 where you would do it. It's very very extensive, and
13 it's a very old database.
14 AHLTA is more for like the primary care areas.
15 There at Naval Hospital Beaufort, we were still using
16 paper charting. Some of the nurses and physicians may
17 have had access to AHLTA, but it's not something that we
18 use on a day-to-day basis. Because through AHLTA, you
19 can actually access CHCS to retrieve lab and
20 radiological reports or look at a patient's medication
21 list.
22 And then there's also ESSENTRIS, just in case
23 it ever comes up. That is another electronic medical
24 records system that we have which we didn't also use in
25 the department.
00038:01 Q. I'm sorry. That you did not use?
02 A. No. We were all paper charting for the most
03 part.
04 Q. Can you describe for me what you mean by paper
05 charting?
06 A. Yes. Instead of having a digital record of an
07 ER visit, we old-fashioned paper -- paper charts. The
08 nursing note was in paper. We had -- well, they were
09 paper T sheets, which are the treatment records that the
10 physician would document on. Discharge information was
11 printed on -- from online and then printed -- it's all
12 just like a stack of papers that was the -- the
13 emergency treatment record, the paper chart.
14 Q. Lieutenant Brannon, as you know, this case
15 involves Calvin Hunt's stealing a fire truck and hitting
16 a pedestrian after he'd left the Naval Hospital
17 Beaufort. Are you aware of any policy in place at Naval
18 Hospital Beaufort on February 24, 2012, that prevented
19 patients from leaving the emergency department?
20 A. No, I'm not aware.

20. PAGE 40:03 TO 40:09 (RUNNING 00:00:23.701)

03 Q. How about for just stepping outside of the
04 emergency department, not necessarily leaving without
05 treatment as you described before? Was there a policy
06 that prevented patients from stepping outside, either
07 into the hallway or outside of the building for a few
08 minutes with the intent of returning?
09 A. Not to my knowledge.

21. PAGE 40:12 TO 41:09 (RUNNING 00:01:44.320)

12 Q. After the incident on February 24, 2012, did
13 you contact anyone at the CasePro corporate office to
14 discuss the incident?
15 A. I don't ever contact CasePro directly. My
16 liaison is a contract officer representative, which

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17 would be Deb Mayo. She would make contact with them.
18 Q. Do you know one way or the other if Deb Mayo
19 had any contact with CasePro about the incident after --
20 afterwards?
21 A. I don't know if she did.
22 Q. If you had a concern about the care rendered in
23 the emergency department by CasePro personnel, you
24 would -- would you convey that concern to Deb Mayo?
25 A. Yes, I would. And I would also keep my
00041:01 director in -- in the loop, so he's not caught off
02 guard.
03 Q. Would it surprise you to find out that CasePro
04 corporate office first found out of this incident in
05 November 2012 when the -- when it was served with this
06 lawsuit?
07 A. Well, yes, I would be surprised.
08 Q. Why would you be surprised?
09 A. Just because of the length of time.

22. PAGE 42:03 TO 42:16 (RUNNING 00:01:02.598)

03 Q. If the Navy had concerns about Dr. Jansen, Joe
04 McDonald's, or Janice McDonald's treatment of Calvin
05 Hunt in the Emergency Department at the Beaufort Naval
06 Hospital on February 24, 2012, did the Navy have
07 authority to take action with regards to their
08 privileges at the Naval Hospital?
09 A. There is a mechanism in place.
10 Q. Is that a yes?
11 A. Yes.
12 Q. Okay. To your knowledge, was any disciplinary
13 action taken by the Navy in response to the treatment
14 provided to Calvin Hunt to the Emergency Department of
15 Beaufort Naval Hospital on February 24, 2012?
16 A. No.

23. PAGE 44:11 TO 44:13 (RUNNING 00:00:10.557)

11 Q. Do you believe that Dr. Jansen, Joe McDonald,
12 and Janice McDonald had adequate medical training and
13 experience to treat a patient like Calvin Hunt?

24. PAGE 44:16 TO 45:05 (RUNNING 00:00:48.841)

16 THE WITNESS: Part of the hiring process, the
17 providers, which are your medical providers and your
18 nurses, must meet certain criteria per the contract. So
19 they have to come to the department ready and
20 experienced in order to be licensed. Then the
21 assumption would be made that they are qualified based
22 on their training, their licensure, and certifications
23 they may carry.
24 MR. MACKELCAN:
25 Q. And I'm you asking specifically as the
00045:01 supervisor for these personnel at that time
02 approximately six months you had been their supervisor.
03 Did you -- do you believe that as of that date they had
04 adequate medical training and experience to treat a
05 patient like Calvin Hunt?

25. PAGE 45:08 TO 46:04 (RUNNING 00:01:27.028)

08 THE WITNESS: Okay. During that short period
09 of time, I personally did not have any problems with the
10 care that either of those individuals provided.
11 MR. MACKELCAN:
12 Q. I -- I -- just to clarify, I asked about Dr.
13 Jansen and Joe McDonald and Janice McDonald.
14 A. Yes. That's correct.

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15 Q. So your answer would be to all three of them?
16 A. Yes. During that period of time, I did not
17 have any problems or concerns with the care that they
18 had provided.
19 Q. Are you -- how familiar are you with the care
20 that was provided to Calvin Hunt on February 24th, 2012?
21 A. I don't remember the actual chart. I just --
22 it's very vague. I was hoping that there'd be a copy of
23 it so I could review it, but there isn't. So I'd say
24 vaguely familiar.
25 Q. Okay. Do you have a recollection that Dr.
00046:01 Jansen requested a psychiatric consultation?
26 A. Yes, I am.
27 Q. Was that an appropriate action for Dr. Jansen
28 to take according to hospital policy?

26. PAGE 46:07 TO 46:11 (RUNNING 00:00:13.190)

07 THE WITNESS: Again, that's something -- that's
08 at the discretion of the medical physician who is there
09 in the ER department. Just as if a patient presented
10 with a broken leg, they would consult or seek expert
11 consultation with an orthopedic surgeon.

27. PAGE 47:07 TO 49:02 (RUNNING 00:02:43.732)

07 Q. If -- is it also your understanding that when
08 the psychiatric consultation was requested by Dr. Jansen
09 the first step of that process is a psychiatric
10 technician comes to the ER to interview the patient?
11 A. Yes, I'm aware that that's how the psych -- the
12 psych department conducts their consultations.
13 Q. Did you know -- I believe his name is Arthur
14 Manning, who is -- who was the psych tech on that day?
15 A. Do I know him? No.
16 Q. But you are generally familiar with -- with the
17 fact that -- or are you generally familiar that -- that
18 Mr. Manning came down and interviewed Calvin Hunt?
19 A. I'm aware that a psych tech came down to
20 evaluate Mr. Hunt, yes.
21 Q. What is your understanding of the purpose of a
22 psychiatric tech interviewing a patient?
23 A. My understanding is that the psych tech comes
24 down and does the initial intake of a patient and then
25 reports back to their -- the mental health provider
00048:01 that's assigned to them.
26 Q. If the psych tech was concerned for the
27 patient's safety or concerned about the patient causing
28 harm to others at the end of his interview with the
29 patient in the emergency department, would you expect
30 the psych tech to convey those concerns to the nurses
31 and doctors on duty in the emergency department?
32 MR. HOYLE: Objection. Form. Witness can
33 answer.
34 THE WITNESS: I wasn't there, but had I been
35 there, I would hope that the individual would convey
36 that message to me.
37 MR. MACKELCAN:
38 Q. And I'll recognize that you weren't there. I'm
39 asking you as the -- department head of the emergency
40 department whether you would expect the psych tech to
41 convey concerns to the doctors and nurses?
42 A. Yes, I would. We have a system in place
43 throughout Navy medicine we call SBAR in which, you
44 know, nurses, corpsmen, doctors, anybody that's part of
45 the health care team, we communicate with each other.
46 The hope is through SBAR, which means we present to each
47 other say, for instance, I'm given report or hand off on

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24 a patient, what the situation is, the background on that
25 patient, my assessment, and any recommendations. And by
00049:01 doing that, hopefully we capture everything that's
02 pertinent to that patient.

28. PAGE 53:04 TO 53:12 (RUNNING 00:00:25.491)

04 Q. In 1.12 where it defines supervisor, the
05 definition is "the government official whose duty it is
06 to provide day-to-day direction to and oversight of
07 contractor personnel including supervisory functions
08 such as time and attendance." Did I read that
09 correctly?
10 A. Yes, you did.
11 Q. Was that you?
12 A. Yes, that would be me.

29. PAGE 53:24 TO 56:09 (RUNNING 00:03:55.225)

24 Q. I'm sorry. 108. In 9.6, beginning at the end
25 of the first line, it says "the supervisor is best
00054:01 served by supervising the contract personnel in the same
02 manner as they supervised the government personnel of
03 their staff." Did you supervise contractor personnel on
04 the same manner as government personnel?

05 A. Well, when I first got there, I didn't have any
06 government personnel. Are you considering the enlisted
07 as government personnel?

08 Q. That's really up for you -- up to you to decide
09 how you want to answer. I'm not sure what that means.

10 A. Well, this is very -- a very vague question,
11 because there's a lot that goes into the supervisory
12 aspect of supervising personnel. Because it's not like
13 working at AT&T or Google. You know, we are dealing
14 with patient's lives every day, and every decision or
15 inaction affects someone.

16 So in the sense of supervising, is the
17 environment safe? Are they rendering safe patient care?
18 Are they treating our patients and beneficiaries with
19 the utmost respect and dignity that they deserve? Then
20 yes.

21 They were not treated any different in the
22 sense that I render the same amount of respect as I
23 would to a contract employee as I would to a government
24 employee as I would to military personnel. And as far
25 as requirements ensuring that, you know, their
00055:01 certifications are current or anything like that, then
02 yes. Ensuring they're ready for work, they're wearing
03 their staff badges, that they're communicating
04 effectively, that they're working as part of the team,
05 then yes.

06 Q. Did you do all of those things --

07 A. Yes.

08 Q. -- with regards to the CasePro health care
09 workers?

10 A. Yes. Because it's all part of patient safety.

11 Q. And that -- that was one of your
12 responsibilities --

13 A. Yes.

14 Q. -- as a supervisor?

15 A. That was one of many, yes.

16 Q. In 9.7, the paragraph below, states "the
17 supervisor's responsibility for supervision of
18 contractor personnel extends to the normal feedback that
19 should be provided to any employee regarding the quality
20 of their performance." Did you provide feedback to
21 contractor personnel?

22 A. Yes, I did.

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23 Q. If you could go back or go to the front of the
24 document, page three. In B6a where it states
25 "performance of health care worker services at any
00056:01 Department of Defense or Coast Guard Military Treatment
02 Facility within the States of North Carolina, South
03 Carolina, and Tennessee shall be considered within the
04 scope of this contract."
05 A. Okay. I see that.
06 Q. Okay. On -- on February 24th, 2012, were Dr.
07 Jansen, Joe McDonald, and Janice McDonald performing
08 services that were within the scope of the contract?
09 A. Yes.

30. PAGE 56:22 TO 57:23 (RUNNING 00:01:11.145)

22 THE WITNESS: Okay. I haven't read the entire
23 contract from its entirety, so within the scope of this
24 contract to my understanding the portions that I do
25 know, then I would say yes. But I'm not an expert in
00057:01 contracts.
02 MR. MACKELCAN:
03 Q. What -- what services was Dr. Jansen providing
04 on February 24th, 2012?
05 A. He --
06 Q. What was his role?
07 A. He was the attending physician in the emergency
08 department.
09 Q. Okay. And what role was Joe McDonald?
10 A. Joe McDonald was the bedside nurse and ER
11 nurse.
12 Q. And -- and Janice McDonald's role -- what was
13 her role?
14 A. She was the ER nurse that day, and she was in
15 triage.
16 Q. Were the McDonalds performing nursing services
17 on February 24th, 2012, in the emergency department at
18 Beaufort Naval Hospital?
19 A. Yes, they were.
20 Q. Okay. Was Dr. Jansen performing doctor
21 services at the emergency department at Beaufort Naval
22 Hospital on February 24th, 2012?
23 A. Yes, he was.

31. PAGE 58:02 TO 58:14 (RUNNING 00:00:39.341)

02 Q. Okay. 2.3 states that HCWs, which is -- is
03 that the health care workers?
04 A. Yes, it is.
05 Q. Okay. "HCWs providing services under this
06 contract shall be rendering personal services to the
07 government and shall be subject to day-to-day
08 supervision and control by government personnel." Did I
09 read that correctly?
10 A. Yes, you did.
11 Q. Okay. What other government personnel did you,
12 and possibly Dr. Jordan, depending on when she took on
13 that role -- what other government personnel provided
14 day-to-day supervision to the health care workers?

32. PAGE 58:17 TO 59:06 (RUNNING 00:00:58.137)

17 THE WITNESS: In an indirect manner, I would
18 say perhaps the director of medical services, but he's
19 not directly involved in the day-to-day supervision. He
20 relies on his leaders which are under him to actually
21 carry out those tasks.
22 MR. MACKELCAN:
23 Q. You use the term leaders there. Are you

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24 referring to yourself and other department heads?
25 A. Yes, I am.
00059:01 Q. Paragraph 2.3 goes on to state "supervision and
02 control is the process by which the individual HCW
03 receives technical guidance, direction, and approval
04 with regard to a task within the requirements of this
05 contract." Did I read that correctly?
06 A. Yes, you did.

33. PAGE 59:16 TO 60:20 (RUNNING 00:01:35.728)

16 Q. What sort of guidance did you provide to them?
17 A. There is the guidance that comes out all the
18 time. For instance, the Emergency Nurses Association
19 has statements on, let's say, triage of patients. And
20 so my role is to make sure if something new comes out
21 that I stay abreast of new information so that I can go
22 ahead and implement it in the department.
23 Such as, just so you understand, door to EKG
24 times. If a patient comes in, and they're exhibiting
25 any cardiac symptoms or symptoms that could potentially
00060:01 indicate that the patients may be having a cardiac
02 event, then the standard would be to bring the patient
03 in and actually conduct an EKG within ten minutes.
04 Because as you may or may not know, door to EKG time is
05 critical to identifying patients who are at risk for
06 having an acute MI. That would be one example.
07 Reassessment of patient's vital signs. There's
08 certain periods that they should be reassessed. So when
09 it came to things like this, yes. And they were
10 provided feedback.
11 As far as the physicians, I'm not a physician.
12 So for me to tell a physician how to be a physician
13 would not be within the scope of my nursing practice.
14 Q. Who was -- who did that at the Naval Hospital
15 Beaufort?
16 A. I would -- I'd be making an assumption here,
17 but I would assume it would be the director of medical
18 services since he's also a family practice physician.
19 Or guidance would come down from the Executive Committee
20 on Medical Services.

34. PAGE 61:25 TO 62:04 (RUNNING 00:00:12.926)

25 Q. Can a contract health care worker provide
00062:01 services at the Naval Hospital Beaufort if they do not
02 have approval from the credentialing department at
03 Beaufort Naval Hospital?
04 A. They would not be allowed to work there.

35. PAGE 62:10 TO 62:17 (RUNNING 00:00:23.959)

10 Q. Did you ever personally share the results of
11 any peer reviews or performance evaluations with
12 CasePro?
13 A. I never interacted directly with CasePro. With
14 Ms. Mayo, yes, if there was something. But the majority
15 of the time there was no issues. But she was kept
16 abreast of any issues that they were. I always kept her
17 in the loop.

36. PAGE 66:07 TO 66:24 (RUNNING 00:01:06.814)

07 Q. So in the next sentence in -- in that paragraph
08 that I had been reading from says "the emergency room
09 will operate under the clinical oversight of the ER
10 medical director who does not provide regular staff
11 physician service in the emergency room."
12 A. I see that.

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13 Q. Okay. So if on February 24, 2012, Dr. Jordan
14 had not assumed the role as ER medical director, there
15 was nobody in that position?
16 A. Not in the department itself.
17 Q. So that -- would that role have been served by
18 the director of medical services?
19 A. I would be making an assumption, but I would
20 assume yes. But he's not ER trained. So I don't know
21 if this oversight -- ER medical director, if the intent
22 was specifically for it to be an emergency room
23 physician who is the director or if it's just a medical
24 director who oversees the ER.

37. PAGE 66:25 TO 67:09 (RUNNING 00:00:35.991)

25 Q. Who provided clinical oversight prior to Dr.
00067:01 Jordan taking on that role?
02 A. Clinical oversight of the physicians would have
03 fallen under our director medical services.
04 Q. That was --
05 A. Commander -- yes.
06 Q. Commander Thier?
07 A. Yes.
08 Q. Was Dr. Jordan a GS employee?
09 A. Yes, she was.

38. PAGE 70:07 TO 70:15 (RUNNING 00:00:26.299)

07 Q. And when you say an internal document, are you
08 referring to Department of Navy?
09 A. No. I believe -- I'm not sure if the civilian
10 sector uses something similar to this, but it's
11 something tied into what the Joint Commission on
12 Accreditation does. It's a quality management system.
13 Q. So is it -- you are referring to a government
14 system?
15 A. I believe it's a government --

39. PAGE 70:19 TO 71:01 (RUNNING 00:00:21.068)

19 Q. Do you know whether CasePro had any involvement
20 or -- with or access to patient safety reports?
21 A. No, that would be a Hippa violation.
22 Q. So they did not -- CasePro did not have access
23 to those --
24 A. No.
25 Q. Is that your --
00071:01 A. No, they don't. Neither does Deb Mayo.

40. PAGE 86:19 TO 86:24 (RUNNING 00:00:17.732)

19 Q. This particular instruction defines a personal
20 service contract as a contract that its expressed terms
21 or as administered makes the contract or personnel
22 appear in effect to be government employee. Did I read
23 that correctly?
24 A. Yes.

41. PAGE 89:05 TO 89:09 (RUNNING 00:00:27.000)

05 clarity. But I believe the word appearance refers in
06 terms of how the contractors appear to the patient.
07 Is -- would there be any way for a patient to know that
08 a particular health care provider was a contractor
09 versus a GS employee at the Naval Hospital Beaufort?

42. PAGE 89:13 TO 90:02 (RUNNING 00:00:43.947)

13 THE WITNESS: Okay. Not unless the contract
14 employee actually identified themselves as such, because

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15 we have a mix. The majority of our employees, the
16 federal employees, and the contract employees that work
17 there, they make up the majority of the -- just the
18 staffing there. The military, we're a small percentage
19 of it. And I don't think --
20 MR. MACKELCAN:
21 Q. Do they have different uniforms?
22 A. No. We all -- well, the military wear their
23 uniform. We're in scrubs. Civilian -- the GS personnel
24 may wear their own scrubs. The contractors may wear
25 their own scrubs. There's no way to distinguish them,
00090:01 because we're all essentially there to provide patient
02 care.

43. PAGE 93:17 TO 93:23 (RUNNING 00:00:20.692)

17 Q. In the next paragraph it says PSC shall be
18 subject to the same quality assurance, risk management,
19 credentials review, and clinical privileging standards,
20 including licensure, as those required military and
21 civil service HCP." Was that your experience at Naval
22 Hospital Beaufort while you were there?
23 A. Yes.

44. PAGE 97:21 TO 98:08 (RUNNING 00:00:45.536)

21 Q. Lieutenant, are you familiar with the document
22 that I have just handed -- or has just been handed to
23 you?
24 A. Yes.
25 Q. So you have seen this document before?
00098:01 A. Yes.
02 Q. Was this the policy at the Naval Hospital in
03 Beaufort in effect as of February 24th, 2012?
04 A. I would like to say yes, but I know that the
05 mental health department was actually in the process of
06 redoing this instruction or another instruction that
07 pertained to said patients. So whether it was in effect
08 at that time or not, that's above my pay grade.

45. PAGE 101:21 TO 102:10 (RUNNING 00:00:37.163)

21 Q. Lieutenant Brannon, good afternoon.
22 A. Good afternoon.
23 Q. My name is David Hoyle. I'm a lawyer from
24 Mount Pleasant, South Carolina. We met earlier today
25 through the miracles of video conferencing. Let me
00102:01 begin by, one, thanking you for your service, and two,
02 thanking you for agreeing to do this deposition on a
03 Sunday. I'm sure there are a number of other things
04 you'd rather be doing today.
05 A. You're welcome.
06 Q. Ma'am, if I understand your testimony
07 correctly, you did not manage or control the actual
08 medical care and treatment of Calvin Hunt on
09 February 24, 2012, correct?
10 A. That is correct.

46. PAGE 102:13 TO 103:23 (RUNNING 00:01:17.464)

13 Q. I'm sorry, ma'am? Your answer?
14 A. Yes, that is correct.
15 Q. Further, you did not manage or control the
16 actual nursing care rendered to Calvin Hunt on February
17 24th, 2012, correct?
18 A. That is correct.
19 MR. MACKELCAN: Object to the form.
20 MR. HOYLE:
21 Q. In fact, you were not involved in the

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22 day-to-day directing of medical services performed by
23 Dr. Jansen at the Naval Hospital in Beaufort, South
24 Carolina, correct?
25 A. That is correct.
00103:01 Q. For example, you did not tell Dr. Jansen what
02 tests to run on patients, correct?
03 A. That is correct.
04 Q. For example, you did not tell Dr. Jansen what
05 differential diagnosis to make with respect to patients
06 at the Naval Hospital Beaufort, correct?
07 A. That's correct.
08 Q. For example, you did not tell Dr. Jansen what
09 diagnosis to make with respect to patients at the Naval
10 Hospital Beaufort, correct?
11 A. That is correct.
12 Q. For example, you did not tell Dr. Jansen what
13 treatment to render to patients at the Naval Hospital at
14 Beaufort, South Carolina, correct?
15 A. That is correct.
16 Q. For example, you did not tell Dr. Jansen what
17 medications to prescribe patients for the Naval Hospital
18 in Beaufort, South Carolina, correct?
19 A. That is correct.
20 Q. And lastly, for example, you did not direct Dr.
21 Jansen whether or not to admit a patient at the Naval
22 Hospital in Beaufort, correct?
23 A. That is correct.

47. PAGE 104:01 TO 106:07 (RUNNING 00:02:36.489)

00104:01 Q. Lieutenant Brannon, is it fair to say that you
02 did not stand over CasePro employees in the emergency
03 room at the Naval Hospital Beaufort and dictate what
04 they were to do with particular patients?
05 A. That is correct.
06 Q. In other words, you did not tell the CasePro
07 employees working in the emergency room at the Naval
08 Hospital in Beaufort what to do with respect to a
09 patient or what not to do with respect to a patient?
10 A. That is correct.
11 Q. Your job, as I understand your testimony, was
12 basically an administrative one unless you were called
13 on to assist in an emergency as you previously
14 testified, correct?
15 A. That pretty much sums it up. And with the
16 administrative task involves anything else that would
17 fall under it, such as standard operating procedures or
18 anything related to patient safety.
19 Q. Thank you, ma'am. As a registered nurse, do I
20 understand correctly that you could not have supervised
21 the medical care provided by Dr. Jansen?
22 A. That is correct.
23 Q. In other words, as a registered nurse, even
24 with your advanced education and your advanced training
25 and experience, you would not have been able to tell him
00105:01 how to practice medicine, correct?
02 A. That is correct.
03 Q. That would be outside the field of your
04 expertise, correct?
05 A. That is correct.
06 Q. And I believe your testimony as you sit here
07 today is you do not know the exact date in 2012 that Dr.
08 Gina Jordan became a civilian employee at the Naval
09 Hospital in Beaufort. Is that correct?
10 A. That is correct.
11 Q. Lieutenant Brannon, earlier today you in
12 response to questions by prior counsel, talk about a

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13 hypothetical patient coming in to the emergency room
14 with a possible case of tuberculosis. Do you recall
15 that?
16 A. Yes, I do.
17 Q. Have you ever actually treated someone with
18 tuberculosis?
19 A. Yes, I have.
20 Q. Okay. Is tuberculosis what's known as a
21 contagious disease?
22 A. Yes, it is.
23 Q. And what can happen if somebody with
24 tuberculosis, oh, I don't know, walks out of a medical
25 facility and decides to go to Wal-Mart? What could
00106:01 happen?
02 MR. MACKELCAN: Objection to the form.
03 THE WITNESS: They could potentially expose
04 other people to tuberculosis.
05 MR. HOYLE:
06 Q. Would that be putting people at risk?
07 A. Yes, it would.

48. PAGE 106:11 TO 107:22 (RUNNING 00:01:34.796)

11 Ma'am, if someone came into an emergency
12 hospital setting in which you were the nurse tending to
13 that patient --
14 A. Yes.
15 Q. -- and he or she had tuberculosis. And they
16 asked permission to just get up and walk right on out of
17 the emergency room, would you give it to them?
18 MR. MACKELCAN: Objection.
19 THE WITNESS: Well, I can't grant permission or
20 take away permission. But my job as a nurse would be to
21 talk to the patient and explain what is going on and
22 that I have a concern.
23 At that time, I would notify the physician and
24 -- who would then talk to the patient. The patient can
25 very well say I don't want to be here. I want to leave
00107:01 and decide to leave. But anyone in the health care
02 setting know that that patient poses a risk, you know,
03 to other people. So we would notify the authorities.
04 MR. HOYLE:
05 Q. And by the authorities, you are referring to
06 law enforcement?
07 A. Yes. At a military setting, we have -- we have
08 security. Our own security team. And if they need to
09 make the notifications to get like the sheriff, the
10 police department involved, then that would be taken up
11 that way.
12 Q. But your testimony as you sit here today as a
13 registered nurse who's practiced in military hospitals
14 for a good long while --
15 A. Yes.
16 Q. -- is that if our hypothetical patient who
17 presents to the emergency room with tuberculosis --
18 A. Yes.
19 Q. -- asks for your permission to leave the
20 emergency room, you would first notify the attending
21 physician. Did I hear that correctly?
22 A. I would notify them, yes.

49. PAGE 110:17 TO 112:13 (RUNNING 00:02:29.473)

17 Will you agree with me, Lieutenant Brannon,
18 that there may be other situations that present in an
19 emergency room setting other than a potential
20 tuberculosis case in which there could be a concern
21 developed that the patient may elope and may pose a risk

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22 of harm to persons outside the hospital?
23 A. There's many. I think there's -- off the top
24 of my head, anything. CDIFF is highly contagious.
25 There's -- I mean, latest in the news was the ebola.
00111:01 There's many many things that could happen.
02 Q. Let's assume somebody's been traveling to West
03 Africa.
04 A. Okay.
05 Q. And they show up in the ER with a fever and
06 some of the textbook signs of ebola. And that's one of
07 your concerns; that this person may be a potential
08 carrier for ebola.
09 A. Okay.
10 Q. If that patient asked your permission to walk
11 right on out of the emergency room and you felt fairly
12 certain that he or she would follow your advice, what
13 would you tell them?
14 A. I would just tell them I have a concern. I
15 know you are scared. But let me explain to you the
16 seriousness of this. I would, you know, tell them that
17 I know that they have families and loved ones. Usually
18 patients can connect when you make whatever it is
19 personal.
20 Ask them about their family. Do you have any
21 family members. Do you have any children. I have been
22 able to deescalate situations like that. Just trying to
23 calm down, make non-threatening gestures, because I have
24 seen that sometimes when a patient's already anxious
25 doing all this makes the situation even worse.
00112:01 Trying to make them feel like a person. And
02 let them understand the seriousness of what is going on.
03 And that they will be kept informed.
04 They have rights as a patient. They have a
05 right to know the treatment plan. They have a right to
06 be treated with dignity and respect. We will keep them
07 abreast of anything that's going on. We will keep them
08 informed, and we will provide the best care.
09 Everybody's experience is different. I'm very
10 comfortable in a hospital setting, and mostly it's
11 because I have worked there my entire Navy career. But
12 the ER setting can be very intimidating for a lot of
13 people.

50. PAGE 114:18 TO 115:04 (RUNNING 00:00:32.084)

18 Q. And -- and certainly, ma'am, you did not see
19 these records until after Calvin Hunt had left the
20 medical -- Naval Hospital in Beaufort, correct?
21 A. That is correct.
22 Q. And prior counsel did not show them to you here
23 today, correct?
24 A. That is correct.
25 Q. All right. Will you agree with me, ma'am, that
00115:01 if something is obvious that it is not hidden?
02 A. Is this a leading question? I am --
03 Q. It is not a leading question.
04 A. Okay. Yes. I agree with you.

51. PAGE 116:01 TO 119:23 (RUNNING 00:04:38.254)

00116:01 Q. Did I hear correctly that the badges that the
02 contractors, such as CasePro employees, would have worn
03 in the Naval Hospital at Beaufort were different than
04 the badges that you and other uniform badges in the
05 United States Navy would have been wearing?
06 A. The actual staff badge? The only -- I'm taking
07 a wild guess here, so I don't really want to be put on
08 the record as this being fact. But I know on my

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09 military badge or the staff badge, not the CAT card,
10 that it would say registered nurse, and it may have my
11 service affiliation.
12 And as far as a contractor's, without actually
13 seeing them, I think they may say contractor or just RN.
14 But I'm not sure.
15 Q. Okay. Not a hundred percent sure --
16 A. No, I'm not.
17 Q. -- as you sit here today. Is that fair?
18 A. That's fair.
19 Q. Okay. There were some questions earlier, and
20 I'm not going to slide down to the other end of the
21 table to pick them up, but there were some questions
22 that prior counsel asked you about the contract between
23 the federal government and CasePro. Do you recall that?
24 A. Yes.
25 Q. Okay. And there were some questions that prior
00117:01 counsel asked you about the task set forth within the
02 contract. Do you recall that?
03 A. Yes.
04 Q. Okay. And we actually looked at something
05 known as a task order. Do you recall that?
06 A. Yes.
07 Q. For your purposes for what you were doing at
08 the Naval Hospital in Beaufort, were -- was your job as
09 the department head to make sure that the task order was
10 being fulfilled?
11 A. Well, my portion, the -- if you have looked at
12 the task order, it's pretty lengthy. So for me to know
13 every single detail that doesn't pertain to me would be
14 irrelevant. When I first assumed the role, I had the
15 part that was specific to me that was -- that led to the
16 actual -- the staffing and basically the guidelines
17 and -- of the actual contract that pertained to the ER
18 setting in addition to the supervisory role.
19 The larger portion of the contract I didn't
20 receive until after the fact until -- I have my
21 certificates at home. But I actually attended the
22 contract officer's course, and it was a three-day
23 course. And then I knew now, you know, getting a little
24 bit more advanced training, all -- not all, I can say
25 more the intricacies that are involved in federal
00118:01 government, contract acquisitions, and you know, more
02 about the rules and can'ts and do's and don'ts with
03 contract employees.
04 So I need to ask and you know at that point is
05 when I asked Ms. Deb Mayo well can I get a copy of the
06 contract so I can see it. Some of it, even now I mean,
07 I can review it, but some of the lingo that's in there
08 is probably written by a lawyer. Because I couldn't
09 understand it.
10 Q. That's certainly -- certainly fair, ma'am.
11 When you referenced the staffing, you were referencing
12 the fact that under the contract, the federal government
13 paid CasePro, a company out in Texas, cash money to have
14 one medical doctor and two registered nurses in the
15 emergency room at Naval Hospital, Beaufort, 24/7/52. Is
16 that correct?
17 A. That is correct.
18 Q. And that's one of the things you were concerned
19 with, making sure that these people showed up and the ER
20 was staffed, correct?
21 A. Yes.
22 Q. And I believe you told us that in -- a rare
23 circumstance where one of these didn't come to work --
24 or a nurse didn't come to work that you would actually

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25 fill in yourself. Did I hear that correctly?
00119:01 A. Yes, that's correct.
02 Q. How frequently did that happen, ma'am?
03 A. I think when I was there, maybe twice. CasePro
04 actually was pretty good about actually staffing the
05 facility. But there was twice that they didn't work
06 out. During that period of time, 2012. We had plenty
07 of other issues with staffing after the fact.
08 Q. And we'll talk a little bit about that more in
09 a minute. But let me continue down my train of thought,
10 ma'am. I know there were some questions by prior
11 counsel about how you treated various folks there in the
12 emergency room at Naval Hospital, Beaufort, regardless
13 of whether or not they were civilian, contractor, or
14 uniform military. Do you recall that?
15 A. Yes.
16 Q. Is it fair to say that you treated everyone the
17 same because that's what statute -- the Equal
18 Opportunity Act required you to do?
19 A. That is correct.
20 Q. But certainly from a chain of command
21 standpoint, I know for a good long while you were an
22 enlisted member of the service, correct?
23 A. That is correct.

52. PAGE 120:25 TO 122:15 (RUNNING 00:01:57.709)

25 Q. I take it that as someone who is soon going to
00121:01 be promoted that you have persons who from time to time
02 have to salute you. Is that true?
03 A. Yes.
04 Q. Okay. Certainly someone who salutes you is
05 underneath you in the chain of command, correct?
06 A. That is correct.
07 Q. And then I imagine that there are times where
08 there are persons above you in the chain of command that
09 you yourself have to salute. Is that fair?
10 A. That is correct.
11 Q. And that would include people like the
12 commanding officer of a military hospital, correct?
13 A. That is correct.
14 Q. Did any of the CasePro employees that we've
15 been talking about -- Chris Jansen, Joe McDonald, Janice
16 McDonald, did any of those three persons ever salute
17 you?
18 A. No.
19 Q. Did you ever salute them?
20 A. No.
21 Q. They weren't in your chain of command one way
22 or the other. Is that correct?
23 A. That is correct.
24 Q. If someone is within your chain of command and
25 you give them a lawful order under the Uniform Code of
00122:01 Military Justice, what can happen to that person if he
02 or she doesn't do what you lawfully ordered them to do?
03 A. They can be charged under the UCMJ, which is
04 the Uniform Code of Military Justice.
05 Q. And they can end up being court-martialed. Is
06 that correct?
07 A. They could.
08 Q. What about with respect to a contractor
09 employee, such as Chris Jansen, Joe McDonald, or Janice
10 McDonald? If they didn't do something that you told
11 them to, could they be charged under the UCMJ?
12 A. No.
13 Q. That's a little bit different than a military
14 court, correct?

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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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Delaney (Miller) v. CasePro. Inc,
Et al. 2012-CP-07-03782

Count's
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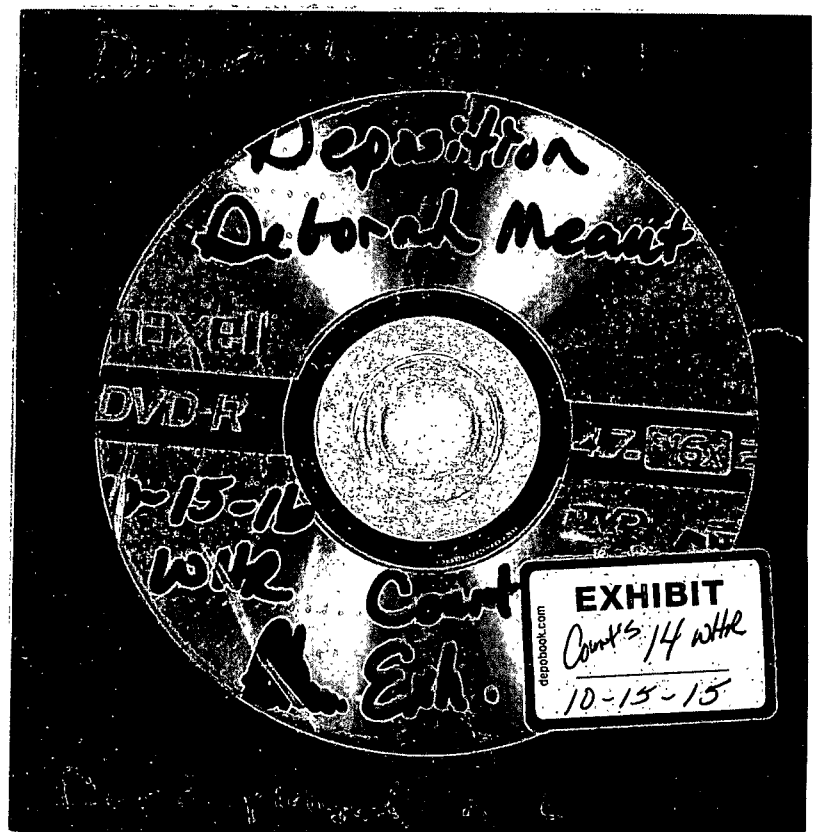
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 Meaut, Deborah J. (Vol. 01) - 09/16/2015

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)

03 Q Good morning, Ms. Meaut.
04 A Good morning.
05 Q My name is Doug MacKelcan. As you just
06 heard, I represent CasePro, Inc. who's the defendant
07 in this lawsuit. We're here today to take your

2. PAGE 9:04 TO 9:09 (RUNNING 00:00:17.330)

04 Q All right. When did you first learn of
05 the incident on February 24th, 2012?
06 A I don't really recall.
07 Q Were you working at the Naval Hospital,
08 Beaufort on that day?
09 A Yes.

3. PAGE 9:15 TO 9:22 (RUNNING 00:00:27.355)

15 Q Following the incident, what was your
16 involvement at the Naval Hospital with any response
17 to the incident or investigation?
18 A Nothing. No involvement.
19 Q Did you have any conversations with
20 anyone from CasePro's corporate office about the
21 incident following February 24th, 2012?
22 A No.

4. PAGE 9:25 TO 10:12 (RUNNING 00:01:01.230)

25 Q Did you have any communications with
00010:01 other federal employees either at the Beaufort Naval
02 Hospital or in Virginia, or wherever the -- your
03 bosses are located, about this incident?
04 A No.
05 Q Can you state your full name for the
06 record?
07 A Deborah Jane Meaut.
08 Q What is your home address?
09 A 584 Broad River Boulevard, Beaufort,
10 South Carolina, 29906.
11 Q How long have you lived there?
12 A Twelve years. Almost 12 years.

5. PAGE 11:02 TO 13:17 (RUNNING 00:03:31.970)

02 Q Where do you currently work?
03 A The Naval Hospital, Beaufort, South
04 Carolina.
05 Q What is your title at the Naval
06 Hospital, Beaufort?
07 A Contracting officers representative.
08 Q How long have you served in that
09 capacity?
10 A Since January of 2010.
11 Q What did you do for work prior to that?
12 A I worked in the commanding officer's
13 office at the Naval Hospital.
14 Q When did you start in that position?

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15 A October of 2006.
16 Q How about before that position in the
17 CO's office?
18 A I wasn't employed. We had just moved
19 back to Florida.
20 Q So since you've lived in Beaufort
21 County, you have only worked at the Naval Hospital,
22 Beaufort?
23 A I helped my husband with his business
24 before I did that.
25 Q Okay. What was your job when you worked
00012:01 in the CO's office?
02 A Secretary/administrator assistant.
03 Q Who was the CO at that time?
04 A When I started, it was Captain Elaine
05 Wagner.
06 Q And then who was it after that?
07 A Captain Mark Bernier.
08 Q How do you spell that?
09 A B-E-R-N-I-E-R.
10 Q What led you to switch to become the
11 COR, or a COR I should say? Are there more -- is
12 there more than one COR?
13 A Yes.
14 Q Okay. What led you to switch to become
15 a COR at the Naval Hospital, Beaufort?
16 A Promotional opportunity and to get back
17 into a field I was working in.
18 Q Had you worked as a COR before?
19 A I worked as a contract specialist
20 before.
21 Q Where did you do that?
22 A Department of the Army in Warrenton,
23 Virginia.
24 Q When did you work as a contract
25 specialist in Virginia?
00013:01 A 1990 to 1993.
02 Q Have you had any other jobs in
03 contracting in your professional career?
04 A No, just that.
05 Q Okay. So you got the three years in the
06 Department of the Army, and then over five years now
07 at the Naval Hospital, Beaufort?
08 A Yes, sir.
09 Q What is your educational background?
10 A Graduated from high school. Went to
11 Mohawk Valley Community College, Utica, New York,
12 with an Associate's degree in legal stenography.
13 Q Did you work as a stenographer?
14 A No, never did.
15 Q Do you have any other education other
16 than the Associate's degree and high school?
17 A No.

6. PAGE 17:03 TO 20:04 (RUNNING 00:04:53.000)

03 Q When you're working -- when you have
04 been working as the COR at the Naval Hospital,
05 Beaufort, how many different contracts are you
06 responsible for?
07 A Me individually? Somewhere, anywhere
08 between 15 to 25.
09 Q At the same time?
10 A Yes.
11 Q Do you recall serving as the COR for the
12 contract with CasePro, Inc.?
13 A Yes.

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14 Q How would you describe your job as a
15 COR?
16 A I'm the liaison between the contracting
17 officer at Navy Medicine Logistics Command and the
18 contract company who was given the award, the
19 contract award.
20 Q All right. And as the liaison, what do
21 you do on a daily or weekly basis?
22 A Multiple things: Bring the new contract
23 employees on board once the company provides me all
24 their pertinent information; I approve invoice
25 payments to the contract company; I monitor the
00018:01 expenditures throughout the course of the fiscal
02 year.
03 Q Is there anything else?
04 A There's a lot more. But I mean, it's
05 just the day-to-day operation of -- of the COR
06 office.
07 Q And -- and what -- what does that do?
08 I'm sorry. We just -- that's just not something
09 that I'm familiar with, so I'm trying to understand
10 what that involves.
11 A Okay. As an example, let's say we have
12 a vacancy -- and this is just an example. Let's say
13 we have a vacancy for a nurse position within the
14 hospital, the contract company would recruit for an
15 employee to fill that position. They've gotten the
16 award for the contract to fill that position, so
17 they do all the leg work. It's their employee,
18 their. They hire the employee. They negotiate the
19 terms of their employment, how much they make, what
20 benefits they're going to give them. We're not part
21 of that. But what they do is they provide us with a
22 credentials package prior to that employee starting
23 work. And once I receive that package on an
24 individual, we route that for the credentials
00019:01 process. I ensure that they have the requisite
02 security clearance to work on a military facility.
03 I ensure that they meet occupational health
04 requirements so that -- they're working in a
05 hospital environment, and you know, it's much
06 different than working at the local hardware store.
07 They have to meet certain occupational health
08 requirements before they come on board. We bring
09 that person on board. Just a day-to-day --
10 that's -- that's bringing in new hires.
11 We also issue government credentials,
12 CAT cards we call them, so that that employee can
13 work and access government computer systems.
14 I also review invoices every two weeks
15 to make sure that what's invoiced is proper in
16 accordance with the contract and ensure that the
17 company is paid.
18 Q You mentioned that you serve as a
19 liaison between the contractor and Naval Medical
20 Logistics. Who is your direct supervisor at Naval
21 Medical Logistics?
22 A Contracting officer that I would call
23 there for questions -- I technically report to my
24 boss physically at the Naval Hospital.
25 Q Who is that?
00020:01 A Lieutenant Lucas Ricker, R-I-C-K-E-R.
02 But my point of contact at NMLC would be Andrea
03 Greybush-Mangroo, M-A-N-G-R-O-O.
04 G-R-E-Y-B-U-S-H-Mangroo. She is a warranted
contracting officer at NMLC.

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7. PAGE 20:13 TO 21:13 (RUNNING 00:01:16.830)

13 A And of course, you know, lieutenants --
14 the military officers change about every two years,
15 so I've had a couple of different lieutenants that I
16 reported to.
17 Q Who are the other lieutenants that
18 you've reported to?
19 A Lieutenant Terri Osner; I can't believe
20 I remembered her name. And Lieutenant Rachel Smith.
21 Q Do you recall who was the lieutenant you
22 reported to on February 24th, 2012?
23 A I don't recall. I'd have to go back and
24 look and see who was here.
25 Q And when you say you report to that
00021:01 lieutenant, what -- what does that mean?
02 A In the chain of command with the
03 military. I mean, there's a definite chain of
04 command that you go to if I have an issue for
05 anything, whether it's specifically related to my
06 job or it's a personal issue. You start with who
07 your department head is and you work your way up.
08 Q Do they do your performance reviews?
09 A Come from Lieutenant Ricker -- actually,
10 they come from my assistant department head who is
11 Lori Beck.
12 Q Is she at the Naval Hospital, Beaufort?
13 A Yes.

8. PAGE 23:21 TO 25:07 (RUNNING 00:02:30.770)

21 Q Okay. So it sounds like your, to
22 summarize, and I realize not everything is going to
23 fit into this category. But it sounds like
24 administratively with your job at the Naval Hospital
25 you report to a lieutenant, but anything that has to
00024:01 do with performance under the contract you're going
02 to report to the Naval Medical Logistics; is that
03 accurate?
04 A Yes, that's accurate.
05 Q Okay. And the question that I asked
06 before, is Naval -- the Naval Medical Logistics in
07 Maryland is the agency that has issued the contract
08 to CasePro; is that correct?
09 A Correct.
10 Q Who assigns a particular contract to you
11 as the COR?
12 A I have a coworker in my office and we
13 divide the contracts according to dollar value,
14 complexity, just to balance the workload.
15 Q How familiar are you with the CasePro
16 contract with the Naval Medical Logistics Command?
17 A Pretty familiar.
18 Q What is the -- just in your own words,
19 what is the purpose of the contract?
20 A Purpose of the contract is, the
21 government has hired CasePro to provide qualified
22 employees in accordance with a specific task order
23 to provide services at our facility.
24 Q What -- who determines whether the
25 healthcare workers are qualified? To use the word
00025:01 that you just used in your last answer.
02 A Who determines if they're qualified?
03 CasePro, or whoever has the award, it's their
04 responsibility to hire employees to fill that
05 contract. So that contract company needs to
06 determine their -- if their qualifications meet the

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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 RREF 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

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16 that in terms of the statement of work and the task
17 orders that describes the responsibilities CasePro
18 has to the United States government under this
19 contract?
20 A No.

12. PAGE 31:02 TO 31:08 (RUNNING 00:00:12.720)

02 Q Okay. All right. If you look at 1.1,
03 it says: The Contractor shall provide the health
04 care personnel in accordance with the terms and
05 conditions of this contract and each task order
06 issued under this contract.
07 Did I read that correctly?
08 A Yes, you did.

13. PAGE 33:24 TO 34:16 (RUNNING 00:00:53.450)

24 Q In 2.3 it states: HCW's providing
25 services under this contract shall be rendering
00034:01 personal services to the government and shall be
02 subject to day-to-day supervision and control by
03 government personnel. Supervision and control is
04 the process by which the individual HCW receives
05 technical guidance, direction and approval with
06 regard to a task within the requirements of this
07 contract.
08 Did I read that correctly?
09 A Yes, you did.
10 Q Okay. Who -- do you recall who the
11 supervisor was for the CasePro workers involved in
12 this case, Joe McDonald, Janice McDonald and
13 Dr. Jansen on -- on February 24th, 2012?
14 A Yes, I believe it was Lieutenant
15 Brannon; I don't remember her first name. And
16 Dr. Gina Jordan.

14. PAGE 34:20 TO 34:22 (RUNNING 00:00:07.900)

20 Q Okay. Did you have any interactions
21 with Lieutenant Brannon during the time she was
22 supervising the CasePro employees?

15. PAGE 34:24 TO 34:24 (RUNNING 00:00:01.424)

24 A No.

16. PAGE 34:25 TO 35:17 (RUNNING 00:00:45.450)

25 Q Okay. Who did you communicate with
00035:01 about the CasePro contract?
02 A Who did I communicate with regarding the
03 CasePro contract? I mean, CasePro had a lot of
04 different task orders.
05 Q Who was your point person for discussing
06 issues about the contract?
07 A At CasePro?
08 Q At CasePro.
09 A At the time, it was Tracey Braswell, I
10 believe.
11 Q Okay. Would you speak directly with the
12 health care workers? Or did everything you did go
13 through Tracey Braswell?
14 A It would go through Tracey.
15 Q All right. Who was your source of
16 information from within the federal government?
17 A Lieutenant Brannon and Dr. Jordan.

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17. PAGE 35:23 TO 36:04 (RUNNING 00:00:23.100)

23 Q Following this incident February 24th,
24 2012 -- I apologize if I've asked you this question
25 already -- but do you recall receiving any
00036:01 communications from anyone in the government
02 indicating that Dr. Jansen, Joe McDonald or Janice
03 McDonald did anything inappropriately during their
04 time at the Naval Hospital, Beaufort on that day?

18. PAGE 36:07 TO 36:13 (RUNNING 00:00:20.863)

07 A No.
08 Q If you had received that, what would --
09 any information that was indicating concern about
10 they -- how their involvement in this incident,
11 generally what would be your response as the COR?
12 A I wasn't even aware the incident had
13 transpired.

19. PAGE 36:20 TO 37:04 (RUNNING 00:00:29.690)

20 in any of your contracts, when you're made aware of
21 a performance concern, attendance concern, any of
22 the issues that you deal with as the COR, what is
23 your response to that?
24 A I would reach out to the project
25 manager, in this case Tracey Braswell, and we'd have
00037:01 a discussion over the phone about, you know, a plan
02 of action, what -- what did they plan to do with
03 their employee. Because ultimately it was up to
04 them to figure that out.

20. PAGE 37:05 TO 37:11 (RUNNING 00:00:15.110)

05 Q Okay. And if you had -- if you had
06 been -- but you were never contacted about any --
07 any issues with the incident on February 24th, 2012?
08 A No. No.
09 Q All right. So that was why that you had
10 no communications with CasePro about the incident?
11 A Correct. Correct.

21. PAGE 47:18 TO 48:08 (RUNNING 00:00:47.248)

18 Q Ms. Meaut, looking back onto page 29 of
19 Exhibit 1, 7.11.1 states: Each HCW providing
20 service under this contract or resultant Task Orders
21 shall undergo an orientation.
22 Did I read that correctly?
23 A Yes.
24 Q Where does that orientation take place?
25 A At the Naval Hospital.
00048:01 Q Who conducts the orientation?
02 A Various people throughout the hospital.
03 It's a two-day sit-and-learn event about all the
04 various departments within the hospital and what
05 they offer.
06 Q Is it run and organized by the
07 government?
08 A Yes, education and training.

22. PAGE 49:18 TO 50:06 (RUNNING 00:00:34.780)

18 stated. You can answer.
19 A That's what it states here in the
20 contract, you know, that that's the preference to
21 have --
22 Q Is that your experience?

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23 A Yes, we tend to get people that work for
24 a significant amount of time.
25 Q Are there health care workers who worked
00050:01 at the Naval Hospital under a different contract and
02 then assumed responsibilities under a new contract
03 but perform the same job?
04 A Yes.
05 Q Is that fairly commonplace?
06 A Yes.

23. PAGE 51:03 TO 52:12 (RUNNING 00:01:53.400)

03 Q The question is, does the government
04 encourage new contractors to hire health care
05 workers that are already working or have already
06 been working at the Naval Hospital, Beaufort under a
07 different contract?
08 A The -- I'm not quite sure how to answer
09 this. I think there's some clause. I can't --
10 don't quote me on the clause, but it's
11 non-displacement of a current worker, they're
12 encouraged to hire the incumbents.
13 Q Okay.
14 A So if I understand your question.
15 correctly, I think you're meaning going from one
16 contract company to another contract company.
17 Q You -- you -- I think you answered my
18 question.
19 A Yeah.
20 Q Thank you.
21 Page 40 deals with general duties. In
22 9.2 at the bottom it references the Joint
23 Commission. What is that?
24 A It's an organization that accredits
25 hospitals, and that's all I know about it.
00052:01 Q And this paragraph states: Comply with
02 the standards of the Joint Commission, applicable
03 provisions of law, and the rules and regulations of
04 any and all governmental authorities pertaining to
05 licensure and regulation of health care personnel
06 and medical treatment facilities, the regulations
07 and standards of medical practice of the MTF and the
08 bylaws of the MTF's medical staff. Adhere to and
09 comply with all Department of the Navy, Bureau of
10 Medicine and Surgery and local instructions and
11 notices which may be in effect during the term of
12 the contract.

24. PAGE 53:13 TO 53:21 (RUNNING 00:00:19.810)

13 Q All right. Now, as -- as the COR,
14 you -- one of your responsibilities is to ensure
15 that the terms of this contract are complied with by
16 CasePro.
17 A Uh-huh.
18 Q Is that right?
19 A Yes.
20 Q Okay. And so one of those being 9.2?
21 A Uh-huh.

25. PAGE 67:13 TO 67:17 (RUNNING 00:00:25.450)

13 Q All right. So CasePro had satisfactory
14 performance under the contract?
15 A Yes.
16 Q Okay. All right. In page 103, can you
17 tell me what the surveillance plan is?

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26. PAGE 68:17 TO 68:25 (RUNNING 00:00:25.007)

17 Q Okay. In 2.5 on page 104, it states:
18 The government supervisory personnel specified in
19 the task order are responsible for providing
20 day-to-day supervision and control of contract
21 personnel. This includes provision of technical
22 guidance, direction and approval of tasks performed
23 to satisfy requirements of the contract/task order.
24 Did I read that correctly?
25 A Yeah.

27. PAGE 69:03 TO 69:06 (RUNNING 00:00:11.290)

03 Q What did your surveillance plan involve
04 to ensure that the government's supervisory
05 personnel referenced in 2.5 were supervising the
06 health care workers?

28. PAGE 69:09 TO 69:18 (RUNNING 00:00:25.450)

09 A What did -- what did I do? Repeat that
10 for me again, please.
11 Q Yeah. What did -- this is in the
12 section Surveillance Plan, so --
13 A Uh-huh.
14 Q -- what did you do through your
15 surveillance plan to ensure that the government
16 supervisory personnel, in 2.5 that we just talked
17 about, were actually providing day-to-day
18 supervision and control of contract personnel?

29. PAGE 69:20 TO 70:16 (RUNNING 00:00:48.530)

20 A I walked through the department, make
21 sure they're there, see if they have any issues. I
22 mean, I'm just a presence.
23 Q And you're talking about Brannon, Angela
24 Brannon or Gina Jordan?
25 A Uh-huh.
00070:01 Q All right. So you would walk through,
02 you would talk to them, make sure that they're
03 there?
04 A Yeah, make sure the employees are there.
05 Q Where in particular would Ms. Brannon or
06 Ms. Jordan be within the Naval Hospital?
07 A They would be in the ER, or they would
08 be in their office. Dr. Jordan had an office
09 adjacent to the ER.
10 Q All right. So you would physically walk
11 past into the ER, past the ER, past her office to --
12 A Many times.
13 Q Okay. To ensure that she was there?
14 A Right.
15 Q And supervising the contract personnel?
16 A Right.

30. PAGE 74:22 TO 75:08 (RUNNING 00:00:36.251)

22 Q Okay. Is that something that you look
23 for when you're overseeing Brannon and Jordan or
24 anyone else?
25 MR. BERLINSKY: Object to the form.
00075:01 MR. HOYLE: Plaintiff joins.
02 A I mean, it's just -- you're expected to
03 treat everyone the same, while they are different.
04 You know, you're supervising them on a day-to-day
05 basis. You're approving leave, you're not approving
06 leave. You would be doing the same whether you're,

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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.

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15 Q And originally you were working as an
16 administrative assistant/secretary; is that correct?
17 A Yes, at the Naval Hospital, 2006, right.
18 Q Okay. What training, if any, did you
19 have in order to become an administrative
20 assistant/secretary at the Naval Hospital?
21 A Previously when I worked for federal
22 government I had worked in that field.
23 Q Okay. Doing administrative type tasks?
24 A Right.
25 Q Okay. And then in 2010 you transitioned
00081:01 from being an administrative assistant/secretary in
02 the office of the commanding officer to being a COR,
03 correct?
04 A Correct.
05 Q Okay. What training, if any, did you
06 undergo when you became a COR?
07 A When I got the job here at the Naval
08 Hospital?
09 Q Yes, ma'am.
10 A Contracting officer training through
11 NMLC.
12 Q And that training, is that something you
13 had to go to a specific place in order to receive
14 instruction, or was it done through a book? Was it
15 done online? Help me understand.
16 A Right. I went to Camp Le Jeune, North
17 Carolina.
18 Q And how long were you up there at Camp
19 Le Jeune?
20 A A week.
21 Q Okay. And you had classes or
22 instructions in some sort of classroom-type setting?
23 A Yes.
24 Q And did you receive written materials
25 that you had to review?
00082:01 A Yes.
02 Q Is there any type of test you had to
03 take?
04 A No.
05 Q Okay. And again not to belabor the
06 point, but you became a COR in 2010, correct?
07 A Correct.
08 Q If you look at the document that my
09 friend Mr. Mackelcan marked as Exhibit No. 1 to your
10 deposition, it's a document that he spent some time
11 examining you on, correct?
12 A Uh-huh.
13 Q That's a yes?
14 A Yes. That's a yes.
15 Q Okay. And if you on the very first page
16 of the document that's been marked as Exhibit No. 1,
17 the page that is Bates stamped in the lower
18 right-hand corner as 00001, we have an award
19 contract with an effective date of September 28th,
20 2007, correct?
21 A Yes.
22 Q Not to state the obviously, but
23 September 28th, 2007, was before you were the COR
24 for this particular project, correct?
25 A Correct.
00083:01 Q Okay. So when CasePro came in to the
02 Naval Hospital here in Beaufort and began providing
03 services under the contract that has been marked as
04 Exhibit No. 1 to your the deposition here today, you
05 were not the initial COR, correct?

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06 A Correct.
07 Q When CasePro came in to the Naval
08 Hospital in Beaufort, South Carolina and began
09 providing services in response to the contract
10 marked as Exhibit No. 1 to your deposition here
11 today back in 2007, you would have had no personal
12 firsthand involvement with the implementation of
13 that project until sometime in 2010, correct?
14 A Correct.
15 Q Almost three years later?
16 A Yes.
17 Q Okay. There was a term I heard earlier,
18 I believe it was the word "incumbent." Do you
19 recall using that?
20 A Yes.
21 Q Okay. What is an incumbent?
22 A The individual who's been in that job up
23 until that point.
24 Q Okay. So fair to say somebody who
25 leaves the employment of a contractor and has a
00084:01 break in service, let's say that individual goes and
02 works somewhere else, like at the Hampton Hospital,
03 and then comes back to the Naval Hospital several
04 years later, that person would not be an incumbent,
05 correct?
06 A Correct.
07 Q Okay. Now, there were some questions
08 about the contract that had been marked in Exhibit
09 No. 1. And then there were some contracts (sic)
10 about a task order, correct?
11 A Correct.
12 Q And just so we're all clear, the task
13 order that's at issue in this case is not contained
14 within the 131 pages of Exhibit No. 1, correct?
15 A Correct.
16 Q I'll come back and ask you some
17 questions in a minute about the contract. But for
18 sake of today's proceedings, I'm going to mark as
19 Exhibit No. 2 a multipage document that's been
20 produced in this litigation that's MR-Miller 18
21 through 28, it was also identified as Exhibit No. 3
22 at the Rule 30(b)(6) deposition of CasePro, Inc.
23 Ma'am, I'm handing you that document.
24 And take as much time as you need to flip through it
25 and tell me if you've seen it before.
00085:01 (Exhibit No. 2 is marked for identification.)
02 MR. BERLINSKY: Let me see when you're
03 through, ma'am, please.
04 A (Document tendered to Mr. Berlinsky.)
05 MR. BERLINSKY: Okay (document tendered
06 to the witness.)
07 BY MR. HOYLE
08 Q Ma'am, have you had an opportunity to
09 look at the document that I've marked as Exhibit
10 No. 2 to your deposition here today?
11 A Yes.
12 Q And this says on the face of the
13 document that it is an order for supplies or
14 services, correct?
15 A Correct.
16 Q And it has a date of order/call of
17 October 1st, 2011, correct? In box No. 3 at the top
18 of the page?
19 A Yes.
20 Q And for those of us who have never
21 worked for the federal government, October 1st is

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22 the beginning of the fiscal year, correct?
23 A Correct.
24 Q Is that when new contracts and new task
25 orders typically begin with respect to persons or
00086:01 entities providing contractual services to the
02 federal government?
03 A Yes.
04 Q Okay. And on this document which we've
05 marked as Exhibit No. 2, can you tell us who the
06 contractor is?
07 A CasePro.
08 Q Okay. And this is for supplies or
09 services at the Naval Hospital here in Beaufort,
10 correct?
11 A Correct.
12 Q Okay. And the very first page of this
13 document bears a signature in block No. 24 on the
14 very page of a contracting/ordering officer of the
15 United States of America, correct?
16 A Correct.
17 Q Do you recognize whose signature that
18 is?
19 A Yes.
20 Q Whose signature is that?
21 A Melanie Musgar, she's a contracting
22 officer.
23 Q And do you believe she's authorized by
24 the United States of America to sign contracts
25 behalf of the government?
00087:01 A Yes, sir.
02 Q Okay. And this specific task order
03 provides that certain payments will be made to
04 CasePro, Inc. with respect to certain services being
05 provided, correct?
06 A Correct.

34. PAGE 89:04 TO 93:16 (RUNNING 00:03:36.630)

04 Q All right. Turn with me to section C of
05 this task order which begins on the page that is
06 Bates stamp MR-Miller-000023. The services that are
07 going to be provided under this task order are going
08 to be in the emergency room at the Naval Hospital in
09 Beaufort, correct?
10 A Correct.
11 Q And the contractor, that means CasePro,
12 a company out in Texas, is going to provide
13 personnel from three labor categories: Physician,
14 registered nurse and licensed practical nurse,
15 correct?
16 A Correct.
17 Q And we see further down this page in
18 point number 4, hours of operation, that the
19 contractor, that means CasePro, a company out of
20 Texas, shall provide emergency room services on a
21 24-hour basis daily including holidays, correct?
22 A Correct.
23 Q So every hour of the day Monday through
24 Friday, Saturday and Sunday there is going to be
25 personnel in the emergency room from CasePro during
00090:01 this contract period?
02 A Yes.
03 Q Okay. And in fact, if you look at the
04 next page of the document I've marked as Exhibit No.
05 2, we actually have a handy little chart that even
06 shows that on Sunday, Monday, Tuesday, Wednesday,
07 Thursday, Friday and Saturday there is going to be

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08 one physician, two registered nurses and one
09 licensed practical nurse on duty at all times,
10 correct?
11 A Correct.
12 Q And those individuals who I just
13 enumerated, the physician, the two registered nurses
14 and the licensed practical nurse, are all going to
15 be employees of CasePro, Inc., correct?
16 A Correct.
17 Q And if you look above that handy little
18 grid that we have setting forth the days of the week
19 and the personnel that CasePro is going to provide,
20 we have language that says: The contractor, that
21 means CasePro, is responsible for scheduling
22 personnel to cover the schedule?
23 Did I read that correctly?
24 A Yes.
25 Q That's your understanding of what
00091:01 CasePro undertook to do, correct?
02 A Correct.
03 Q You didn't make this schedule for this
04 doctor, the two nurses or the LPN, correct?
05 A Well, we -- we identified what we
06 needed, what our needs were.
07 Q Okay. And the needs were set forth in
08 this task order?
09 A Correct. Correct.
10 Q Was there any day of the week in which
11 there would be two doctors instead of one?
12 A No.
13 Q Was there any day of the week in which
14 there would be three registered nurses working
15 instead of two?
16 A No.
17 Q Is there any day of the week in which
18 there'd be two licensed practical nurses working
19 instead of one?
20 A No.
21 Q What the government set for is set forth
22 in the plain text on the page we were just looking
23 at, that being the page Bates stamped MR-Miller-24
24 in document Exhibit No. 2 to your deposition,
25 correct?
00092:01 A Correct.
02 Q Okay .so the government said this is
03 what we need. But it was up to CasePro, the folks
04 from Texas, to actually schedule personnel to meet
05 this schedule?
06 A Correct.
07 Q That's not something you did, correct?
08 A Correct.
09 Q All right. This task order also says:
10 The contractor, that means CasePro, is responsible
11 for providing the leave benefit for these personnel.
12 Is that correct?
13 A Correct.
14 Q This document also says: The
15 contractor, that means CasePro, is responsible for
16 approving leave for these personnel.
17 Is that correct?
18 A Correct.
19 Q This document also says: The
20 contractor, meaning CasePro, is responsible for
21 providing any holiday benefit.
22 Correct?
23 A Correct.

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24 Q And in that same paragraph, that being
25 paragraph section C, subpart 5, subpart B: The
00093:01 contractor, meaning CasePro, shall maintain
02 sufficient backup personnel to ensure coverage of
03 the schedule during periods of both scheduled and
04 unscheduled absence.
05 Correct?
06 A Correct.
07 Q So the responsibility to make sure that
08 at all times, whether you're talking about 2 o'clock
09 in the morning or 2 o'clock in the afternoon,
10 whether you're talking about a Monday, or whether or
11 not you're talking about a Thursday, make sure there
12 is one medical doctor, two registered nurses and one
13 licensed practical nurse physically present during
14 this time period in the Naval Hospital, Beaufort's
15 Emergency Room fell to CasePro, correct?
16 A Correct.

35. PAGE 102:03 TO 103:14 (RUNNING 00:01:13.790)

03 Q Okay. Did you have understanding, going
04 back to the task order I've marked as Exhibit 2,
05 that the contractor, meaning CasePro, shall have an
06 emergency-medicine-trained physician perform a peer
07 review on the treatment on all emergent patients and
08 not less than 10 percent of all urgent patients?
09 A What was that question again?
10 Q Sure. If you look at page 24 --
11 A Okay.
12 Q -- of Exhibit No. 2 to your deposition,
13 where in paragraph 6 it says Duties. Do you see
14 that?
15 A Yes.
16 Q And these are some additional duties
17 that the contractor, in this case CasePro, has
18 undertaken, correct?
19 A Uh-huh.
20 Q That's a yes?
21 A Yes.
22 Q Okay. And one of those additional
23 duties is that an emergency-medicine-trained
24 physician shall perform a peer review on the
25 treatment of all emergent patients and not less than
00103:01 10 percent of all urgent patients. Did I read that
02 correctly?
03 A Yes.
04 Q Since you were the COR for this contract
05 in this task order, can you tell the court and the
06 jury which emergency-medicine-trained physician
07 CasePro, Inc. designated to do that peer review?
08 A I don't know.
09 Q Did you ever know?
10 A No.
11 Q So that's not something you knew back in
12 2011 and 2012 and you forgot, you just never knew
13 that?
14 A I wouldn't be involved in that.

36. PAGE 105:05 TO 115:03 (RUNNING 00:10:34.520)

05 Ma'am, we were looking at the schedule
06 contained within the task order that's been marked
07 as Exhibit No. 2, correct?
08 A Uh-huh.
09 Q That's a yes?
10 A Yes?
11 Q And that task order reflects that the

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12 emergency room is going to be opened at the Naval
13 Hospital in Beaufort 24 hours a day, 7 days a week,
14 52 weeks out of the year, correct?
15 A Yes.
16 Q Was Dr. Gina Jordan physically present
17 24 hours a day, 7 days a week, 52 weeks out of the
18 year?
19 A I didn't supervise Dr. Jordan so I don't
20 know for a fact.
21 Q Okay. Who did supervise Dr. Jordan?
22 A Her director, Dr. Their at the time.
23 Q Okay. She wasn't your direct report?
24 A Pardon?
25 Q You were not her direct supervisor,
00106:01 correct?
02 A No, I was no one's supervisor.
03 Q Same thing would be true with respect to
04 Nurse Brannon, correct?
05 A Correct.
06 Q Who did Nurse Brannon work for?
07 A Her director, Dr. Their.
08 Q Okay. So both those individuals
09 reported to -- I believe he held the rank of
10 commander?
11 A Commander, uh-huh.
12 Q That's a yes?
13 A That's a yes.
14 Q Okay. So you don't know for sure
15 whether or not Nurse Brannon or Dr. Jordan were
16 physically there 24 hours a day, 7 days a week, 52
17 weeks out of the year; is that correct?
18 A I didn't know what their schedule was,
19 no.
20 Q Okay. Other than Nurse Brannon or
21 Dr. Jordan, are you aware of any other uniformed
22 military personnel that actually would ever set foot
23 in the emergency room at the Naval Hospital in
24 Beaufort other than being a patient?
25 A I wouldn't know.
00107:01 Q Not something you know?
02 A Not something that I was -- would be
03 aware of, no.
04 Q Okay. Fair to say that you're not the
05 best person to ask as to what actually went on on a
06 day-to-day base in the ER?
07 A Correct.
08 Q There were some questions earlier about
09 the supervision that either Dr. Jordan or
10 Ms. Brannon provided to others. Do you recall that?
11 A Yes.
12 Q Okay. Do you actually have firsthand
13 personal knowledge of what supervision, if any,
14 either Dr. Jordan or Nurse Brannon provided to any
15 employees of CasePro, Inc.?
16 A Do I have knowledge of their direct
17 supervision?
18 Q Yes, ma'am.
19 A Yes.
20 Q Okay.
21 A Because they would come to me
22 occasionally with issues on attendance, or what have
23 you, minor issues.
24 Q Okay. And your understanding from those
25 conversations was that that was dealing with things
00108:01 like time, attendance, punctuality, that kind of
02 thing, minor issues, as you said?

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03 A Yes.
04 Q Okay. Scheduling, perhaps?
05 A Uh-huh.
06 Q That's a yes?
07 A That's a yes.
08 Q Okay. Did either Nurse Brannon or
09 Miss -- or Dr. Jordan ever come to you and talk to
10 you about the actual way -- we'll start with the
11 doctor -- one of the CasePro, Inc. employed doctors
12 was utilizing his knowledge, expertise and skill to
13 treat patients?
14 A Ask me that question again.
15 Q Sure. I'll ask it a little slower.
16 During the time that you were the COR for the
17 contract and task order that we were talking about
18 here today, did either Nurse Brannon or Dr. Jordan
19 come to you with a concern about how any CasePro,
20 Inc. employed doctor was utilizing his or her
21 education, training and experience to treat
22 patients?
23 A Not that I could recollect, no.
24 Q Same question with respect to any
25 CasePro, Inc. employed nurse?
00109:01 A How -- with a problem on how they were
02 treating patients?
03 Q Yes, ma'am.
04 A Maybe occasionally on minor things, but
05 nothing major that sticks out in my mind.
06 Q And that's specific to medical
07 treatment?
08 A Yes.
09 Q Okay. When in 2010 did you begin doing
10 work as a COR?
11 A January 2010.
12 Q Can you tell the court and jury who
13 Amanda Rutten is?
14 A She was one of my points of contact at
15 NMLC years ago when I first started working there.
16 Q This would be back in 2010?
17 A Uh-huh.
18 Q That's a yes?
19 A Yes, that's a yes.
20 Q What was her job title at NMLC?
21 A I don't recall. I don't know if she was
22 a contracting officer or a contract specialist. I'm
23 not sure.
24 Q We've talked a little bit today or
25 danced around this concept of chain of command. Are
00110:01 you familiar with that concept?
02 A Yes, I am.
03 Q Okay. And certainly we have the civil
04 command authority, the president of the United
05 States at the top, and then we may have someone who
06 just took the oath of enlistment 10 minutes ago at
07 the bottom, is that fair kind of --
08 A Sure, that's fair.
09 Q Okay. Where within the chain of command
10 was Ms. Rutten with respect to you? Was she your
11 superior or your junior or your co-equal?
12 A Probably my superior.
13 Q Okay. Generally speaking, what, if
14 anything, did Ms. Rutten have to do with peer review
15 of physicians at the Naval Hospital in Beaufort?
16 A I would have no knowledge. She worked
17 at NMLC. She didn't work at the Naval Hospital.
18 Q Okay. And for those persons who weren't

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19 paying attention earlier, NMLC is located at Fort
20 Detrick, Maryland?
21 A Correct.
22 Q Did you ever actually meet Ms. Rutten in
23 person?
24 A Yes, I did.
25 Q How many times?
00111:01 A Once.
02 Q Okay. And what was the circumstance
03 that led you and Ms. Rutten to meet?
04 A She was down at the Naval Hospital on
05 a -- I think it was a training session.
06 Q Was she conducting training that you
07 yourself attended?
08 A Yes.
09 MR. HOYLE: I'm marking a two-page
10 document that's been produced in this litigation as
11 Defendant RRFP 333 and 334. Having previously
12 marked the notice for today as Exhibit 3. This will
13 be Exhibit 4, Counsel.
14 (Exhibit No. 4 is marked for identification.)
15 BY MR. HOYLE
16 Q And ma'am, I'm going to hand and I'll
17 ask you a threshold question first after you've had
18 a moment to look at it.
19 MR. BERLINSKY: This is Exhibit 4?
20 MR. HOYLE: Yes. The Notice is 3.
21 MR. MACKELCAN: Do you have copies of
22 that?
23 MR. HOYLE: I do not.
24 MR. MACKELCAN: Okay. May I take a look
25 that the, please?
00112:01 MR. HOYLE: Sure (document tendered to
02 Mr. Mackelcan).
03 MR. MACKELCAN: Thanks.
04 BY MR. HOYLE
05 Q Ma'am, I showed you a moment ago a
06 two-page string of e-mails that's been marked as
07 Exhibit No. 4 to your deposition. Let me just ask a
08 foundational question. Have you ever seen these
09 emails prior to today?
10 A No.
11 Q Okay. There's some information
12 contained an email that Craig Martin sent Wednesday,
13 April 28th, 2010?
14 MR. BERLINSKY: I just want to make a
15 clarification? The witness testified to your
16 question she hadn't seen those before today, the
17 deposition. But she has seen them today, this
18 morning. So I just want to make sure that the
19 record's clear and we don't bind Ms. Meaut into
20 inconsistent testimony.
21 BY MR. HOYLE
22 Q Okay. Let me try and straighten this
23 out. Prior to this deposition starting, had you
24 ever seen this email before?
25 A Yes.
00113:01 Q Okay. Before Ms. Galuppo made you raise
02 your right hand and swear an oath to tell the truth,
03 you'd seen these two pieces of paper, correct?
04 A Today.
05 MR. BERLINSKY: Today.
06 BY MR. HOYLE
07 Q Okay. Without divulging to me any
08 communications between and perhaps Mr. Berlinsky,
09 I'm just going to ask you this question, did

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10 Mr. Berlinsky show you these two pieces of paper?
11 A Yes.
12 Q Okay. Prior to Mr. Berlinsky showing
13 you these two pieces of paper this morning prior to
14 your deposition, had you ever seen this email
15 exchange before?
16 A No.
17 Q And I appreciate Counsel cleaning that
18 up.
19 Ma'am, there's some information
20 contained in an email that Craig Martin sent Amanda
21 Rutten back on April the 28th, 2010. And what is
22 your understanding of who Craig Martin is?
23 A He was CasePro's project manager on that
24 contract.
25 Q The contract that we've been talking
00114:01 about here today that's been marked Exhibit No. 1
02 and the task order that's marked as Exhibit No. 2?
03 A Yeah, uh-huh.
04 Q Is that yes?
05 A Uh-huh, yes. That's a yes.
06 Q And you used the term earlier in
07 describing what you did as the COR as a liaison. Do
08 you recall using that word?
09 A Yes.
10 Q Okay. Fair to say that with respect to
11 the contract for the provision of personnel in the
12 emergency department at the Naval Hospital, Beaufort
13 that at some period of time Craig Martin was your
14 liaison at CasePro?
15 A For some period of time, yes.
16 Q Okay. And then after he moved on to
17 something else, Tracey Braswell took over that part?
18 A Yes, uh-huh.
19 Q He was, in essence, your counterpart?
20 A Yes.
21 Q Okay. How frequently would you
22 communicate with Craig Martin? Is this somebody
23 you'd send a Christmas card to in December and not
24 hear from all year? Or would you be talking to him
25 on, I don't know, a weekly basis?
00115:01 A I wouldn't be talking to him. I was new
02 to the job in January. I had very little dealing
03 with Craig Martin at all until much later.

37. PAGE 118:16 TO 119:09 (RUNNING 00:00:59.770)

16 Q Okay. In the email that you first saw
17 this morning from Amanda Rutten -- excuse me -- from
18 Craig Martin to Amanda Rutten, there's a reference
19 to a request made by the COR to CasePro, "To
20 terminate Dr. Jansen immediately by direction of the
21 CO."
22 Did you recall reading that in the email
23 that you looked at here today?
24 A I read that, yes.
25 Q Okay. Prior to reading that in the
00119:01 email here today, did you yourself have any personal
02 knowledge of that request made sometime in April of
03 2010?
04 A No.
05 Q That's not something that you and
06 Ms. Smith ever discussed?
07 A No.
08 Q Okay. Let's go back to this concept,
09 though. Who is the CO? Let's start there.

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38. PAGE 119:14 TO 120:11 (RUNNING 00:00:45.180)

14 MR. BERLINSKY: Time period.
15 BY MR. HOYLE
16 Q Let me ask you the question this way
17 then. We talked a little bit earlier today about a
18 hierarchy or chain of command within the military,
19 correct?
20 A Uh-huh.
21 Q Is that a yes?
22 A Yes, that's a yes?
23 Q Okay. If one were to set foot on the
24 grounds of the Naval Hospital, Beaufort, South
25 Carolina today, what is the significant of an
00120:01 individual being introduced as the CO, or commanding
02 officer.
03 A Very significant?
04 Q How so?
05 A That's the commanding officer. You
06 don't -- it doesn't get much higher than that on the
07 post.
08 Q Is that the highest ranking military
09 officer there on the grounds at the Naval Hospital
10 in Beaufort?
11 A Yes.

39. PAGE 120:21 TO 121:17 (RUNNING 00:00:43.710)

21 A The CO is the commanding officer in the
22 Naval Hospital. She's the commander of the ship, he
23 or she.
24 Q Everybody on that post reports to him or
25 her, correct?
00121:01 A Yes.
02 Q In the civilian world, we'd call that
03 the boss, correct?
04 A Correct.
05 Q How many persons back in, oh, let's just
06 say, 2010 were physically present on a daily basis
07 on the grounds of the Naval Hospital in Beaufort?
08 A Oh, I don't know.
09 Q Are we talking 10 people? 100 people?
10 1000 people? Give me an estimate.
11 A Probably between 500 to 1000.
12 Q And of those 500 to 1000 people, the CO,
13 or the commanding officer, that's the top dog,
14 correct?
15 A Yes.
16 Q That's the person in charge, correct?
17 A Yes.

40. PAGE 122:03 TO 123:21 (RUNNING 00:01:29.100)

03 Q As you sit here today, do you have any
04 information or testamentary evidence that you can
05 provide that disputes what's set forth in this email
06 dated April 28th, 2010, that the commanding officer
07 of the Naval Hospital, Beaufort, in April 2010,
08 directed CasePro, Inc. to terminate Dr. Jansen
09 immediately?
10 A Do I have any information that disputes
11 that?
12 Q Yes, ma'am.
13 A I don't have any information that
14 disputes it. That's the first I saw that email
15 today.
16 Q Okay. If -- do you plan on going into
17 the office today after you leave here?

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18 A It depends.
19 Q Let's assume we finish in the next 15
20 minutes?
21 A Yes.
22 Q Okay. If you were to go back into the
23 office today at the Naval Hospital in Beaufort and
24 your telephone rang and it was the commanding office
25 at the Naval Hospital in Beaufort, would you pick up
00123:01 the telephone?
02 A Yes.
03 Q Wouldn't let that call roll over to
04 voicemail, would you?
05 A No.
06 Q And why is that?
07 A That's an important person to talk to.
08 Q All right. Probably the most important
09 person on that post, correct?
10 A Yes.
11 Q Short of President Obama, or somebody
12 from the Joints Chief of Staff showing up, that's
13 the most important person that anyone on that post,
14 whether military or civilian is going to listen to,
15 correct?
16 A Correct.
17 Q If the commanding officer called you up
18 on the telephone and told you that he wanted one of
19 the contractors, on one of the contracts for which
20 you are the COR, to terminate one of their
21 employees, would you ignore the CO telling you that?

41. PAGE 123:24 TO 124:11 (RUNNING 00:00:21.560)

24 Q You can answer?
25 A I wouldn't ignore, but it's not the
00124:01 right course of action.
02 Q And why is that?
03 A Because it's not my place to do that.
04 It's not my place to give an order to terminate an
05 employee.
06 Q Particularly somebody who doesn't work
07 for you, correct?
08 A Correct.
09 Q Particularly for somebody who doesn't
10 work for the government of the United States,
11 correct?

42. PAGE 124:13 TO 124:24 (RUNNING 00:00:35.160)

13 A Correct.
14 Q Who a contractor hires or doesn't hire,
15 or conversely, who a contractor fires or doesn't
16 fire, that's up to the contractor, correct?
17 A Correct.
18 Q And at the end of the day while persons
19 on the post, whether they wear a uniform, whether
20 they be civilian, while they've got to reason listen
21 to the commanding officer of the United States Navy
22 who has been dutifully assigned to that post, folks
23 out in Texas at a private company, they don't have
24 to listen to the commanding officer, do they?

43. PAGE 125:01 TO 125:05 (RUNNING 00:00:16.682)

00125:01 A No. I mean, they would get their
02 instruction from the contracting officer.
03 Q And under the contract, it's the
04 contractor that has the right to hire and fire,
05 correct?

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44. PAGE 125:07 TO 125:07 (RUNNING 00:00:01.044)

07 A Yes.

45. PAGE 130:05 TO 132:21 (RUNNING 00:02:44.290)

05 Q Ma'am, just a few brief questions in
06 follow-up. You weren't the one actually making the
07 schedule for the doctor, the two nurses and the LPN,
08 correct?
09 A No.
10 Q That's something that a CasePro employee
11 did and emailed to you?
12 A Correct.
13 Q That would typically, I would imagine,
14 come from your liaison, either Craig Martin or
15 Tracey Braswell, correct?
16 A Right.
17 Q That's a correct?
18 A Yes.
19 Q Okay. There were some questions a
20 minute ago about what steps taken prior to
21 privileges being granted. Do you recall that line
22 of questioning?
23 A Uh-huh.
24 Q That's a yes?
25 A Yes.
00131:01 Q Okay. With respect to a particular
02 person, let's say a particular doctor, the doctor
03 himself or herself would not submit a packet of
04 materials concerning his or her credentials; is that
05 fair?
06 A That's correct.
07 Q That package, instead, would actually
08 come from the contractor in this case, CasePro,
09 correct?
10 A Correct.
11 Q And did CasePro, with respect to a
12 particular one of its employees, send things to you
13 piece mill, meaning they'd send you a transcript
14 from college and a board certification from a
15 medical society another day? Or did they send it
16 all in one nice, pretty packet?
17 A All in one packet.
18 Q And typically -- strike that.
19 And if you pull back out contract
20 number -- I mean document No. 1, Exhibit No. 1 --
21 it's getting late in the day. I apologize. Use.
22 This is the contract. Turn with me to the 28th page
23 of that document, that's section 7.10.3.
24 A Uh-huh.
25 Q Is that correct?
00132:01 A That's correct.
02 Q You look in the last sentence of that
03 paragraph, does it provide that the contractor, in
04 this case CasePro, shall discontinue the service of
05 an individual who fails to maintain compliance with
06 qualification and credentialing requirements?
07 MR. MACKELCAN: Object to the form.
08 A What's the question?
09 Q Is that -- I'll say it a little slower,
10 okay?
11 A Uh-huh.
12 Q Look at 7.10.3.
13 A I am.
14 Q Okay. The last sentence.
15 A Yes, I am.

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16 Q Does the contract provide that the
17 contractor, in this case CasePro, shall discontinue
18 the service of an individual who fails to maintain
19 compliance with qualification and credentialing
20 requirements? Yes or no?
21 A Yes.

46. PAGE 133:01 TO 133:23 (RUNNING 00:00:43.590)

00133:01 Q At one point in time, did they have
02 contracts in addition to the one that we've been
03 talking about here today for services in the ER?

04 A Yes.

05 Q How many contracts to do you think
06 CasePro had to provide persons to do work at the
07 Naval Hospital?

08 MR. MACKELCAN: Objection, calls for
09 speculations.

10 Q Approximately, ma'am?

11 MR. MACKELCAN: Same objection.

12 A About 8 to 10.

13 Q And were you the COR for several of
14 those contracts?

15 A Several of them, yes.

16 Q How many specific contracts with
17 CasePro, Inc. were you the COR for, if you can
18 recall?

19 A How many specific ones?

20 Q Yes, ma'am?

21 A I think approximately 10.

22 Q Have to use both hands to count them?

23 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

Case No. 2012-CP-07-03782

RECEIVED
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SC Court of Appeals

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

Appellant,

v.

CasePro, Inc.,

Respondent.

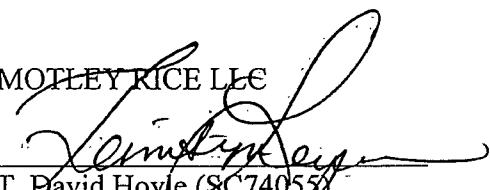
CERTIFICATE OF COUNSEL

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

MOTLEY RICE LLC


T. David Hoyle (SC74055)

W. Christopher Swett (SC748251)

Temitope O. Leyimu (SC101288)

28 Bridgeside Blvd.

Mount Pleasant, SC 29465

(843) 216-9000 | (843) 216-9440 (Facsimile)