

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178
Appellate Case No. 2017-002299

RECEIVED

JUN 11 2018

SC Court of Appeals

Treva C. Flowers, Tristan
Flowers, and Ashley F., an
infant under the age of
fourteen (14) years, by and
through her next friends,
Treva C. Flowers and Tristan
Flowers,

Appellants,

v.

Bang N. Giep, M.D., and
Spartanburg & Pelham OB-
GYN, P.A. (formerly
Spartanburg OB-GYN, P.A.),

Respondents.

RECORD ON APPEAL

Volume I

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FORM 4

**STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG
IN THE COURT OF COMMON PLEAS**

**JUDGMENT IN A CIVIL CASE
CASE NUMBER 2016CP4203178**

Treva C Flowers	Tristan Flowers	Bang N Giep Md	Spartanburg And Pelham Ob-Gyn, Pa

PLAINTIFF(S)

DEFENDANT(S)

Submitted by: The Court

Attorney for: ☐ Plaintiff ☐ Defendant
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit);
☐ Rule 43(k), SCRPC (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRPC; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

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

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

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk: **On October 13, 2017, the Jury rendered a verdict for the defendant.**

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.

Note: Title abstractors and researchers should refer to the official court order for judgment details.

E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

ELECTRONIC SIGNATURE PAGE TO FOLLOW

Circuit Court Judge

2053

Judge Code

ELECTRONICALLY FILED - 2017-Oct 31 10:46 AM - SPARTANBURG - COMMON PLEAS - CASE#2016CP4203178

For Clerk of Court Office Use Only

This judgment was entered on , and a copy mailed first class or placed in the appropriate attorney's box on , to attorneys of record or to parties (when appearing pro se) as follows:

Charles L. Henshaw Jr. 1534 Blanding St. Columbia, SC 29201

Lee Cannon Weatherly 40 Calhoun St., Ste. 400 Charleston, SC 29401

Dennis Gary Lovell Jr. 40 Calhoun Street Suite 400 Charleston, SC 29401

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

M Hope Blackley - Clerk of Court

Court Reporter: Pam Green

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

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.



Spartanburg Common Pleas

Case Caption: Treva C Flowers VS Bang N Giep Md

Case Number: 2016CP4203178

Type: Order/Form 4

IT IS SO ORDERED !

s/ J. Derham Cole

Electronically signed on 2017-10-27 10:39:58 page 3 of 3

ROA 3

STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS

Treva C. **FLOWERS**, Tristan **FLOWERS**,
And Ashley **F**, an infant
Under the age of fourteen (14) years, by
And through her next friends, Treva C.
FLOWERS and Tristan **FLOWERS**,

Plaintiffs,

VERDICT FORM

Civil Action No.: **2016-CP-42-03178**

Bang N. **GIEP**, M.D. and **SPARTANBURG &**
PELHAM OB-GYN, P.A.,)

Defendants

1. Do you find that the plaintiffs have proven by the greater weight or preponderance of the evidence that the defendants, by and through Bang N. Giep, were negligent in the providing of medical care during and in the course of the birth and delivery of Ashley **F** and that such negligence was a proximate cause of some injury or other loss sustained by the plaintiffs ?

YES

or

NO

(Circle your finding)

(If you answered "**NO**" above, **STOP** and **DELIBERATE NO FURTHER**, your verdict would be for the defendants. If you answered "**YES**" above, go to Question #2)

2. Do you find that the defendants have proven by the greater weight or preponderance of the evidence that the medical care rendered by the defendants, by and through Bang N. Giep, during the birth and delivery of Ashley **F**, was rendered in a genuine emergency situation where she was not medically stable and was in immediate threat of either death or serious bodily injury ?

YES

or

NO

(Circle your finding)

(If you answered "**YES**" above, **STOP** and **DELIBERATE NO FURTHER**, your verdict would be for the defendants. If your answer is "**NO**" above, go to Question #3)

3. What is the total amount of actual damages that you find have been sustained by the plaintiff **Ashley** **F** which were proximately caused by the negligence of the defendant Bang N. Giep during and in the course of her birth and delivery ?

(\$ _____).

4. What is the total amount of actual damages that you find have been sustained by the plaintiffs **Treva C. Flowers** and **Tristan Flowers** which were proximately caused by the negligence of the defendant **Bang N. Giep** during and in the course of the birth and delivery of Ashley F ?

(\$ _____).

October 13, 2017.


Foreperson

STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

TREVA C. FLOWERS, TRISTAN
FLOWERS, and ASHLEY

F, an infant under the age of
fourteen (14) years, by and through her
next friends, TREVA C. FLOWERS and
TRISTAN FLOWERS,

Plaintiffs,

vs.

BANG N. GIEP, M.D., and
SPARTANBURG & PELHAM OB-GYN,
P.A. (formerly SPARTANBURG OB-
GYN, P.A.),

Defendants.

IN THE COURT OF COMMON PLEAS

C/A

2011-CP-42-4281

NOTICE OF INTENT TO FILE SUIT

Pursuant to S.C. Code § 15-79-125(A), the plaintiffs submit their notice of intent to file suit against the defendants above-named and state the following:

Ashley F is the minor child of Treva C. Flowers. Treva C. Flowers and Ashley F came under the medical care of Spartanburg Ob-Gyn, P.A., and its employees and agents, who managed the pregnancy of Treva C. Flowers in 2008. One of those employees was Bang N. Giep, M.D., who performed the birth delivery of Ashley F on October 7, 2008, at Spartanburg Regional Medical Center in Spartanburg County, South Carolina.

Treva C. Flowers's pregnancy with Ashley F was complicated by gestational diabetes, which was known or should have been known to Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.) and Bang N. Giep, M.D.. Ashley F suffered a brachial plexus injury at birth, after Bang N. Giep, M.D., encountered a

ROA 6

birthing complication known as shoulder dystocia and applied traction to deliver the baby vaginally.

Bang N. Giep, M.D., as an employee of Spartanburg & Pelham Ob-Gyn, P.A., deviated from generally recognized and accepted standards of care and failed to render medical care expected of a reasonably competent medical practitioner under the same or similar circumstances by applying excessive traction during the delivery of Ashley F and causing injury to her brachial plexus and by failing to properly advise the mother of cesarean section as a birthing option. The standard of care required the obstetrician in the face of shoulder dystocia to complete the vaginal delivery through a series of maneuvers without excessive traction. Excessive traction was manifested in this instance by an extremely large neuroma involving the entire brachial plexus in the area of the left clavicle with extensive damage to the C5, C6, and C7 nerve roots of the child's cervical spine. The neuroma most probably was caused by trauma during the birth process from excessive traction.

As a result of excessive traction during birth Ashley F suffered nerve damage within her shoulder that has resulted in permanent physical disability of her left arm and hand.

Treva C. Flowers and Tristan Flowers give notice of intent to file suit for their losses as parents of the minor child. Ashley F, an infant under the age of 14 years, gives notice of intent to file suit for her personal injuries by and through her next friends, Treva C Flowers, her mother, and Tristan Flowers, her father.

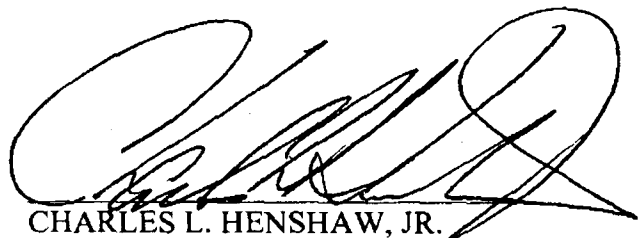
Treva C. Flowers and Tristan Flowers have suffered and will suffer extraordinary financial losses related to Ashley F medical, hospital, special needs, and caretaking expenses; and Ashley F endured and will endure personal injuries

including physical pain and suffering, mental anguish and emotional distress, physical disability and impairment, loss of enjoyment of life, physical disfigurement, and medical, hospital, and caretaking expenses. Treva C. Flowers and Tristan Flowers, individually and as representatives for the child, are informed and believe that their injuries and losses were the direct and proximate result of the negligence, wantonness, willfulness, recklessness, and gross negligence of Bang N. Giep, M.D., and employees and agents of Spartanburg & Pelham Ob-Gyn, P.A. Treva C. Flowers and Tristan Flowers is informed and believes that Spartanburg & Pelham Ob-Gyn, P.A., is liable for the acts and omissions of its agents and employees.

Under the law of South Carolina, Bang N. Giep, M.D. and Spartanburg & Pelham Ob-Gyn, P.A., can be subject to punitive damages for wanton, willful, or reckless misconduct.

Disclosures pursuant to the South Carolina Rules of Civil Procedure are attached, and the affidavit of an expert as required by S.C. Code § 15-36-100 is also attached.

By:



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ATTORNEYS FOR PLAINTIFF

R. HOPE BLACKLEY

OCT - 7 AM 9:24

COMMUNITY

October 4, 2011

STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

TREVA C. FLOWERS, TRISTAN
FLOWERS, and ASHLEY

F. , an infant under the age of
fourteen (14) years, by and through her
next friends, TREVA C. FLOWERS and
TRISTAN FLOWERS,

Plaintiffs,

vs.

BANG N. GIEP, M.D., and
SPARTANBURG & PELHAM OB-GYN,
P.A. (formerly SPARTANBURG OB-
GYN, P.A.),

Defendants.

IN THE COURT OF COMMON PLEAS

C/A No. **2012-CP-42-1144**

COMPLAINT
(Jury)

The plaintiffs complaining of the above-named defendants allege the following:

1. That the plaintiffs are residents of Greenville County, South Carolina.
2. That Ashley F. is an infant under the age of fourteen (14) years, and she pursues this action by and through her next friends, Treva A. Flowers and Tristan Flowers, who are her parents.
3. That plaintiffs are informed and believe that defendant Bang N. Giep, M.D. is a resident of Spartanburg County, South Carolina.
4. That plaintiffs are informed and believe that defendant Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.) is a business organization organized and existing under the laws of South Carolina with its principal place of business being in Spartanburg County, South Carolina.

5. That plaintiffs are informed and believe that at all times mentioned herein defendant Giep was an agent and employee of Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.).

6. That plaintiffs are informed and believe that Spartanburg & Pelham Ob-Gyn, P.A., is liable for the acts and omissions of its agents and employees pursuant to the law of respondeat superior.

7. That plaintiffs gave notice of intent to file suit on October 7, 2011, as required by S.C. Code Ann. § 15-79-125, in the Spartanburg County Court of Common Pleas, where the notice of intent was filed under docket number 2011-CP-42-4281.

8. That the matter could not be resolved through mediation, and a mediator declared an impasse between the parties on or about January 16, 2012.

9. That at all times mentioned herein defendant Giep was a medical doctor licensed by the State of South Carolina, and he held himself out as a specialist in obstetrics/gynecology.

10. That on October 7, 2008, at Spartanburg Regional Medical Center in Spartanburg, South Carolina, defendant Giep undertook to medically manage the labor of Treva A. Flowers and the birth of her viable, female child, Ashley F.

11. That the birth of Ashley F on October 7, 2008, was complicated by shoulder dystocia.

12. That in the course of delivery Ashley F suffered an injury to the brachial plexus nerve bundle on her left side and the C5, C6, and C7 nerve roots were severely damaged.

13. That plaintiffs are informed and believe that the defendant Giep deviated from generally recognized and accepted standards of care, failed to render medical care expected of a

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SPARTANBURG COUNTY
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MEMORANDUM
BLACKBERRY

reasonably competent medical practitioner under the same or similar circumstances, and was negligent, wanton, willful, reckless, and grossly negligent in at least one of the following ways:

- a. In applying excessive traction while delivering the baby;
- b. In failing to recommend cesarean section delivery to the mother;
- c. In failing to deliver the baby by cesarean section;
- d. In failing to use timely and appropriate maneuvers to release the baby from shoulder dystocia during delivery.

Any and all of which defendant Giep knew or should have known was contrary to the health and well being of the mother and child.

FOR A FIRST CAUSE OF ACTION

(On behalf of Ashley F)

14. That plaintiffs incorporate the allegations of paragraphs 1-13 as if stated herein verbatim.

15. That plaintiffs are informed and believe that as a direct and proximate result of the acts and omissions of the defendants Ashley F suffered extensive damage to the C5, C6, and C7 nerve roots of her spine, resulting in permanent physical disability of her left shoulder, arm, and hand and causing her to endure physical pain and suffering; mental anguish and emotional distress; physical disability and impairment and loss of enjoyment of life; physical disfigurement; loss of income and earning capacity; and medical, hospital, and caretaking expenses.

16. That plaintiffs are informed and believe that Ashley F is entitled to recover compensation from the defendants for her actual losses and damages and to recover punitive damages as allowed by law.

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SPARTANBURG COUNTY
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M. HOPE BLAKLEY

FOR A SECOND CAUSE OF ACTION

(On behalf of Treva C. Flowers and Tristan Flowers)

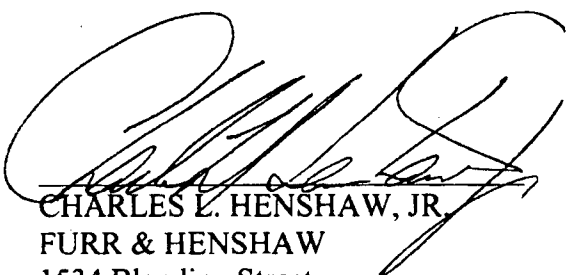
17. That plaintiffs incorporate the allegations of paragraphs 1-13 as if stated herein.

18. That plaintiffs are informed and believe that as a direct and proximate result of the acts and omissions of the defendants Ashley F suffered extensive damage to the C5, C6, and C7 nerve roots of her spine, resulting in permanent physical disability of her left shoulder, arm, and hand and Treva C. Flowers and Tristan Flowers, as parents of the child, have suffered and will suffer extraordinary financial losses related to Ashley F's medical, hospital, special needs, and caretaking expenses during the period of her childhood.

19. That plaintiffs are informed and believe that Treva C. Flowers and Tristan Flowers are entitled to recover compensation from the defendants for actual losses and damages and to recover punitive damages as allowed by law.

WHEREFORE, the plaintiffs demand a jury trial and pray for judgment against the defendants for actual and punitive damages and for the costs of this action and for such further relief as the Court deems them entitled.

By:


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ATTORNEY FOR PLAINTIFFS

March 12, 2012

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SPARTANBURG COUNTY
2012 MAR 12 PM 1:20
M. HOPE BLACKLEY

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	CASE NO.: 2012-CP-42-1144
	)	
TREVA C. FLOWERS, TRISTAN	)	
FLOWERS, AND ASHLEY	)	
F	)	
, AN INFANT UNDER THE	)	
AGE OF FOURTEEN (14) YEARS AND	)	ANSWER OF DEFENDANTS BANG N.
BY AND THROUGH HER NEXT	)	GIEP, M.D. AND SPARTANBURG &
FRIENDS TREVA C. FLOWERS AND	)	PELHAM OB/GYN, P.A.
TRISTAN FLOWERS,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	
	)	
BANG N. GIEP, M.D. AND	)	
SPARTANBURG & PELHAM OB-GYN,	)	
P.A. (FORMERLY SPARTANBURG OB-	)	
GYN, P.A.)	)	
	)	
Defendants.	)	

COMES NOW Bang N. Giep, M.D. and Spartanburg & Pelham OB/GYN, P.A., Defendants in the above-styled civil action, and present this their Answer to the Complaint and show the Court as follows:

FIRST DEFENSE

At all times relevant to the matters complained of in the Complaint, these Defendants exercised that degree of skill and care required of them by law.

SECOND DEFENSE

There is no causal connection between any alleged act or omission on the part of these Defendants and the alleged injuries or damages claimed by Plaintiffs.

THIRD DEFENSE

The claims for non-economic damages are limited in amount under South Carolina law.

FOURTH DEFENSE

Any claims for punitive damages, and the statutes of the state of South Carolina purporting to authorize those claims, violate these Defendants' rights as guaranteed under the Constitutions of the United States of America and of the State of South Carolina.

FIFTH DEFENSE

Defendants respond to the numbered allegations of the Complaint and show the Court as follows:

1. Defendants lack sufficient information to form a belief as to the truthfulness of the allegations of Paragraphs 1 and 2 of the Complaint. Therefore, those allegations can neither be admitted nor denied at this time.

2. Defendants admit the allegations of Paragraph 3, 4, and 5 of the Complaint. Defendants deny any allegations of negligence or liability in those paragraphs.

3. In response to the allegations of Paragraph 6, Defendants admit that Dr. Giep was acting within the course and scope of his employment with Defendant Spartanburg and Pelham OB/GYN, P.A. at the time of his rendition of medical care to the Plaintiff and Plaintiff's child. Defendants deny all other allegations of Paragraph 6.

4. In response to the allegations of Paragraph 7 and 8, Defendants admit that the Parties complied with the requirements of South Carolina law with regard to the Notice of Intent

to File Suit. Defendants deny any allegations of negligence on their part or liability to Plaintiffs that were contained in the Notice of Intent to File Suit proceedings.

5. Defendants admit the allegations of Paragraphs 9 and 10 of the Complaint.

6. In response to the allegations of Paragraphs 11 and 12, Defendants admit that the minor child suffered from various medical conditions, including shoulder dystocia, during delivery. Defendants lack sufficient information to form a belief as to the truthfulness of the remaining allegations of Paragraphs 11 and 12. Therefore, those allegations can neither be admitted nor denied at this time.

7. Defendants deny the allegations of Paragraphs 13, 15, 16, 18, and 19.

8. In response to the allegations of Paragraph 14, Defendants incorporate, as if fully set forth herein, their responses to Paragraphs 1 through 13.

9. In response to the allegations of Paragraph 17, Defendants incorporate, as if fully set forth herein, their responses to Paragraphs 1 through 13.

10. Defendants deny each and every allegation of the Complaint not specifically responded to in the preceding paragraphs of this Answer.

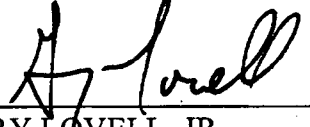
WHEREFORE, having fully responded to the Complaint, Defendants demand that they be dismissed with costs taxed against the Plaintiffs. Defendants further demand a trial by a jury of twelve persons.

SIGNATURE PAGE TO FOLLOW

ROA 15

Respectfully submitted,

CARLOCK, COPELAND & STAIR, L.L.P.

By: 

D. GARY LOVELL, JR.

State Bar No.: 69293

LEE C. WEATHERLY

State Bar No.: 71109

Attorneys for Defendants Bang N. Giep, M.D.
and Spartanburg & Pelham OB/GYN, P.A.

40 Calhoun Street, Suite 400
Charleston, South Carolina 29401-3531
843-727-0307

ROA 16

NOTICE OF APPEAL IN A CIVIL CASE

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178

Treva C. Flowers, Tristan
Flowers, and Ashley F., an
infant under the age of
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Treva C. Flowers and Tristan
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v.

Bang N. Giep, M.D., and
Spartanburg & Pelham OB-
GYN, P.A. (formerly
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Respondents.

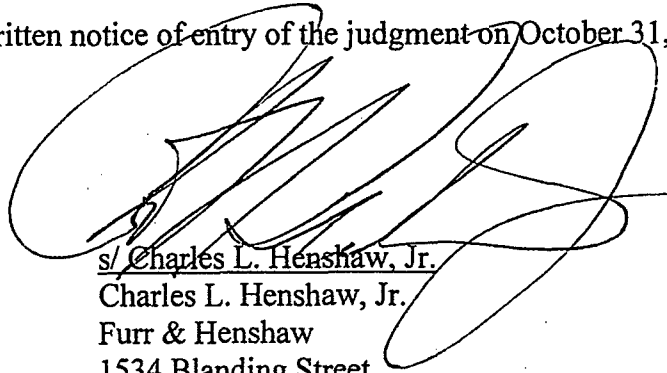
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SC Court of Appeals

NOTICE OF APPEAL

Treva C. Flowers, Tristan Flowers, and Ashley F., an infant under the age of fourteen (14) years, by and through her next friends, Treva C. Flowers and Tristan Flowers, appeal the trial rulings of the Honorable J. Derham Cole dated October 9-13, 2017; Judge Cole's denial of motion for new trial on October 13, 2017; and the judgment entered by Judge Cole on October 31, 2017 for defendants. Among the grounds for appeal is that S.C. Code Ann. Section 15-32-230 is

unconstitutional pursuant to the equal protection clauses of the United States and South Carolina constitutions. Appellants received written notice of entry of the judgment on October 31, 2017.

November 1, 2017



s/ Charles L. Henshaw, Jr.
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Attorney for Respondents

FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2016CP4203178

Treva C Flowers

Tristan Flowers

Bang N Giep Md

Spartanburg And Pelham
Ob-Gyn, Pa

PLAINTIFF(S)

DEFENDANT(S)

Submitted by: The Court

Attorney for: ☐ Plaintiff ☐ Defendant☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit);
☐ Rule 43(k), SCRPC (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRPC; ☐ Bankruptcy; ☐ Other: _____
- ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

RECEIVED
NOV 03 2017
SC Court of Appeals

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

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

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk: On October 13, 2017, the Jury rendered a verdict for the defendant.

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.

Note: Title abstractors and researchers should refer to the official court order for judgment details.

E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

ELECTRONIC SIGNATURE PAGE TO FOLLOW

2053

Circuit Court Judge

Judge Code

For Clerk of Court Office Use Only

This judgment was entered on , and a copy mailed first class or placed in the appropriate attorney's box on , to attorneys of record or to parties (when appearing pro se) as follows:

Charles L. Henshaw Jr. 1534 Blanding St. Columbia, SC
29201

Lee Cannon Weatherly 40 Calhoun St., Ste. 400 Charleston,
SC 29401
Dennis Gary Lovell Jr. 40 Calhoun Street Suite 400
Charleston, SC 29401

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

M Hope Blackley - Clerk of Court

Court Reporter: Pam Green

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

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.



Spartanburg Common Pleas

Case Caption: Treva C Flowers VS Bang N Giep Md

Case Number: 2016CP4203178

Type: Order/Form 4

IT IS SO ORDERED !

s/ J. Derham Cole

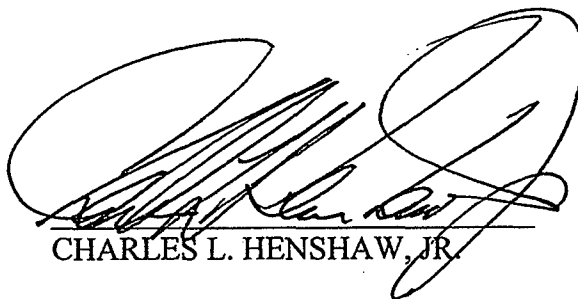
Electronically signed on 2017-10-27 10:39:58 page 3 of 3

CERTIFICATE OF SERVICE

I hereby certify that on this date I caused to be served a copy of the foregoing **NOTICE OF APPEAL** upon the individuals whose names and addresses are listed below placing a copy in the United States Mail with proper first-class postage affixed thereon.

Mr. D. Gary Lovell, Jr.
Mr. Lee Weatherly
Carlock, Copeland & Stair, LLP
40 Calhoun Street, Suite 400
Charleston, SC 29401-3531

RECEIVED
NOV 03 2017
SC Court of Appeals


CHARLES L. HENSHAW, JR.

Nov 2, 2017

1	STATE OF SOUTH CAROLINA	}	COURT OF COMMON PLEAS
2	<u>COUNTY OF SPARTANBURG</u>		
3			
4	TREVA C. FLOWERS, TRISTAN FLOWERS,	}	TRANSCRIPT
5	ASHLEY GRACE FLOWERS, AN INFANT UNDER		OF
6	THE AGE OF FOURTEEN (14) YEARS, BY AND		RECORD
7	THROUGH HER NEXT FRIENDS, TREVA C.		
8	FLOWERS AND TRISTAN FLOWERS,		
9			
10	PLAINTIFFS,		
11	VS.		
12			2016-CP-42-3178
13	BANG N. GIEP, M.D. AND SPARTANBURG &		
14	PELHAM OB-GYN, P.A. (FORMERLY		
15	SPARTANBURG OB-GYN, P.A.		
16	DEFENDANTS.		

October 9th, 10th, 11th, and 13th, 2017
Spartanburg, South Carolina

B E F O R E:

THE HONORABLE J. DERHAM COLE, Judge; and a jury.

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

CHARLES L. HENSHAW, JR.
ESQ.
Attorney for the Plaintiffs

D. GARY LOVELL, JR.
ESQ.
Attorney for the Defendants

PAMELA E. GREEN
Circuit Court Reporter
Seventh Judicial Circuit

1 juror's place. And, in that event, you would become the
2 twelfth juror, and, in that event, you would participate
3 throughout the trial, including the jury deliberations at
4 the trial's conclusion.

5 If, however, at the end of the trial, when the jury
6 does go back to begin deliberations, if the original 12 are
7 able to participate, then your service, as alternates, would
8 end and that's because the decision of a jury is that of 12,
9 and no more than 12 are permitted to engage in that
10 deliberation process, but it is important that you pay just
11 as careful attention, as we ask of all of the jurors in this
12 case, because it does occur from time to time for one reason
13 or another, one or two of these jurors may be unable to
14 continue. In that event, one or both of you, as alternates,
15 would be called upon to become the twelfth juror.

16 So, we do appreciate your participation as alternate
17 jurors just as we appreciate the participation of each of
18 you jurors who have been selected for the purpose of
19 deciding the verdict in this particular case.

20 You may swear the panel.

21 (WHEREUPON, the jury panel was placed under oath at
22 this time.)

23 THE COURT: All right. Ladies and gentlemen, as you
24 know, you've been selected to decide this verdict in the
25 case of Treva C. Flowers, Tristan Flowers, and Ashley

1 F . They are plaintiffs. They brought the lawsuit.
2 It's been brought against Bang N. Giep, who's a medical
3 doctor, and Spartanburg & Pelham OB-GYN, which is a
4 professional association of doctors. And the lawsuit has
5 been brought because the plaintiff claims that the defendant
6 was negligent in the providing of medical care to her at the
7 time that the child, Ashley F , was born, and
8 that that negligence resulted in some physical injury to the
9 child for which the plaintiffs are asking to be compensated.

10 In response to those allegations made by the plaintiff
11 in their complaint, the defendant has responded by admitting
12 that they had a physician/patient relationship and admitting
13 to participating in the delivery of a child, but the
14 defendant denies that he was negligent in any way in his
15 providing medical care to any of the plaintiffs in this
16 case, and, therefore, any injury that she may have suffered
17 was not caused by his negligence but was caused by some
18 other circumstance.

19 Now, this, this is what is called a medical malpractice
20 or a medical negligence lawsuit. In this case, the
21 plaintiff, Treva Flowers and Tristan Flowers, allege that
22 they sought medical care from a doctor in a child delivery,
23 that he provided care, and that he was negligent in the
24 providing of that care.

25 Now, in order for a plaintiff to be entitled to a

1 recovery in a medical negligence lawsuit, the plaintiff has
2 to prove four essential elements in order to be entitled to
3 a recovery. If any of those four elements are not
4 established, then the plaintiff is not entitled to recover
5 against the defendant.

6 So, in a medical, medical negligence lawsuit, the
7 plaintiff must first present evidence to the jury
8 establishing what the applicable standard of medical care
9 was that's relevant to the circumstances attending this
10 particular case.

11 Secondly, the plaintiff has to prove that the defendant
12 inappropriately deviated or departed from that applicable,
13 applicable standard of care. In other words, it has to be
14 proven that the defendant's care and treatment that was
15 provided in this case did not conform to or comply with the
16 applicable standard of medical care required of physicians
17 if acting under the same or similar circumstances as
18 established by the evidence in this case.

19 Thirdly, the plaintiff has to prove that any injury
20 complained of was sustained and some loss was suffered, and
21 that it was the defendant's deviation and departure from the
22 applicable standard of care. In other words, it was the
23 defendant's negligent providing of medical care that was a
24 proximate cause of some injury claimed to have been
25 sustained by the plaintiffs for which they are asking for

1 compensation.

2 Now, in this case, the way the trial will proceed is
3 that, in a moment, the lawyers are going to address you in
4 what are called opening statements. There are two occasions
5 in the trial of a civil lawsuit where lawyers are permitted
6 to address the jury and that is at the beginning of the
7 trial before any evidence is introduced, then again at the
8 conclusion of the trial after all of the evidence has been
9 received, but keep in mind, as I've just indicated, that the
10 evidence comes in -- the evidence upon which you will base
11 your decision comes in-between the opening and the closing
12 statements.

13 And so what the lawyers tell you in their opening and
14 closing statements is not to be considered by you as any
15 evidence upon which you will base your decision, and that's
16 because the lawyers aren't witnesses to anything. They
17 don't know anything about this case of their own personal
18 knowledge or perception like witnesses will be testifying to
19 when they take the witness stand and testify before you.
20 The lawyers aren't gonna take the witness stand. They're
21 not gonna be placed under oath, and they're not gonna be
22 subjected to direct and cross-examination like every witness
23 will be when the witness provides evidence here in Court,
24 but you should listen to what the lawyers have to say even
25 though it's not evidence because those statements do serve a

1 purpose.

2 The opening statements will serve to provide you with a
3 basic understanding as to what this case is about from both
4 the prospective of the plaintiffs and of the defendant so
5 that you'll have some context in which to place the evidence
6 that we will be receiving shortly thereafter.

7 The closing statements occur after the evidence has
8 been received, and, again, while those statements are not
9 evidence, it does afford the lawyers an opportunity to
10 discuss with you the evidence that you have seen and heard
11 during the trial of this case, and it will provide them with
12 a chance to try to persuade you or to convince you that the
13 evidence in the case does or does not support a particular
14 decision depending upon which lawyer is arguing that case
15 before you, and it's in-between those opening and closing
16 statements accomplished by the lawyers that we actually
17 receive the evidence upon which you will decide the facts
18 and you will determine whether or not the plaintiff is
19 entitled to a recovery.

20 The plaintiff has the burden of proof. As I've told
21 you, the plaintiff has to prove those four essential
22 elements in order to be entitled to a recovery. If the
23 plaintiff does prove those four essential elements, then the
24 plaintiff would be entitled to a recovery and the jury would
25 have to determine what amount of money is appropriate to be

1 paid to the plaintiff by the defendant in order to
2 compensate them for those losses and injuries proven to have
3 been sustained. And, as I've stated, if the plaintiff fails
4 to prove any one or more of those elements, then the
5 plaintiff would not be entitled to a recovery and your
6 verdict would be for the defendant.

7 The plaintiff goes forward first in their presentation
8 because they have the burden of proof. They have to
9 establish their entitlement to a recovery. Once the
10 plaintiff has concluded in their presentation of evidence,
11 the defendant will have an opportunity to present evidence.
12 After all of the evidence has been received, you know that
13 you'll hear from lawyers in their final summations after
14 which I will instruct you on the law fully as it relates to
15 the civil law generally, and as it relates to this
16 particular type of cause of action specifically, and then
17 you'll be asked to go back and begin with your
18 deliberations, and, through that process, you'll examine all
19 of the evidence.

20 You will evaluate the credibility of testimony of
21 witnesses whether they be lay witnesses or expert witnesses.
22 You will determine what you believe to be the facts as they
23 relate to the allegations in this case. Once you've decided
24 those facts, you'll then apply the law that I will have
25 provided you, and you will determine whether or not the

1 plaintiff is entitled to a recovery. If the plaintiff is
2 entitled to a recovery, recovery, then you determine the
3 amount of damages. And if the plaintiff is not entitled to
4 a recovery, then you will indicate your verdict is for the
5 defendant.

6 Now, during the course of any trial, there are often
7 times where there is a conflict in testimony. Now sometimes
8 those conflicts don't make any difference because they don't
9 relate to any material fact that needs to be decided in
10 order for a jury to arrive at a decision. In other words,
11 if it's said something occurred during the daytime and
12 somebody else said it occurred in the nighttime, that
13 doesn't matter what time it occurred. It's the event that's
14 important, and, of course, it might be important if it's in
15 the night in some, some given case, but not necessarily so.
16 But if it's not a material fact, then it doesn't make any
17 difference necessarily.

18 But where the testimony conflicts and it does relate to
19 a material fact that needs to be decided by the jury in
20 order to arrive at a decision, you are the persons who get
21 to decide that fact. You are the persons who get to decide
22 the credibility and the believability of any witness that
23 testifies before you during the trial of this case. That
24 goes for lay witnesses and it also goes for expert
25 witnesses.

1 You are the judges of the facts. You determine what
2 the facts are. It is your prerogative, in determining those
3 facts, you get to assess the credibility of witness
4 testimony, and whether it be a lay witness or an expert
5 witness, you can believe everything that a witness testified
6 to.

7 You may choose to believe none of it. You may believe
8 some portion of a witness's testimony and reject some other
9 portion of that same witness's testimony. You may believe
10 one witness as opposed to several or several as opposed to
11 one. But in order for you to be in a proper position to be
12 able to fairly evaluate and assess a witness's credibility,
13 you've got to give every witness that testifies the same
14 degree of attention while they testify so that, in the end,
15 when you do go back to begin deliberation, you'll be in a
16 position to fairly evaluate their testimony in light of not
17 just their own testimony given here in Court, but in light
18 of all of the other testimony and other evidence received
19 during the course of the trial. And it's also important
20 that you keep an open mind throughout the course of the
21 trial, and that simply means that you are not to begin
22 making up your minds or formulating your opinions as to what
23 you think the ultimate decision in this case ought to be
24 until all of the evidence has been presented, until I have
25 instructed you on the law, and until you've been asked to

1 begin with your deliberations in the case.

2 That is the process that has been designed over the
3 last 240 years to ensure that you can arrive at a fair and
4 just decision in any case, but specifically in this case
5 today.

6 So, I do want to thank you in advance for your
7 participation as well as for your careful attention.

8 I will ask that you please give the lawyers your
9 attention now as they give you their opening statements.

10 Mr. Henshaw.

11 MR. HENSHAW: May it please the Court?

12 THE COURT: Yes, sir.

13 MR. HENSHAW: Ladies and gentlemen of the jury, my name
14 is Charles Henshaw. I am very proud to be representing
15 Tristan and Treva Flowers and their daughter, Ashley, in
16 this case that we are going to present to you this week.

17 I hope that you will find it to be an interesting case.
18 I hope that we will be able to present it to you in a way
19 that you will be able to understand.

20 In a medical malpractice case, sometimes people feel
21 concerned or they're very concerned that they won't be able
22 to apply their own common sense and knowledge to the case.
23 You certainly can do that. And by the time this case is
24 over and you will know enough about the medicine that you
25 will know what the standards of care are and what was to be

1 done or what should have been done on the night that Ashley
2 F was delivered on October 7, 2008, here at
3 Spartanburg Regional Medical Center.

4 Bang Giep holds himself out in this community as a
5 medical doctor. That means he has intended and graduated
6 from a medical school where he was academically educated and
7 trained in the principles and science of medicine. He puts
8 the initials M.D. behind his name because he is licensed by
9 the State of South Carolina to practice medicine in this
10 state. Bang Giep holds himself out in this community as a
11 medical specialist in obstetrics. That means he undertakes
12 to help women by medically managing their pregnancies and
13 delivering their babies at birth. For this, he entered and
14 completed a residency program where he concentrated on
15 obstetrics and gynecology and had multiple years of training
16 in obstetrical standards and practices that are generally
17 recognized and accepted by experienced and reasonable
18 physicians.

19 By the time October 7, 2008, arrived, he knew what was
20 to be done and he was expected to do it. That was his job.
21 That's what he got paid for.

22 Doctor Giep further underwent testing to demonstrate
23 his proficiency, which has allowed himself -- allowed him to
24 hold himself out to the public as a board certified
25 obstetrician meaning that he has been measured by national

1 standards of practice. Not just local standards.

2 In 1995, he joined Spartanburg OB-GYN, now Spartanburg
3 Pelham OB-GYN, and he began practicing here in Spartanburg
4 County where he and all the other members of the practice
5 held themselves out to the public as board certified medical
6 specialists in obstetrics.

7 A pregnant woman came under the care of Spartanburg
8 OB-GYN for pregnancy in 2008, she could expect to see each
9 of the doctors in the practice with the further expectation
10 that each doctor was fully qualified and competent to manage
11 her pregnancy. She could also expect that each doctor in
12 the practice was fully qualified, experienced, and
13 reasonably competent, competent to recognize and respond to
14 complications of her delivery.

15 Much of obstetrical medicine is about managing the
16 complications of pregnancy. Since the beginning of time,
17 women have been having babies without the benefit of an
18 obstetrician and without encountering risks of pregnancy,
19 labor and delivery, that, in some cases, resulted in death,
20 disfigurement, or physical impairment to either the mother,
21 the child, or both, but science and medicine have showed
22 that many complications of pregnancy can be managed and
23 eliminated when the mother comes under the care of a
24 reasonably competent practitioner.

25 Consequently, in modern times, most women choose to be

1 seen in pregnancy by board certified obstetrical specialists
2 such as Doctor Giep. By law, by law, each of those women
3 can expect that the practitioner will act according to
4 generally recognized and accepted standards of care, and to
5 do what would be expected of a reasonably competent
6 practitioner under the same or similar circumstances.

7 That is the law and duty of every person who holds
8 themselves out as a medical doctor in South Carolina, to act
9 according to the standards of care, and to do what a
10 reasonably competent practitioner would do under the same or
11 similar circumstances. In this case, it's what a board
12 certified obstetrician would do under the same or similar
13 circumstances that presented themselves on the night of
14 October 7, 2008, at Spartanburg Regional Medical Center.

15 Treva Flowers, at age 34, came under the care of
16 Spartanburg OB-GYN in 2008 when she became pregnant for the
17 first time. She and her husband, Tristan, wanted a baby.
18 Tristan worked at Spartanburg Regional in communications and
19 was recommended to Spartanburg OB-GYN.

20 Treva met every appointment and did everything she was
21 told. Tristan usually went with her to every appointment.
22 She circulated through the different doctors in the
23 practice. That was the way that they had it set up. They
24 wanted each patient to know every doctor, but she mostly saw
25 Doctor Ashley Fowler, and she saw Doctor Giep in his office

1 three times during the multiple visitations she had in the
2 office before she delivered.

3 In about her 32nd week of pregnancy, standard testing
4 showed that she had gestational diabetes, a complication of
5 pregnancy that sometimes caused babies to be large. Up
6 until that time the pregnancy had been absolutely normal.

7 Treva, excuse me, Treva's gestational diabetes was
8 managed by diet alone. She did not require Insulin.
9 Otherwise, except for the gestational diabetes, the
10 pregnancy went well and the baby developed normally. Four
11 ultrasounds were taken during the entire pregnancy. They
12 all showed that the baby was developing according to the
13 norms.

14 The baby was considered to be big, about in the 85th
15 percentile, but that's not abnormally large, and the
16 ultrasound showed that there were no abnormalities in her
17 development. There was nothing wrong with her legs or her
18 arms, her toes, or her fingers. She was a normal healthy
19 baby in utero.

20 Early on October 7, 2008, when Treva was at full term,
21 only four days away from her due date of October 11, her
22 water broke at home, early in the morning, two o'clock.
23 First time baby, you can imagine the excitement.

24 As planned, Tristan took her to Spartanburg Regional
25 where she was admitted for labor. She was admitted,

1 admitted under the care of Doctor Fowler, and Doctor Fowler
2 managed her labor throughout the day until about seven
3 o'clock in the evening.

4 Then Doctor Giep took over, according to the schedule
5 of the medical practice. It was basically they work what
6 they call half days, one doctor on, and then another doctor
7 would come on, and Doctor Giep's turn -- it was Doctor
8 Giep's turn to come on at about seven o'clock, maybe a
9 little bit earlier.

10 But, by then, the baby's head -- by the time he came
11 into the room where Treva was laboring, the baby's head was
12 crowning. The nurses were calling for the doctor to be
13 ready for the delivery. Crowning means that the baby's
14 scalp was beginning to appear between the mother's legs.
15 They could see the hair.

16 Doctor Giep came into the room, assessed the situation,
17 and applied a vacuum extractor. He pulled twice with the
18 vacuum extractor and the baby's head emerged.

19 Unfortunately, with the head out, the body would not
20 come. The baby's left shoulder was caught or hung on the
21 mother's pubic bone.

22 Now, this is called a -- this is a complication of
23 labor known as shoulder dystocia.

24 We need to have the -- we're gonna need to have that --
25 there we go. I think we can see it now.

1 Thank you, Your Honor.

2 THE COURT: You, you need to leave the lights on is
3 what you said?

4 MR. HENSHAW: Yes, sir.

5 THE COURT: Okay.

6 MR. HENSHAW: So they can -- yes, sir.

7 This is the pubic bone or the pubis symphysis of the
8 mother's pelvis. In this case, this is the baby's left
9 shoulder. The baby's head has been delivered, but the
10 shoulder is caught behind the pubis symphysis not allowing
11 the body to deliver, and that's called shoulder dystocia.

12 When shoulder dystocia will occur is unpredictable. It
13 can happen in any pregnancy, but it does happen more often
14 with larger babies or where there has been gestational
15 diabetes, and this is where obstetricians earn their pay.
16 They are trained in maneuvers that can free the baby's
17 shoulder and allow the body to emerge.

18 Doctor Giep employed at least two of the maneuvers.
19 They're called the McRoberts maneuver and suprapubic
20 pressure. This is the opposite view of the shoulder
21 dystocia.

22 Can you turn that?

23 The McRoberts maneuver is where the mother is directed
24 and helped to pull her legs back toward her chest. Both
25 legs come back. In this case, the nurse -- a nurse was used

1 on one side and Mr. Flowers was on the other leg pulling
2 back, and that helps position the baby in a better position
3 to allow the shoulder to be released. In addition,
4 suprapubic pressure was used in this case, and there's where
5 a nurse is directed by the doctor to use one of her hands or
6 both to push down on the pubis symphysis, the pubic bone, or
7 just above it actually and apply pressure to try to compress
8 the shoulder so that it makes for a smaller presenting part
9 to, to be released and come on out of the birth canal.

10 This depiction shows the nurse standing there, but, in
11 this case, the nurse actually climbed up on a chair or some
12 type of step stool so that she could get more leverage to
13 push down on the shoulder.

14 There was a third maneuver that Doctor Giep will tell
15 you that he used called the Rubin's Maneuver, which is where
16 he actually attempts to move his hand up and take the
17 shoulder and sweep it in a way that releases the shoulder.
18 That was not documented in his records but -- and what the
19 records indicate is that these two maneuvers, the McRoberts
20 maneuver and the suprapubic pressure maneuver by the nurse,
21 actually allowed the baby to be released within two minutes
22 after the shoulder dystocia was recognized.

23 Ashley was born weighing seven pounds eleven ounces.
24 An injury to her left shoulder was immediately apparent.
25 She could not move her arm.

1 Doctor Giep and his attorney will tell you that the
2 injury was unavoidable. They will say that the forces and
3 complications of labor caused the injury. We say that
4 Doctor Giep caused the injury to Ashley's left shoulder
5 through negligence.

6 We know this because three nerves in her neck and
7 shoulder, the nerve C5, C6, and C7, were ruptured. A fourth
8 nerve, C8, was so badly stretched that it developed
9 scarring. Scarring is called a neuroma. These were
10 permanent injuries from which Ashley will never fully
11 recover.

12 Show the illustration as the nerves.

13 Yeah, this one right here. That's fine. That's good.
14 Can we blow that up at all?

15 Is that, that as large as we can make it?

16 Okay. That's fine.

17 This doesn't illustrate very well, but depicted on this
18 illustration are where the nerves come off the spinal cord.

19 You can see them here. This is the spinal cord and
20 each of the nerves comes off and they are numbered five,
21 six, seven, and eight, and then T1 I believe is what's
22 depicted there. They were stretched so severely that C5,
23 C6, and C7 were ruptured. Not just stretched. Ruptured.
24 And then C8 was so badly stretched that it developed
25 scarring, inflammation that caused it to scar over so that

1 no electrical stimulation could go through these nerves -- I
2 mean go from the brain down the spinal cord and through
3 these nerves into her arm.

4 when it was all over, at best, she had the movement of
5 only two fingers. She couldn't flex the arm. She couldn't
6 raise it. She couldn't move it laterally. Essentially it
7 was dead.

8 Ruptured nerves and permanent injuries are not the
9 expected results of shoulder dystocia. Shoulder dystocia is
10 a bad complication, but this injury suffered by Ashley
11 F is not the expected result.

12 There are a group of cases where, in the course of
13 delivering babies, temporary injuries to these nerves will
14 be caused by stretching during the delivery, temporary
15 injuries will be caused by stretching, and that is
16 considered to be a -- that is considered to be an
17 unfortunate, but accepted, complication of a shoulder
18 dystocia occurring during the delivery of a baby. Ruptures
19 and permanent injuries are not considered to be acceptable
20 injuries occurring during the delivery of a baby because of
21 shoulder dystocia.

22 The only time that this much force can be used by a
23 doctor in delivering a baby is when the baby is facing near
24 certain death, that there is no other way out, and then it
25 would be considerable -- it would be considered acceptable

1 to sacrifice the arm in order to save the baby, but this
2 baby was not at near certain death. And this much force was
3 not necessary in order to save the baby, and that's the
4 reason this was negligence. This was malpractice.

5 Negligence, malpractice, deviation, departure from
6 standard medical care, they all mean the same thing. The
7 doctor did not do what would be generally recognized and
8 accepted of a reasonably competent practitioner under the
9 same or similar circumstances.

10 And why do we know that?

11 Because by simply using McRoberts maneuver, and by
12 suprapubic pressure, Ashley's shoulders released within two
13 minutes, more like a minute, but within two minutes, and she
14 was no where near death and this amount of force was not
15 necessary.

16 Moreover, Doctor Giep himself, who documented what
17 happened and who has testified in this case and will testify
18 again, is, in no way, indicated this baby was near death and
19 that he was in the process of having to make a decision to
20 use this much force. He doesn't get up -- he doesn't get to
21 get up and say to you I was trying to save this baby's life
22 by using excessive force, that I was gonna sacrifice the arm
23 in order to save the baby. That was never a decision that
24 he had to make.

25 He didn't document it. He's never testified to it, and

1 if he tries to say it in this trial, he'll be changing his
2 testimony and his documentation.

3 He asserts that he applied only gentle traction, but
4 gentle traction does not cause ruptured nerves and does not
5 cause permanent injury.

6 You will hear Doctor Giep and experts that his attorney
7 has retained come and testify that what happened here may
8 have been caused by maternal forces of labor. In other
9 words, during the process of the mother having contractions
10 to force the baby out, in combination with the shoulder
11 impacting against the pubic bone, then that somehow caused
12 damage to these nerves.

13 In the history of medicine, there is only one case
14 where this type of damage, permanent injury, has been known
15 to be caused to a baby who did not have traction applied
16 during the -- who did not have traction applied during the
17 delivery, and it was written up and published in medical
18 journals. It was so unusual.

19 If nothing else, if this is that case or like that
20 case, then Doctor Giep owed it to the entire world to
21 publish this case so that other people could understand how
22 it could happen even though he applied only general traction
23 or no traction. That's how unusual it would be.

24 Now, at the end of this case, the judge will tell you
25 that you're entitled to use your common sense and collective

1 wisdom in making a decision about what the truth is about
2 what most likely happened. He will also explain to you
3 that, when you make a decision in this case, you don't make
4 it on the basis of absolute certainty or even scientific
5 certainty or what you believe happened beyond a reasonable
6 doubt. We don't have to prove our case beyond a reasonable
7 doubt, and the reason I bring this up is cause what we have
8 to prove to you is what probably happened, what probably
9 happened, and the evidence will be, at the end of this case,
10 is that when this type of injury occurs, that is ruptures of
11 three nerves, severe stretching of a fourth nerve with
12 permanent injury, what most probably happened is that Doctor
13 Giep used too much force.

14 Now, he not only used -- in order to have a result like
15 this, he most probably -- turn it please the other way.

16 All right. So, here's the way the baby's head is
17 suppose to come out. It's suppose to come out in line with
18 the body, but what most probably happened was -- is that
19 there was what is called lateral traction. The baby's head,
20 the opposite ear, in this case the right ear, was probably
21 pushed down toward the lower shoulder, and it causes a
22 stretch, and that stretch is more than that area of nerves
23 can take. That area of nerves is called the brachial
24 plexus, and you'll see injury to the brachial plexus.

25 And so, a combination of tugging on the head, along

1 with lateral traction toward the opposite shoulder, is what
2 most probably caused this injury, and that's what's
3 generally recognized and accepted to cause these injuries
4 when they're permanent and when they, when they result in
5 rupture. Otherwise, it should be published. The world
6 needs to know cause that's malpractice.

7 That's medical negligence right there. That's a
8 deviation from standard medical care. That's not what a
9 trained board certified obstetrician is expected to do under
10 these circumstances. Not when it's -- not when it's a
11 situation where the doctor's not making a, a conscious
12 decision to sacrifice the arm in order to save the baby.

13 There will be experts presented by both sides. We will
14 present to you Doctor Edith Gurewitsch and, and her husband,
15 Doctor Robert Allen. They are -- Doctor Gurewitsch is an
16 obstetrician at Johns Hopkins University whose written
17 extensively on the management of shoulder dystocia, and her
18 opinion is, is that, unfortunately, Doctor Giep committed
19 malpractice.

20 Doctor Allen is a biomedical engineer, and he has
21 studied the forces that are involved in delivering babies
22 with shoulder dystocia, and has studied the forces that can
23 cause this type of injury. And he will explain how the --
24 what those forces are and what kind of tugging a nerve can
25 withstand and what kind of tugging a nerve can not.

1 withstand.

2 Doctor Gurewitsch herself has had a circumstance in
3 which she delivered a baby with shoulder dystocia and there
4 was permanent injury. She believes that the circumstances
5 justified what she did in that case. She does not believe
6 that what Doctor Giep did here, when he was able to release
7 the baby within two minutes with two maneuvers, and there
8 are at least five other maneuvers that can be employed that
9 are known to physicians if they feel like they need to use
10 them, and he did not need to implore all those maneuvers in
11 order to deliver this baby.

12 So, under these circumstances, she does not feel that
13 it fell within acceptable care to use as much force as he
14 did to release this baby for the purposes of delivering.

15 Ashley F is now nine years old and I feel that
16 she's old enough to make an appearance in this courtroom and
17 let it -- let her talk to you herself. If she was a younger
18 child, I might only let her parents speak for her, but she's
19 going to come speak to you tomorrow and she'll be here. And
20 she's a beautiful young girl. Just beautiful. And
21 charming, vivacious. Got a lot of spunk. And she would be
22 nearly perfect except for her arm, which is disfigured.

23 She's had three surgeries to try to restore some
24 function of the arm, and she's very proud of what she can do
25 with it. She'll impress you with what she can do with that

1 arm, but she will never be whole, and she'll tell you that.

2 More than \$600,000 has been spent to try to restore
3 this arm, and she will live with a disfigured arm and a
4 dysfunctional arm for the rest of her life. And I tell you
5 that, in part, in hopes that you will appreciate and
6 understand how important this case is to Ashley and her
7 parents, but it's important to everybody in this courtroom.
8 Absolutely important.

9 I will tell you that this case will move along very
10 quickly. We hope to be through by the end of the week.
11 That's pretty fast for a case of this magnitude, but we can
12 do it, and the concern that we often have in a situation
13 where we are moving this quickly is that jurors will not
14 actually realize how important the case is until maybe the
15 second or third day. And if you wait for that long to wake
16 up to how important the case is, it will be too late. You
17 will have missed significant testimony, and the failure to
18 appreciate what you really need to appreciate to be able to
19 decide this case.

20 We believe that, at the end of this case, you will
21 understand that, number one, when a doctor -- a doctor is
22 expected to know how to identify shoulder dystocia and how
23 to deal with it. He's expected to know what maneuvers he
24 needs to make in order to release the body. He's expected
25 to be able to do that without applying too much force to the

1 baby's head and without applying lateral traction, dragging
2 the baby's head over toward one shoulder so as to stretch
3 the nerves in the opposite shoulder.

4 And if he fails to do that, under circumstances where
5 there was no need to do that in order to save the baby's
6 life, in other words, there was no need to sacrifice the arm
7 in order to save the baby, then, under those circumstances,
8 he has committed malpractice. And if he has committed
9 malpractice, then the patient is entitled to be compensated
10 for the injuries that she has sustained, and she has
11 sustained much. And we believe, at the conclusion of this
12 case, you will find on behalf of Tristan and Treva and
13 Ashley.

14 Thank you.

15 THE COURT: Mr. Lovell.

16 MR. LOVELL: Thank you, Your Honor.

17 Good afternoon.

18 I'm Gary Lovell and I represent Doctor Giep and his
19 practice in this lawsuit.

20 Opening statement is where we lawyers outline what we
21 think the evidence will show in the case, and you heard the
22 judge tell you a few minutes ago, because the plaintiffs
23 have the burden of proof, they will go first. They'll take
24 part of today and probably the remainder of today and
25 probably all of tomorrow putting up their witnesses.

1 what I ask that you promise me at this early phase and
2 promise Doctor Giep is that you don't start making up your
3 mind until you've heard from our portion of the case, which
4 comes possibly into Wednesday, maybe a little bit of
5 Thursday, cause you won't have heard all of evidence about
6 what happened in this scenario, what caused the injury that
7 this young lady suffers until you've heard from our side of
8 the case. So, please make me a promise that you won't make
9 your mind up until you've heard all of the evidence.

10 Now, what plaintiff's attorney didn't tell you about
11 this case and what the evidence is gonna show is, is -- he's
12 right about a couple of things. This was a relatively
13 uneventful pregnancy. Mrs. Flowers started with the
14 practice in January of '08. Everything was going very well.
15 She developed gestational diabetes after a few months, but
16 it was managed very well with diet. Doctor Giep was one of
17 the doctors that helped make that diagnosis.

18 Ultrasounds were showing what they could show, and
19 ultrasounds aren't like an MRI or other studies that tell
20 you everything about what's going on inside of the body, but
21 they give you some, some rough idea of what's about the size
22 of the baby, when it's probably gonna be due, does it have
23 five fingers, five toes, two arms, two legs, but it doesn't
24 tell you other things about what's going on inside the
25 baby's body.

1 But everything went along well. This was a, a large
2 baby, but not so large that there was concern that it might
3 not deliver the natural way, vaginally.

4 So, in October, Doctor Flowers sat down with -- I mean
5 Doctor Fowler sat down with, with Mrs. Flowers and said
6 okay, your due date's coming up. You know, if we get a
7 little further on, we might have to induce you, but we'll
8 just wait and see what happens.

9 So, on October the 7th, about 2:30, 3:00 in the
10 morning, her water broke. So, the induction was now no
11 longer necessary. She's headed to the ER to the labor and
12 delivery department of the hospital, and she's gonna deliver
13 the baby.

14 The evidence will show that the doctor works 12 hours
15 shifts, 7:00 at night till 7:00 in the morning is when, when
16 Doctor Fowler was in. 7:00AM -- I'm sorry. I got it
17 backwards. 7:00AM, yeah, Doctor Giep comes on duty and he
18 has the next shift. He is the doctor who was on duty when
19 the baby was delivered.

20 Doctor Giep will tell you that his standard practice
21 is, when he's gonna deliver, he goes and evaluates the
22 patient, checks on her. The labor and deliver nurses then
23 follow the patient throughout delivery. And what you're
24 gonna see, ladies and gentlemen, is that, as this delivery
25 progressed, and I'm a little bit somewhat low tech, but

1 you're gonna hear from Nurse Phillips, who you heard about
2 earlier, she was primarily the one that was following the
3 patient pretty much all day when her shift started.

4 when the afternoon came, and these are all military
5 times, so it's 19:47 is 7:47, they went into what's called
6 the second stage of labor where mom starts pushing. Those
7 of you who have children just really know what we're talking
8 about. Mom starts pushing and the baby begins moving down
9 the birth canal.

10 You're gonna hear some testimony from Doctor Giep and
11 some other experts about what happens to babies as they move
12 down the birth canal. You'll hear them testify about
13 something that plaintiff's attorney alluded to called
14 maternal forces. Maternal forces are where the contractions
15 and the muscles that are contained within the body of the
16 mother, and what I'm showing you here is an idea or diagram,
17 and we'll have a lot of different videos of things, but as
18 the body begins to move down the birth canal here, forces
19 apply to it -- to the body and they affect parts of the body
20 as the baby is moving down. Those are what's called
21 maternal forces.

22 You're gonna hear that those forces have a profound
23 effect on healthy babies, and they have an even more
24 profound effect on babies who aren't quite as healthy.

25 One thing the plaintiff's counsel didn't talk with you

1 about that I think the evidence will clearly show, ladies
2 and gentlemen, is that there's a point in time, beginning
3 about here; when the mother had been pushing for quite a bit
4 with contractions, the baby is moving down, and things are
5 going as they expect. They have her on a medication called
6 Pitocin to situate how the, the labor and the delivery is
7 progressing, but there came a point in time, when the head
8 began to crown, that the baby began to show evidence of
9 what's called fetal distress.

10 And what that means is the doctors are measuring the
11 baby's heartbeat as it's coming through the birth process,
12 and you, by the end of this trial, will be able to read this
13 thing that I'm putting up here. It's called a fetal monitor
14 strip.

15 The top part shows the baby's heartbeat measured in
16 beats per minute and there's little scales that go from 30
17 to 240. The little squiggly line is where the baby's
18 heartbeat is, and the evidence will show that, as we got
19 into the seven o'clock towards the eight o'clock hour, that
20 this baby's heartbeat was in the 130 beats per minute range
21 and it kind of stayed there. The bottom part is what shows
22 the contractions of the mother, and as her muscles begin to
23 contract, and the, and the birth process device is on there
24 that measures them, and it shows when she's having
25 contractions and when she's not, and kind of how big they

1 are.

2 At about 7:55, as the second stage was going, the
3 nurses began watching these strips and they noticed, in
4 about 8:04 in the afternoon, that the baby's heart rate
5 began to change. It began to drop below the 120 where it
6 had been staying, and it started getting into an area down
7 here in the 90s. That was a little concerning. Not
8 necessarily concerning enough that you worried that the baby
9 may be having a lot of instant problems because babies can
10 lay on their umbilical cord, and it can cause a problem like
11 that, or the mother can be shifting side-to-side and create
12 some problems on the umbilical cord, and it can create that
13 if it's just temporary.

14 The problem we had with this case is that, as the
15 nurses began to change the position of the mother, the heart
16 rate stayed down there low. It didn't come back up and stay
17 up. So, at about -- at about 20:11, they decide we're gonna
18 get Doctor Giep. So, they call him and he comes in to the
19 bedside. They put the patient on her right side, moved her
20 to her left side, and try to see if they could relieve the
21 cord thing.

22 Doctor Giep comes in and he does his examination, and
23 he'll explain to you what he does in his initial evaluation
24 at that point, but he's concerned about this baby's heart
25 rate. He's concerned that we're now down into the 90s and

1 it's not recovering. He's concerned that, if I let this
2 continue and I let mom continue to try to deliver vaginally
3 with natural contractions, this baby could get in trouble.
4 So, he decides that what he's going to do is what's called a
5 vacuum assisted delivery. He used a device called a Kiwi
6 vacuum that he placed on the top of the baby's head when the
7 baby was born or when the baby's head was doing what they
8 called crowning, and he used that to assist in removing the
9 baby or guiding the baby out to the position we see here.

10 Now, at this point, this is a suprapubic maneuver we're
11 gonna talk about in a minute, but the vacuum extractor was
12 used simply to try to assist the mom in getting the baby to
13 deliver naturally. The problem developed. At that point,
14 the baby's shoulder got stuck on the mother's pubic bone.
15 That was the shoulder dystocia.

16 So, what you have was a baby who, for several minutes,
17 had been having a heart rate in the 90s. That was
18 concerning. You now have a baby whose shoulder has gotten
19 stuck on the mother's pubic bone, which is what all of the
20 doctors that come in here, including Doctor Gurewitsch, will
21 agree is a medical emergency.

22 At that point, Doctor Giep will tell you he has but one
23 option and that is to deliver this baby and deliver it
24 within a period of a few minutes. After two or three or
25 four or five minutes, the baby can develop brain injury.

1 The baby can develop cerebral palsy. The baby can even die.
2 So, he's faced with a medical emergency at 20:18 and 20:19
3 where he has to deliver the baby.

4 Now, Doctor Giep will tell you, and we'll bring in the
5 nurse that will also tell you, what he did to do that. The
6 baby was safely delivered to the point where the vacuum had
7 delivered the head, but once the shoulder got stuck, the
8 baby has got to come out within a period of a few minutes.
9 Doctor Giep will tell you that the first thing he asked the
10 nurses to do was he asked them to put the patient in the
11 McRoberts position, what you saw, with her legs elevated so
12 that that would open up the pelvic anatomy with the mother.
13 Nurse Phillips will explain this in her video deposition,
14 but that, as they pulled the pelvis up, it opens it up and
15 the hope is that that will be enough to free up that
16 shoulder. Sometimes it works. Sometimes it doesn't.

17 Doctor Giep will tell you the next thing that he
18 instructed the nurses to do was to apply the suprapubic
19 pressure, and you'll hear from all of the experts that this
20 was the appropriate thing to do. Try this. You've got the
21 legs up. You've opened the pelvis. Hopefully the nurse
22 pressing on the area of the shoulder will allow it to slide
23 under that pubic bone. That's the hope. Hopefully that
24 works.

25 Unfortunately, Doctor Giep will tell, in this

1 situation, it did not free the shoulder. He had to proceed
2 to a third maneuver, and, in this third maneuver, it's
3 called a Rubin II. He takes his hand and he inserts it into
4 the mother's birth canal and he attempts to help guide the
5 shoulder below the area of the pubic bone.

6 So, what he does, as you see here, he first -- before
7 he does the Rubin II, he tries to reach in coming from this
8 direction to see if I can grab the arm that's stuck and
9 slide it forward and maybe it will come over. He couldn't
10 reach the arm he'll tell you. So, then he used what's
11 called Rubin II where he comes over and under, and he takes
12 his hand and he very gently pushes that shoulder over
13 towards the chest, and, when he did that, the baby
14 delivered.

15 We'll have a video animation to show you that's a re --
16 a little more fluid way of showing what all I just described
17 to you, but Doctor Giep will tell you that that's what he
18 did in this case to deliver the baby. He delivered the baby
19 using all three maneuvers within two minutes of the
20 development of the medical emergency. He delivered a baby
21 that didn't have brain damage. He delivered a baby who
22 didn't have cerebral palsy. He delivered a live baby.
23 Three of the complications that could have occurred if this
24 baby had not been delivered in the manner it was.

25 You've heard a lot of testimony about what type of

1 forces the doctor used and what he wrote in his chart, and
2 perhaps what he didn't write about the McRoberts,
3 suprapubic, and then what he didn't write about Rubins II.
4 He'll tell you the reason Rubin II is not written is that's
5 something he always does in a procedure like this. When the
6 applied suprapubic doesn't work, the McRoberts doesn't work,
7 he always goes to Rubin II. The reason he writes the
8 Rubin -- the McRoberts and the suprapubic is because
9 somebody else is applying it, but he doesn't write the Rubin
10 II down since that's something he does, and he always does
11 it in that order.

12 One thing we do know is that, on the day of the
13 delivery, the delivery was at, excuse me, 8:11 in the
14 morning, he's handed the baby off to mom and everything and
15 the baby's in NICU. At 9:11, he wrote the note summarizing
16 of the occurrence and this is what you got to do in the
17 hospital. You got to write what you do, you know, what's
18 happened and when it occurred.

19 well, he wrote in his note minimum traction performed.
20 His handwriting is terrible, but he'll help interpret it.
21 That's what he wrote at 9:11 describing the amount of forces
22 that he used on the baby in this delivery.

23 Two days later he's talking to the parents again trying
24 to explain to them what happened with the injury to this
25 child, and he wrote in his note gentle and constant traction

1 applied to infant head after McRoberts maneuver, suprapubic
2 pressure. Dystocia lasted approximately one minute. He
3 wrote in his note a description of what he did.

4 Now, eight years after the fact, tomorrow, I think,
5 you'll hear from Doctor Gurewitsch who's gonna say that's a
6 lie. What he wrote in his note was -- is not true.

7 He didn't use minimum traction. He didn't use gentle
8 positive pressure. He used 35 plus pounds of pressure on
9 this baby's head. She'll tell you what was written in the
10 notes, eight years ago, must be a fabrication. That's for
11 you to decide.

12 We're gonna bring you some expert witnesses to talk
13 about the care that Doctor Giep rendered, but, before that,
14 I want to talk for a second about Doctor Giep. I want to
15 talk about that.

16 Doctor Giep was born in Pennsylvania. His parents had
17 come here from Vietnam. He went back over there with his
18 parents for a while, and then moved back to the United
19 States at the end of the Vietnam War. He attended college
20 here at Wofford, went to medical school at the Medical
21 University of South Carolina Charleston, did a residency,
22 did training programs in obstetrics and gynecology, got
23 board certified, as the plaintiff's counsel mentioned, where
24 the boards were given to him. He took an oral test, written
25 test. He was certified as being -- having expertise in

1 obstetrics and gynecology.

2 He started practicing medicine here in 1995 with his
3 father. His brother joined the practice along with a lot of
4 other doctors who you heard mentioned in our jury selection.

5 He has delivered hundreds, if not thousands, of babies.
6 He has encountered shoulder dystocia, the hung shoulder as I
7 call it, on other births both before and after this one.

8 This is the only birth he's ever had that suffered a
9 permanent injury. All the others were temporary. But what
10 Doctor Giep will tell you is that, in his delivery of this
11 baby, he used the same types of forces, the same direction
12 of forces that he's used on all of the deliveries of babies
13 he's had with shoulder dystocia.

14 Now, it will be for you to decide if what Doctor Giep
15 describes to you and the method that he delivered the baby
16 is what most obstetricians, in general, would have done
17 under the same circumstances, the circumstances of a child
18 whose got a heart rate that's dropping to a concerning
19 level, the circumstances of a child whose got a dystocia,
20 and circumstances where you try two of the basic maneuvers
21 and it didn't work.

22 Doctor Giep will explain to you, as he wrote in his
23 notes, the type of pressure he uses, the direction that he
24 does it, his position with the mom as he's doing that, and
25 you'll hear him describe how the position he is in prohibits

1 him from doing what the plaintiff's pictures show up there.

2 We'll have a couple of experts to talk about standard
3 of care from the obstetrician only standpoint. We're gonna
4 bring to you Doctor Robert Arnett. He's an OB-GYN doctor
5 here in Spartanburg.

6 Doctor Arnett has looked at this case. He's reviewed
7 all of the materials. He will come in and tell you that
8 what Doctor Giep describes as doing and what he's written in
9 his notes about the traction with the forces he used was
10 what most OB-GYNs would have done. It was within the
11 standard of care.

12 We'll also bring to you Doctor Roger Gowers. He's an
13 OB-GYN that practices in Greenville. He will tell you the
14 same thing, that he knows, from his training of residents
15 and his experience, the types of forces that are used and he
16 looks at what Doctor Giep did under the circumstances he was
17 faced with, and these were the types of forces and the
18 direction of forces that most doctors would do.

19 So, the question may be in your mind, at that point,
20 well, how could the injury occur?

21 Well, we're gonna bring in a couple of other experts to
22 talk about that issue. We will have for you Doctor Joseph
23 Ernest, who is what's called a maternal fetal medicine
24 specialist. That is an obstetrician/gynecologist who goes
25 and gets even more training on what happens to babies when

1 they're developing and when they're being born.

2 What he's gonna tell you is that brachial plexus
3 injuries can occur even when the forces applied by the
4 physician during the delivery are the normal ones that, that
5 all or most physicians will use. He'll explain to you that
6 sometimes, when maternal forces and the baby is moving down
7 the mother's birth canal before its head ever gets down to
8 the crowning or the bottom part, that those forces and the
9 movement of the baby itself can cause these types of nerve
10 injuries. Very similar, if not like the ones that this
11 patient suffered.

12 He'll also talk to you about other things that can
13 happen to babies while they're being born that can cause the
14 muscles and the tone in the area that protects the nerves to
15 become a little bit weak and not provide the normal
16 protection that babies who are healthy would have at the
17 time of the delivery. He will tell you that, in this case,
18 when he looked at the records of Miss Ashley F after
19 the birth, her muscle tone was not normal.

20 She started out with the fetal distress that we saw and
21 the heart rate sort of dropping into the 90s, and Doctor
22 Ernest will tell you and the evidence will show that, when a
23 baby's beginning to have heart distress, sometimes the
24 muscle tone becomes weak, and, when it becomes weak, it's
25 not protecting the neck as it's moving down the birth canal.

1 And sometimes that can predispose those nerves to being
2 injured when normal forces of delivery are used. He will
3 tell you that's a possibility of what happened here.

4 How do we know that Ashley had a muscle tone that
5 wasn't normal?

6 You're gonna hear from the NICU nurse, Ms. Dowis, I
7 think, who will tell you that, when they scored the muscle
8 tone of the baby after, they use a zero, one, and a two
9 where zero is no muscle tone, two is normal, Ashley suffered
10 or scored out a four. One minute after birth and a -- I'm
11 sorry. A one -- at one minute after birth and a one at five
12 minutes after birth or at four minutes later. That tells us
13 that her muscle tone wasn't normal.

14 You'll hear the family testify that, when she was born,
15 she was blue. She didn't cry normal and it took them a
16 little while to get her crying, crying and up to normal.
17 So, she wasn't a normal healthy baby at the time of birth.
18 That can affect those nerves and make them more predisposed
19 to the types of injuries she suffered when the shoulder
20 dystocia occurred.

21 One thing plaintiff's counsel said that I agree on is
22 that shoulder dystocia -- stuffed -- the shoulder is
23 unpredictable. The doctors have no way of knowing this is
24 going to occur until it occurs. You can't see it in
25 advance. There's no test you can do that says oh, this

1 one's gonna be a dystocia and that one's not.

2 So, you'll hear from Doctor Ernest that there are
3 reports in all of the medical research and the literature
4 they write after it where people can develop a permanent
5 brachial plexus injury with normal forces of traction. They
6 surmise that it's because the nerves are injured before the
7 baby ever gets down there. They surmise that the nerves are
8 injured because the baby's tone is a little weak and that
9 you score the ten, the fifteen, the normal pressures -- the
10 normal angles, that's what causes the injury.

11 we'll bring you also another maternal fetal expert,
12 Doctor Suneet Chauhan, who practices now in Houston who
13 practiced here in Spartanburg for a while. He is one of the
14 nationally recognized investigators on the causes of
15 brachial plexus injury. He was part of the American College
16 of Obstetrics & Gynecology, which most of these experts all
17 belong to. They had a Task Force studying this very
18 occurrence and they published the report a couple years ago
19 that was called the Task Force Study on Neonatal Brachial
20 Plexus Palsy. He was the number two author.

21 Doctor Chauhan will come in and explain to you many of
22 the very things I've talked about and what causes these
23 types of injuries, even when the doctor's not yanking or
24 pulling hard, how these things can occur. He's also gonna
25 tell you that, from the research he has done and he has

1 observed, this idea that just because there's an injury at a
2 certain level of nerves, C4 to C5 to C6, C8, C7, that
3 doesn't mean that that was caused by a doctor applying too
4 much force or too much force in the wrong direction. He'll
5 tell you there's no valid scientific support for that
6 theory.

7 He'll also tell you, and I'll ask you to listen closely
8 when he testifies, that there's no correlation between the
9 fact that it's a permanent injury to the degree of force it
10 is. Babies are all different. Things happen to them
11 before -- while they're in the mom's womb and developing.
12 Things happen as they're moving through the birth canal.
13 And people are just different. Babies are all different and
14 he'll tell you there's no scientific support for the
15 theories that the plaintiff's experts will ask you to
16 believe.

17 All of the doctors, Doctor Giep, Doctor Gowers, Doctor
18 Chauhan, Doctor Arnett, Doctor Ernest will say that the
19 techniques that Doctor Giep used and the rest of the
20 delivery team were all within the standard of care, the
21 standard of care practiced by obstetricians when faced with
22 a patient with this type of delivery with the situation that
23 they found themselves in with Ashley F . When the
24 medical emergency developed at the time of the shoulder
25 dystocia, the responses were all appropriate.

1 Plaintiffs are bringing you the husband and wife team
2 of Doctor Gurewitsch and Doctor -- Engineer Allen. They
3 testify in a lot of these cases. They'll tell you how many
4 and they make a lot of money doing it. You'll hear how
5 much.

6 I ask that, as you listen to Doctor Allen's testimony
7 and the things that he says are the basis for his opinions,
8 ask yourself is it really based on real science. He's doing
9 cadaver studies. He uses models that aren't live births.
10 He's never done a live birth. He's never measured the
11 forces that somebody like Doctor Giep uses in a situation
12 like this. He's done some simulations. He's done some
13 tests but what -- when you, when you get him on -- when you
14 hear his testimony, I ask that you listen for how many
15 actual doctors delivering real live babies who've had
16 shoulder dystocia he's observed as he, as he arrives at all
17 of his opinions.

18 To summarize, ladies and gentlemen, we believe, at the
19 conclusion of the case, you'll have seen and we'll present
20 evidence that Doctor Giep, when this shoulder
21 dystocia occurred, a medical emergency was present, he
22 exercised the skill and care that he had learned over his
23 decades and decades of training and practice. He delivered
24 this baby using the same degree of forces he had used on
25 every other time, and that he complied with the standard of

1 care and the procedures that he utilized.

2 The baby was delivered in less than two minutes from
3 the time of the dystocia. A lot of these folks will say,
4 you know, that's good cause you only got about a five minute
5 window before really, really bad things like brain injuries,
6 cerebral palsy, and death occur.

7 I'd ask that you remember the promise I asked you to
8 make. Wait until you've heard all the evidence before you
9 make up your mind.

10 We hope to get it all in with you by Thursday. A
11 couple of video depositions. They're not much fun to watch,
12 but we ask that, when you do see them, you know, pay
13 attention. You know, just because it's on a TV, it may be a
14 little hard to pay attention to, but we ask that you pay
15 attention, you make up your mind after you've heard all of
16 the evidence, but, most importantly, I think, you know, as
17 you're listening to people talk about what was done, when it
18 was written, and things of that sort, I'd ask that you focus
19 on what was written in September the -- I mean October the
20 7th at 9:11 in the morning, that minimum traction was
21 performed, and the next two days later, when he's talking to
22 the family, gentle and constant traction applied.

23 And when you hear the testimony of some of the other
24 folks who are saying well, that just can't be right, because
25 of all of these theories they have, just ask yourself what

1 was written back when this was done.

2 Thank you.

3 THE COURT: Let's take a short break before we start.

4 So, I'll ask you to please go to your jury room. Don't
5 discuss the case. I'll bring you back after your short
6 break.

7 (WHEREUPON, a juror approached the judge and spoke to
8 Judge Cole at the bench while the jury was leaving the
9 courtroom.)

10 THE COURT: We'll be at ease for ten minutes.

11 (WHEREUPON, a short recess was taken at this time.)

12 THE COURT: As the lawyers are aware, but for the
13 record, Juror 114 has expressed some reservation and
14 difficulty in being able to continue due to the nature of
15 the case itself, and he got upset when he saw the
16 photographs. He's got some personal issues at home and
17 personal issues himself about being able to continue.

18 So, I discussed that with counsel and they have both
19 told me that they have no objection to Juror 114 being
20 excused.

21 Is that true?

22 MR. LOVELL: That is correct, Your Honor.

23 MR. HENSHAW: That is correct, Your Honor.

24 THE COURT: All right. And we've discussed also his
25 replacement, and the parties have agreed that Juror 169 will

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1 Now, when it's taken by way of written deposition, in
2 other words, it's transcribed, the witness is not present
3 and the witness is not gonna be seen by way of videotape,
4 but someone will be reading the testimony, the questions,
5 and the answers just as they were asked and answered by the
6 witness during the course of their deposition.

7 Is that a satisfactory explanation or does anybody need
8 additional clarification?

9 (No response.)

10 THE COURT: Okay. Mr. Henshaw.

11 MR. HENSHAW: Thank you, Your Honor.

12 Your Honor, my law clerk, Grace Chandler, will read
13 Doctor Armenta's answers to the questions that were posed to
14 him.

15 THE COURT: Okay.

16 MR. HENSHAW: Grace, if you'll take the stand so that
17 we can all hear you.

18 THE LAW CLERK: Yes, sir.

19 MR. HENSHAW: The question to Arturo Armenta posed on
20 October 5, 2015.

21 We are here today to take your deposition and you
22 likely or, as a matter of fact, I know that you've had your
23 deposition taken before.

24 A. Yes.

25 Q. So, today I'm going to be asking you questions

Deposition of Arturo Armenta

1 primarily about your treatment of Ashley F .

2 Am I correct in that the only materials you reviewed in
3 this case are what is contained in your chart that you sent
4 us under the request that we sent your office?

5 A. Yes.

6 Q. All right. You've not reviewed any depositions in
7 this case, no outside medical records, no pleadings, no
8 affidavits, nothing of that sort?

9 A. No.

10 Q. All right. Have you, in your -- both your medical
11 and your academic pursuits, have you ever conducted
12 yourself -- have you ever conducted, yourself, any studies
13 on the injury thresholds of neonatal nerves?

14 A. No.

15 Q. Did you ever do any testing on Ashley F
16 nerves to determine their strength?

17 A. No.

18 Q. Would you agree with me that every child is
19 different, and even within the same child, there may be
20 variations between the strength of tissues such as bones,
21 muscle, nerves, tendons, ligaments, things of those -- that
22 nature?

23 A. Yes.

24 Q. Okay. Let's kind of jump off into your treatment
25 of Ashley F , and I have marked as Exhibit 1 what

Deposition of Arturo Armenta

1 appears to me to be your final report regarding this surgery
2 you performed on Ashley on June 5th, 2009.

3 Is that correct?

4 Is that your final report sort of memorializing what
5 you saw during that surgery?

6 A. Yes.

7 Q. Another way to ask you would be, in your experience
8 in dealing -- in repairing brachial plexus nerves, do you
9 encounter a large variation in the amount of scarring that
10 you see once you get in and dissect into that brachial
11 plexus area?

12 A. Yes.

13 Q. Is that the amount of scarring that you see in the
14 brachial plexus injury or, or that brachial plexus where
15 there is an injury or where there is a separation of the
16 nerves?

17 Does that medically tell you anything about the injury?

18 A. It can depending as to the amount of injury that
19 you encounter.

20 Q. Are there times that you see minimal scarring with
21 very severe injury, and are there times where you see
22 extensive scarring in what is a less severe injury?

23 A. Yes.

24 Q. Would a good description of a neuroma be the
25 scarring after a nerve injury where those nerves attempt to

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1 reconnect with each other?

2 A. Yes.

3 Q. Does the size of a neuroma tell us anything about
4 the amount of force that caused the separation of those
5 nerves?

6 A. It can, yes.

7 Q. In this case, when you saw the scarring with Ashley
8 F , did that tell you anything about the amount of
9 force that it required to create the injury that she
10 sustained?

11 A. Yes, a rather large neuroma involving C5, C6, C7,
12 C8, and the lower route would signify that she did sustain a
13 large injury, traction injury, to her brachial, brachial
14 plexus.

15 Q. And you kind of tailed off toward the end of that
16 answer there. You did -- did you say that the neuroma
17 encompassing C5, C6, C7, as well into C8, indicated that she
18 sustained a large injury to her brachial plexus?

19 A. Yes.

20 Q. Okay. Now, when you, during that surgery, when you
21 dissected down into the brachial plexus, that neuroma
22 encompassed C5, C6, and C7 and tell me how much it
23 encroached into that C8 area?

24 A. So, it says the C5 nerve root was noted to be
25 encased in a large neuroma. However, we were able to free

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1 the C8 nerve root and its contribution to the lower trunk
2 from the neuroma without complication.

3 Q. Does that indicate that the neuroma or the scar
4 tissue had grown into the C8 nerve, but that nerve was not
5 injured?

6 A. Well, not necessarily. It just meant that there
7 could have been a traction injury where it didn't rupture,
8 but we were able to free it without causing damage to the
9 nerve during the neurolysis.

10 Q. And would that be indicative, I guess, of or tell
11 me, in your opinion, did the, did the C8 nerve rupture at
12 some point and then, and then regrow together or was there
13 not a complete rupture of the C8 nerve?

14 A. There's no way to tell that. The only thing you
15 can tell is that there was some form of injury. It could
16 have been a combination of what you described. However,
17 just the fact that there was scar tissue around the nerve
18 did signal some type of injury that then we were able to
19 remove scar tissue from around the nerve.

20 Q. Is it also possible, in scenarios like that, for
21 the scar tissue to, to form around the nerves that are above
22 the C8 and grow into the C8 even if it was not injured
23 itself?

24 A. Well, I wouldn't say, say that they were -- would
25 grow into, but they might compress.

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1 Q. Okay. Do we know whether or not that happened in
2 this case?

3 A. No.

4 Q. Okay. No involvement of the T1 nerve?

5 A. No.

6 Q. And these nerves at C5, six, and seven, they're
7 what's called ruptured?

8 Is that, is that accurate?

9 A. Yes.

10 Q. And the C5 through seven, that's what's considered
11 the upper brachial plexus.

12 Is that fair?

13 A. C5/C6 are upper and C7 is middle trunk.

14 Q. All right. And nerves in that area, are they more
15 likely to rupture or separate in the middle then separate at
16 the root, at the spine, at the connection to the spinal
17 canal because that's the area where they are generally the
18 weakest?

19 A. Well, previous studies -- excuse me. Previous
20 studies have shown that the upper roots are more, are more
21 prone to rupture versus avulsion. So, they tend to be more
22 pliable at that area versus weaker.

23 Q. All right. During this surgery, the scar tissue
24 had also grown into the collar bone or the clavicle.

25 Is that correct?

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1 A. It might have gone underneath, yes.

2 Q. And so you had to separate that collar bone in
3 order to perform the surgery?

4 A. Yes.

5 Q. Describe that for me. Tell me how that -- tell me
6 what, what that entailed and what, if anything, that that
7 scar tissue growth into the clavicle indicated to you?

8 A. Well, the indication is that it's just a very large
9 neuroma indicating a large amount of trauma, and the fact
10 that the space that you have available on in a child this
11 small, you're talking about a few centimeters. So, with the
12 scar extending underneath the clavicle, in order to get
13 appropriate exposure, so you can do -- have enough room to
14 do surgery. You know, sometimes you have to separate the
15 clavicle in order to get down into the large area, area of
16 the injury.

17 Q. Before this case, had you ever had to do that
18 before?

19 A. In my personal case, no, but in residency and
20 training, yes.

21 Q. Okay. Have you had to do this, separate the
22 clavicle or had scar tissue growing into an area of the
23 clavicle where you couldn't have room to move since Miss
24 Flowers surgery?

25 A. Yes.

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1 Q. Okay. Now, the bone there wasn't injured before
2 you had to separate it, was it?

3 A. From my recollection, no, but I do not remember
4 whether she had a fractured clavicle prior or during birth.

5 Q. Okay. So, after you were able to expose these
6 nerves, I guess dissect or take the neuroma away, send that
7 off to pathology, you then harvested four nerves
8 4-centimeters in length, and you were going to use those to
9 graft those C5, C6, and C7 nerves from the root to a, to a,
10 I guess, a proximal location on the brachial plexus.

11 would that be accurate?

12 A. Yes.

13 Q. And you didn't have to do any repair to C8 or to
14 T1, correct?

15 A. Correct.

16 Q. Now, in many cases, there are injuries that you've
17 performed surgery on where there are complete separations,
18 either ruptures or avulsions, to the entire brachial plexus,
19 C5, C6, C7, C8, and T1, right?

20 A. Correct.

21 Q. But this was not one of those cases?

22 A. No.

23 Q. All right. What, in your practice, is a general
24 what I'll call spontaneous recovery rate meaning that the
25 child's affected arm returns to normal function without

1 surgical intervention?

2 what is the general spontaneous recovery rate in
3 children that have injuries only to C5, six, and seven?

4 A. I would say the great majority is kind of both with
5 the literature and in conjuncture with the patients that we
6 see, anywhere from 70 to 80 percent will recover
7 spontaneously.

8 Q. All right. So, so, Ashley F requiring
9 surgery and not having a full recovery would, would not be a
10 normal outcome for a child that had an injury to C5, six,
11 and seven?

12 would that be fair?

13 A. Yes.

14 Q. I included my exhibits as Exhibit 2, which is the
15 pathology report from that initial brachial plexus surgery.

16 what, if anything, does that tell us about her brachial
17 plexus nerves or her injury, if anything?

18 A. The fact that she did have, in fact, a traumatic
19 neuroma involving C5, C6, C7, and then that there is a
20 segment of a peripheral nerve of the interior division of
21 the -- I'm assuming it's the upper trunk, and then the
22 posterior division of the upper trunk.

23 Q. Does it tell us anything else?

24 A. Not in the diagnosis, but I have not gone through
25 the microscopic description.

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1 Q. Well, if you take a second to review that and tell
2 me if it -- if microscopic description tells us anything
3 else about this injury that you weren't able to discern
4 while viewing it both with the naked eye and under the
5 microscope you used during the initial procedure?

6 A. No, it falls within the general sort of findings
7 that we have. It's a large neuroma involving the upper and
8 middle trunks, and then, as we dissect distally and
9 proximally, we have a, you know, healthier nerve that wasn't
10 involved in the zone of injury.

11 Q. And so would it be kind of -- be fair to say that
12 what you do here is you take, you take out the largest part
13 of the neuroma, and then you kind of start slicing back,
14 almost like slicing bread, until you find healthy nerve root
15 and healthy distal nerves that you can then achieve that
16 graft and make that connection with?

17 A. Yes.

18 Q. All right. I read previously where you said that a
19 two and half to 3-centimeter gap between a nerve root and a
20 distal nerve is about average. I read in your operative
21 report here that there was a 4-centimeter gap between the C5
22 root and the suprascapular and the anterior division of the
23 upper trunk.

24 How would you classify that?

25 A. As a larger than normal zone of injury.

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1 Q. Other than measuring how large a graft that you
2 need to, I guess, bridge that gap, was there any medical
3 importance to that, that length of division?

4 A. Yes, of course, the smaller the nerve gap there is,
5 the better chance for a better return of function. The
6 larger the nerve gap is, you know, the decreased amount of
7 nerve fascicles.

8 Q. Fascicles.

9 A. Fascicles that are able to per se repair themselves
10 through the gap.

11 Q. Does that gap indicate that there was a, I guess, a
12 break or a rupture and the two ends just ended up further
13 apart or is that a situation where there were multiple
14 breaks which led to varying pieces over that 4-centimeter
15 gap?

16 A. That's a great question. It's difficult to answer.
17 You know, you're -- I mean you'd have to have been present
18 at the time of the -- of injury in order to make that
19 microscopic diagnosis. The only thing you could really say
20 by now is that there was a, you know, large area of injury
21 and that the two nerve roots, as the proximal root tried to
22 repair itself, it just got caught up in scar.

23 Q. So, other than knowing that there is, I guess,
24 4-centimeters between healthy nerve distally and healthy
25 nerve proximally, there's not a whole lot we can tell about

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1 the original injury other than it is now encased in scar
2 tissue and it was not able to reconnect?

3 A. Yes.

4 Q. Okay. Other than having to separate the collar
5 bone, was this initial surgery without complications?

6 A. Yes.

7 Q. Okay. Does the, does the rupture of C5 and C6 and
8 C7, does that encompass the majority of brachial plexus
9 injuries that are permanent or there have -- or that have
10 long lasting residual effects?

11 A. A difficult question to answer. There's a lot of
12 variation to that. They're the most common, upper and
13 middle trunk, the ones and twos per your classification, but
14 as the most common, they also recover most spontaneously.

15 Q. How many patients do you see or that are referred
16 to your practice do not end up requiring surgery to regain
17 full function of their injured extremity?

18 A. As I've answered previously, 70, 80 percent.

19 Q. And so, of those 32 or 20 to 30 percent of patients
20 that do require surgery, how would you, how would Ashley
21 F injury fall in those in terms of severity?

22 A. Moderate.

23 Q. Does that mean essentially right in the middle?

24 A. Yes.

25 Q. So, about half of the patients you operate on have

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1 less severe injuries and about half of the patients you
2 operate on have more severe injuries?

3 A. Yes.

4 Q. All right. So, after the first surgery, did Ashley
5 F have some improvement in her -- the function of her
6 left arm?

7 A. Yes.

8 Q. And -- but you did a second surgery on
9 February 4th, 2011, it's my understanding, to relieve some
10 shoulder contractures and further examine the nerves in her
11 brachial plexus?

12 A. Yes.

13 Q. And I have marked as Exhibit 4 what it -- what I
14 understand to be your final report from that surgery.

15 Is that accurate?

16 A. Yes.

17 Q. And I don't want you to kind of go through this
18 little by little because, you know, I can, I can read what
19 it says just as easily as you can read it to me, but my
20 reading of that says there was severe scarring on the median
21 radial ulnar and musculocutaneous nerves.

22 Is that a result of the June 5, 2009, surgery or were
23 those undiagnosed issues from, from something that happened
24 at birth?

25 A. No, it's not undiagnosed. It just all goes along

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1 with the sequela.

2 Q. Sequela.

3 A. Sequela of the brachial plexus injury and shoulder
4 contractures.

5 Q. Tell me how that scarring develops.

6 Is that scarring, it develops after your initial
7 surgery?

8 A. Well, it's sort of a combination of the
9 developments. As the shoulder contractures develop, so do
10 the contractures in the arm and elbow and, you know, in some
11 situations, hand. So, as a patient is able to fully move,
12 function, you get tightness of the shoulder. You know,
13 inflammation. Inflammation then causes a scar and, you
14 know, continue and continue and continue.

15 Q. Okay. So, am I understanding you correctly then
16 that the lack -- Ashley F lack of ability to fully use
17 her arm, it not only causes the contractures in muscles, but
18 it also causes scarring in the nerves?

19 A. Yes.

20 Q. Okay. Thank you for explaining that to me.

21 A. Sure.

22 Q. Was that unusual to see that amount of scarring
23 after one of your primary surgeries?

24 A. Yes.

25 Q. Do you have any thoughts as to why there was that

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1 much scarring at the time of your second procedure?

2 A. Just going back and sort of evaluating the injury,
3 back to the first surgery, it was a very severe injury. So,
4 I would say, you know, just the fact that she did have a
5 very large neuroma that required grafting of, you know,
6 4-centimeters as, you know, she didn't have, you know, a
7 small gap to jump from, you know, 2-centimeters. It was
8 4-centimeters. So, that doesn't surprise me that she would,
9 you know, continue to have significant residual deficits.

10 Q. All right. So, then you harvested -- I guess you
11 cleaned up the neuroma or all of the scarring around those
12 nerves, and then you decided to harvest the nerve from the
13 muscle that runs between the shoulder and the shoulder blade
14 in order to further, I guess, facilitate a conduction
15 between, I guess, that was around the axillary nerve.

16 Is that right?

17 A. Yes.

18 Q. Okay. And when you, I guess, created or dissected
19 the nerve from the teres major muscle, it was a little too
20 short. So then you had to use a tiny piece of cadaver nerve
21 to, I guess, bridge that -- the rest of that gap.

22 Is that right?

23 A. Yes.

24 Q. And then you released the muscles and tendons in
25 order, to put it in layman's terms, to loosen up her

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1 shoulder muscles?

2 A. Yes, to rebalance, that's correct.

3 Q. What causes the contractures necessitating those
4 procedures?

5 A. Well, there's a -- kind of a lot of muscle and
6 imbalance at play. So, with the upper trunk being weak and
7 the axillary nerve being compressed by the triceps, tendon,
8 and the humerus, sort of like a carpal tunnel. You know,
9 the compression on the nerve will cause decreased function.
10 Decreased function then causes a tighter joint, tighter
11 muscles, less range of motion, you know, pain, et cetera, et
12 cetera. So --.

13 Q. Okay. Now, after that procedure, did she continue
14 to improve as you understand it?

15 A. Yes. However, she was still left with some
16 residual deficits that continued to have a need for, you
17 know, additional recovery.

18 Q. And that was accomplished with occupational therapy
19 and things of that nature?

20 A. Yes.

21 Q. And you saw Ashley again on May 24th, 2014, to
22 evaluate her.

23 Is that right?

24 A. Yes, April I think. Hold on. May 24th, yes,
25 2014. Sorry.

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1 Q. And is that -- are your observations from that
2 examination reflected in Exhibit 5?

3 A. Yes.

4 Q. And on that visit, she -- you scheduled or
5 recommended that she have a third surgery.

6 Is that right?

7 A. Yes.

8 Q. Was that examination, in 2014, was that conducted
9 in Charlotte or Texas?

10 A. In Charlotte.

11 Q. It says on there a temporary hold on occupational
12 therapy.

13 Do you know why that was -- at that time -- why that
14 was at that time?

15 A. Well, that was per the family. The first page is
16 sort of the concerns or issues that the family has. So, I,
17 I don't know why they held that for the family.

18 Q. Okay. It also says, on that first page, it says is
19 the patient having pain now and circled no.

20 Is that generally accurate of children with this injury
21 or it's not a painful condition?

22 A. For the most part, yes.

23 Q. Have you evaluated Ashley since May 24th, 2014?

24 A. Yes, we just saw her, let me get my record here, on
25 8/29/2015.

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1 Q. If you can, tell me how she was doing on May
2 29th, 2015.

3 A. Well, the parental concerns were the same as the
4 last visit. Change in function, same as last visit. OT,
5 adjusting perimeters of OT. There's splinting at night and
6 developmental level is first grade and she's not having any
7 pain.

8 Q. Did you do any examinations about what type things
9 she's able to do or not do in her activities of daily
10 living?

11 A. Yes, she's still having deficits and weakness with
12 the wrist and finger extension and still with some tightness
13 in supination.

14 Q. And I meant more specifically did you inquire as to
15 what things she was able to do and not do?

16 Such as can she button buttons or pick things up with
17 her left-hand or --?

18 A. Yeah, she's having difficulty with the fine motor
19 skills, excuse me, with the fine motor skills. As you say,
20 you know, dressing, buttons, fine motor skills in school.

21 Q. Were there any visits in-between May 24th, 2014,
22 and May 29th, 2015?

23 A. That's a good question. Let me -- I have to dig
24 through the chart. One second. A quick cursory look, no.

25 Q. Okay. Did you have any surgeries planned at, at

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1 the end of that visit?

2 A. We discussed the fact that she has some weakness in
3 her deltoid and elbow contractures and weak wrist extension,
4 and that she will eventually need additional tendon
5 transfers in order to allow her to stabilize her wrist and
6 increase function there.

7 Q. Other than the additional tendon transfers, are
8 there any other future procedures that you believe that
9 Ashley F will need?

10 A. Well, she's continuing to have to splint her elbow
11 due to elbow contractures. Right now the elbow extension
12 protocols are working. So, you know, she may need a --
13 either biceps, tendon lengthening, or elbow contracture
14 release in the future in addition to the tendon transfers
15 for the wrist.

16 Q. Anything else?

17 A. Not unless something develops, no, not foreseen.

18 Q. Okay. Finally, Exhibit 6, is that your operative
19 report for the third surgery performed on Miss Flowers?

20 A. That is correct.

21 Q. Is that an accurate depiction of the procedure --
22 of that procedure?

23 A. Yes.

24 Q. And there were no complications during that
25 procedure in order to help the extension of her wrist?

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1 A. Not that I recall offhand, no.

2 Q. All right. Ashley was first referred to you by
3 Doctor Nelson.

4 Is that correct?

5 A. Yes.

6 Q. And I guess, although Doctor Nelson was working in
7 Charlotte at the time, she had previously worked with you in
8 Texas at the Texas Children's Hospital.

9 Is that accurate?

10 A. Yes.

11 Q. Okay. So then when she moved to Charlotte, she
12 still sent all her patients with brachial plexus injuries, I
13 guess, to you in Texas.

14 Is that right?

15 A. Yes.

16 Q. Okay. Was her presence in Charlotte the reason
17 you, I guess, began operating a clinic in Charlotte twice a
18 year?

19 A. Yes.

20 Q. You have written an article with Doctor Nelson,
21 published last year, called Birth Brachial Plexus Update.

22 Is that accurate?

23 A. Yes.

24 Q. Now, I mark that as Exhibit 7. I'm just going to
25 ask you a couple of brief questions about it.

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1 On the bottom of Page 2 or Page 85, whichever way
2 you're looking at it, but the second page of the article, at
3 the bottom you cited study that says 80 or 88 percent of
4 children with birth brachial plexus palsy play sports, which
5 is similar to the general pediatric population.

6 Is that statistic, to your knowledge, still accurate?

7 A. Yeah, that portion was written by Doctor Nelson,
8 but, you know, from a general understanding of general
9 population, sure, yes.

10 Q. You don't have any reason to disagree with those
11 studies?

12 A. No.

13 Q. On the next page, Page 3 or Page 81, whichever way
14 you'd like to refer to it, at the top it says, in the first
15 paragraph on the second column, first full paragraph,
16 neuropathic pain is commonly reported in adults and older
17 children after traumatic brachial plexus injuries. It is
18 not generally described after birth brachial plexus injury.

19 Is that what we are talking about earlier where this is
20 generally not a painful condition?

21 A. Yes.

22 Q. And the next full paragraph, was this also written
23 by Doctor Nelson, the quality of -- excuse me. By Doctor
24 Nelson?

25 A. The quality of life?

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1 Q. Yes.

2 A. Yes.

3 Q. Okay. It says a pilot study on quality of life
4 showed that most teens and their parents reported good
5 quality of life despite residual impairments.

6 Do you have any reason to disagree with that part of
7 your argument?

8 A. No.

9 Q. In your examinations of Ashley F , have you
10 ever determined that she had any developmental delays or any
11 brain damage due to an injury at birth?

12 A. No, that's not my area of expertise. So, no.

13 Q. Okay. What I'm saying is you talked with the
14 child.

15 You didn't notice anything out of the ordinary with
16 her?

17 A. No.

18 Q. If she continues with her therapy and home
19 exercises, would you expect her to continue to improve?

20 A. Yes.

21 Q. You did your undergraduate at Stanford, got your MD
22 from Baylor in 1999.

23 Is that right?

24 A. Yes.

25 Q. You did a research fellowship at Baylor for two

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1 years in the division of plastic surgery?

2 A. Yes.

3 Q. Then you did a general surgery residency and then a
4 fellowship with the division of plastic surgery followed by
5 three year plastic surgery residency?

6 A. Yes.

7 Q. And you concluded all of that in 2008.

8 Doctor, are you board certified?

9 A. Yes.

10 Q. By what certifying authority?

11 A. The American Board of Plastic Surgery.

12 Q. Is that one of the recognized specialties of the
13 American Medical Association?

14 A. Yes.

15 Q. Please define the term neuroma.

16 A. Neuroma is a nerve that's encased in scar tissue
17 and inflammatory mediators.

18 Q. What, in the context of a brachial plexus nerve,
19 what would the term avulsion mean?

20 A. Nothing. I think you mean avulsion.

21 Q. Avulsion, yeah, or avulsion, yes, sir. I was going
22 to ask you to define that next.

23 A. So, avulsion is a tear of the nerve root from the
24 spinal cord to where the cell body lies outside of the
25 spinal cord -- canal. Sorry.

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1 Q. And if there's a tear that is beyond that
2 particular area, what would that be called in regard to a
3 brachial plexus nerve?

4 A. If the cell body's in tact with the proximal
5 portion and the tear is outside of the spinal canal, it
6 would be a rupture.

7 Q. All right. Now, in terms of using this
8 terminology, were there any avulsion of Ashley F
9 nerves?

10 A. According to our testing, no.

11 Q. Were there any ruptures of her nerves?

12 A. We do believe that the C5, C6, C7, upper and middle
13 trunk were ruptured, yes.

14 Q. All right. And then there was a neuroma that was
15 found at the time of your surgery.

16 Is that correct?

17 A. Yes.

18 Q. Now, a neuroma being a type of scar formation. .
19 would that have been immediately present at the time of
20 the initial surgery?

21 A. No, it is something that develops.

22 Q. It develops over time?

23 A. Yes, as the nerve attempts to regenerate and you
24 have scar and growth and nerve fibers entangled.

25 Q. Now, once you were able to perform surgery, as I'm

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1 understanding correctly, doctor, that what you did was you
2 surgically implanted nerve grafts to cover the area where
3 there was no signal in the nerve roots of C5, C6, and C7?

4 A. Well, we removed the neuroma then and grafted the
5 space that was left by the neuroma from the nerve roots to
6 the distal nerve roots or the nerve ends.

7 Q. And did you place an individual nerve graft on C5
8 and then one on C6 and then on C7 or did, at any point, did
9 you attempt to?

10 I'll just leave that as the question that you placed
11 nerve grafts at C5 and then C6 and then C7.

12 A. We grafted individual strength of nerve, yes, from
13 C6 -- C5, C6, and C7, yes.

14 Q. I see.

15 Have, have you or are you now able to determine which
16 of the grafts were successful and which were not?

17 A. Well, she has some, you know, as we said, residual
18 deficits predominantly in the posterior cord and some
19 weakness in the shoulder. So, I would say, with C5, there
20 was some limitation, and C7, there was some limitation.

21 Q. C5 would control what areas that a lay person could
22 have recognized?

23 A. C5 predominantly controls your deltoid region. C6
24 controls your bicep. C7 controls your triceps and wrist and
25 finger extension. And C8 and T1 control wrist and finger

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1 flexion.

2 Q. Okay. So, where along her shoulder, arm, wrist,
3 and hand does she continue to have deficits?

4 A. Well, she has issues at the shoulder with weakness.
5 She has weakness at the triceps with elbow contracture and
6 she has weakness of wrist extension, which is tied into the
7 posterior cord.

8 Q. Now that she has had these surgical grafting
9 implants, given that she continues to have some deficits in
10 the arm, will you be recommending additional nerve grafts at
11 anytime?

12 A. At this point, no. It's mainly tendon transfers or
13 contracture releases.

14 Q. So, these weaknesses that you've identified, will
15 they continue most likely for the rest of her life?

16 A. Yes.

17 Q. Have -- will you -- will, will there come a point
18 when she is older and reaches physical maturity that you
19 would consider making further recommendation either for
20 functionality or cosmetic purposes?

21 A. Possibly, yes.

22 Q. Can you give any prognosis at this point as to
23 where -- what areas you might want to consider discussing
24 with the patient or the parents?

25 A. Elbow and wrist.

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1 Q. What is it about her elbow that may cause you, in
2 the future, to consider recommending further surgery?

3 A. She has an elbow contracture. So, she's unable to
4 fully extend her elbow, and then her wrist, she's unable to
5 fully extend her wrist.

6 Q. What type, if surgeries were to be recommended, can
7 you say at this point what would that be?

8 A. Tendon transfers for wrist extension and either
9 biceps, tendon lengthening to improve the extension of the
10 elbow or contractor releases in the elbow.

11 Q. Are you able to say now what additional
12 functionality would be achieved, if any?

13 A. Well, it will give her near normal elbow extension
14 if we need to do that, and then it will give her an ability
15 to extend her wrist or at least stabilize her wrist should
16 she have a better grasp with her wrist in a neutral position
17 or able to extend her wrist.

18 Q. All right. Are you able to say, at her age now,
19 that -- say, at her age now, what the likelihood is that
20 these procedures will be recommended or is that just too
21 uncertain to know?

22 A. Well, it's highly likely that she will need tendon
23 transfers for wrist extension.

24 Q. Now, the ability to raise her arm and place her
25 hand behind her head, will she ever achieve that?

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1 A. well, she can do that currently with a lot of
2 compensation, but she needs to continue physical therapy and
3 strengthening, especially during growth spurts, in order to
4 strengthen those muscles that are involved in that activity
5 in order to regain better function.

6 Q. What I was going to ask is these injuries that Miss
7 Flowers had, were they axonal nerve injuries?

8 A. Yes.

9 Q. That means that they went to the core of the nerve
10 rather than just to the sheath of the nerve?

11 A. That's correct, yes. I understand, yes.

12 Q. You understand what I'm asking now?

13 A. Yes, sir, it was a complete rupture. So --.

14 Q. So, without there -- at the time that you undertook
15 surgery, if there were to be no surgery, was there any
16 possibility that C5, C6, C7 could have repaired themselves?

17 A. No.

18 Q. That's all the questions I have for you, doctor.
19 Thank you.

20 That completes the reading of the deposition.

21 THE COURT: Okay.

22 MR. HENSHAW: Your Honor, may I consult with counsel
23 very quickly?

24 THE COURT: Sure.

25 (Pause.)

Robert Allen - Direct examination
by Mr. Henshaw

1 THE COURT: He's through with you.

2 THE LAW CLERK: Okay. Thank you.

3 MR. HENSHAW: May we approach, Your Honor?

4 THE COURT: Sure.

5 (WHEREUPON, a bench conference was held out of the
6 hearing of the jury at this time.)

7 MR. HENSHAW: Your Honor, at this time, we would call
8 Robert Allen to the stand.

9 ROBERT ALLEN, being first duly
10 sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MR. HENSHAW:

13 Q Please state your full name.

14 A Robert Harry Allen.

15 Q Where do you reside?

16 A In Baltimore.

17 Q And what is your age?

18 A Sixty-one.

19 Q What is your occupation?

20 A I'm a retired engineer. Faculty member from Johns
21 Hopkins University.

22 Q All right.

23 A Biomedical engineering and obstetrics and gynecology.

24 Q Now, does Johns Hopkins have a department?

25 A Yes.

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by Mr. Henshaw

1 Q What is your relationship with that department?

2 A I was a faculty member in the Department of Biomedical
3 Engineering and also in the Department of Gynecology and
4 Obstetrics.

5 Q All right. Now, do you -- are you now retired?

6 A I am.

7 Q And so what have you retired from specifically?

8 A Specifically from teaching classes. I --.

9 Q And what classes did you -- have you taught?

10 A In the biomedical engineering department, I primarily
11 taught design to biomedical engineers. Also taught
12 biomechanics and I ran the independent design program. In
13 gynecology and obstetrics, my role is primarily in
14 simulation, simulation training of obstetricians.

15 Q Okay. Now, are you ending your affiliation from these
16 activities completely?

17 A No.

18 Q What will you continue to do in your retirement?

19 A We're continuing with simulation training in obstetrics
20 and I just gave a talk to the University of Washington, for
21 example, to the obstetrics department.

22 Q Okay. So, where were you trained?

23 A I was trained as an engineer in New York at Stony Brook
24 University as a Bachelor's of Engineering. I achieved a
25 Master's of Science in -- at Berkeley in 1978, and I earned,

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by Mr. Henshaw

1 after working for a couple years, I went back and got a
2 Ph.D. from Carnegie Mellon University in civil engineering
3 in 1984.

4 Q All right. So, you have a Ph.D.?

5 A Yes.

6 Q And when you were on the faculty, are you referred to
7 as Doctor Allen?

8 A Yes.

9 Q Okay. Now, in your interest -- well, tell us -- first
10 of all, the term biomedical, what does that mean?

11 A Biomedical means, by itself, you kind of -- it's kind
12 of like an adjective. So, biomedical engineering --

13 Q All right.

14 A -- is the application of engineering principles to
15 biomedical systems.

16 Q All right. And what about the term biomechanical?

17 Is that in any way related to the term biomedical?

18 A Yes, biomechanical is a subspecialty of bioengineering
19 or biomedical engineering, and it relates to the mechanics
20 of biomedical systems.

21 Q All right. Now -- so, when you are working at Johns
22 Hopkins, are you working in the Department of Biomedical
23 Engineering?

24 A Yes.

25 Q And as part of that biomedical engineering department,

Robert Allen - Direct examination
by Mr. Henshaw

1 do you teach biomechanical principles and knowledge?

2 A Yes, I developed a course in biomechanics at -- in the
3 department of biomedical engineering. That was in 2007 --

4 Q All right.

5 A -- was the first time I offered it.

6 Q And -- but does your work in biomechanical principles
7 and knowledge predate 2007?

8 A Yes.

9 Q And, and when did you get involved in biomechanical
10 engineering?

11 A I first got involved by an invitation from a high risk
12 obstetrician who was my neighbor at the time in Houston, and
13 he had an engineering -- he tells me he has an engineering
14 problem and would like me to help him and I did.

15 Q What was that -- what was that doctor's name?

16 A Doctor Bernard Gonik, G-O-N-I-K.

17 Q And what type of doctor was he?

18 A He was a high risk obstetrician or a maternal fetal
19 medicine specialist.

20 Q And were you involved in academic work at that time?

21 A I was.

22 Q Where?

23 A I had an appointment at the University of Houston. He
24 had an appointment -- and, and he had an appointment at the
25 University of Texas Medical Center, which is also in

1 Houston.

2 Q So, what did the two of you set out to do?

3 A Doctor Gonik was very interested in figuring out how
4 much force it takes to deliver a baby, and whether a certain
5 position of the mother was helpful for resolving shoulder
6 dystocia.

7 Q All right. So -- and what did the two of you do in
8 order to try to make determinations about that?

9 A I developed a sensing system, a four sensing system
10 that could be used during deliveries, and I also developed a
11 simulator that could mimic the, the physical effects of
12 shoulder dystocia.

13 Q And how did you apply these devices that you developed?

14 A For the measuring force in the clinical setting, we had
15 sensors that were placed on the far fingertips of Doctor
16 Gonik's hand, worn underneath the surgical glove, and these
17 were wired off to a distant computer where, for each
18 delivery, we were able to measure the force that he was
19 applying during those deliveries.

20 Q What -- you mentioned that he was interested in a
21 particular position that the mother could assume during
22 delivery.

23 Did I understand you correctly?

24 A Yes.

25 Q And what position was that?

1 A It's called McRoberts position. It's kind of like --
2 it's when your knees -- when, when mom's knees are pressed
3 against her shoulders. So, kind of like this.

4 Q And, and he was interested in knowing what that could
5 do to facilitate a delivery?

6 A Yes.

7 Q And did it make any difference to him as to whether it
8 was shoulder dystocia or a non-shoulder dystocia situation?

9 A He was particularly interested in shoulder dystocia.

10 Q Okay. So, did your research with Doctor Gonik result
11 in any, any conclusions from a biomedical standpoint?

12 A Yes. From the clinical study, we were able to
13 establish that routine deliveries, term deliveries, when we
14 talk about deliveries, we're talking about head first
15 deliveries through the birth canal, not cesarean section,
16 and that it takes between five and ten pounds or so to
17 deliver the baby. That's traction by the physician's hands
18 on the head in order to deliver the rest of the body.

19 Q All right. Now, doctor, please keep any conclusions
20 that you tell us about to what you know as a biomechanical
21 engineer or biomechanical principles.

22 Okay?

23 A Yes.

24 Q That's gonna be very important because of the
25 limitations on what you can testify about.

1 All right?

2 A Yes.

3 Q Now, so -- but recognizing that that's the way that we
4 need you to deal in your testimony, what, what does a
5 biomedical engineer such as yourself bring to research like
6 you were performing with Doctor Gonik?

7 A The -- I mean throughout my career, this was done in
8 the mid-80s. Throughout my career, I've focused on
9 developing technology that would help understand the
10 phenomenon, the mechanics of birth, and ultimately to help
11 train obstetricians for better outcomes.

12 Q Well, is, is the birth of a baby a biomechanical, a
13 biomechanical event?

14 A It actually was characterized that way in, in the 43
15 paper by, by Woods as a maneuver called the Woods maneuver,
16 and he said, in the vast majority of cases, the birth of the
17 baby is an engineering problem.

18 Q All right. And do you agree with that?

19 A Yes.

20 Q So, in looking at what happens in the birth of a baby,
21 are you focused on the forces, the various conditions of
22 force that can occur during that procedure?

23 A Yes, that's part of what I'm interested in.

24 Q All right. So, with Doctor Gonik in your first
25 research with him, you were looking at -- were you looking

1 at forces?

2 A Yes.

3 Q And, and particularly what would happen when a patient
4 was placed in the McRoberts position?

5 A Yes, we were looking at that and we had 29 deliveries
6 in which we measured force, and it just so happened that two
7 were shoulder dystocia where he actually employed McRoberts
8 maneuver.

9 Q So, did that research result in any type of
10 publication?

11 A Yes.

12 Q And where were you published?

13 A It was first published in the Journal of
14 Instrumentation for Electrical Engineering and then
15 subsequently published in Obstetrics and Gynecology.

16 Q And what is the Journal of Obstetrics and Gynecology?

17 A It's one of the primary journals in the field, and
18 it's, it's ACOG, the American College of Obstetricians and
19 Gynecologists central publication.

20 Q All right. Is it a peer reviewed publication?

21 A Yes.

22 Q And please explain what it means to be peer reviewed?

23 A Peer reviewed means that, when one has a research
24 result, that they submit it to a journal, a specific
25 journal, and the -- one of the editors who's in charge of

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by Mr. Henshaw

1 that field sends it out to different experts in the field,
2 and they provide reviews. And based on the reviews, the
3 editor makes a decision to either accept the paper, usually
4 with some changes, or decline it and say you can't publish
5 this. So, when those two publications were both -- were
6 judged both by engineers and by obstetricians as being
7 results that were worthy of publication.

8 Q Acceptable for publication?

9 A Yes.

10 Q Did -- to your -- well, that gets into medicine. We'll
11 talk about that later.

12 But after you did the research, that first research
13 with Doctor Gonik, did you continue to do research in this
14 area of, of labor and delivery?

15 A Yes. So far we just talked about the clinical study
16 with Doctor Gonik. I also go to our first simulator that
17 simulated shoulder dystocia, and we demonstrated that fact
18 McRoberts maneuver, mechanically, positioned the pelvis --
19 both face the pelvis from about 26-degrees in the vertical
20 from ten and, as a result, it creates and flattens the, the
21 curved part, the sacrum, and it also---

22 Q The sacrum is the spine -- the back bone?

23 A It's the---

24 Q The lower part of the back bone?

25 A The back bone that kind of curves, and then the, the

1 pubic bone, it raises the pubic bone almost a centimeter.
2 And so those are advantageous positions of the pelvis for
3 the baby to fit through.

4 Q All right. So, after that project, were there other
5 projects that you've been involved in?

6 A Yes.

7 Q And what was the next one?

8 A The next one I was involved with, I moved to the
9 University of Delaware in '88, and I worked with David
10 Nagey, N-A-G-E-Y, the late David Nagey, has passed away
11 since, also developing simulators and finding out more about
12 traction and how to apply during different types of
13 delivery.

14 Q And, and specifically looking at what areas in -- with
15 Doctor Nagey?

16 A In that study, we looked at traction. When you talk
17 about force, it has directions. So, one direction is this
18 way, another direction is this way, and the three
19 dimensions, another direction, another direction that way.

20 Q So, you use your finger to show directions and look---

21 A Horizontally.

22 Q One is side -- to the side?

23 A Yes.

24 Q Either side?

25 A Either side.

1 Q And the other one is down?

2 A Down or up.

3 Q And that's what forces can do?

4 A Yes.

5 Q To what area are these forces being applied that you're
6 talking about?

7 A In the case that we were capturing, these were forces
8 applied by healthcare providers to the fetal head during
9 simulated shoulder dystocia.

10 Q All right. And you did that with Doctor Nagey?

11 A Yes.

12 Q And did that also result in a publication?

13 A Two publications.

14 Q And both involving the same areas of interest?

15 A Yes, both in engineering and in obstetrics and
16 gynecology.

17 Q All right. And were they peer reviewed as well?

18 A Yes.

19 Q Do you recall what publications they appeared in?

20 A The first one, the engineering publication was in -- I
21 think the journal title was Engineering, Physics, and
22 Biology and the other publication was in the American
23 Journal of Obstetrics and Gynecology, which is the other
24 primary journal for obstetrical publications.

25 Q Now, from a bioengineering or biomechanical standpoint,

1 limiting, limiting it to that, what did you learn from that
2 work with Doctor Nagey?

3 A We learned that the traction that doctors apply during
4 routine difficulty in shoulder dystocia included both
5 traction sideways or out and also traction vertically or
6 down.

7 Q All right.

8 A And it also involved torque. So, to take the head, it
9 was torqued to one side or the other kind of like going like
10 this or this. We also were able to measure that.

11 Q All right.

12 A And what we observed was that that generally, from
13 routine difficulty in shoulder dystocia, the forces
14 generally increased and, and they increased in various ways.
15 It's generally increasing lateral or vertical traction as
16 shoulder dystocia develops, and that limiting those forces
17 to, to a certain force value will reduce the risk of injury.

18 Q Now, this term traction is being used quite often in
19 this case.

20 Please tell us what traction means to a biomechanical
21 engineer or biomedical engineer.

22 A In a general sense, traction means pulling. I mean
23 perhaps some of you have, if you ever had a neck injury, you
24 were placed perhaps in traction. So, your head is being
25 pulled from your body. It's done in other medical

1 procedures as well.

2 In this particular circumstance, we're talking about
3 the forces that are applied by the doctor to the head at the
4 time of delivery.

5 Q All right.

6 A And that, that is generally out and down.

7 Q All right. So, if the doctor can apply force to the
8 baby's head called traction, what is, what is his means for
9 doing that?

10 A He uses his hands and it's, it's the strength of his
11 hands involved leaning into it. So, some body weight or
12 pulling back. So, yeah.

13 Q And in the cases that you've looked at, have you
14 limited your research to the placement of hands and the
15 traction force that that involves?

16 A Well, one of the things that we learned was that
17 different doctors apply their hands in different locations.
18 Many apply it so that they're grabbing the fetal chin, and
19 some apply it more sideways so that they're more on ear to
20 ear.

21 Q What about devices such as forceps or, or vacuum
22 extractors, have you researched in that area, the traction
23 that can be applied when those devices are implemented?

24 A The traction that's been applied by forceps and vacuum
25 have long been established in research from the 60s. We

1 were primarily not interested in that because it's --
2 they're not used after the head delivers.

3 Q Okay.

4 A They're taken off once the head delivers.

5 Q So, so, in terms of your involvement in, in these types
6 of cases, it's involving what happens after the head
7 delivers and the placement of the doctor's hands and the
8 amount of traction that -- or, or force that gets applied?

9 Is that correct?

10 A That's correct.

11 Q Okay. So, after you worked with Doctor Nagey, what
12 was -- what did you do next that's related to this, this
13 area?

14 A Well, I moved to the University of Maryland for a few
15 years, and, at that time, I developed a relationship with
16 Georgetown University and did research with a number of
17 faculty in obstetrics there.

18 Q Okay. And what was the focus of that research?

19 A The focus was several fold, but, primarily, we wanted
20 to do -- wanted to learn whether early McRoberts maneuver
21 before the head delivery had any mechanical benefit, and we
22 wanted to establish that the effect of delivery of a, of the
23 posterior arm, which is a technique that's used to manage
24 shoulder dystocia, was beneficial mechanically.

25 Q Is it, is it -- is that one of the maneuvers that a

1 doctor might use if faced with shoulder dystocia?

2 A Yes.

3 Q And there are -- do you, as a biomechanical engineer,
4 do you understand that there are various maneuvers?

5 We've already talked about McRoberts.

6 Is that right?

7 A Yes.

8 Q We've talked about -- and now you're talking about
9 taking the arm out --

10 A Yes.

11 Q -- before -- after the head delivers, but before the
12 body delivers?

13 A Correct.

14 Q What about suprapubic pressure?

15 Have you done any research related to that?

16 A I've looked at the mechanical effects of suprapubic
17 pressure.

18 Q And from a biomechanical standpoint, what is the effect
19 of suprapubic pressure during a shoulder dystocia delivery?

20 A Suprapubic pressure is applied just over the pubic
21 bone, and the idea is, if the shoulder -- if the baby's
22 shoulder is there, and you're pushing down on it, you
23 compress some of the soft tissue. And if you, if you're
24 able to, you can rotate the shoulder into the, into a bigger
25 dimension of the pelvis to make this easier for delivery.

1 Q All right. So, after you worked with doctors at
2 Georgetown, University of Maryland on the effects of
3 maneuvers such as early use of McRoberts, what did you do
4 next in this area?

5 A Well, we, we did that. We established mechanical
6 reasons why delivery of posterior arm was -- created more
7 room than McRoberts maneuver, and then I joined Hopkins in
8 2000, and I've continued my research there for the last 15
9 years.

10 Q And do you teach?

11 A Yeah, I taught.

12 Q And, as part of your teaching, do you actually teach
13 biomechanical engineers only or do you teach doctors?

14 A I teach biomedical engineers, I teach medical students,
15 and I teach residents and attending physicians on mechanics
16 of shoulder dystocia.

17 Q Have you lectured doctors on the area of shoulder
18 dystocia and the forces that come into play?

19 A I've lectured many times to obstetricians and I
20 discussed forces at play, forces that play, and also many
21 other issues.

22 Q In order to acquire knowledge in that area of
23 biomechanical engineering, what have you had to do?

24 A I mean the research that I described up to now was --
25 formed a large basis of that. I also became quite familiar

1 with the literature in the field. And so I was able to talk
2 about it from a mechanical point of view that is of interest
3 to obstetricians. Again, my reasons for doing this are
4 helping to understand mechanics of it so that injuries,
5 brachial plexus injuries, can be prevented in the future.

6 Q All right. Now, the literature that you're referring
7 to, is this a new subject area for biomechanical engineers
8 or people who work in, excuse me, bioengineers or is it an
9 area that people who've been interested in these forces
10 have -- it's been ongoing for some time?

11 A That's a good question. The original work on forces
12 was a instrument that -- forceps and they actually used
13 those for delivery. In terms of measuring the forces
14 associated with delivery after the head is out, that hadn't
15 been done until Doctor Gonik and I did it in the early --
16 mid-80s.

17 Q All right. Now---

18 A It's subsequently been done by others.

19 Q Okay. In more recent years, what has been the focus of
20 your research?

21 A Oh, there are many. We looked at whether it's
22 beneficial, whether an episiotomy is needed to manage
23 shoulder dystocia.

24 Q And what is an episiotomy?

25 A It's, it's a cut of the perineal area to allow for more

1 room, soft tissue room, and the doctor needs to insert his
2 or her hand. Makes it easier for that.

3 Q All right. Anything else that you could tell us about
4 that that relates to this area of research?

5 A Yeah. Yes. Just thinking of major results. We
6 established that up to six minutes after the head delivers
7 is not a risk for brain injury.

8 MR. LOVELL: Objection, Your Honor. I think he's now
9 getting into medical issues.

10 THE COURT: Sustained.

11 MR. HENSHAW: Your Honor, may I approach?

12 THE COURT: You may.

13 (WHEREUPON, a bench conference was held out of the
14 hearing of the jury at this time.)

15 THE COURT: All right. Ladies and gentlemen, I've got
16 one matter I'll need to address before we go further. I'll
17 ask you please go to your jury room. Don't talk about the
18 case. I'll bring you back in a few minutes.

19 (WHEREUPON, the following takes place outside the
20 presence of the jury.)

21 THE COURT: All right. Mr. Henshaw, you want to go
22 ahead and proffer the testimony?

23 MR. HENSHAW: Yes, sir. Thank you.

24 CONTINUED DIRECT EXAMINATION

25 BY MR. HENSHAW:

1 MR. HENSHAW: I do.

2 THE COURT: Well, they've already heard it.

3 I'm guessing you have another witness that will be
4 testifying to the same thing, don't you, one that is
5 qualified?

6 MR. HENSHAW: Well, kind of, yes, sir. I mean it would
7 only be the obstetricians.

8 THE COURT: Yeah.

9 MR. HENSHAW: Yes, sir.

10 (WHEREUPON, the following takes place within the
11 presence of the jury.)

12 THE COURT: All right. You may continue with the
13 direct examination.

14 MR. HENSHAW: Thank you.

15 Your Honor, at this time, I would offer Doctor Allen as
16 an expert in biomedical engineering and the biomechanics
17 within -- to the extent of that biomedical engineers or
18 biomedical engineer can know an expert as to the
19 biomechanics of, of birth.

20 MR. LOVELL: No objection on that limited---

21 THE COURT: All right. He is so qualified in that
22 limited field.

23 MR. HENSHAW: Thank you.

24 CONTINUED DIRECT EXAMINATION

25 BY MR. HENSHAW:

1 Q Now, Doctor Allen, we were, in your qualification phase
2 of your testimony, we were talking about forces that can
3 come to bare during the delivery of a child and you've
4 studied that?

5 A Yes.

6 Q And you've worked with different doctors in doing that?

7 A Yes.

8 Q And in terms of the forces that can come into play --
9 let me see. Excuse me.

10 would this illustration be of any assistance to you in
11 explaining to the jury where these forces apply and how they
12 occur during the process of birth?

13 A Yes.

14 Q All right. Doctor, I don't know whether this will --
15 whether you could use this or not, but if it helps you
16 explaining things, please use it.

17 So, what we have here is an illustration of a baby and
18 does this illustration indicate that the baby's head had
19 been delivered, but the body has not?

20 A Yes.

21 Q Okay. So, what forces are -- tell us what forces are
22 at play for as a biomedical engineer.

23 A The forces that are at play are the maternal forces by
24 the uterus, which pretty much are along this red line here.

25 THE COURT: Excuse me just a minute.

1 would it help you any if you could stand up and, and
2 look at that?

3 THE WITNESS: Yes.

4 THE COURT: All right. You see that microphone that's
5 hanging down from the ceiling right in front of you here,
6 the white one?

7 If you'll stand just behind it and project your voice
8 upward -- not that one. Over here.

9 MR. HENSHAW: Right, right here.

10 THE COURT: And if you'll stand behind it, and project
11 your voice upward best you can, it should pick up
12 everything.

13 (WHEREUPON, the witness comes down from the stand.)

14 THE WITNESS: Okay. Is this good?

15 THE COURT: Sure.

16 A So, this shows basically the axes of the forces. As
17 I indicated earlier, force has both a magnitude, a size, as
18 well as a direction, and this is the direction of the
19 uterine forces. And when doctors apply forces to the head,
20 they're more lateral. And so they tend to act where the
21 green arrow is, and there's a component that's both vertical
22 and horizontal as I explained earlier.

23 Q All right. Now, is this what we're seeing here without
24 the force of traction or is there traction involved in there
25 as well?

1 A This is the clinician applied forces. That's traction.

2 Q All right. So, if the hands were actually showing
3 there then and pushing down in that green arrow direction,
4 that would be traction?

5 A Correct.

6 Q All right. But, but if that does not occur, if the --
7 basically if it's just the uterine forces, then, then that's
8 a straight-line out?

9 A Yes, it's almost in line with the fetal spine.

10 Q All right. Now, the uterus, if you would, show us
11 where that is?

12 A The uterus is this red area that encompasses the fetus.

13 Q And does that -- does the uterus apply any force that
14 would be considered traction?

15 A It doesn't apply traction. It's a contracting muscle.
16 Contracting muscles contract and, therefore, compress and,
17 in this case, the fetus is compressed outward.

18 Q Is that a pushing motion?

19 A That is a pushing motion.

20 Q All right.

21 A Yes.

22 Q All right. Whereas traction is a pulling motion?

23 A Correct.

24 Q All right. And does that make a difference in terms --
25 as a biomechanical ear -- from what you know as a

1 biomechanical engineer, does that make a difference in terms
2 of where forces get applied to the various parts of the
3 baby?

4 A Yes, a pushing force tends to push things. A pulling
5 force tends to pull things. So, if you look at it this way,
6 a pushing force, when I put my fingers together like this,
7 I'm pushing against one another and they're not moving. If
8 I take a rubber band and I pull on it, that's traction.

9 Q All right. And when it comes to areas within the body
10 such as nerves around the neck, does that make a difference
11 in terms of what happens to those nerves?

12 A Yes, in terms of the, the nerves within the fetus,
13 specifically the brachial plexus, the nerves, as you can
14 see, are -- the shoulder -- the shoulder dystocia is up
15 against here. The nerves that are deeply embedded in there.
16 Not really affected that much in a shoulder dystocia by the,
17 by the, by the expulsive forces of maternal contractions.

18 Q All right. Let me -- does this illustration help
19 explain what you were telling us about by telling us where
20 the locations of these nerves are?

21 A In a very crude sense. This is published, as you can
22 see, in the 19th Century. So, it had a crude understanding
23 of what was going on, but they already knew then that
24 lateral traction had the potential to break the -- what they
25 draw as the brachial plexus nerves. It's not anatomically

1 correct as we know today, but it's approximate.

2 Q All right. So, tell us what, what -- where the nerves
3 are that are being affected.

4 A Now, I think this V is five. This VI is six. VII,
5 seven, and I can't really make out the last two, but I
6 assume they're the C8 and T1.

7 Q All right. And does this illustration help explain
8 what you've just told us about?

9 A Yes, this is, this is actually published in Williams in
10 1941.

11 Q And what is Williams?

12 A It's, it's probably the primary textbook in obstetrics.
13 It's been published for many, many years and it gets new
14 editions every year or every so often.

15 Q All right. And so what is this illustrating?

16 A It's illustrating that the traction applied by the
17 physician and left is downward traction. It causes
18 stretching of, in this case, the left side of the neck and,
19 in this case, there's upward traction showing that it can
20 also be upward.

21 Q All right. Now, so, traction is pulling and the uterus
22 compresses --

23 A Yes.

24 Q -- or pushes?

25 A Yes.

1 Q Is, is there a difference, from what you know as a
2 bio -- from what you've studied as a biomechanical engineer
3 in terms of these forces, is there a difference in terms as
4 to what they do to the nerves of the brachial plexus, these
5 different forces?

6 A Yes, the---

7 Q And what is that difference?

8 A The pushing forces of the uterus, when shoulder
9 dystocia happens, have no affect on it. The traction forces
10 do as shown in these two pictures.

11 Q And can you give us a reason, as a biomechanical
12 engineer, why that would be the case?

13 A Well, if the nerves are, are here and you see this
14 stretch, you can see that there's stretching that occurs as
15 a result of the traction applied by the doctor. Without
16 that traction, if you go back to the first image?

17 You want to go back?

18 Q Oh, go back to the first image.

19 All right.

20 A In this image, there are no indications of forces other
21 than the external arrows, but you can just sense that, when
22 the shoulder's up against the pubic bone and mom's pushing
23 down or bearing down or contracting or both, that those,
24 those forces are not affecting the baby.

25 Q Now, have you heard the term maternal forces of labor?

1 A Yes.

2 Q And, as a biomechanical engineer, what does that mean
3 to you?

4 A As a biomechanical -- as a biomedical engineer, I
5 understand what the muscle does. It contracts and it's a
6 natural process. It allows the fetus to descend into the
7 pelvis and actually make it out, and those forces are
8 typically on the order of 20-pounds or so. That's the --
9 when there's, when there's a fetal heart monitor tracing,
10 there's also measuring contraction strength, and based on
11 that contraction, contraction strength, we can, we can
12 understand what the forces are.

13 Q All right. And if, if you'll have a seat please,
14 doctor.

15 A (The witness returns to the stand.)

16 Q Have either you or other experts attempted to measure
17 what causes -- what amount of force causes injury to the
18 nerve roots in-between C5 and C8?

19 A Yes, the first experience that we had was back in
20 Houston where, among those 29 deliveries, and there were two
21 shoulder dystocia deliveries, one of those infants suffered
22 a fractured clavicle and a temporary brachial plexus injury.
23 And we had the force value associated with that.

24 Q All right.

25 A So, that was a live birth. It's not something we

1 planned. It wasn't planned. It just happened and we saw
2 that that force level was about 22-pounds of traction and it
3 caused the temporary injury.

4 Q All right. Now, what, what is the difference between a
5 temporary injury and a permanent injury as far as you're
6 concerned?

7 A A temporary injury resolves over time spontaneously.
8 It can take anywhere from hours to months. And a permanent
9 injury is one that does not resolve into some deficit beyond
10 typically two years.

11 Q All right. Are you familiar with the term rupture of,
12 of C5 or C6 or C7?

13 A Yes.

14 Q And what does that mean to you?

15 A Rupture means a break in the nerve or a gap in the
16 nerve.

17 Q And what -- how does that get characterized as to
18 whether it's temporary or permanent?

19 A That indicates that it's permanent. It is a break in
20 the nerve. That means the conduction from the nerve to the
21 muscles is broken.

22 Q All right. Now, we've also heard the term neuroma and
23 that's also been explained in Doctor Armenta's deposition.

24 what is it, what is -- are you familiar with that term
25 as a biomedical engineer?

1 A Yes.

2 Q And what does that mean to you?

3 A The neuroma is also a permanent injury. It's one that
4 where the -- there's scar tissue surrounding the nerve, but
5 individual components of the nerve within the sheath are
6 broken. And so it's, it's a partial rupture.

7 Q All right. And what -- is, is there any significance
8 if, if there is a neuroma of C8?

9 A Yes, the extent of the injury is very important. The
10 first nerves that are generally injured, if there is an
11 injury, is C5 and C6. That's the -- go back to --.

12 Q Oh, okay.

13 A -- the nerve drawing. It's these two nerves and they
14 do intersect. That's Erb's -- that's called Erb's point.
15 And so an Erb's injury is -- that's E-R-B.

16 THE COURT: Be sure you use the microphone. That's the
17 reason I had you stand up. You don't need to, but just be
18 sure you turn and use the microphone when you respond.

19 THE WITNESS: Thank you.

20 So, that's the Erb's point and that's the most common
21 place for an injury, whether it's temporary or permanent
22 because that's the one that's most susceptible to the
23 stretch.

24 Q All right.

25 A And so that was actually understood even then in 1897.

1 Q Now, Doctor Allen, if Ashley F had a rupture of
2 C5, C6, and C7 and a neuroma that encased those three nerves
3 along with C8, as a biomedical engineer, do you have an
4 opinion, to a reasonable degree of biomedical certainty, as
5 to whether that injury -- those injuries to those nerves
6 were most probably caused by traction or caused by
7 compression?

8 A They're caused by traction.

9 Q And would there be any other forces, other than
10 traction or compression, that could, could have caused
11 injuries to those nerves in that way?

12 A No.

13 Q Doctor, are you related to Doctor Gurewitsch?

14 A Yes.

15 Q And what is your relationship with her?

16 A I'm her husband.

17 Q Okay. And have you worked on this case with her
18 together or separately?

19 A That's my understanding. We don't talk about cases in
20 the home, but I understand she was deposed in this case.

21 Q All right. Do you know anything other than that?

22 A No.

23 Q Have you coached her in any way about your opinions
24 about this case?

25 A No.

1 Q And did she coach you in any way about her opinions in
2 this case?

3 A No.

4 Q Have you given expert testimony before?

5 A I have.

6 Q And approximately how many jurisdictions have you been
7 recognized as an expert?

8 A At least half the states --

9 Q Okay.

10 A -- and the federal government.

11 Q All right. Doctor, that's all the questions I have for
12 you at this time. Please answer any questions defense
13 counsel may have.

14 A Okay.

15 THE COURT: Mr. Lovell.

16 MR. LOVELL: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. LOVELL:

19 Q Now, Doctor Allen --

20 A Morning.

21 Q -- fair to say you're not a medical doctor, right?

22 A Correct.

23 Q And I think you and I have met before on other cases
24 of -- similar to this. So, it's not the first time we've
25 seen each other.

1 A Correct.

2 Q You've not been licensed by any state to practice
3 medicine?

4 A No.

5 Q Never delivered a baby yourself?

6 A Not a doctor, no.

7 Q You haven't been licensed as a certified scrub tech or
8 a labor and delivery nurse?

9 Never done that?

10 A No, I'm not a medical care provider in any way.

11 Q No formal medical training?

12 A Correct.

13 Q You have never entered a delivery -- a labor and
14 delivery room where you were the person in charge of
15 delivering the baby when the baby had a heart rate that went
16 from the 130s down to the 90s?

17 A No.

18 Q You have never been charged with the decision of how to
19 manage the labor and delivery in a situation where a baby's
20 heart rate dropped within a few minutes from 130 to down to
21 the 90s?

22 A That's correct.

23 MR. HENSHAW: Your Honor, we will stipulate that Doctor
24 Allen is only being called to testify as a biomedical
25 engineer.

1 THE COURT: Okay.

2 Q As far as forces involved in labor, you've never
3 inserted your hands into the mother's birth canal to try to
4 maneuver an arm or rotate a shoulder?

5 A Not in a real delivery. I've done it in simulated
6 deliveries.

7 Q We're only talking real deliveries and real ones.

8 A Okay.

9 Q Not simulations.

10 Okay. As far as managing the actual guidance of the
11 baby's head after it has been delivered out with the body
12 still inside and a shoulder dystocia has occurred, you've
13 never physically put your hands on a live baby's head to do
14 so?

15 A No.

16 Q Never warn the, the gloves that the doctors wear when
17 they're doing that?

18 A I've, I've worn gloves. Not when they're doing the
19 delivery.

20 Q Okay. When they're doing, that means by doing the, the
21 live delivery, right?

22 You've never felt how slippery a baby's head as it's
23 coming out of the mother's birth canal is when you put those
24 gloves on, have you?

25 A Never have.

1 Q Have you ever sat at the stool that doctors like Doctor
2 Giep sit on when they're doing a delivery, a live delivery
3 where there's a live delivery going on?

4 Have you ever done that yourself?

5 A I have not.

6 Q Okay. Have you ever tried, when you're sitting on that
7 stool and you've got your hands on the baby's head as Doctor
8 Giep described, the maneuver of trying to do this downward
9 traction you call it?

10 Have you ever done that in a real world setting?

11 A Not in a real world setting. In a simulated setting,
12 yes.

13 Q And I think we just heard that you'll agree you're not
14 qualified to come to this jury and give any opinion on the
15 standard of care that should of been exercised by my client,
16 correct?

17 A That's correct.

18 Q All you're doing is coming in here as an engineer and
19 using engineering principles, and I think you called it
20 bio -- as they applied to biomedical systems?

21 A Yes.

22 Q Now, let's talk for a second about these publications.

23 The one that you were talking about with Doctor Gonik,
24 that was published, was it, in the early 90s?

25 1990 I think?

1 A 1991 and also 1989 was a simulation study.

2 Q Okay. And you've acknowledge that, since then, 27
3 years ago, a lot of other papers have been published on all
4 of these issues by a lot of people besides you and Doctor
5 Gonik?

6 A A fair number, yeah.

7 Q And you mentioned that the only forces y'all studied in
8 Doctor Gonik's study were the forces that are applied by
9 physicians, right?

10 A We had the, the uterine forces that were generated in
11 those deliveries as well.

12 Q But as far as a study of the forces applied to the
13 brachial plexus nerves in the shoulder dystocia scenario in
14 a live birth, y'all aren't studying that?

15 A That can't be done. It can only be done in a
16 simulator, which we have done.

17 THE COURT: You're, you're gonna have to get a little
18 bit closer to that microphone please, sir.

19 THE WITNESS: Yes.

20 Q Now, let's talk about compressive forces and these
21 stretch forces.

22 when we were looking at our suprapubic pressure
23 diagram, and let me get the one I've got, just to set the --
24 sort of the stage for this, when you were looking at the
25 diagram where you had the lines drawn sort of vertically and

1 horizontally, or I might have that backwards, you would
2 agree, in general, that, as a baby is moving down the
3 mother's birth canal is the term I'm using, that might not
4 be the right one, as they get down towards the exit point,
5 the babies move?

6 A Yes.

7 Q Their head might move one way, the body might move a
8 little bit differently?

9 A They certainly do.

10 Q The shoulders rotate sometimes in a different direction
11 from the head?

12 A Yes.

13 Q And as these forces you're talking about are the
14 maternal forces, and, and we use that term.

15 That's just what the uterus and the stomach muscles are
16 doing as the mom's having sort of these involuntary
17 contractions?

18 A Yes.

19 Q And sometimes she's having voluntary contractions.

20 If they're saying push, push, and she's kind of pushing
21 down, that creates forces, right?

22 A Yes.

23 Q And so all of those forces are acting upon this baby as
24 it begins to transition from up here to down here to down
25 here to down there, the various stages of delivery, right?

1 A Yes.

2 Q Okay. So, as the baby is moving down and these
3 compressive forces begin to apply, when the baby's head gets
4 down into the pelvis, what the doctors called engaged in the
5 pelvis, the forces begin to come more from the back of the
6 baby towards the head, right?

7 A That's truth through all of the second stage of labor,
8 but yes, that's true.

9 Q And I'm talking from a mechanical engineer type
10 standpoint.

11 A Yes.

12 Q And I've got sort of a diagram. It's not as fancy as
13 the one y'all had, but it sort of shows the baby's position
14 when the head is just barely coming out, and we're not in
15 shoulder dystocia, correct?

16 A It's pretty close, but --.

17 Q Okay. But it's not---

18 A The shoulder's up against the pubic bone there.

19 Q But when we talk about the axial plane of the spine,
20 you're talking about down the baby's spine, and if the head
21 were straight like I'm standing, it would kind of be a
22 straight-line?

23 A Yes.

24 Q Right?

25 A Yes.

1 Q But when the baby's heads turn as they're moving
2 through the body and the shoulder's turn and things
3 different, the axial spine is never really a straight up and
4 down line?

5 A Well, the axial spine is straight, but yes, it, it --
6 as you demonstrated, the head moves around relative to the
7 body. We actually studied that in -- during the cardinal
8 movements when the baby's in the pelvis.

9 Q So, as the baby is coming down and these forces -- and
10 the only way the forces can be passed from the bottom end of
11 the baby up towards the head are really through the spine,
12 right?

13 That's the only kind of ridged structure of the baby.

14 A I'm sorry. I didn't understand the question.

15 Q The way the forces, these compressive forces, get sort
16 of passed through the baby's body are along that spine, the
17 bones, and the connective ligaments?

18 A Well, it, it acts along the whole baby. It, it -- so,
19 it really doesn't act just along the spine but---

20 Q Some down the spine.

21 A Right.

22 Q How about that?

23 Because you do have contractions that are occurring
24 down here?

25 A Yes.

1 Q And muscle---

2 A Yeah.

3 Q The whole thing---

4 A It's contracting.

5 Q And obviously the lower---

6 A But the overall, the overall thrust to get -- to move
7 the baby into the pelvis and out is in that direction.

8 Q And compression occurs as the baby is moving down and
9 as those muscles are squeezing the baby's body and trying to
10 help it exit the mother, right?

11 A Yes.

12 Q And that's the compressive forces that are part of the
13 maternal forces of delivery?

14 A Yes.

15 Q And whether it's the contraction, involuntary
16 compressive forces, or the mom being told push, push, those
17 are compressive forces?

18 A Yes.

19 Q All right. When the baby's head has been delivered out
20 of the baby's body, I'm gonna show you the suprapubic one.
21 This is, again, not the one y'all have but similar.

22 But once the baby's head is out of the mom's vagina or
23 bottom end, the head itself has now come outside and it's
24 not subject to these forces of mom anymore, right?

25 A Correct.

1 Q But before the baby's head comes out, as it's beginning
2 to exit the opening, there are compressive forces on the
3 head, from an engineering standpoint, right?

4 A The compressive forces on the head are mostly before
5 it's engaged in the pelvis, but, once it's engaged, the
6 pressures are mostly on the body.

7 Q But the head has to push through something to come out,
8 right?

9 A I mean it has to get through the pelvis and it's, it's
10 usually a tight fit.

11 Q And, and you understand, in this case, Doctor Giep used
12 a vacuum extractor to assist the pelvis -- the baby's head
13 to getting out, right?

14 A Yes.

15 Q And that vacuum extractor doesn't exert tons of force
16 on the baby coming out.

17 Most of the force is still mama's compressing, pushing
18 from the inside out, correct?

19 A The force of the, of the, of the vacuum itself is, is
20 applied to the head. It creates a vacuum. So, it's able to
21 pull. The pulling forces created by the physician, and the
22 contraction forces are the contraction forces. The relative
23 size of those two is really dependent on, on how much
24 traction's applied and how much contraction strength is.

25 Q And mom's anatomy and all?

1 A Yeah.

2 Q Lots of different factors go into all of these things
3 we're talking about, right?

4 A Right, but the important point of the vacuum is it's,
5 it's stretching the head and it's along its axis. And so
6 its effect, mechanically, from the nerves is minimal.

7 Q And, at that point, the shoulder is not stuck behind
8 the pubic bone?

9 A Correct. This is done before the head is delivered.

10 Q The body's still moving sort of as a unit?

11 A Yes.

12 Q And subject to the -- getting the different movements
13 of the body and such?

14 A Right?

15 Q So, once the head is out, and the shoulder becomes
16 stuck, as I've got here on my diagram, there are still
17 forces coming from mama and the compressive forces on the
18 way trying to get baby birthed---

19 A Yes.

20 Q ---and out, right?

21 And those do create compression in the area of the
22 brachial plexus, those forces, right?

23 A No. No.

24 Q Why not?

25 A It creates compression between the pubic bone and the

1 end of the shoulder. The brachial plexus nerves are
2 actually far deeper into the muscle. They're not being
3 compressed.

4 Q The axial forces on baby's body are still going in
5 generally that direction, right?

6 A Correct.

7 Q And so, as those forces get passed and the head begins
8 to come out -- you've heard of the turtle sign, right?

9 A Yes.

10 Q And that's where, when the head delivers, the neck
11 comes out and you've got the exiting vagina area, and then
12 the head kind of goes back in?

13 A Yes.

14 Q And then a stretch and a retraction involved in that?

15 A Correct.

16 Q And that's what occurs, unfortunately, when brachial
17 plexus happens a lot of times?

18 A A turtle sign is, is -- occurs during head and shoulder
19 dystocia.

20 Q When this nurse, you told us, is pressing on this bone,
21 the pubic bone, right here---

22 A Above the pubic bone.

23 Q Above it. I'm sorry.

24 The goal is to try to put pressure on the area here and
25 maybe rotate the shoulder a little. Maybe press it below

1 the area that it's stuck.

2 A Exactly.

3 Q Again, compressive forces?

4 A Yes.

5 Q Okay. Not stretch, but compression?

6 A Compression.

7 Q Okay. Now, you understand in this case -- let me ask
8 you.

9 You've reviewed all the depositions that were taken in
10 this case, right, and---

11 A I don't know how many all of them are. I've reviewed
12 quite a few.

13 Q Family members that were there. The doctor that did
14 the delivery. The nurses that were present.

15 I assume you reviewed everybody that was in the room
16 that had something to say about how the delivery went?

17 A I believe so, yes.

18 Q All right. Maybe not all the experts or whatever.

19 Did you review Doctor Armenta's?

20 A Yes.

21 Q Okay. And I think you heard -- were you in here when
22 he testified a few minutes ago?

23 A Yes.

24 Q You heard him say and do you agree that there are
25 variations in every baby, from one baby to the next, about

1 the strength of the various nerves in the brachial plexus?

2 A Yes, and there's also variation in anatomy.

3 Q Sure. Everybody's different.

4 A Everybody's different.

5 Q Every baby's different. You and I are different.

6 We're all different.

7 And those variations are factors that can affect how
8 strong the nerve is in responding to the engineering forces
9 of delivery that you've been talking about, right?

10 A Yes, they can. The, the only way to know is to
11 actually test them mechanically at different -- say at
12 different gestations. That hasn't been done.

13 Q But Doctor Armenta, as you've heard, didn't test her
14 nerves when he was operating on her to make any
15 determinations about the conditions of her particular
16 nerves, right?

17 A Correct.

18 Q And obviously you haven't done so either?

19 A Correct.

20 Q Did you hear Doctor Armenta state that, in his
21 experience, and it sounds like he's done a lot of these
22 severe injury type cases, sometimes he sees minimal scarring
23 when he's in there looking at the nerves with his
24 eyeballs---

25 A Uh-huh. (Affirmative).

1 Q ---with very severe injuries, and then also the
2 converse, sometimes he sees extensive scarring with less
3 severe injuries.

4 Is that consistent with what you heard and what you
5 understand?

6 A I believe so. I didn't particularly hear that, but it
7 sounds right.

8 Q Is axial force of the traction that you've talked
9 about, you showed in those two diagrams that came out of
10 that old medical book, one situation where the baby's head
11 was angled upward towards this direction if mom's laying
12 flat, and one where baby's head is angle downward, right?

13 A Correct.

14 Q That's what you call the lateral traction that might be
15 applied during the delivery?

16 A Yes, that is applied during delivery.

17 Q In your review of the information associated with this
18 case, didn't you see, in the deposition of Mrs. Bowen, where
19 she said that -- the question was asked when the doctor was,
20 as you say, pulling your grandchild, was he pulling him
21 straight, pulling him up, or was he pulling him down, and
22 her answer was straight, correct?

23 A I, I don't recall what -- but if you have it there---

24 Q well, let's---

25 A ---and reading it accurately, I believe you.

1 Q Let's look at it.

2 Your Honor, I have the original deposition of Mrs.
3 Bowen.

4 THE COURT: Okay.

5 Q I'm gonna open this original deposition.

6 I'll direct you over to Page 31, doctor.

7 First, let me get you to look at the front.

8 Do you see where it was taken December 8th of the
9 2015?

10 A Yes.

11 Q We had a court reporter and all that stuff---

12 A Yes.

13 Q ---is there.

14 On Page 31, beginning, beginning at Line Number 15, the
15 question was okay. When the doctor was, as you say, pulling
16 your grandchild, was he pulling him straight, was he pulling
17 him up, was he pulling him down?

18 what was the answer she gave?

19 A She said he was pulling him straight.

20 Q That's information that's important cause that's
21 somebody who's there watching the delivery, right?

22 A Yes, it's a lay person describing straight traction.

23 Q You haven't done an assessment on Ashley F on the
24 effect that the low muscle tone in her might have on the
25 strength of her actual nerves in her neck, the brachial

1 plexus, right?

2 A No.

3 Q But you agree that low muscle tone can affect the
4 strength of those nerves?

5 A The tone affects the muscles as opposed to nerves.
6 They become weaker so that the brachial plexus is more
7 susceptible.

8 Q When the muscles are less resistant to the forces of
9 traction as you call it, right?

10 A Correct.

11 Q And so, if her muscle tone was a one instead of a two,
12 her muscles would of been less resistant to the forces of
13 the delivery and traction from either the doctor or whatever
14 force that it came from?

15 A Yes.

16 Q Right?

17 The -- excuse me. I think that's all I have. Thank
18 you very much, doctor.

19 REDIRECT EXAMINATION

20 BY MR. HENSHAW:

21 Q In terms of the angle at which the doctor was applying
22 his hands and pulling the baby's head, does it necessarily
23 remain constant once the doctor begins to pull?

24 A No, it definitely does not remain constant. That's not
25 done.

1 Q So, hypothetically, could it be that there were times
2 when he was pulling straight and then there were times when
3 he was pulling at an angle?

4 MR. LOVELL: That calls for speculation, Your Honor. I
5 object.

6 THE COURT: Rephrase it.

7 MR. HENSHAW: I didn't, I didn't---

8 THE COURT: He objected based on the fact that it
9 caused this witness to speculate as to the answer.

10 Q All right. Well, the question you were asked only
11 asked for a moment in time about what she saw.

12 Is that, is that what you understood?

13 A That's what I understood, yes.

14 Q All right. Does it necessarily mean that, if he was
15 seen pulling straight at one time, that it absolutely means
16 that he had to be pulling straight the entire time?

17 MR. LOVELL: Again, speculation, Your Honor.
18 Objection.

19 THE COURT: I don't think this witness has that
20 information, and, and, if he does, it doesn't help the jury.
21 They can answer that question for themselves.

22 MR. HENSHAW: All right, sir. All right. Thank you,
23 Your Honor. That's all the questions that I have.

24 THE COURT: All right. You may step down.

25 THE WITNESS: This here---

1 of a videotaped deposition that I explained previously. And
2 this is the videotaped deposition of Shelley Mahaffey, who
3 is a medical doctor, who has information relating to the
4 case.

5 Now, sometimes videotaped depositions, as well as
6 written depositions, are not quite as exciting as having a
7 live witness testify. So, please resist the temptation to,
8 to tend to lose focus and be sure that you pay attention
9 from start to finish because every witness' testimony is
10 important. And if you miss some of it, then you've missed
11 some of the case.

12 So, you've been selected for a very special purpose
13 this week, and that is to decide the fair and just verdict
14 in this case. So, be sure you pay attention to every
15 witness from beginning to end so that, when you do go back
16 and begin deliberation, you'll have all of the information
17 and, and can judge it fairly.

18 Okay. All right. You may proceed.

19 (WHEREUPON, the following is the testimony played to
20 the jury by videotape deposition.)

21 THE VIDEOGRAPHER: We're on the record at 11:06AM.
22 This is the video deposition of Shelley Mahaffey, MD. Today
23 is Thursday, September 24th, 2015.

24 Will the court reporter please swear the witness?

25 SHELLEY MAHAFFEY, being first duly

Deposition of Shelley Mahaffey

1 sworn, testified as follows:

2 DIRECT EXAMINATION

3 BY MR. HENSHAW:

4 Q. Please state your full name.

5 A. It's Shelley Hammett Mahaffey.

6 Q. Thank you.

7 You are a medical doctor, is that correct?

8 A. Yes.

9 Q. And do you practice here in Spartanburg?

10 A. Yes.

11 Q. What is the nature of your practice?

12 A. I'm a general, general pediatrician.

13 Q. And where do you practice here in Spartanburg?

14 A. I am employed by Spartanburg Regional, but I
15 practice at the Medical Group of the Carolinas Pediatrics
16 Westside.

17 Q. All right. Where did you go to Medical School?

18 A. Medical University of South Carolina.

19 Q. Graduating when?

20 A. In -- I'm sorry. '98.

21 Q. Okay. And did you have postgraduate training after
22 that?

23 A. Yes, and---

24 Q. Where was that at?

25 A. ---residency at Texas Tech University.

Deposition of Shelley Mahaffey

1 Q. Are you a board certified---

2 A. Yes.

3 Q. ---pediatrician?

4 A. I am.

5 Q. Are you a general pediatrician or are you more
6 specialized than that?

7 A. General pediatrician.

8 Q. Have you had a patient in your practice by the name
9 of Ashley F ?

10 A. Yes, sir, I have.

11 Q. When did Ashley become one of your patients?

12 A. She was four months old.

13 Q. So, had you been acquainted with her at all at the
14 time of birth or in that four month period---

15 A. No, sir.

16 Q. ---prior to her coming to your office?

17 A. No, sir.

18 Q. So, since she was four months old, have you
19 continued to be her pediatrician?

20 A. Yes, sir.

21 Q. And are you continuing to be her pediatrician as we
22 speak now?

23 A. Yes, sir.

24 Q. If you would -- if you continue to be her
25 pediatrician in the future, to what age would she get to

Deposition of Shelley Mahaffey

1 before she was turned over to someone else?

2 A. Eighteen.

3 Q. And so that's the way that pediatricians go from
4 birth to about 18.

5 Is that right?

6 A. Typically, yes, sir.

7 Q. What has been your role in Ashley's medical care
8 since her -- since she was four months old?

9 A. We -- I've seen her for her well care. Just
10 general well visits, immunizations, that kind of thing, and
11 any sicknesses that she's come in for.

12 Q. Generally speaking, what has her health been up to
13 this point?

14 A. She's in good health.

15 Q. Does she have any problems, any disease processes,
16 or anything like that that will affect her health -- that
17 have affected her health in the past or will affect her
18 health in the future?

19 A. You mean in general --?

20 Q. In general.

21 A. -- or --?

22 Q. In general.

23 A. No, I mean she's a healthy -- she's a healthy girl.

24 Q. All right.

25 A. She's rarely sick and not, not in my office very

Deposition of Shelley Mahaffey

1 much.

2 Q. Does she have a medical problem with one of her
3 extremities, specifically her left shoulder and arm and
4 wrist---

5 A. Yes, sir.

6 Q. ---and hand?

7 A. Yes, sir, she does.

8 Q. To what, to what extent are you involved in the
9 treatment of her left shoulder, arm, wrist, and hand?

10 A. Well, evaluating that is part of my well visits
11 when she comes, and I'm the one who prescribes or continues
12 to prescribe her occupational therapy and physical therapy.

13 Q. Does she have any problems or deficits with her
14 right arm, shoulder, wrist, her hand?

15 A. No, sir.

16 Q. Does she have any problems with her right or left
17 legs?

18 A. No, sir.

19 Q. Does she have any internal problems --

20 A. No, sir.

21 Q. -- or any -- does she have -- appear to have any
22 deficits in terms of her intellectual capacity?

23 A. No, sir.

24 Q. So, as of today, if she has a medical problem, is
25 it limited to her shoulder, arm, wrist, and hand?

Deposition of Shelley Mahaffey

1 A. Yes, sir.

2 Q. Can you just give us an overview as -- from your
3 prospective as her pediatrician, as to what's going on with
4 her left extremity?

5 A. Well, she has a brachial plexus injury and she has
6 had several surgeries for that, but her, her limitation is
7 of her shoulder, elbow, and, and hand in that, that arm.

8 Q. What is your role, at this time, in terms of the
9 treatment of her left shoulder, arm, wrist, and hand?

10 A. As far as treatment for her, I really don't have a
11 role at all. I -- it's like I said, prescribe her physical
12 therapy or occupational therapy ongoing as she needs that.

13 Q. And who are the doctors who are specifically
14 treating her left extremity or have been?

15 A. I'm not a hundred percent sure who she sees. I
16 believe her surgical team is in Texas, but I, I've never had
17 any interaction with them other than, you know, their notes
18 when they come from postop and things.

19 Q. Do, do you have interaction with them so that you
20 know what physical therapy, therapy to prescribe?

21 I mean do they give some direction with regard to that?

22 A. Not really in particular. That -- it would be --
23 my, my prescriptions are very generic. They are to the
24 occupational therapists, evaluate and treat, as necessary.
25 So, it's more the therapist that decides what physical

Deposition of Shelley Mahaffey

1 therapy she needs than me.

2 Q. Do you recall, from having worked with Ashley, the
3 way that the arm appears?

4 A. Currently or --?

5 Q. Currently, yes, ma'am.

6 A. The last time I saw her I believe was her six year
7 old well visit when I would of -- when she's almost seven.
8 So, when I would of evaluated that. So, I'm not sure if
9 there's been a difference between then and now, but she does
10 not -- her shoulder is limited as far as how far up she can
11 move her shoulder. Her elbow, I believe, stays in sort of a
12 flexed position, but she has some mobility there, and her,
13 her grip is, is affected, but has been getting stronger
14 every time I've seen her, her hand grip. But she has
15 some -- she has effects of her entire extremities, the
16 shoulder, elbow, and wrist, and hand.

17 Q. Have you been able to observe how she's adapting to
18 this particular problem with her left extremity?

19 A. I, I don't know if I can answer that specifically.
20 I know that she does -- she's a precocious little girl and
21 does things with her right hand, and has some, some function
22 of her left extremity as well. Generally, she can do most
23 things. I think that she has some limitation obviously
24 because of that, that left arm, but other than that, I don't
25 know that I can really comment on, on those things. Again,

Deposition of Shelley Mahaffey

1 I just see her for her, for her checkups. So, I'm not
2 sure---

3 Q. Okay.

4 A. ---if I'm answering that correctly.

5 Q. That's, that's fine, Doctor Mahaffey. Thank you
6 very much.

7 Now, please answer any questions defense counsel had.

8 A. Okay.

9 CROSS-EXAMINATION

10 BY MR. WEATHERLY:

11 Q. Doctor Mahaffey, my name's Lee Weatherly, and we've
12 met for the first time today, but I represent Doctor Giep in
13 the lawsuit that Ashley's parents have filed against him,
14 and I'd like to ask you some questions kind of just on two
15 topics today.

16 The first of those topics being actual mental
17 development, and the second of those being the improvement
18 in her left arm since she first started seeing---

19 A. Okay.

20 Q. Okay. And so first what I'd like to do is start at
21 her 18-month checkup.

22 Okay. And I'm gonna hand you, if you would like to
23 look at it, your record from that checkup.

24 A. Okay.

25 Q. And this checkup was done when Ashley was, I guess,

Deposition of Shelley Mahaffey

1 a year and a half old, right?

2 A. Yes, sir.

3 Q. And under the developmental milestones, at this
4 time, Ashley's able to walk both forwards and backwards.

5 Is that correct?

6 A. Yes.

7 Q. And she was able to throw a ball?

8 A. Yes, sir.

9 Q. And she was able to use two word phrases like my
10 toy or more please or things like that?

11 A. Yes.

12 Q. All right. She was able to stop -- stack three and
13 four blocks on top of each other.

14 Is that right?

15 A. Yes.

16 Q. All right. She was able to use a spoon and a cup?

17 A. Yes.

18 Q. She was able to follow simple directions?

19 A. Yes, sir.

20 Q. And she could scribble on a piece of paper?

21 A. Yes.

22 Q. And she was able to point to some of her body parts
23 such as you might say Ashley, where are your eyes---

24 A. Correct.

25 Q. ---and she could point to her eyes?

Deposition of Shelley Mahaffey

1 A. Yes, sir.

2 Q All right. And she could remove her clothing?

3 A. Yes, sir.

4 Q. And you did a neurological examination of her on
5 that day?

6 A. Yes.

7 Q. And that was completely normal?

8 A. I mean that -- well, other than her, her arm.

9 Q. Sure.

10 A. And I did that as an extremity exam, but yes.

11 Q. And what I mean by the neurologic examination being
12 her cognitive function?

13 A. Absolutely, yes.

14 Q. Okay. And there were no delays in her motor
15 function, her language, or her social development?

16 A. No, sir.

17 Q. So, despite the events at her birth, including
18 experiencing shoulder dystocia, there was no evidence that
19 she suffered any type of brain injury, right?

20 A. No, sir.

21 Q. Okay. Now, at this point, at 18-months, when you
22 examined her left arm, it just kind of hung by her side.

23 Is that accurate?

24 A. Yes, not as much as it had in the past, but, but
25 yes, it still hung to her side.

Deposition of Shelley Mahaffey

1 Q. So, before she was a year and a half old, it, I
2 guess, it had less function?

3 A. Yes.

4 Q. And it had improved by 18-months, but it still just
5 kind of --?

6 A. Correct. She had had, let me see, one of her
7 surgeries, I believe, by this time, and I had -- and there
8 were some increase. I believe I said at the elbow was
9 primarily where I had noticed increase range of motion.

10 Q. All right. What I'd like to do next is
11 fast-forward to her two year well visit.

12 A. Okay.

13 Q. And I'll hand you your record from there.

14 Now, this was on July 21st, 2011, and she's born on
15 October 7th, 2008. So, she's almost three years old at this
16 point---

17 A. Yes.

18 Q. ---but it's called --

19 A. It's imperfect.

20 Q. ---the two year well visit?

21 A. Yes.

22 Q. Okay. Now, the arm that -- the description of the
23 arm that you gave us before that it was just kind of hung by
24 her side, it had improved by her two year well visit.

25 Is that correct?

Deposition of Shelley Mahaffey

1 A. Yes.

2 Q. She had increased range of motion meaning that she
3 could move it around a lot better than she could before?

4 A. Yes, sir.

5 Q. And, by this time, she was able to grip things with
6 her left-hand?

7 A. Yes.

8 Q. And she could move her elbow at this point.
9 Is that correct?

10 A. Yes.

11 Q. All right. And so that was a definite improvement
12 over her two year well exam?

13 A. Well, this is the two year but yes.

14 Q. Excuse me. The 18-months.

15 A. Yes.

16 Q. I'm sorry.

17 A. No, that's okay.

18 Q. All right. Let's then go back to her development a
19 little bit in the developmental milestones, but, first,
20 before we talk about that, the gross and fine motor skills,
21 the language skills, the social development, all of those
22 things were still normal.

23 Is that right?

24 A. Yes, sir.

25 Q. And so, at two years, she's now able to walk up and

Deposition of Shelley Mahaffey

1 down the stairs.

2 Is that correct?

3 A. Yes, sir.

4 Q. She can walk backwards?

5 A. Uh-huh. (Affirmative).

6 Q. She can kick a ball at this point?

7 A. Yes, sir.

8 Q. All right. Now, she's gone from being able to
9 stack three and four blocks to now she can stack five or six
10 blocks.

11 Is that right?

12 A. Yes, sir.

13 Q. She knows at least 20 words at this point?

14 A. Yes, sir.

15 Q. And she knows her name?

16 A. Yes.

17 Q. And she can draw a line on a piece of paper with a
18 pen or pencil at this point?

19 A. Yes.

20 Q. Okay. And she can follow what are called two step
21 commands, correct?

22 A. Yes, sir.

23 Q. And could you give me an example?

24 what's a two step command that you would ask a two year
25 old like Ashley on this visit to do to see if she can do

Deposition of Shelley Mahaffey

1 this or not?

2 A. We would just say can you pick up your cup and
3 bring it to me or can you pick up your socks and put them in
4 the laundry or hamper, or little hamper or something. Two,
5 two, two steps.

6 Q. And she was able to do those things?

7 A. Yes.

8 Q. Okay. And she even imitates housework that her
9 parents do like wiping off the countertop or such as
10 those---

11 A. Right.

12 Q. ---and stuff like that?

13 A. Right.

14 Q. And so she met at two -- at her two year wellness
15 check and met all of her developmental milestones.

16 Is that correct?

17 A. Yes, sir.

18 Q. Okay. And so, again, despite the events that
19 occurred during her birth and despite having experienced a
20 shoulder dystocia, at two years of age, there's no evidence
21 that she suffered any type of brain injury.

22 Is that correct?

23 A. No, sir.

24 Q. Okay. All right. What I'd like to do next is you
25 had done what's called or has prescribed her what's called

Deposition of Shelley Mahaffey

1 occupational therapy during your, during your treatment of
2 her.

3 Is that correct?

4 A. Yes, sir.

5 Q. Okay. What I'd like to do is to hand you a couple
6 of the notes that were in your chart about the occupational
7 therapy.

8 A. Okay.

9 Q. And just ask you a couple of questions from those.

10 A. Okay.

11 Q. That occurred between that two year visit that you
12 had with, with Ashley and the four year old checkup that
13 we're gonna talk about in a second.

14 A. Okay.

15 Q. And so right after she was three years old, and
16 this note is from October 31st, 2011, she got to the stage
17 where she could pick up a small object like a Cheerio with
18 her left-hand.

19 Is that right?

20 A. Yes. Yes, sir.

21 Q. Okay. And if we'll turn onto the next page with a
22 note of January 31st, 2012. At this point, the
23 occupational therapist noted that she's able to remove her
24 coat all by herself by unzipping and zipping the zipper with
25 her left-hand.

Deposition of Shelley Mahaffey

1 Is that right?

2 A. Let me just make sure.

3 Q. Take a---

4 A. Yes.

5 Q. ---second to read it.

6 A. Yeah, yeah, I see it. She is.

7 Q. And so, again, we're getting more improvement then
8 from your two year well check that we just had two months
9 prior, right?

10 A. Yes.

11 Q. Okay. She is learned how to wash her hands using,
12 using both hands. So, kind of rubbing them together in, in
13 that fashion.

14 A. Yes, sir.

15 Q. She can carry a plate and a bowl with both hands?

16 A. Yes.

17 Q. And she can use the restroom without assistance?

18 A. Yes.

19 Q. And she can eat independently without assistance?

20 A. Yes, sir.

21 Q. All right. If we -- and if we could skip ahead, I
22 guess, to September 20th, 2012. At this point she's able
23 to take her shoes and socks on and off all by herself.

24 A. Do I have that?

25 Q. Let me see. It would be on Page 276 at the bottom,

Deposition of Shelley Mahaffey

1 the 9/12/2012.

2 A. Oh, sorry. It's at the end.

3 Q. All right. So, by this point in her occupational
4 therapy, she's able to take her shoes and her socks on and
5 off all by herself?

6 A. Yes, sir.

7 Q. And she's learned how to take a T-shirt on and off
8 by herself?

9 A. Yes, sir.

10 Q. And she's learned how to hold paper with one hand
11 and cut shapes with scissors out of that paper?

12 A. Yes, sir.

13 Q. All right. And these are all significant
14 improvements over what she had had at the two year old well
15 check just a few months before?

16 A. Yes, sir.

17 Q. All right. What I'd like to do next -- and then,
18 and then, again, just to clarify and looking again, in
19 looking at these occupational therapy notes, you know,
20 despite the events of her birth and the shoulder dystocia,
21 we still don't see anything that would indicate she's had
22 any sort of brain injury from birth or anything like that?

23 A. Not at all.

24 Q. All right. That's -- let's now move ahead to your
25 four year old wellness check.

Deposition of Shelley Mahaffey

1 A. Okay.

2 Q. And let me go through the developmental milestones
3 of things you like to see with a four year old when
4 examining them. She can, at this point, she can sing a
5 song?

6 A. Yes, sir.

7 Q. She can make a drawing of a person with three
8 parts?

9 A. Yes, sir.

10 Q. Tell me what that is.

11 What does that mean, drawing a person with three parts?

12 A. Just, you know, when a, when a child first learns
13 to draw a stick figure, it's a developmental milestone
14 depending on what -- how many body parts they put on there.
15 So, a three part would be at least the head and maybe legs
16 or arms or something that would be --

17 Q. Okay.

18 A. -- a progression.

19 Q. All right. At, at this visit, she knew that she
20 was a, a girl instead of a boy?

21 A. Yes, sir.

22 Q. She was able to distinguish between fantasy and
23 reality?

24 A. Yes.

25 Q. And how do you tell that?

Deposition of Shelley Mahaffey

1 How do you tell whether they can distinguish fantasy
2 from reality?

3 A. We really just kind of talk to them about whether
4 or not they pretend and things like that, whether they show
5 imagination when they play.

6 Q. All right. She was able to use words and speak in
7 full sentences?

8 A. Yes sir.

9 Q. She could say, at this point, her first and last
10 names?

11 She can say Ashley and F ?

12 A. Yes.

13 Q. Okay. She knows three or four colors?

14 A. Yes.

15 Q. And she's able to talk about her day?

16 So, you can ask her what did she do today, and she's
17 able to describe it for you?

18 A. Yes.

19 Q. And now she's moved from building a tower with
20 three or four blocks to five or six blocks of, of little
21 while -- I think your previous visit was five or six blocks.
22 Now she can build a tower with ten blocks.

23 A. Correct.

24 Q. She can hop on one foot?

25 A. Yes, sir.

Deposition of Shelley Mahaffey

1 Q. She can ride a bike that has training wheels?

2 A. Yes, sir.

3 Q. She's able to do that.

4 okay. She can throw a ball, I guess, over her head
5 instead of underhanded at this point?

6 A. Correct. Yes, sir.

7 Q. And I'm sure this is a, a big one for parents like
8 myself, she can put her toys away?

9 A. Yes, sir.

10 Q. All right. The only developmental milestone, I
11 guess, that she wasn't able to do as a four year old
12 wellness check was she couldn't button clothes.

13 Is that correct?

14 A. That's correct.

15 Q. And was that due to the, the disability she still
16 had of her left-hand?

17 A. Yes.

18 Q. Okay. So -- and her neurological exam was normal
19 again?

20 A. Yes, sir.

21 Q. And she had no delays in motor skills or speech?

22 A. Correct. Other than, than probably the buttoning.
23 Although there are four year olds who can't do that anyways,
24 but that was, that would probably be the only thing I would
25 say for that.

Deposition of Shelley Mahaffey

1 Q. All right. So, again, despite the events during
2 her birth and including the shoulder dystocia, there's no
3 evidence that she suffered any type of brain injury during
4 birth?

5 A. Correct.

6 Q. All right. Now, the function of her left arm, you
7 tested that function on this four year old wellness check?

8 A. Yes.

9 Q. All right. And that had improved significantly
10 from the previous exams.

11 Is that correct?

12 A. Correct.

13 Q. All right. She had a strong grip at this point and
14 she was able to abduct much more than the previous visit.
15 Tell me what that means, abduct.

16 A. I, I didn't actually specifically say shoulder, but
17 that would of been the range of motion of the shoulder.
18 Abduct is to be able to raise the shoulder up.

19 Q. All right. Okay. And, at this point, you're still
20 prescribing more occupational therapy for her?

21 A. Yes.

22 Q. What I'm gonna hand you next is one of the
23 occupational therapy notes, and this one's from
24 December 14th of 2012. And so this is just after she's
25 four years old, four years old, and a couple of months.

Deposition of Shelley Mahaffey

1 And, at this point, she's able to, to reach over her head
2 more than 90-degrees.

3 Is that right?

4 A. Yes.

5 Q. Can, can you show the jury what that means to be
6 able to raise your shoulder more than 90-degrees?

7 A. Is it the Number 2 that you're talking about with
8 the toy placed --.

9 Q. Yes.

10 A. Okay. She's specifically saying shoulder flexion.
11 So, I'm assuming she's meaning up this way instead of
12 abduction like I was talking about.

13 Q. Okay.

14 A. But, but I assume she's meaning this way. She can
15 reach -- obviously, this is 90. So, above, above
16 90-degrees.

17 Q. All right. And, at this point in her occupational
18 therapy, she is able to write shapes and lines?

19 A. Correct.

20 Q. And she's able to take off her, her pants on and
21 off by themselves?

22 A. Yes.

23 Q. All right. Now let's go to your six year old
24 wellness visit.

25 A. Okay.

Deposition of Shelley Mahaffey

1 Q. And, at this point, and this is on November 18th,
2 2014. At this point, Ashley is in school -- in kindergarten
3 at Taylors Elementary, right?

4 A. Correct.

5 Q. Okay. And she's in normal classes?

6 A. Yes.

7 Q. She has good school performance?

8 A. Yes.

9 Q. She has no behavior concerns?

10 A. No.

11 Q. She's isn't in any kind of special education
12 classes or anything like that?

13 A. No, sir.

14 Q. Excuse me.

15 And then, again, her neurological exam is normal. No
16 delays in motor, speech, or anything like that.

17 A. Correct.

18 Q. At this point, she's able to jump rope.

19 Is that correct?

20 A. I, I -- yeah, that's what's in here. I'm not sure
21 if she could do the rope herself, but jumping it, yes, she
22 can.

23 Q. It was either that or maybe somebody, you know --

24 A. Doing the --

25 Q. -- Double Dutch --

Deposition of Shelley Mahaffey

1 A. Exactly.

2 Q. -- and she's able to get in the middle and jump
3 rope?

4 A. Correct.

5 Q. And she plays an instrument that says.

6 A. Yes.

7 Q. What does that mean?

8 A. I'm, I'm not sure, but my nurse would of asked
9 those questions. I didn't specifically ask her what
10 instrument she played. So, I'm not sure.

11 Q. Okay. She has a lot of friends.

12 A. She does.

13 Q. And despite her left arm injury, she has high
14 self-esteem.

15 Is that right?

16 A. Yes.

17 Q. All right. And so, again, here we are, we're at
18 age six at this point, and despite what occurred during her
19 birth and the fact that she experienced shoulder dystocia,
20 we don't have any evidence of any brain injury due to lack
21 of oxygen or anything like that, right?

22 A. Right.

23 Q. Okay. Now, the last thing that I'm gonna ask you
24 about is the last examination that I have from the
25 occupational therapist in kinetics with Greenville Hospital

1 on it, and this is the, the, the occupational therapy that
2 you most recently prescribed.

3 Is that correct?

4 A. Yes, sir.

5 Q. Okay. And in this occupational therapy, she's
6 getting some therapy with swimming.

7 Is that your understanding?

8 A. I believe so, yes, sir.

9 Q. What I ask you just to turn to Page 3 of that, and
10 at the very top of the handwritten part, it says that she
11 has progressed to the point where she's able to button and
12 unbutton buttons.

13 Is that correct?

14 A. Yes, sir.

15 Q. So, that would be further progression from the
16 last, I guess, examination you have where she wasn't able to
17 do buttons. Now she can unbutton and button things.

18 A. Yes.

19 Q. All right. She can now tie her own shoes?

20 A. Yes, sir.

21 Q. Okay. So, at this point, and this was -- the date
22 of this examination was January 27th, 2015. January 27 of
23 2015, we're continuing to see improvement in her function on
24 her left arm, and she's continuing to be able to do the
25 things that she couldn't do starting at four months, going

Deposition of Shelley Mahaffey

1 to 18-months, and going on and on and on.

2 Is that right?

3 A. Yes, sir.

4 Q. I don't have any further questions for you. Thank
5 you.

6 A. Okay. Thank you.

7 REDIRECT EXAMINATION

8 BY MR. HENSHAW:

9 Q. Doctor Mahaffey, how would you describe the effort
10 that Ashley has made over her lifetime to improve function
11 in her left extremity?

12 A. She's been in therapy and occupational therapy. I
13 believe she's had physical therapy to begin with, but
14 occupational therapy at least weekly for -- since, since she
15 was a baby.

16 Q. I mean she -- and on a personal level, has she
17 worked hard?

18 A. Well, of course, yes.

19 Q. And to try to restore this?

20 A. Yes.

21 Q. She hasn't been lazy or, in any way, slackard in
22 terms of --?

23 A. No, sir. No.

24 Q. She's, she's worked hard?

25 A. Yes, sir, she has.

Deposition of Shelley Mahaffey

1 Q. And would you attribute a lot of what is happened,
2 beneficially to that left extremity, to her own hard work?

3 A. Yes, sir, I would say so.

4 Q. And that -- and the effort of her parents?

5 A. Yes, sir.

6 Q. And the -- obviously, the efforts of the therapy --

7 A. Yes, sir.

8 Q. -- therapist that have seen her?

9 A. Yes, sir.

10 Q. Despite that, does she have a normal left arm at
11 this point?

12 A. No, sir.

13 Q. And, and, doctor, is it likely that she will ever
14 have a normal left arm?

15 A. I don't know that I can answer that. It's not
16 likely. I would say no.

17 Q. All right. Is she, for example, as a little girl,
18 able to take her left arm, in combination with her
19 left-hand, in combination with her right-hand, and tie a
20 ponytail in her hair?

21 A. I don't know that specifically, that specific
22 exercise. I, I don't -- from what I can tell from the range
23 of motion, I would say no to that.

24 Q. So, does she have normal range of motion in the
25 left arm?

Deposition of Shelley Mahaffey

1 A. No, sir.

2 Q. Would you agree, doctor, that, except for the left
3 arm, if you're looking at the whole person of Ashley
4 F , that she is a completely normal little girl except
5 for that left arm?

6 A. Yes, sir.

7 Q. That's all I have. Thank you.

8 MR. WEATHERLY: No further questions from me.

9 THE VIDEOGRAPHER: This concludes the video deposition
10 of Shelley Mahaffey, MD.

11 MR. HENSHAW: Your Honor, we would next show the
12 deposition of Doctor Gurewitsch, the obstetrical expert.

13 THE COURT: And that's the---

14 MR. HENSHAW: It's approximately about an hour---

15 THE COURT: ---greater length than this?

16 MR. HENSHAW: Oh, it runs --

17 THE COURT: Yes. Okay.

18 MR. HENSHAW: -- considerably.

19 THE COURT: All right. Let's do this. Let's break for
20 lunch now. We'll come back after lunch and continue with
21 the presentation of evidence.

22 I'll ask you to please report to your jury room at
23 1:45, 1:45 this afternoon. Don't discuss the case in the
24 mean time.

25 Have a good lunch. I'll see you at 1:45.

1 (WHEREUPON, the following takes place outside the
2 presence of the jury.)

3 THE COURT: Court's in recess until 1:45.

4 MR. HENSHAW: Thank you, Your Honor.

5 (WHEREUPON, Court was in recess for the lunch hour.)

6 MR. HENSHAW: Your Honor, I apologize.

7 THE COURT: Okay.

8 MR. HENSHAW: I am so sorry.

9 THE COURT: All right. Any matters we need to address
10 before the jury is brought in?

11 MR. HENSHAW: Your Honor, our first witness, after
12 lunch, will be Ashley F .

13 THE COURT: Okay. Bring them in.

14 (WHEREUPON, the following takes place within the
15 presence of the jury.)

16 THE COURT: Good afternoon.

17 As you know, when we recessed, the plaintiff was still
18 in the midst of their presentation. So, we'll continue with
19 it this afternoon.

20 Mr. Henshaw.

21 MR. HENSHAW: Thank you, Your Honor.

22 We would call Ashley F .

23 Ashley, come up and be sworn.

24 ASHLEY F , being first duly
25 sworn, testified as follows:

1 DIRECT EXAMINATION

2 BY MR. HENSHAW:

3 Q Hello.

4 A Hi.

5 Q All right. You see that microphone in front of you?

6 A Uh-huh. (Affirmative).

7 Q Have you ever sat behind a microphone before?

8 A No, sir.

9 Q Okay. Can you scoot up a little bit so you can speak
10 more into the microphone and we can all hear you?

11 A (Witness complies.)

12 Q Tell us your name.

13 A Ashley F .

14 Q All right. Ashley, how old are you?

15 A Nine years old.

16 Q And when is your birthday?

17 A October 7th, 2008.

18 Q And you just had a birthday party?

19 A Yes, sir.

20 Q Where was that?

21 A Pump It Up.

22 Q Where was that?

23 A Pump It Up.

24 Q At Pump It Up?

25 A (Witness nods affirmatively.)

- 1 Q And what kind of birthday party did you have?
- 2 A Descendants 2.
- 3 Q And what is Descendants 2?
- 4 A It's a Disney Channel movie.
- 5 Q Okay. And is that your favorite movie?
- 6 A Yes, sir.
- 7 Q And do you have a favorite character?
- 8 A Yes, sir.
- 9 Q And who is your character?
- 10 A Evie.
- 11 Q And why do you like Evie?
- 12 A Because she makes clothes.
- 13 Q Okay. And is that something you want to do?
- 14 A Yes, sir.
- 15 Q What do you want to do when you grow up?
- 16 A Be an illustrator or make clothes and be an artist.
- 17 Q Okay. And are you doing any of that yet?
- 18 A No, sir.
- 19 Q Okay.
- 20 A I just draw.
- 21 Q You draw.
- 22 Okay. How are you doing in school?
- 23 A Good.
- 24 Q And what grade are you in?
- 25 A Third.

1 Q what school do you go to?

2 A Rudolph Gordon.

3 Q And who is your teacher?

4 A Ms. Graham.

5 Q And do you get along with Ms. Graham?

6 A Yes, sir.

7 Q Okay. Do you know why we're here today?

8 A Yes, sir.

9 Q It has to do with your arm.

10 A Yes, it does.

11 Q And, and you understand that?

12 A Yes, sir.

13 Q Okay. Can you just step down?

14 would it be all right, Your Honor, if I ask her to step
15 down in front of the jury?

16 (WHEREUPON, the Court nods affirmatively.)

17 A (Witness complies.)

18 Q You understand that, that we all need to be able to see
19 your arm?

20 A Uh-huh. (Affirmative).

21 Q Is that okay by you?

22 A (Witness nods affirmatively.)

23 Q That's a yes?

24 A Yes.

25 Q All right. You---

1 THE COURT: Now, now---

2 Q You need to speak up.

3 THE COURT: Yeah.

4 Mr. Henshaw, I don't know -- it's fine for her to step
5 down so that you can show what you need to show, but you
6 can't ask her questions while she's there because we can't
7 hear her over here.

8 MR. HENSHAW: All right, sir. Okay.

9 Okay. So, turn toward the jury?

10 A (Witness complies.)

11 Q And hold your arms down by your side?

12 A (Witness complies.)

13 Q Okay. Now, can you hold your arm up like this please?

14 A (Witness complies.)

15 Q Okay. And can you raise your arms?

16 A (Witness complies.)

17 Q And can you hold your arm straight out please?

18 A (Witness complies.)

19 Q Okay. All right. Have a seat.

20 A (Witness complies.)

21 Q Do you remember the surgeries that you went through?

22 A No, sir, just one.

23 Q Okay. And, and did you do okay with that?

24 A Yes, sir.

25 Q Okay. And how do you, do you get along with the arm,

1 the arm in school?

2 A Sometimes.

3 Q What does that mean sometimes?

4 A In gym, I have to find a way how to do push-ups and
5 some things too.

6 Q Okay. Now, are you playing any sports?

7 A No, sir.

8 Q Do you hope to?

9 A No, sir.

10 Q Are you swimming?

11 A No, sir.

12 Q Do you hope to -- are you not planning on doing any
13 swimming?

14 A No, sir. Well, yes.

15 Q Okay. Tell us about that.

16 A I use to swim, but then I quit because I was a little
17 afraid.

18 Q Okay. Now, can you tie your shoe?

19 A Yes, sir.

20 Q How long have you been able to tie your shoe?

21 A Since I was three years old.

22 Q And what about on the playground, can you jump rope?

23 A Yes, sir.

24 Q And how do you jump rope?

25 A I put the rope in front of me and turn it back.

Ashley F - Direct examination
by Mr. Henshaw

1 Q Okay. You go backwards?

2 A Yes, sir.

3 Q Okay. What else do you like to do?

4 A Play soccer for fun --

5 Q Okay.

6 A -- and draw and color.

7 Q Okay. Do you have any problem with people looking at
8 you or staring at you?

9 A Yes, sir.

10 Q And tell us about that.

11 A I get nervous and I get upset sometimes because, in
12 public, if I go to a store with the mom -- the mall, the
13 mall with my mom, people -- sometimes people stare at me and
14 I don't like that.

15 Q Okay. How do you deal with it?

16 A I just leave it alone and I look around and I just stop
17 looking.

18 Q Do any of your friends ever talk to you about, about
19 your arm?

20 A They ask me what -- why is your arm bent and they try
21 to straighten it.

22 Q Okay. And what do you tell them?

23 A I can't do that because I have an injury.

24 Q Okay. Ashley, that's all the questions I have for you.
25 Please answer any questions that Mr. Lovell may have. This

Ashley F - Cross-examination
by Mr. Lovell

1 is Mr. Lovell over here.

2 CROSS-EXAMINATION

3 BY MR. LOVELL:

4 Q Hey, Ashley. We have not met, but I don't have any
5 questions for you today. Thank you.

6 A Okay. Thank you.

7 MR. HENSHAW: Ask that she be allowed to step down and
8 be released, Your Honor.

9 THE COURT: She may.

10 Thank you, Ashley.

11 THE WITNESS: Thank you.

12 MR. HENSHAW: Your Honor, at this time, we will publish
13 the deposition of Doctor Gurewitsch by way of videotape.
14 This is been edited pursuant to discussions with defense
15 counsel.

16 THE COURT: Okay.

17 (WHEREUPON, the following is the videotaped deposition
18 of Doctor Gurewitsch.)

19 EDITH GUREWITSCH, being first duly
20 sworn, testified as follows:

21 DIRECT EXAMINATION

22 BY MR. HENSHAW:

23 Q. Please state your full name.

24 A. Edith Gurewitsch.

25 Q. Doctor Gurewitsch, we're here today to take your

Deposition of Edith Gurewitsch

1 deposition.

2 Have you participated in deposition proceedings before?

3 A. Yes.

4 Q. What is your occupation?

5 A. I'm an obstetrician/gynecologist.

6 Q. And where do you practice medicine?

7 A. At Johns Hopkins Hospital in Baltimore, Maryland.

8 Q. Okay. Do you hold a faculty position there?

9 A. I do.

10 Q. And what is that faculty position?

11 A. I am an associate professor in the Division of
12 Maternal Fetal Medicine.

13 Q. So, you teach obstetrics and gynecology?

14 A. Yes, sir.

15 Q. Do you also practice and actually participate in
16 the delivery of babies?

17 A. Yes.

18 Q. How do you -- how are those responsibilities
19 divided in your particular practice?

20 A. Well, the teaching that we do is essentially
21 on-the-job training. So, clinical practice is accompanied
22 by residents and fellows and medical students who are
23 simultaneously learning while we're treating patients.

24 Q. All right. Do you deal with complications of
25 pregnancy in your practice?

Deposition of Edith Gurewitsch

1 A. Yes.

2 Q. Do complications of pregnancy include a condition
3 known as shoulder dystocia?

4 A. Yes.

5 Q. What is shoulder dystocia?

6 A. Shoulder dystocia, the word dystocia means
7 difficult delivery or difficult labor. Shoulder dystocia is
8 a difficult delivery due to the infant's shoulder being
9 caught. So, that -- this is a condition at the really -- at
10 the last point of birth after the head has delivered through
11 the vagina, and it's outside, but the body has not yet
12 delivered. Normally that would follow very quickly in a
13 matter of seconds. But, instead, the, the body is prevented
14 from delivering such that it's because the shoulder is
15 caught up against the mother's, the mother's pubic bone.

16 Q. Okay. Now, in addition to participating -- well,
17 first of all, have you delivered babies where shoulder
18 dystocia had occurred?

19 A. Yes.

20 Q. And have you researched the subject of shoulder
21 dystocia?

22 A. Yes.

23 Q. What type of research have you done?

24 A. A number of different types of research.

25 Retrospective, simulated, delivery training, analysis of

Deposition of Edith Gurewitsch

1 various maneuvers and their effect on the brachial plexus,
2 methods by which to improve the outcome of shoulder
3 dystocia, training for shoulder dystocia and the like.

4 Q. Where did you attend and graduate from Medical
5 School?

6 A. Columbia University's College of Physician and
7 Surgeons.

8 Q. And when was that?

9 A. That was in 1991.

10 Q. And, after 1991, did you continue to stay in
11 academic medicine as well as practice medicine?

12 A. So, after medical school, I did a residency in
13 obstetrics and gynecology.

14 Q. Where was that?

15 A. At Cornell. That was from '91 to '95, and then I
16 did a two year fellowship in maternal fetal medicine also at
17 Cornell from '95 to '97. And then I came to Johns Hopkins
18 and I've been there ever since. So, I've been there 20
19 years.

20 Q. What is a fellowship in maternal fetal medicine?

21 A. So, most obstetrician/gynecologist will enter
22 practice, whether it's academic or private practice, after
23 completing a residency. Those who are interested in
24 subspecializing, there's a number of different
25 subspecialties. For example, those who do in vitro

Deposition of Edith Gurewitsch

1 fertilization are specialize -- specialists in reproductive
2 endocrinology. Those who are interested in gynecologic
3 cancer would do gynecologic oncology, and those of us who
4 are interested in complications of pregnancy, high risk
5 pregnancy, we do a fellowship in maternal fetal medicine.

6 Q. So, once you completed that fellowship, that's when
7 you joined the faculty at Johns Hopkins?

8 A. Yes.

9 Q. When did you begin to turn your attention to
10 researching and writing and you've written about shoulder
11 dystocia as well.

12 Is that correct?

13 A. Yes.

14 Q. When did you turn your attention to researching and
15 writing about shoulder dystocia as a complication of
16 pregnancy?

17 A. Around 2003.

18 Q. And have you continued to be involved in that type
19 of research and writing?

20 A. Yes.

21 Q. Is -- does it remain a matter of particular
22 interest to you?

23 A. Yes.

24 Q. Now, in, in addition to your faculty assignment in
25 the Department of Obstetrics and Gynecology, do you also

Deposition of Edith Gurewitsch

1 hold positions in other departments?

2 A. I have a joint appointment in biomedical
3 engineering.

4 Q. Now, what is biomedical engineering?

5 A. Biomedical engineering is application of
6 engineering concepts to medical conditions usually to solve
7 medical problems, to research, develop devices, things like
8 that.

9 Q. Now, has that, in any way, helped you in your
10 research in shoulder dystocia matters or is it related in
11 any way to the, to the research that you have done?

12 A. The research that I've done is -- it involves the
13 analysis of forces involved in birth and involved in
14 stretching the brachial plexus, and because of the research
15 I've done in collaboration with biomedical engineering, you
16 know, that's the reason for the joint appointment.

17 Q. I see.

18 Now, you've mentioned the term brachial plexus several
19 times. Please explain what brachial plexus is.

20 A. The nervous system is composed of the central
21 nervous system, which is the brain and the spinal cord, and
22 the peripheral nervous system, which controls sensation and
23 movement of various parts of the body. The brachial
24 plexus -- and those are all -- the peripheral nerves arise
25 from and, and contribute to the spinal cord so that

Deposition of Edith Gurewitsch

1 sensations that you might feel, for example, are transported
2 back to the brain, to the spinal cord, and then, both
3 voluntary and reflex movement, is transmitted from the brain
4 through the spinal column -- spinal cord out to the
5 peripheral nervous system.

6 The brachial plexus is a series of nerve roots that
7 arise from the spinal cord from the level of C5, cervical,
8 cervical vertebrae 5, to---

9 Q. Is that in the area of the neck?

10 A. Yes, and then down to the thoracic -- the first
11 thoracic vertebrae, which is right at the, at the level of
12 the rib cage. So, the brachial plexus arises from, from the
13 neck here and then it traces down across the shoulder and
14 down the arm, and it controls sensation and movement of the
15 shoulder, elbow, wrist, and hand.

16 Q. So, you -- are the nerves that comprise the
17 brachial plexus, do they include the, the designations of
18 nerve C5, C6, C7, C8, and T1?

19 A. Yes.

20 Q. So, basically five nerves?

21 A. Yes.

22 Q. And are they significant to the work you do in
23 shoulder dystocia cases?

24 A. Yes.

25 Q. And why is that?

Deposition of Edith Gurewitsch

1 A. Because the shoulder is stuck on the pubic bone,
2 if---

3 Q. The pubic bone of the mother?

4 A. Yes. And the baby's shoulder is, is obstructed by
5 the pubic bone of the, of the mother, and the delivering
6 clinician, whether it's a, a doctor or a midwife, isn't
7 careful in recognizing and managing the obstruction, injury
8 to the brachial plexus can occur, and sometimes that can be
9 a permanent injury.

10 Q. So, in terms of the work that you're doing, does it
11 include trying to prevent or teach doctors how to prevent
12 brachial plexus injuries?

13 A. Yes.

14 Q. And you've been doing that since approximately
15 2000---

16 A. Three.

17 Q. 2003.

18 Now -- and you do this in conjunction with your
19 husband?

20 A. Part, part of it, yes, we, we work together. We've
21 done research together.

22 Q. And what is your husband's occupation?

23 A. He's a biomedical engineer.

24 Q. And where does he work?

25 A. He just retired from Hopkins.

Deposition of Edith Gurewitsch

1 Q. Okay. So, the two of you work together.

2 Have you written on the subject together?

3 A. Yes.

4 Q. And what types of articles have you written on, on
5 the subject of shoulder dystocia and brachial plexus injury?

6 A. We've written original research articles, review
7 articles. We have been invited to talks, scientific
8 presentations at scientific meetings.

9 Q. Have you also served as an expert witness in
10 medical cases before this?

11 A. Yes.

12 Q. In what jurisdictions have you been recognized as
13 an expert or how many jurisdictions?

14 A. Across the United States.

15 Q. Okay. More than, more than ten states?

16 A. Yes.

17 Q. Okay. More than 20?

18 A. I believe so, yeah.

19 Q. Okay. And so in terms of your expertise or your
20 practice in, in the field of medicine, have you come to
21 recognize that there are generally recognized and accepted
22 standards of care for how obstetricians are expected to deal
23 with a condition of shoulder dystocia if they encounter it?

24 A. Yes.

25 Q. Are obstetricians trained in how to deal with

Deposition of Edith Gurewitsch

1 shoulder dystocia?

2 A. Yes.

3 Q. And when does that training begin?

4 A. Actually it begins in medical school. There's
5 awareness of it in terms of actually managing it that would
6 start in your residency.

7 Q. In the residency.

8 A residency is, is what?

9 A. It's your training period but -- it's four years
10 --.

11 Q. Following medical school?

12 A. Correct. It's four years for obstetrics and
13 gynecology.

14 Q. And is it during that period that doctors are first
15 allowed to actually participate and, and, and actually take
16 the role of delivering a baby that's hung up on the mother's
17 pelvis because of shoulder dystocia?

18 A. Yes.

19 Q. Is that done with a experienced doctor such as
20 yourself standing by and observing and instructing where
21 necessary?

22 A. Yes.

23 Q. And, in some occasions, is it necessary for the
24 experienced doctor to take over and deliver the baby?

25 A. Yes.

Deposition of Edith Gurewitsch

1 Q. Have you had to do that?

2 A. Yes.

3 Q. Now, the, the articles or the, the written
4 materials -- the, the writings that you've done, either on
5 your own or with your husband, have they been submitted --
6 what, what type of journals have they been submitted to and
7 published?

8 A. They're known as peer reviewed journals. They're
9 professional journals. We send a manuscript summarizing
10 your methods, your objectives, results, and conclusions.
11 You -- before publication, the manuscript is usually sent to
12 two or three reviewers, who are familiar with the same type
13 of research, for their critical evaluation, and if they
14 believe it's worthy of publication, they will essentially
15 give -- submit a report to editors who then make a decision
16 about publication.

17 Q. Do you know how many articles you've submitted for
18 peer review and publication related to shoulder dystocia?

19 A. About 12 or 13.

20 Q. Okay. And overall, in terms of your series of
21 publications, how many publications have you had in your
22 career?

23 A. Well, they're, they're sort of divided into
24 different categories, but about 45 publications.

25 Q. And, and 12 to 14 of those have been specifically

1 related to the subject of shoulder dystocia?

2 A. Yes.

3 Q. Now, based upon your experience, training, and
4 knowledge, were you familiar with generally recognized and
5 accepted standards of care related to a doctor's management
6 of shoulder dystocia in the timeframe of October 2008?

7 A. Yes.

8 Q. And were there generally recognized and accepted
9 standards of care related to the management of the condition
10 of shoulder dystocia in that, in that timeframe?

11 A. Yes.

12 Q. Essentially, in summary, what was a doctor expected
13 to do, if he's in the process of delivering a baby, the
14 baby's head comes out, and, and, unfortunately, the shoulder
15 becomes entrapped and shoulder dystocia has occurred?

16 A. Well, first, and most important thing, is to
17 recognize that that has happened. That can occur in one of
18 two ways or, or both ways. Either the head, after it has
19 delivered, pulls back just slightly, not all the way back
20 into the vagina, but it retracts against the mom's bottom,
21 which would indicate that the body is not following as, as
22 it normally would.

23 Q. Is that called turtling?

24 A. That's called a turtle sign or a---

25 Q. Or a turtle sign.

1 A. It's a little bit of a misnomer because a turtle
2 actually pulls its head all the way back into its shell.
3 That's not what we mean with the turtle sign. It just means
4 that the head pulls back a little bit against, against the
5 body or, more commonly, after the head has delivered, a
6 clinician is expecting that, with usual guidance, that the
7 body will deliver on its own and instead encounters
8 resistance.

9 The standard of care would then be to stop what you're
10 doing, and then proceed with a series of maneuvers that,
11 that would -- are designed to release the obstruction, the
12 impaction, and throughout that process, it -- the standard
13 of care is to be used no more force than you would use in a
14 delivery that's not complicated by shoulder dystocia because
15 it's the force that is potentially going to cause an injury.
16 Especially to the brachial plexus.

17 Q. And was that the standard of care in October of
18 2008?

19 A. Yes.

20 MR. HENSHAW: At this time, I would offer Doctor
21 Gurewitsch as an expert in obstetrics and specifically in
22 the area of shoulder dystocia and brachial plexus injury.

23 MR. WEATHERLY: No objection.

24 Q. Doctor Gurewitsch, at my request, have you reviewed
25 materials related to the labor and delivery of Ashley

Deposition of Edith Gurewitsch

1 F at Spartanburg Regional Healthcare Hospital on
2 October 7, 2008?

3 A. Yes.

4 Q. Okay. Can you give us a summary of the pertinent
5 facts that you determined from the review of materials?

6 A. This was her first pregnancy that she carried to
7 term. It was complicated by gestational diabetes. The
8 labor progressed normally. The -- at the point that she
9 became fully dilated, 10-centimeters dilated, and began to
10 push, a decision was made to use a vacuum to assist with the
11 delivery such that the second stage of labor was shortened
12 to 13-minutes, which is considered a precipitous second
13 state. So, she had an operative vaginal delivery and
14 precipitous second stage of labor.

15 There was a complication of shoulder dystocia. It was
16 recognized by Doctor Giep, her obstetrician who was
17 performing the vacuum assisted delivery. He responded by
18 calling for McRoberts position and suprapubic pressure.

19 Q. Now, these are the -- this -- these are maneuvers
20 that can be utilized in the face of shoulder dystocia?

21 A. Yes.

22 Q. I'm sorry. I may have cut you off.

23 A. No, that's okay. And after somewhere between one
24 minute and two minutes, the -- a baby girl was delivered
25 weighing 7-pounds 11-ounces, and immediately, on delivery,

Deposition of Edith Gurewitsch

1 there was notice that the left arm was not moving normally.
2 ultimately, that -- usually 90 percent of those will
3 recover, but this, but this one did, and it required surgery
4 to repair the brachial plexus, and there are still deficits
5 that remain today.

6 Q. All right. Now, you mentioned McRoberts maneuver.
7 Please explain what that is.

8 A. Probably the best way to explain is to give an
9 example of trying to move a piece of furniture through a
10 door. So a lot of times, if you line up the furniture in
11 one particular dimension, it's not gonna fit through the
12 door. But if you either tilt the door or you tilt the piece
13 of furniture, it will fit through the door. So, McRoberts
14 is essentially the equivalent of tilting the door.

15 So, if you imagine that the, that the shoulders are
16 lined up vertically, and that the pubic bone is actually
17 a -- essentially a, a doorway, McRoberts maneuver is where
18 you take the mom's legs out of the stirrups, bend her knees
19 sharply back against -- towards her shoulder, and what that
20 does is it rolls the pelvis backwards so that the pubic bone
21 will, will be elevated some relative to the position of the
22 shoulders.

23 Q. So, it changes the angle that the---

24 A. It changes---

25 Q. ---baby's body is coming out?

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1 A. Relative to the pubic bone exactly. Now, if the
2 baby is -- if that doesn't work, then that will just pull
3 the, the shoulder further back. So, if that's not working,
4 then you would try to do a different maneuver.

5 What was done in this case was supra, was suprapubic
6 pressure. That's actually also done by the nurses. I
7 neglected to say, when you take the, the mother's knees and,
8 and flex them backwards, that's done with the assistance of,
9 of nurses. The, the clinician, the delivering clinician
10 still has their hands on the baby's head, and still guiding,
11 guiding the delivery, and the standard of care requires that
12 you wouldn't use any more level of force trying to get that
13 baby delivered. Because if it actually works, if McRoberts
14 position works, then the shoulder should be free now, and it
15 wouldn't need any more than usual delivery traction to get
16 the baby out.

17 So, with that not working, you shouldn't repeat over
18 and over or pulling on that baby's head. Same thing with
19 suprapubic pressure. Suprapubic pressure -- so, if you
20 imagine that the shoulder is right behind the pubic bone,
21 that you can actually feel that shoulder right above the
22 mother's pubic bone on her, on her abdomen, on the belly,
23 the -- a nurse can come from behind the baby's shoulder
24 essentially -- usually with a fist or with a, with the heel
25 of their hand to try to roll the baby off to a diagonal

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1 position rather than the straight up and down of the
2 shoulders.

3 Q. So, suprapubic pressure is applied by the nurse or
4 by the doctor?

5 A. By the nurse.

6 Q. And is it applied just above the pubic bone with
7 the, with the nurse's hand?

8 A. Yes.

9 Q. So, does that indicate then that, if suprapubic
10 pressure was used in this case, that Doctor Giep, in
11 instructing the nurse to apply this pressure, felt like that
12 the shoulder that was being hung up was the, the shoulder
13 that was in front of the mother's belly -- in the, in the
14 front of the mother's belly or what they call the anterior
15 position?

16 A. I think I understand what you're asking.

17 The -- when the shoulders are caught in a shoulder
18 dystocia, the most common, better than 90 percent of the
19 time, it's the shoulder that's behind the pubic bone and not
20 behind the, the sacrum --

21 Q. Okay.

22 A. -- that which is the back bone --

23 Q. Okay.

24 A. -- of the pelvis. So, so, that's why suprapubic
25 pressure is, is applied just behind, just above the, the

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1 pubic bone to try to move the shoulder off that -- off angle
2 so that it can slip out underneath the pubic bone.

3 Q. But if a -- but if a doctor directs the nurse to
4 apply suprapubic pressure, does that mean he believes that
5 it's the shoulder that's upward that is hanging up, and he's
6 trying to get that pushed down below the pubic bone?

7 A. I mean that's what's most likely. Unless he feels
8 it, though, he's not gonna know.

9 Q. Okay.

10 A. But it's a reasonable thing to ask her.

11 Q. Okay. There are cases where the lower shoulder can
12 get hung up, as you say, on the -- on a location known as
13 the sacral promontory?

14 A. Yes.

15 Q. But that's less likely?

16 A. Much less likely, yes.

17 Q. All right. Now, in, in this particular case,
18 you -- was McRoberts maneuver the appropriate maneuver to
19 undertake by Doctor Giep when he realized there were
20 shoulder dystocia?

21 A. As an initial maneuver, yes.

22 Q. Okay. Was suprapubic pressure an appropriate thing
23 to do once he recognized that there was shoulder dystocia?

24 A. Yes.

25 Q. Now, you mentioned that there could be other

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1 maneuvers that he might utilize if those did not work.

2 Can you give us an explanation of those possibilities?

3 A. So, the most common for obstetricians, after trying
4 McRoberts and suprapubic pressure, would be to actually
5 reach in past the head into the vagina, and actually try to
6 move the body in some way. So, there's a number of options.
7 You can try, in a similar way to the suprapubic pressure, to
8 just maybe roll the butt, the body only about 30-degrees,
9 either clockwise or counterclockwise depending on the
10 position, so that the shoulders are no longer straight up
11 and down but are in a diagonal relative to the pelvis, which
12 is a, a roomier way to fit through the door so to speak or
13 you can actually turn the baby 180-degrees. That actually
14 creates a forward motion and so it's more like a winding
15 motion.

16 Q. Is that some kind of pelvic corkscrew maneuver?

17 A. Right. So, that's sometimes called corkscrew or
18 Woods screw after the clinician who, who described that
19 maneuver. So that can be done because that can also, in
20 that winding process, essentially wind the baby right out
21 from the obstruction.

22 Another possibility is to take the arm that is lowered
23 down in a -- towards, towards the mom's bottom and attempt
24 to deliver that first. And that would be sort of the
25 equivalent of, let's say, a, a truck was stuck, was too big

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1 to fit under an overpass. It would be the equivalent of
2 letting the air out of the tires. So, it will let the whole
3 body sink down so that it would fit to come through and
4 that's called---

5 Q. What is that maneuver called?

6 A. Delivering the posterior arm. It has other names,
7 but that's the most common.

8 Q. Have you ever heard of a term called the Rubin
9 maneuver?

10 A. So, the 30-degree rotation is also known as Rubin's
11 maneuver.

12 Q. Now -- and you reviewed the labor and delivery
13 records?

14 A. Yes.

15 Q. And what did you find in the labor and delivery
16 records as the type of maneuvers that were used to deliver
17 Ashley F ?

18 A. McRoberts and suprapubic pressure were what was
19 listed and suprapubic pressure---

20 Q. Okay. Were any others listed?

21 A. ---was listed by the nurse, and McRoberts and
22 suprapubic pressure was in Doctor Giep's delivery --
23 written, handwritten delivery note.

24 Q. And did you find any other maneuvers indicated by
25 the medical records?

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1 A. No.

2 Q. And did you review any of the depositions?

3 A. Yes.

4 Q. Did you find that Doctor Giep indicated in his
5 deposition that he used another maneuver of some type?

6 A. Yes.

7 Q. And what did -- what was that?

8 A. The Rubin maneuver.

9 Q. And would that have been appropriate?

10 A. It, it would of. All three, however, McRoberts,
11 suprapubic, and Rubins, all involve still repeating traction
12 on the baby's head. And so, while the maneuvers themselves
13 are appropriate, it's the traction that is applied that
14 risks the brachial plexus.

15 Q. Okay. And so, in this case, is the question
16 whether -- not whether Doctor Giep used appropriate
17 maneuvers, but whether he used an amount of traction that
18 was unnecessary for the delivery?

19 would that be an appropriate way to question -- to ask
20 the question?

21 A. Yes, I think that's fair.

22 Q. And, and based upon the outcome, do you have
23 opinions about whether or not Doctor Giep met the standard
24 of care in the amount of traction that he applied?

25 A. So, there are a number of things that are

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1 noteworthy. So, first of all, the fact that there was a
2 shoulder dystocia, the fact that this was a permanent
3 injury, the fact that it was evident immediately at birth,
4 that there wasn't any evidence that the injury was
5 longstanding, meaning it had occurred months early while in
6 utero, which would of presented as a, a withered arm that
7 was already of a different length. Some of the things we
8 see later in, in the baby were not evident at birth. So, it
9 suggested that, that -- an injury that occurred during the
10 birth process.

11 The nature and extent of the injury. So, extent means
12 how many nerve roots were involved. The -- almost the
13 entire brachial plexus was involved. C5, C6, C7, and C8 all
14 required some degree of surgical repair or dissection, and
15 nerve grafts were needed to, to overcome the lack of --
16 essentially there was a, a split of the nerves, a rupture of
17 the nerves, C5, C6, and C7, that, that -- so that such that
18 there was no longer nerve conduction and there -- it would
19 never recover without a graft.

20 Q. When you say nerve conduction, are you referring to
21 the signal that gets transmitted from the brain, through the
22 nerve itself, to whatever muscle that needs to be
23 innervated?

24 A. Yes, it's not even necessarily of the, of what we
25 call voluntary motion. Like if I were to decide I want to

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1 pick up this pencil from the, from the desk, the brain sends
2 a signal and I voluntarily move my arm, obviously through
3 nerve signals, to, to various muscles but even reflexes.
4 So, if I touch something hot, you pull away, which only goes
5 to the spinal cord, but it still has to go out through the,
6 the brachial plexus nerves in order to get that muscle
7 contraction to, to pull your hand away.

8 Q. So, in Ashley F case, was she subsequently
9 treated and the types of nerve injuries identified in, in
10 her arm?

11 A. Yes.

12 Q. And, and which shoulder or arm was affected?

13 A. Her left shoulder and arm.

14 Q. And---

15 A. Her left brachial plexus actually.

16 Q. In your opinion, is that most likely the shoulder
17 that was up against the pelvis during the delivery?

18 A. Statistically so. We don't know from the record.

19 Q. The record does not specifically identify that?

20 A. No.

21 Q. Now, the, the types of injury to these nerves, were
22 they all the same, C5 through C8, or did -- were they -- did
23 they vary?

24 A. They varied.

25 Q. So, what do you understand, from the review of

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1 medical records, as to how they varied?

2 A. So, the injury to the nerves of the lower plexus,
3 like C8 and -- could -- essentially were involved and
4 scarred, but if you loosen the scar, then there was return
5 of, of nerve conduction. So, just the dissection alone was
6 able to restore some function.

7 Q. That scarring around C8, is that called a neuroma
8 --

9 A. Yes.

10 Q. -- when it occurs?

11 A. Yes.

12 Q. And is it significant to you that scarring formed
13 around the C8 nerve?

14 A. It indicates that the nerve was injured and
15 underwent a process of scarring.

16 Q. Okay.

17 A. A neuroma is a scar.

18 Q. And so -- and what about the other nerve, C5
19 through C7, what type of injury did they have?

20 A. So, even once they were dissected freely from the
21 scar, they still could not conduct nerve impulses. And so
22 grafts were, were -- essentially the damaged area was
23 spliced out and then grafted.

24 Q. Okay.

25 A. Replaced.

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1 Q. Did, did -- was the term rupture ever used?

2 A. No. Essentially nonconduction means that
3 there's -- that, that there is a, a, a gap in the nerve
4 tract such that there -- that it's not going to recover. As
5 opposed to basically the nerve root was actually pulled out
6 of the spinal cord. That would be called an avulsion, and
7 that -- you would need to do a transfer because, if it's
8 pulled out of the spinal cord, you can fix it all you want
9 out here with grafts, but it's never gonna communicate with
10 the spinal cord. But that wasn't---

11 Q. Cause it's not---

12 A. ---the case.

13 Q. ---connected up?

14 A. Correct.

15 Q. But the types of injuries that were found by the
16 doctors who later treated Ashley, do they, in any way, form
17 a basis of any opinion you may have as to what happened
18 during the delivery?

19 Q. Well, in order to get the brachial plexus, which,
20 as I described earlier, comes out of the lower portion of
21 the neck and comes out across the shoulder. So, it's almost
22 perpendicular to, to the spinal column. If the baby's head
23 is coming out of the vagina, and the shoulder is stuck up
24 here, and you pull downward very sharply so that you're
25 getting this motion, ear to shoulder away from the top

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1 shoulder, then you will stretch the brachial plexus nerves.

2 Now, we're all able to do this without injuring our
3 brachial plexus. We can even have a temporary injury where
4 it's pulled quite a bit, and then it takes a couple days to
5 recover, but a permanent injury is when you -- when it
6 actually snaps the nerve, and then the only way to fix that
7 would be with a, with a reconstruction of the brachial
8 plexus using grafts.

9 Q. Do you have an opinion, to a reasonable degree of
10 medical certainty based upon your experience, training, and
11 knowledge, as to what type of injury or damage occurred to
12 Ashley F C5, C6, C7, and C8 nerves?

13 A. I mean I think we've been through this.

14 Q. I understand, but, but I'm asking it to---

15 A. It required---

16 Q. ---an opinion---

17 A. It required primary reconstruction.

18 Q. Okay. And, in your opinion, was it most likely a
19 stretch injury that caused that damage that required---

20 A. Yes. Yes, it was definitely a stretch injury.

21 Q. And that would be your opinion to a reasonable
22 degree of medical certainty?

23 A. Yes.

24 Q. Is that, is that based upon your research?

25 A. No, I think any treating neurologist would, would

1 agree that the type of injury with a neuroma, and the
2 pattern that was noted with a stretch injury, an injury of
3 stretch, not of compression or infection or some sort of
4 congenital maldevelopment or something like that.

5 Q. Do you have an opinion, to a reasonable degree of
6 medical certainty based upon your experience, training, and
7 knowledge, as to what the mechanism of stretch was that
8 could cause that injury?

9 A. Well, the only way you can get the head to bend in
10 that direction, which is, is, is not only sufficient to
11 cause an injury, but necessary. In other words, you've got
12 to get the head to bend laterally. If I were to put the
13 same force straight perpendicular, I would barely move the
14 brachial plexus, but it -- the more I bend the head, ear to
15 the opposite shoulder, the more stretch and the more nerve
16 roots would become affected.

17 So, in the case of a head first presenting vaginal
18 delivery complicated by shoulder dystocia, there is
19 scientific evidence that about 35 to 40-pounds of force
20 applied more than 45-degrees away from the vertical axis is
21 required to produce a, an injury of that extent.

22 Q. Now, if you -- you've already stated that there was
23 a standard of care in 2008 related to the obstetrician not
24 applying unnecessary amount of traction while the
25 obstetrician held the baby's head during the, the maneuvers

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1 to deliver the baby.

2 A. Yes.

3 Q. What about, in regard to the tilting of the head
4 that you've just spoken about, were there a standard -- was
5 there a standard or standards of care applicable to what a
6 obstetrician should do in that circumstance?

7 A. Yes, I mean that's all part of the same standard,
8 which is that, when you apply -- when you guide the head out
9 from -- during a delivery, that it, it be balanced so that
10 the -- you're not having a, a significant deviation of more
11 than 45-degrees away in one direction or the other. That
12 would be part and parcel of---

13 Q. Either upward or downward force?

14 A. Ordinary traction, which is what you're -- the
15 standard of care requires that you use no more than, than,
16 than what would be required in the delivery, but that's
17 unobstructed, cause if you've relieved the obstruction, you
18 shouldn't need that. And if you do any more than that, then
19 you haven't relieved the obstruction and you need to do
20 something else.

21 Q. Now, why does an obstetrician such as Doctor Giep
22 need to have his hands on the baby's head in this situation
23 at all?

24 A. There isn't a way that the baby was going to come
25 out unless there's some, some guidance during maneuvers that

1 are essentially indirect, and they're just having the mom
2 change position or apply suprapubic pressure. That doesn't
3 help the baby actually deliver.

4 Q. So, in this situation, did Doctor Giep have to have
5 his hands on the baby's head?

6 A. Yes.

7 Q. In order to be able to facilitate the delivery?

8 A. Yes.

9 Q. But are you questioning whether, when he had his
10 hands on the baby's head, whether he maintained -- whether
11 he stayed within the standard of care as to, number one, the
12 amount of traction or pulling that he would do and whether
13 or not he tilted the baby's head so severely that it would
14 stretch the nerves in the baby's neck?

15 A. Yes.

16 Q. And based upon the researching that you've done or
17 that you know has been done by others, do you have an
18 opinion, to a reasonable degree of medical certainty, as to
19 how much traction Doctor Giep most likely applied?

20 A. It would be at least 30, 35, to 40-pounds of, of
21 force since all the evidence that we have is not from live
22 births. And so the, the, the dead tissue is more fragile,
23 and we know that 35 to 40-pounds of force would produce
24 multiple level, nerve root level injury, would produce
25 ruptures of the nerve tract. So, at least that much.

1 Q. And, in your opinion to a reasonable degree of
2 medical certainty, based upon your experience, training, and
3 knowledge, was 35 to 40-degree -- 40-pounds of pressure
4 necessary to deliver Ashley F ?

5 A. In my opinion, it was not.

6 Q. And what is that based on?

7 A. Because the shoulder dystocia itself only lasted
8 between one and two minutes. Let's just say one and a half
9 minutes for the sake of argument. But even if it had lasted
10 two minutes, ultimately the baby was able to come out doing
11 McRoberts and suprapubic, but there would of been no
12 justification for pulling that hard and that soon in a
13 shoulder dystocia. So, more likely the baby rotated a
14 little bit on its own over that minute and a half, and the
15 obstruction relieved on its own, and -- but, in the mean
16 time, a significant amount of traction was being applied
17 that was unnecessary.

18 Q. Now, do you have an -- and I may of already asked
19 this, but just to be sure that I've covered it.

20 Do you have an opinion, to a reasonable degree of
21 medical certainty, as to the amount of tilt or upward or
22 downward pressure on the baby's head that was applied to --
23 by Doctor Giep in this case?

24 A. That it was at least 45-degrees.

25 Q. Now, in your opinion to a reasonable degree of

1 medical certainty, was that necessary or unnecessary to
2 deliver this baby?

3 A. It would be improper.

4 Q. Do you have an opinion as to whether or not that
5 caused or contributed to the, the nerve injuries that Ashley
6 F suffered?

7 A. I believe it did.

8 Q. Now, what is the basis of, of that opinion that
9 this was an unacceptable amount of upward or downward
10 pressure on the baby's head?

11 A. Just as I said, in a normal delivery or an
12 unobstructed delivery, which is the standard that would be
13 held to, that you wouldn't use traction that was different
14 from that. You need to have a balance of a -- of the head
15 so that it, it's remaining fairly closely aligned with the
16 spinal cord and not deviated significantly in either
17 direction.

18 Q. Now, Doctor Gurewitsch, based upon your experience,
19 training, and knowledge, do you hold any opinions that there
20 were forces beyond Doctor Giep's control that caused injury
21 to Ashley F brachial plexus?

22 A. I do not.

23 Q. Have you ever heard the term maternal forces of
24 labor?

25 A. Yes.

1 Q. what does that -- what does that mean to you?

2 A. That it would be the pushing force generated by the
3 uterine contractions themselves, coupled with the mother's
4 pushing effort, you know, where she's bearing down to push
5 the baby out.

6 Q. Do you have any reason to believe that the, that
7 any maternal forces of labor caused or contributed to Ashley
8 F having this degree of brachial plexus injury?

9 A. I do not.

10 Q. Now, are there, in fact, degrees of brachial plexus
11 injury that a baby can experience because of shoulder
12 dystocia?

13 A. Yes, about 30-percent of babies that -- whose
14 delivery was complicated by shoulder dystocia will have some
15 injury to the brachial plexus. As I said before, 90 percent
16 of those are temporary injuries that usually resolve
17 quickly. Some can take up to a year to two years to
18 resolve, but still resolve completely without -- with just
19 some physical therapy.

20 Q. Would Ashley F brachial plexus injury be
21 considered a temporary injury?

22 A. No.

23 Q. Would it -- how would it be characterized?

24 A. It would be permanent.

25 Q. And does that make a difference then in terms of

1 your -- what type of opinions you can develop about whether
2 the doctor used unnecessary force or unnecessary traction or
3 tilted the baby's head in an unnecessary, in an unnecessary
4 way?

5 A. I mean it wouldn't be, as I said before, in order
6 to have a permanent injury of the nature and extent that
7 this baby had, it requires significantly more force applied
8 in that lateral or deviated way, off axis way, to the head
9 during delivery.

10 Q. Would maternal forces of labor be capable of that
11 type of, of comparable force to the traction that you're
12 describing?

13 A. No.

14 Q. Or would it, the maternal forces of labor, cause
15 the baby's head to tilt downward more than 45-degrees?

16 A. No.

17 Q. What about anything that occurred during the baby's
18 growth over the course of pregnancy, congenital type
19 injuries?

20 Is there any evidence that Ashley F had
21 developmental problems during the pregnancy that would
22 result in this type of injury to the brachial plexus?

23 A. No.

24 Q. So, in your opinion to a reasonable degree of
25 medical certainty, are there any other forces, other than

1 those applied by Doctor Giep, that most probably caused the
2 injury to Ashley F brachial plexus?

3 A. No.

4 Q. Doctor, in your opinion, to a reasonable degree of
5 medical certainty, based upon your experience, training, and
6 knowledge, did Doctor Giep deviate from the generally
7 recognized and accepted standard of care in the manner in
8 which he delivered Ashley F on October 7, 2008?

9 A. I believe that he deviated it from the standard of
10 care in the application of traction that was more than
11 necessary for the circumstances.

12 Q. Doctor, do you have an opinion, to a reasonable
13 degree of medical certainty, based upon your experience,
14 training, and knowledge, as to whether or not the deviations
15 from standard of care that you've identified most probably
16 caused injury or caused or contributed to injury of Ashley
17 F brachial plexus?

18 A. I believe it did.

19 Q. Doctor, do you have an opinion, to a reasonable
20 degree of medical certainty, based upon your experience,
21 training, and knowledge, as, as to whether the injuries
22 sustained by Ashley F to her brachial plexus could
23 most probably have been avoided if Doctor Giep had followed
24 standard medical care in the delivery of, of that baby?

25 A. Yes, I think he could of avoided the, the extensive

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1 and permanent injury that occurred here.

2 Q. Okay. Doctor, if, if I may, I'd like to, to go off
3 line so that I can review my notes and see whether I have
4 any further questions before I turn you over to defense
5 counsel for cross-examination.

6 A. Okay.

7 THE VIDEOGRAPHER: The time is now 4:14. We are going
8 off the record.

9 (Pause.)

10 THE VIDEOGRAPHER: The time is now 4:20. We are back
11 on the record.

12 Q. Doctor Gurewitsch, in, in your review of the
13 records, did you find that Doctor Giep used a vacuum
14 extraction device during his delivery of the baby?

15 A. Yes.

16 Q. Do you have an opinion, to a reasonable degree of
17 medical certainty, as to whether the vacuum extraction
18 device in any way caused or contributed to Ashley F
19 having permanent injury to her brachial plexus?

20 A. I do not think it contributed to the injury.

21 Q. Doctor, did you find in the record that, at the
22 time of birth, Ashley F was found to have a fractured
23 clavicle?

24 A. Yes.

25 Q. And what is a clavicle?

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1 A. The clavicle is a collarbone.

2 Q. And, doctor, do you have an opinion, to a
3 reasonable degree of medical certainty, as to whether or not
4 the fractured clavicle caused or contributed to Ashley
5 F having permanent injury to her brachial plexus?

6 A. My opinion is that the fractured clavicle did not
7 cause or contribute to the brachial plexus injury.

8 Q. Does it have any association with the brachial
9 plexus injury?

10 A. It has. It can result from a number of different
11 mechanisms, any of which are plausible here. One is as a
12 result of suprapubic pressure being applied forcefully
13 causing a -- the collarbone to snap.

14 The other is the same force pulling the baby's brachial
15 plexus. There's also pulling of the collarbone through the
16 pubic, the pubic bone. And it also could be pushed through
17 past the pubic bone either, which would cause compression
18 and a fractured clavicle.

19 Q. That's all the questions that I have. Please
20 answer any questions that defense counsel may have.

21 CROSS-EXAMINATION

22 BY MR. WEATHERLY:

23 Q. Doctor, my name's Lee Weatherly and I represent
24 Doctor Giep and Spartanburg OB-GYN.

25 Did you just testify that Ashley F suffered a

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1 fractured clavicle during her delivery?

2 A. Yes.

3 Q. Did you review her medical records from the
4 hospital when, when coming to your opinions in this case?

5 A. Yes.

6 Q. Did you review the x-rays that were taken of her
7 clavicle in the hospital?

8 A. Yes.

9 Q. Did you note that none of those x-rays showed a
10 fractured clavicle?

11 A. I thought there was fractured clavicle. So, I --
12 as I recall.

13 Q. And, doctor, when you are acting as an expert
14 witness, you have the duty to review, to review all of the
15 materials and to form your opinion based on an accurate
16 review of those materials, do you not?

17 A. Yes.

18 Q. And so you were not aware that Ashley F
19 clavicle was not fractured during her delivery, but was
20 later fractured during her brachial plexus surgery by Doctor
21 Armenta so he could reach a different part of her scar
22 tissue?

23 You were not aware of that?

24 A. I was not.

25 Q. Did you review his records?

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1 A. Yes. So, the, the clavicle is typically purposely
2 separated in order to explore the brachial plexus.

3 Q. Did you read his deposition, Doctor Armenta?

4 A. Yes, a while ago.

5 Q. And you didn't -- testifying here today under oath,
6 you didn't remember that the first time that Ashley F
7 clavicle was fractured was when he did it during the surgery
8 to repair her nerves?

9 You didn't know that?

10 A. No.

11 Q. Doctor, you serve as an expert witness very
12 frequently, correct?

13 A. Yes.

14 Q. In fact, you make between a hundred and \$150,000 a
15 year testifying for lawyers in medical malpractice cases,
16 correct?

17 A. Yes.

18 Q. You depend on that money you charge attorneys like
19 Mr. Henshaw for half of your annual income, don't you?

20 A. Yes.

21 Q. And a lot of that is testifying against doctors
22 just like Doctor Giep in cases involving shoulder dystocia
23 just like this one, isn't it?

24 A. Yes.

25 Q. And none of that money goes to Johns Hopkins or

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1 anyone like that?

2 It goes directly to you, correct?

3 A. Yes.

4 Q. And you're getting paid, what is it, \$3,500 for
5 coming to this conference room here in Baltimore, in your
6 hometown, to testify on video for Mr. Henshaw and his
7 clients, correct?

8 A. Yes.

9 Q. And your husband is Mr. Henshaw's other expert in
10 this case, right?

11 A. I believe so, yes.

12 Q. Robert Allen, that's your husband, correct?

13 A. Yes.

14 Q. And your husband depends on cases like this for a
15 third of his income, doesn't he?

16 A. Yes.

17 Q. Okay. He won't tell us how much he makes a year
18 being a witness.

19 Do you know why that is?

20 A. No.

21 Q. But so, in total, about 40-percent of your family
22 income comes from, comes from providing testimony in cases
23 just like we're here from today?

24 A. Yes.

25 Q. All right. And your husband is who first got you

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1 involved in shoulder dystocia issues, correct?

2 A. Yes.

3 Q. Okay. Cause he use to work with a doctor named
4 Bernard Gonik on shoulder dystocia and brachial plexus
5 insured, excuse me, in brachial plexus injury research,
6 didn't he?

7 A. He did.

8 Q. And they were neighbors, correct?

9 A. Yes.

10 Q. Okay. And let me, let me rephrase my question.

11 Doctor Gonik's published research does not agree with
12 your position that injuries like Ashley F can only be
13 caused from 35-pounds of physician traction, correct?

14 A. I can't answer that one way or the other.

15 Q. You've not reviewed his research --

16 A. I have.

17 Q. -- since he's split off from your husband?

18 A. I have reviewed that. It, it doesn't talk about
19 any cause of permanent brachial plexus injury.

20 Q. But Doctor Gonik now does research on shoulder
21 dystocia and brachial plexus injuries with a different
22 biomechanical engineer named Michele Grimm in Michigan,
23 correct?

24 A. Yes.

25 Q. Okay. We'll talk about -- well, let's go back to

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1 your husband.

2 when he was no longer doing work with Doctor Gonik, you
3 moved in next door to him, right?

4 He moved here to Baltimore and then you moved in next
5 door to Doctor Allen, right?

6 A. No.

7 Q. All right. And then your husband picked you to
8 work with him on his theories of brachial plexus injuries,
9 correct?

10 A. We worked together.

11 Q. Okay. And then---

12 A. He never picked me.

13 Q. And then you started dating and then you got
14 married, correct?

15 A. Yes.

16 Q. You kept your last name, Gurewitsch, for
17 professional reasons and did not take the last name Allen,
18 correct?

19 A. Actually I go by Gurewitsch-Allen professionally.

20 Q. Is any of the literature you've published have
21 Gurewitsch-Allen?

22 A. Yes.

23 Q. Okay. I have not seen that research. So, I
24 apologize.

25 My understanding is, and tell me if I'm incorrect, that

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1 when you two are expert witnesses in cases, you have a
2 pretty simple standard for taking on a case for a
3 plaintiff's attorney is that, unless there are extreme
4 circumstances, you believe, that when a child has a ruptured
5 or avulsed brachial plexus nerve, the doctor must have been
6 negligent.

7 Isn't that essentially what you and your husband's
8 opinions boil down to?

9 A. I think that it's common, but it is not a formula.
10 Each case is reviewed for its individual circumstances, but
11 it is true that, that, unless there are extenuating
12 circumstances, which is what we're reviewing, that a
13 permanent brachial plexus injury that is moderate to severe
14 is the result of traction that is more than usual traction,
15 and what is being evaluated by me, I can't speak for him,
16 he's not a physician, is whether that was medically
17 justified.

18 Q. So, essentially, if you can't -- if there's no in
19 medical justification, which often, in your mind, is a
20 brachial plexus -- is a shoulder dystocia event lasting
21 longer than five, six, or seven minutes, if that doesn't
22 exist, and there is a rupture avulsion leading to a
23 permanent injury in a child, you believe that the doctor
24 must have been negligent, correct?

25 A. That would be a typical conclusion that I would

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1 reach, yes.

2 Q. And what -- you've -- have you ever been to South
3 Carolina?

4 A. Yes.

5 Q. What were you there for?

6 A. Just pleasure. Vacation.

7 Q. Have you ever met Doctor Giep?

8 A. No.

9 Q. Have you ever spoken to him?

10 A. Nope.

11 Q. And you requested that we come to Baltimore today
12 to put your testimony on video.

13 Why was that?

14 A. Because of my clinical responsibilities. I can't
15 take the time off that would be required to come for
16 traveling the day before and then the day after giving
17 testimony.

18 Q. All right. So, you're gonna be able to testify
19 that Doctor Giep was negligent in this case without ever
20 having to be in the same room with him, right?

21 A. Yes.

22 Q. And this is how you make half of your living,
23 correct?

24 A. (No audible response.)

25 Q. Doctor, before coming here today, I read one of the

Deposition of Edith Gurewitsch

1 articles you and your husband wrote published back in 2007
2 just called shoulder dystocia.

3 Do you know the article that I'm talking about?

4 A. From 2007, in Seminars in Perinatology?

5 Q. Yes.

6 And, in that article, you and your husband give advice
7 to experts and lawyers and all the such as to how to more
8 effectively argue these shoulder dystocia cases in Court.

9 Those---

10 A. No, that's not---

11 Q. No?

12 A. No.

13 Q. Okay. In that article, do you not give advice to
14 expert witnesses involved in shoulder dystocia cases?

15 A. No. No, I discussed the various arguments from an
16 evidence -- from a medical evidence prospective.

17 Q. Okay. In this article---

18 A. But not advice.

19 Q. Would it be fair -- oh, excuse me. I apologize. I
20 don't mean to interrupt, ma'am.

21 A. It's not advice of any kind. It was a -- the whole
22 issue of Seminars in Perinatology was devoted to
23 medical/legal issues in perinatology. I was asked to write
24 a -- the two of us were asked to write a chapter or a
25 contribution on shoulder dystocia, specifically the

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1 medical/legal issues in shoulder dystocia, and review the
2 typical plaintiff and defense arguments from the point of
3 view of the medical literature period. No advice one way or
4 the other.

5 Q. You don't tell them in this article what arguments
6 will be more effective than other arguments?

7 A. No.

8 Q. I must have read it incorrectly. I apologize for
9 that.

10 But you do give one good piece of advice in here that
11 says, realistically, experts often have to make concessions
12 to the opposing side because it's rare that all aspects of
13 care were substandard.

14 You wrote that, right?

15 A. Yes.

16 Q. Okay. Well, let's, let's see what concessions we
17 can, we can come up with from you right now.

18 Now, all of Mrs. Flowers prenatal, meaning the care
19 before she went into labor, that was appropriate, wasn't it?

20 A. Yes.

21 Q. And the management of her gestational diabetes,
22 that was appropriate, wasn't it?

23 A. Yes.

24 Q. And, in this case, it was appropriate for Doctor
25 Giep to deliver Ashley F the traditional way,

1 vaginally, wasn't it?

2 A. Yes.

3 Q. And you'll admit the standard of care doesn't
4 require Doctor Giep or any of his partners to recommend or
5 perform a C-section at anytime on Mrs. Flowers, do you?

6 A. I -- the standard of care would not require that,
7 no.

8 Q. All right. And that's because, at 39 weeks and
9 four days and approximately 3,500 grams, Ashley was not
10 large enough of a baby to where the guidelines recommend a
11 C-section, correct?

12 A. That's right.

13 Q. And doing a C-section on everyone, that's not a
14 viable option to prevent brachial plexus injuries from
15 shoulder dystocia, is that---

16 A. Not at all.

17 Q. Okay. Great.

18 So, so far, we're, we've got good care by Doctor Giep
19 and the other members of Spartanburg OB-GYN, correct?

20 A. Yes.

21 Q. Great.

22 Let's talk about the first stage of labor. That's when
23 the mom is having contractions and her cervix is opening;
24 but she's not yet pushing.

25 Is that correct?

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1 A. That's correct.

2 Q. And Doctor Fowler was the obstetrician who managed
3 most of the first stage of labor, and then Doctor Giep came
4 on towards the end, correct?

5 A. Yes.

6 Q. All right. And the first stage of labor, in this
7 case, lasted 12-hours and two minutes, correct?

8 A. Yes.

9 Q. And towards the end of this first stage of labor,
10 they gave Mrs. Flowers a dose of antibiotics because she was
11 what's called Group B strep positive meaning there was
12 certain bacteria in her vagina, correct?

13 A. Yes.

14 Q. And that dose of antibiotics is to help prevent her
15 from passing that infection onto her baby while the baby's
16 being born, correct?

17 A. Yes.

18 Q. All right. And that was appropriate care, wasn't
19 it?

20 A. Yes.

21 Q. And all of Doctor Giep's care of Mrs. Flowers and
22 Ashley F was appropriate during the entire first stage
23 of labor, wasn't it?

24 A. From the point he took over, yes.

25 Q. Now, let's talk -- and all of Doctor Fowler's

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1 management before Doctor Giep was all appropriate, wasn't
2 it?

3 A. Yes.

4 Q. Now, let's talk about the second, the second stage
5 of labor where Mrs. Flowers cervix is fully dilated and she
6 can start pushing.

7 Now, you said, in your direct examination, that the
8 second stage of labor was 13-minutes.

9 That's not correct, is it?

10 A. That's what it says in the record.

11 Q. Well, let me hand you Defendant's Exhibit 1, and
12 I'll also, while we're at it, hand you the fetal monitoring
13 strip marked as Defendant's Exhibit 3. Now, let's look at
14 Defendant's Exhibits 1.

15 Did you review this before your testimony here today?

16 A. I did.

17 Q. Okay. And if you look over to hours and minutes,
18 it says second stage of labor, it says 43-minutes, doesn't
19 it?

20 A. I read that as -- I read that as 13-minutes.

21 Q. Okay. Well, let's look over here to complete
22 dilated right next to there. That says at 19:32.

23 That means 7:32 in the evening, doesn't it?

24 A. Yes.

25 Q. Okay. And what time did -- was Ashley F

Deposition of Edith Gurewitsch

1 born?

2 8:20 in the evening?

3 A. 8:20:51.

4 Q. Excuse me?

5 A. 20:51.

6 Q. Don't you mean 20:20?

7 8:20 in the evening?

8 A. I'm looking at the vaginal delivery spontaneous
9 time. Oh, that's the placenta.

10 Q. That's when the placenta was delivered.

11 That's the third stage of labor?

12 A. 20:20.

13 Q. Let's stay in the second stage.

14 So, 20:20 -- 19:32 to 20:20, that's not 13-minutes, is
15 it?

16 A. No.

17 Q. Okay. So, wouldn't it be more accurate to say that
18 the second stage of labor, the period where the mom's cervix
19 is fully dilated, wasn't 13-minutes, was it?

20 A. No.

21 Q. It's 43-minutes, correct?

22 A. Yes.

23 Q. All right. Now, when Mrs. Cervix (sic) was finally
24 dilated, she began complaining of pain, correct?

25 A. Yes.

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1 Q. All right. And do you recall that from the record?

2 A. There was a note.

3 Q. Sure. I'll be happy to---

4 A. A written note.

5 Q. I'll be happy to hand you that record and you can
6 refer to it if you'd like so we don't -- so we're working
7 off the same thing, ma'am.

8 A. This isn't what I was referring to. There's a
9 delivery note.

10 Q. Well, you can look at 7:42 in the evening.

11 The nurse writes down patient complains of pain and
12 cramping, correct?

13 A. Correct. She's not fully dilated yet.

14 Q. Well, ma'am, if you look at Exhibit 1, she's fully
15 dilated at 19:32, correct?

16 A. Yes.

17 Q. And this note where she's complaining of pain is at
18 19:42, correct?

19 A. 19:42.

20 Q. So, this is ten minutes after she's fully dilated,
21 correct?

22 A. Right. Yes.

23 Q. All right. So, the nursing staff, before they have
24 her start pushing, they called the anesthesia team and they
25 came to gave her -- to give her more pain medication,

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1 correct?

2 A. Yes.

3 Q. And that was all appropriate care, wasn't it?

4 A. Yes.

5 Q. And then they took Mrs. Flowers catheter out,
6 didn't they?

7 A. Yes.

8 Q. And that's important because, having the catheter
9 in, can reduce the space that the baby has to come out of
10 the birth canal, correct?

11 A. Yes.

12 Q. All right. And that was appropriate care, correct?

13 A. Yes.

14 Q. And so after they had taken care of Mrs. Flowers,
15 her pain, and they had taken out the catheter, she started
16 pushing at 7:55PM, correct?

17 A. Yes.

18 Q. All right. Now, not long after that, the baby's
19 heart rate drops into the 90s and it had some attempt at a
20 slow recovery, but with continued deceleration around
21 8:05PM, correct?

22 A. Yes.

23 Q. All right. And Doctor Giep has called and he
24 arrived at Mrs. Flowers bedside at 8:11PM, correct?

25 A. Yes.

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1 Q. Now, right before he got into the room, the nurses
2 had turned off the Oxytocin that Mrs. Flowers was receiving
3 because the baby's heart tones were down in the 90s,
4 correct?

5 A. Yes.

6 Q. And that was good care, wasn't it?

7 A. Yes.

8 Q. And they had moved Mrs. Flowers onto her right side
9 because they were afraid that the baby might be laying on
10 the umbilical cord and that gravity was keeping that baby
11 from getting the oxygen she needed, correct?

12 A. Gravity?

13 Q. They moved her onto her side so they could move the
14 baby off of the umbilical cord if that was what was causing
15 her heart rate to drop, right?

16 A. Actually, no. It increases the blood flow to the
17 uterus.

18 Q. Okay.

19 A. That doesn't have anything to do with the cord.

20 Q. But all of that was because they were concerned the
21 baby might not be getting enough oxygen at that point,
22 correct?

23 A. That's the appropriate response to deceleration of
24 the heart beat, yes.

25 Q. Very good.

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1 And that's all good care, correct?

2 A. Yes.

3 Q. And they began giving Mrs. Flowers oxygen to try to
4 get more oxygen to her, and, therefore, get more oxygen to
5 the baby, correct?

6 A. Yes.

7 Q. And normal baby heart tones are usually between 110
8 and 160, correct?

9 A. Yes.

10 Q. And this baby's heart tones had been in the 130s,
11 mostly the 140s, for most of the labor, hadn't they?

12 A. Yes.

13 Q. All right. So, a drop to 90 was something that
14 attention needed to be paid to that, correct?

15 A. Yes.

16 Q. That was an unusual finding, right?

17 A. It's fairly typical of the second stage.

18 Q. But it's something that required action, correct?

19 A. Yes.

20 Q. All right. So, at this point, even before the
21 shoulder dystocia occurs, there was some concern that from
22 8:05 to maybe 8:12 that the baby wasn't getting enough
23 oxygen, correct?

24 A. I wouldn't agree with that.

25 Q. Well, there was at least enough concern to where

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1 they had turned off the Pitocin. They had rolled her onto
2 her side. They had given her oxygen.

3 They had done all of those things because they were
4 concerned the baby wasn't getting enough oxygen, correct?

5 A. The appropriate response.

6 Q. Very good.

7 And, at that point, everything the medical staff was
8 doing, during this second stage of labor, was appropriate,
9 correct?

10 A. Yes.

11 Q. So, when Doctor Giep arrives, he's got the ability
12 to then look at the fetal monitoring strip that you have
13 there as Exhibit 3 and see what's been going on for the last
14 say five or six minutes before he arrives, correct?

15 A. Correct.

16 Q. All right. And right after he arrives, at about
17 8:11PM, that heart rate starts to rebound at about 8:12PM,
18 correct?

19 A. Yes.

20 Q. All right. And five minutes after he arrives,
21 Doctor Giep orders them to restart the Oxytocin at 8:16PM,
22 correct?

23 A. Yes.

24 Q. Now, that's appropriate, isn't it?

25 A. Yes.

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1 Q. And Doctor Giep does an assessments of Mrs. Flowers
2 and checks her cervical dilation, correct?

3 A. Yes.

4 Q. All right. And that's good care, correct?

5 A. Yes.

6 Q. He checks her pelvis, correct?

7 A. Yes.

8 Q. And that's good care?

9 A. Yes.

10 Q. And he was able to determine that the child was
11 occiput anterior and that means that she's facing down,
12 right?

13 A. Her head is facing down, yes.

14 Q. That's right.

15 And that would mean that her left shoulder would be
16 anterior, which would be the one that's facing up, correct?

17 A. No, it wouldn't mean anything.

18 Q. Okay.

19 A. Occiput anterior, it wouldn't, no.

20 Q. But making that determination that the baby is
21 occiput anterior, that's good care, correct?

22 A. Yes.

23 Q. And he was able to determine the baby was what he
24 called a plus three station meaning Ashley F head is
25 all the way engaged in the mother's birth canal, correct?

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1 A. Yes.

2 Q. And determining that is good care, correct?

3 A. Yes.

4 Q. All right. But then, again, we've got these
5 previous decelerations and this previous heart rate in the
6 90s, and Doctor Giep didn't think he could get the baby
7 delivered in a reasonable time.

8 So, he decided to use what's called a Kiwi vacuum to
9 deliver the baby's head, correct?

10 A. Yes.

11 Q. And he's doing that because he's concerned that the
12 baby won't have enough oxygen reserve to make it through a
13 prolonged delivery, correct?

14 A. He didn't indicate one way or the other.

15 Q. Did you read his deposition, ma'am?

16 A. Yes.

17 Q. Okay. Do you remember, in his deposition,
18 testifying that the reason he used the Kiwi was because he
19 did not believe that he could deliver the baby in a
20 reasonable amount of time without it?

21 A. He didn't think the mother could deliver it within
22 a reasonable amount of time without a vacuum.

23 Q. Yes.

24 A. He did not say it was because he was concerned
25 about a lack of oxygen.

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1 Q. If it were not for a lack of oxygen, why would he
2 be concerned that the mother would not be able to deliver
3 the baby in 15 to 20-minutes?

4 A. He didn't say it was specifically 15 to 20-minutes,
5 and one of the common indications for vacuum or forceps
6 assisted delivery is to assist with maternal explosive
7 effort, which is what he was describing.

8 Q. But he didn't say that the mom wasn't unable to --
9 was unable to push, did he?

10 A. He didn't say one way or the other, but he
11 certainly didn't say he was concerned about fetal
12 oxygenation.

13 Q. You don't recall that from his deposition?

14 A. No.

15 Q. Okay. Nevertheless, it was appropriate for Doctor
16 Giep to use the Kiwi to assist in the delivery, correct?

17 A. Yeah, it was reasonable.

18 Q. All right. No criticisms for anything Doctor Giep
19 did regarding the Kiwi, correct?

20 A. Nope.

21 Q. And -- now, using the Kiwi to get the baby's head
22 out, Doctor Giep makes an incision that's called an
23 episiotomy to give the baby more room to be fully delivered,
24 correct?

25 A. Yes.

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1 Q. And that's within the standard of care, correct?

2 A. Yes.

3 Q. And he also asked the nurse to call the NICU so
4 there will be someone there to help with the baby should she
5 be in distress when she's born, correct?

6 A. Yes.

7 Q. And that's good care, isn't it?

8 A. Yes.

9 Q. And this all happened before the shoulder dystocia
10 occurred, correct?

11 A. Yes.

12 Q. And then, when he was able to deliver the head
13 using the Kiwi, he bulbed the baby's nose and mouth and
14 that's good care, isn't it?

15 A. Yes.

16 Q. All right. And he checked to make sure the baby's
17 umbilical cord isn't wrapped around its neck because that's
18 what may have been causing her decelerations a few minutes
19 prior, correct?

20 A. No, you always check for the, the presence of
21 umbilical cord because you don't want to deliver the body
22 with the cord wrapped around the neck. You can damage the
23 cord that way, and, and cause problems with the delivery.
24 That's just routine.

25 Q. Do you remember Doctor Giep's testimony in this

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1 case that he especially checked for a nuchal card, which
2 means the umbilical cord wrapped around the baby's neck, in
3 this case because the previous deceleration?

4 A. I don't recall that.

5 Q. Nevertheless, he's providing Mrs. Flowers and her
6 baby excellent care here, correct?

7 A. He's providing reasonable care up to this point,
8 yes.

9 Q. And when -- then, after the head was delivered, he
10 asked the mom to push and used gentle downward traction to
11 try and deliver the baby's body, correct?

12 A. That's what he testified to, yes. It's not in the
13 record.

14 Q. All right. And asking the mom to push at that
15 point, and using gentle downward traction is within the
16 standard of care, correct?

17 A. Yes.

18 Q. But the baby's body doesn't deliver, does it?

19 A. That's correct.

20 Q. And when you have what we described earlier as the
21 turtle sign, meaning the head is, is coming out, but then
22 retracting slightly, kind of like when a turtle is scared
23 and, to an extent, goes back into his or her shell, right?

24 A. Yes. Although the head does not go all the way
25 back into the vagina.

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1 Q. All right. And I think we described them earlier.
2 Now, if the doctor's paying close attention, this can
3 be a sign of shoulder dystocia, correct?

4 A. That's correct.

5 Q. And Doctor Giep was paying close attention cause he
6 saw this and diagnosed the shoulder dystocia, didn't he?

7 A. That's correct.

8 Q. And, in your opinion, some doctors don't diagnose
9 the shoulder dystocia in this situation, and they just keep
10 using traction until the baby's delivered, right?

11 A. That can happen.

12 Q. And that would be negligence, wouldn't it?

13 A. It depends on the circumstances.

14 Q. Well, if there's a shoulder dystocia and the doctor
15 fails to diagnose it, fails to use any maneuvers, and just
16 continues pulling on the baby until the baby's delivered,
17 that would be negligence, right?

18 A. Usually, yes.

19 Q. Okay. And doctor -- but Doctor Giep didn't do
20 that, did he?

21 A. No.

22 Q. No, he diagnosed it.

23 So, we have another -- yet another instance of Doctor
24 Giep practicing the standard of care, correct?

25 A. Yes.

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1 Q. All right. And a shoulder dystocia is not
2 preventable in all cases, is it?

3 A. No, it's not.

4 Q. It's not predictable, is it?

5 A. No.

6 Q. And there's no doubt this is a medical emergency we
7 have now, isn't it?

8 A. Yes.

9 Q. And a shoulder dystocia is not going to resolve
10 itself, is it?

11 A. It can.

12 Q. Well, in this case, let's use this case, in this
13 case, this shoulder dystocia is not going to resolve itself
14 if Doctor Giep doesn't do something, is it?

15 A. It required maneuvers to get the baby delivered.

16 Q. Right.

17 It requires Doctor Giep to do something to release this
18 shoulder, doesn't it?

19 A. Yes.

20 Q. All right. If Doctor Giep just stands there and
21 does nothing, this baby is not going to deliver, is it?

22 A. That's correct.

23 Q. All right. And we will talk in a little bit about
24 how long a shoulder dystocia can last before the baby starts
25 having brain damage or die.

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1 But, no doubt, for a shoulder dystocia, a baby can have
2 a serious brain injury or can die as a result of a shoulder
3 dystocia, correct?

4 A. It can.

5 Q. And that's -- and more likely than not, in this
6 case with Ashley F , if Doctor Giep doesn't do
7 something when this shoulder dystocia occurs, the baby is
8 going to die, isn't she?

9 A. I can't answer yes or no.

10 Q. If Doctor Giep does not do something in this case
11 to relieve the shoulder dystocia, Ashley Rivers -- Ashley
12 F is going to have a brain injury, isn't she?

13 A. Again, can't answer that with reasonable certainty.

14 Q. Babies do die from shoulder dystocia, don't they?

15 A. They can.

16 Q. And that's because, when the head is delivered but
17 the body is not yet delivered, the baby is not getting
18 oxygen, correct?

19 A. It may not be getting oxygen.

20 Q. All right. And there's no doubt in this case,
21 through the actions of Doctor Giep, that Ashley F
22 avoided brain damage and even death, didn't she?

23 A. Yes.

24 Q. I'm interested as to why you now can not give an
25 opinion that, in this case, if Doctor Giep didn't do

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1 something that Ashley F. would die.

2 A. Because all that was done was McRoberts and
3 suprapubic pressure. He took -- which only takes a matter
4 of seconds, and this was persisted for one to two minutes.
5 In one place in the record it says one to two minutes.
6 Another place it says approximately one minute.

7 More likely than not, over that period of time, the
8 baby rotated to a position spontaneously that allowed it to
9 eventually be delivered with the force that was used because
10 the McRoberts and suprapubic pressure didn't resolve it
11 earlier. So, that's the reason that if that had -- there
12 had just been some care in the amount of traction that was
13 used, just the passage of a minute to two minutes would of
14 probably resolved the shoulder dystocia on its own. And so
15 the risk of a life threatening situation wasn't there.

16 Q. Certainly Doctor Giep is taking care of this
17 patient. Doctor Giep doesn't have evidence that, if he
18 stands back and does nothing, the baby is gonna live and
19 it's gonna resolve on its own, does he?

20 A. I didn't say he should stand back and do nothing.
21 He is suppose to use no more than the amount of traction
22 that you would need to use in a delivery that's not
23 complicated by shoulder dystocia. He did not do that and he
24 even testified, in, in his deposition, that he applied
25 traction several times during the McRoberts and suprapubic

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1 pressure instead of switching to other maneuvers to relieve
2 the shoulder dystocia.

3 Q. Well, doctor, we're gonna talk about the other
4 maneuvers that, that he says that he attempted in a minute.
5 Let's go back to the shoulder dystocia.

6 Doctor Giep, once he diagnosed the shoulder dystocia,
7 immediately began to employ maneuvers to un-lodge this
8 shoulder from the mother's pubic bone, correct?

9 A. Yes.

10 Q. And that's good care, correct?

11 A. And it is provided that you maintain force and that
12 is no more than that which he would use in a delivery that's
13 not complicated by shoulder dystocia --

14 Q. All right. And---

15 A. -- which I don't believe he did in this case.

16 Q. Okay. We're gonna talk about the level of traction
17 in a moment, but I want to get back to these things that
18 Doctor Giep did right and that you are willing to admit that
19 he did right.

20 He first instruction -- instructed the nurses to put
21 the patient in the McRoberts position, which is her knees
22 all the way up to sort of her shoulders, correct?

23 A. Yes.

24 Q. All right. And that's good care, correct?

25 A. Yes.

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1 Q. All right. And we already talked about what the
2 purpose of that is, to open up the birth canal, but he next
3 instructed Nurse Natalie Phillips to perform suprapubic
4 pressure, correct?

5 A. Yes.

6 Q. And you described that very well for us, how the
7 nurse can then guide that shoulder underneath the pubic bone
8 with that maneuver to try to unstick that shoulder, correct?

9 A. Yes.

10 Q. And Doctor Giep ordering Nurse Phillips to do that
11 was good care, wasn't it?

12 A. Yes.

13 Q. And Nurse Phillips appropriately, appropriately
14 applied that pressure in the correct spot, correct?

15 A. As best I can tell --

16 Q. All right.

17 A. -- as she documented it, yes.

18 Q. And all of that -- all of those actions were good
19 care, correct?

20 A. Yes.

21 Q. All right. Now, at this point, while Mrs. Flowers
22 is in McRoberts and Nurse Phillips is applying suprapubic
23 pressure, that's when you have the single criticism of
24 Doctor Giep's care, and you're saying that he was negligent
25 and that he used 30 to 40-pounds of traction, and it's your

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1 opinion that the standard of care only allows for up to
2 30-pounds of traction, correct?

3 A. Yes.

4 Q. All right. Now, so, your sole allegation of Doctor
5 Giep, your sole allegation that he was negligent, was that
6 he used as little as 5-pounds more traction during this
7 maneuver than the standard of care allows, correct?

8 A. In combination with the direction in which he did
9 it.

10 Q. Well, let's talk about that direction for a second,
11 doctor, because you say that Doctor Giep used 45-degrees of
12 downward traction, correct?

13 A. Had to have in order to stretch down to the level
14 of C8 nerve root.

15 Q. But using 45-degrees of traction, if you -- no,
16 excuse me.

17 Using 45-degree angle with your traction, if you're
18 using, say, 30-pounds of force, is within the standard of
19 care, isn't it?

20 A. No.

21 Q. Doctor, in this case, isn't it true that it wasn't
22 the angle of his traction that was improper?

23 It was the angle combined with the amount of force?

24 A. Yes.

25 Q. All right. So, if he had used less force, the

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1 45-degree angle, it's within the standard of care, correct?

2 A. No. But less likely to be injurious.

3 Q. Well, doctor, let's talk about -- you've reviewed
4 the American College, the American College of Obstetrics and
5 Gynecologist Neonatal Brachial Palsy Task Force report,
6 correct?

7 A. Yes.

8 Q. Did your testimony that Doctor Giep applied,
9 applied an angle of traction 45-degrees below the axis of
10 the baby's spine?

11 A. Yes, that's how you can get a stretch injury all
12 the way down to C8. It's the only way you can get a stretch
13 injury down to C8.

14 Q. So, what pounds of force would it be acceptable to
15 use that angle of traction?

16 A. It wouldn't be. That's below the standard of care.
17 It's just less likely to have -- to cause a rupture or
18 avulsion if it's less than 30-pounds. But the combination
19 of lateral force, laterally applied force, in excess of
20 30-pounds is what caused this pattern of injury, what was
21 necessary to cause that pattern of injury, and is below the
22 standard of care.

23 Q. Now, doctor, if you could turn to Page 72 of your
24 deposition in front of you, please, and turn to Line 12.

25 I asked you the question, I'm saying do you have an

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1 opinion that Doctor Giep applied a further downward angle of
2 traction beyond 45-degrees.

3 what was your answer?

4 A. I think it's about 45-degrees or so, yes.

5 Q. And I asked you so, in this case, it wasn't the
6 angle of his traction that was improper. It was a angle
7 coupled with the amount of force.

8 what was your answer?

9 A. Yes.

10 Q. Thank you.

11 A. Which is what I said here.

12 Q. Doctor, I understand or do you believe or do you
13 not believe that Doctor Giep did a Rubin II maneuver as the
14 final maneuver that he claims it took to relieve the
15 shoulder dystocia?

16 A. I don't have an opinion one way or the other.

17 Q. Because whether or not he did that maneuver doesn't
18 really matter for your opinion, does it?

19 A. No.

20 Q. But two or one and a half minutes is plenty of time
21 to perform McRoberts with suprapubic pressure and move on to
22 another maneuver, isn't it?

23 A. Yes.

24 Q. All right. And his description in his deposition
25 of how he did the Rubin II maneuver is within the standard

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1 of care, isn't it?

2 A. Again, provided that the traction that's applied at
3 the same time or just after meets the standard of care,
4 which I do not believe he met.

5 Q. When you're doing the Rubin maneuver or Rubin II
6 maneuver, you're not applying traction, are you?

7 A. Yes, after you rotate the baby 30-degrees, you
8 still apply traction to the head and neck.

9 Q. But after you've rotated the baby 30-degrees, the
10 shoulder has been released, correct?

11 A. It may or may not have been released.

12 Q. But you understand that, in his deposition, he
13 testified under oath that the Rubin II maneuver is what
14 released the shoulder from behind the mother's pubic bone,
15 correct?

16 A. Correct. And whether he did it or not, I believe
17 the injury occurred during McRoberts and suprapubic press,
18 and the application of traction during that time more likely
19 than not.

20 Q. Very good.

21 And whether or not he wrote that he did or didn't do
22 the Rubin II maneuver in his medical record wouldn't have
23 had any outcome on this case or wouldn't of had any outcome
24 on Ashley F injury, would it?

25 A. Whether he wrote it?

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1 Q. Yes.

2 A. No.

3 Q. And in this scenario, if he had used 30-pounds of
4 traction instead of 35-pounds of traction, he would not have
5 been negligent, correct?

6 A. Assuming it wasn't 45-degree lateral application,
7 that would be correct, but then you wouldn't have an injury
8 like this.

9 Q. So, in a nutshell, your opinion is, is that,
10 between 8:18PM and 8:20PM, Doctor Giep used five more pounds
11 of traction at 45-degrees that the standard of care allows,
12 right?

13 A. That was at least what he did, yes.

14 Q. All right. And you understand that Doctor Giep
15 strongly denies that he used any kind of scalp traction when
16 delivering this baby, don't you?

17 A. I understand that.

18 Q. And has never -- he has never said otherwise, has
19 he?

20 A. No, he hasn't.

21 Q. All right. Doctor, a baby that you delivered
22 several years ago suffered from a permanent brachial plexus
23 injury from a shoulder dystocia, didn't it?

24 A. Yes.

25 Q. Was that baby a boy or a girl?

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1 A. I can't talk about that case.

2 Q. So, you can't tell me if that baby was a boy or a
3 girl?

4 A. No.

5 Q. All right. But even though this baby, be it a boy
6 or girl, had a permanent injury to his or her arm, you
7 claimed you were not negligent in causing that injury.

8 Isn't that correct?

9 A. I can't talk about that case.

10 Q. You can answer the question as to whether you
11 believe you were negligent or not.

12 So, you are not willing to say, even though that you
13 have testified in the past extensively about that case,
14 you're not willing to stay in front of this jury, and say
15 whether or not you were negligent in the care of that child?

16 A. My willingness -- I am not allowed to talk about
17 that.

18 Q. Well, why, why were you willing to talk about it in
19 previously under oath, but you're not willing to talk about
20 it now?

21 A. Now -- I was earlier.

22 Q. Who's not permitting you to talk about that case
23 now?

24 A. I can't talk about that case.

25 Q. Well, this is gonna be heard in front of a judge,

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1 and the judge is going to be able -- is going to either
2 require you to answer these questions or not. So, part of
3 that is going to be you explaining why you're not allowed to
4 talk about that case now.

5 So, who is not allowing you to talk about that case?

6 A. I can not talk about that case.

7 Q. Why are you not allowed to talk about that case?
8 What reasons?

9 A. I can't talk about it.

10 Q. Legal reasons?

11 A. I can't talk about it.

12 Q. Doctor, when you were testifying on direct
13 examination, you stated that your opinions that Doctor Giep
14 had breached the standard of care were based on your
15 education, training, but, most importantly, your experience,
16 correct?

17 A. Yes.

18 Q. And your experience with brachial plexus injuries,
19 not only in your research, but also in your personal
20 practice, went into formulating those opinions, correct?

21 A. For this particular case, no.

22 Q. So, your experience in delivering babies and how to
23 respond to a shoulder dystocia had absolutely no role in the
24 formulation of your opinions in this case?

25 A. No, I don't think that's a fair statement.

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1 Q. So, your response to brachial plexus, I mean,
2 excuse me, to shoulder dystocia events and, and your
3 experience in 20 years as an obstetrician played a role in
4 the, in the opinions that you have provided to this jury
5 here today, correct?

6 A. Yes.

7 Q. And, doctor, you have experienced brachial plexus
8 injuries in your patients in the past, correct?

9 A. Yes.

10 Q. All right. And one of those patients suffered from
11 a permanent brachial plexus injury, correct?

12 A. I can't discuss that case.

13 Q. Doctor, isn't it true that you have testified under
14 oath specifically in the past about this case?

15 A. Yes.

16 Q. All right. I'm gonna hand you a deposition from
17 the case of Jackson v. Hankla that was pending in the State
18 of Georgia in 2008. Hand you your transcript there.

19 Do you remember testifying as an expert in that case?

20 A. Not as I sit here today.

21 Q. I will ask you to turn to Page 28 of this
22 deposition, and what I'd like for you to do is to read to
23 yourself Page 28, Page 29, Page 30, and Page 31, and tell me
24 when you've completed that.

25 A. Okay.

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1 Q. And, in this deposition, you confirmed that you had
2 delivered a baby in the past that had a permanent brachial
3 plexus injury, correct?

4 A. I can't talk about that case.

5 Q. What I'm asking is this, this for the transcript of
6 this you under oath says?

7 A. I understand the question. I can't answer it.

8 Q. Does this transcript state -- was this -- does this
9 transcript contain sworn testimony by you that, in that
10 delivery, you used suprapubic pressure, McRoberts, and a
11 Rubin's maneuver, as well as a delivery of a Wood's Screw to
12 deliver the posterior arm in that case?

13 A. I can't talk about that case.

14 Q. Does this transcript that you provided testimony
15 under state that, despite the fact that this child had a
16 permanent injury to her C5 and C6 nerve roots, you believed
17 you complied with the standard of care?

18 A. I can't talk about that case.

19 Q. All right. Doctor, I'm gonna hand you a transcript
20 from the case of Graves v. Robinson. It was pending in Clay
21 County, Iowa and ask you to turn to Page 44. I'm gonna ask
22 you to read Pages 44 and 45 of this transcript that was
23 taken in 2010.

24 A. Okay.

25 Q. Doctor, you'd agree with me that your sworn

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1 testimony in -- on May 12th, 2010, stated that you had
2 delivered a child that had a permanent Erb's palsy as a
3 result of a shoulder dystocia?

4 A. I can't talk about that case.

5 Q. Doctor, would you agree with me that this sworn
6 testimony by you in 2010 states that you believe that, in
7 that case, you did not deviate from the standard of care?

8 A. Same answer.

9 Q. Doctor, I'm gonna hand you one more transcript.
10 This one is Perry v. Bronson Methodist Hospital taken
11 September 8th, 2006, in Kalamazoo, Michigan.

12 Do you recall being an expert witness in this case?

13 A. Not as I sit here right now.

14 Q. I would ask you to turn to Page 99 of that
15 transcript and please read Page 99, 100, and 101.

16 MR. HENSHAW: Do you have a copy of that, that
17 deposition transcript please?

18 MR. WEATHERLY: Yes.

19 MR. HENSHAW: Thank you.

20 And the page number?

21 THE WITNESS: This page only -- this one only goes to
22 Page 73.

23 MR. WEATHERLY: I'll hand you this.

24 MR. HENSHAW: Oh, okay. Do you have a copy for me
25 please?

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1 MR. WEATHERLY: That should -- it should be. I think
2 you may have my good copy.

3 MR. HENSHAW: Oh, okay. Do you want this back?

4 MR. WEATHERLY: No, it's fine.

5 MR. HENSHAW: And what page was that?

6 THE WITNESS: This is a different deposition.

7 MR. WEATHERLY: Oh, excuse me. I'm sorry. Give me one
8 moment please.

9 Charles, do you have Marsalik (phonetic)?

10 We've not yet discussed---

11 MR. HENSHAW: Yeah.

12 MR. WEATHERLY: Okay.

13 MR. HENSHAW: Yes, I do.

14 Q. Okay. Marsalik, doctor, I apologize.

15 This is a case pending in the State of Georgia, a
16 deposition you gave March 9, 2011.

17 Do you recall being an expert witness in that case?

18 A. Not as I sit here right now.

19 Q. Then I'd ask you to read Pages 99, 100, and 101
20 please, and tell me when you're finished.

21 A. Okay.

22 Q. And, ma'am, this testimony, in 2011, states that
23 you had a permanent brachial plexus injury in a patient you
24 treated, correct?

25 A. I can't talk about that case.

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1 Q. And that injury involved slow conduction of the
2 nerves of C5 and C6, correct?

3 A. I can't talk about that case.

4 Q. And you testified, under oath in this transcript,
5 it says this delivery lasted two minutes. You used
6 McRoberts, suprapubic pressure, anterior Rubin, and Wood's
7 screws in the delivery of the posterior arm to get the baby
8 out, correct?

9 A. Again, same answer.

10 Q. All right. Let's talk about this case, ma'am.
11 You had your deposition taken on March 1st, 2016, in
12 this case, correct?

13 A. Yes.

14 Q. And, in this case, could you please turn to Page
15 60?

16 A. (Witness complies.)

17 Q. I asked you the question, in this case, under oath,
18 March 1st, 2016, you have had a permanent brachial plexus
19 injury in a patient that you treated.

20 Is that fair?

21 What was your response?

22 A. I can't talk about that case.

23 Q. Ma'am, what was your response in the transcript?

24 A. I can't talk about that case.

25 Q. I asked you the question, and you would agree with

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1 me that, in that real world scenario where you had a
2 permanent brachial plexus injury, you applied somewhere
3 between 20 to 25, maybe even 35-pounds of traction?

4 what was your response?

5 A. I can't talk about that case.

6 Q. And you are unwilling to tell this Court and this
7 jury why you are unwilling to talk about that case, correct?

8 A. That's correct.

9 Q. All right. I will read your answer.

10 I asked you the question, on Page 60, Line 2, you have
11 had a permanent brachial plexus injury in a patient you
12 treated.

13 Is that fair?

14 Your response was yes.

15 Is there anything inaccurate about what I've just read?

16 A. I can't talk about that case.

17 Q Ma'am, on Line 5, I asked you, and you would agree with
18 me, that in the real world scenario where you had a
19 permanent brachial plexus injury, you applied somewhere
20 between 20 to 25, maybe even 35-pounds, of traction?

21 Your response was yes.

22 Is there anything about what I just read of your under
23 oath testimony only a year and a half ago incorrect?

24 A. Same answer.

25 Q. Doctor, I am confused because, in this transcript,

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1 it states that, in the case where you had a permanent
2 brachial plexus injury and you believe that you were not
3 negligent, you applied "maybe even 35-pounds of traction"
4 but, in this case, you claim that Doctor Giep applied
5 35-pounds of traction and was negligent.

6 A. The cases and the injuries and the management are
7 different. I can't talk about the other case.

8 Q. But the level of traction that you estimate for
9 both deliveries, one where you claim you weren't negligent
10 and one where you claim Doctor Giep was negligent, are the
11 exact same, are they not?

12 A. No.

13 Q. Thirty-five is not 35?

14 A. I'm -- I did not say that 35-pounds solely was the
15 deviation from the standard of care. The direction, the
16 maneuvers that were used are different. The, the
17 circumstances are different. I'm limited in what I can tell
18 you to explain the difference.

19 Q. Doctor, you just told us, a few minutes ago, that
20 the angle of Doctor Giep's traction would of been
21 appropriate if he had used less force, and you said the fact
22 that he used 35-pounds of traction was what was negligent
23 about this case and we have a case here---

24 A. That is not what I said.

25 Q. well, we'll let the jury decide for themselves what

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1 you said and what you didn't say.

2 So, is what you're telling me is that 35-pounds of
3 traction, in a delivery that only lasts or a head to body
4 interval in a shoulder dystocia that only lasts a minute and
5 a half to two minutes, is acceptable?

6 A. No, the combination of force and direction and
7 actually the rate at which and the number of times it's
8 repeated are what -- are causative of an injury and whether
9 or not they are within the standard of care or outside the
10 standard of care. I can not give you a comparison cause I
11 am limited in being able to compare it to another case, but
12 that is not what I said about this case. The combination of
13 laterally applied force in excess of 35-pounds.

14 Q. Now, doctor, all this estimation of pounds of
15 traction both in your delivery, Doctor Giep's delivery,
16 that's inexact because doctors aren't wearing gauges that
17 tell them how much traction they're using during delivery,
18 are they?

19 A. That's correct.

20 Q. And they're not---

21 A. But you can infer them from the nature and extent
22 of the injury.

23 Q. But while they're actually delivering the baby,
24 they have no monitor, no gauge, no measuring device that
25 tells them the pounds of traction they're using, correct?

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1 A. That's correct.

2 Q. And there is no device that shows them the angle
3 of, of traction that they are applying, is there?

4 A. That's correct.

5 Q. All right. You're just going by feel, aren't you?

6 A. Yes.

7 Q. When you had any of your previous deliveries where
8 there were any brachial plexus injuries, permanent or
9 temporary, you're not wearing any sort of monitor that
10 gauges you the amount of traction or the degree, were you?

11 A. That's correct.

12 Q. All right. And Doctor Giep's probably never been
13 measured with the amount of traction he uses in deliveries,
14 has he?

15 A. I wouldn't know one way or the other.

16 Q. Most doctors have not, have they?

17 A. That's correct.

18 Q. And these things are not the things that you and
19 your husband use, they're not able for commercial use, are
20 they?

21 A. No.

22 Q. And you admit that doctors actually apply greater
23 force as the dystocia continues and this is sort of an
24 unconscious phenomenon, correct?

25 A. Yes, that's why the standard of care requires you

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1 to consciously limit the amount of force that's used to no
2 more than what is used in a delivery that's not complicated
3 by shoulder dystocia.

4 Q. And you say that's 30-pounds and Doctor Giep used
5 35-pounds, correct?

6 A. Yes.

7 Q. All right. But neither you or your husband have
8 ever measured the traction that a doctor is applying in a
9 delivery where a child had a permanent brachial plexus
10 injury, have you?

11 A. That's correct.

12 Q. You don't have a single real life data point on
13 this issue, do you?

14 A. Correct.

15 Q. And you're aware that, from 1995 until 19 or 2008
16 when Ashley F was born and even since then, Doctor
17 Giep's never had another brachial plexus injury in his
18 career, has he?

19 A. Not that I'm aware of.

20 Q. And you're aware that he testified that he used the
21 same traction in this case that he's used in every other
22 shoulder dystocia he's ever had, right?

23 A. I'm aware.

24 Q. And you've never measured the traction that he
25 applies in shoulder dystocia cases or any other delivery,

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1 correct?

2 A. Correct.

3 Q. And certainly, under you and your husband's
4 therapy, if he was applying 35-pounds of force during every
5 shoulder dystocia, he would of injured every single baby,
6 right?

7 A. No.

8 Q. Or if he was -- let me, let me rephrase that.

9 If he was applying 35-pounds of force at a 45-degree
10 angle with every baby he delivered, every single one of them
11 would be injured, wouldn't they?

12 A. More likely than not.

13 Q. But he hasn't had any, has he?

14 A. It's unlikely that, in those cases, he reached the
15 level of force that is required to get the type of injury
16 that the Flowers baby sustained.

17 Q. So, do you think that he is lying that he used the
18 same traction, used the same angle in this delivery that he
19 has in every other shoulder dystocia or do you think that
20 this was something that unconsciously happened during the
21 delivery and he doesn't recall it?

22 A. I think he's underestimating it.

23 Q. What you're doing, doctor, and correct me if I'm
24 wrong, is you're simply using Ashley F injury and then
25 inferring the amount of traction that Doctor Giep used in

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1 the delivery, correct?

2 A. Yes, to determine the cause of it, yes.

3 Q. And to determine the amount of traction you believe
4 he applied, correct?

5 A. Correct.

6 Q. All right. And determine the angle you believe he
7 applied, correct?

8 A. Yes.

9 Q. There's nothing that Doctor Giep could of written
10 in his note that would change your opinion that he used
11 35-pounds of traction at a 45-degree angle, is there?

12 A. That's correct.

13 Q. In fact, in his note, he wrote minimum traction
14 performed, didn't he?

15 A. Yes.

16 Q. And the next day he wrote a note that said gentle
17 traction applied, didn't he?

18 A. Yes.

19 Q. And you ignore those in your opinion, don't you?
20 You don't factor them into your opinion at all, do you?

21 A. I do. I believe he underestimated them as most
22 obstetricians.

23 Q. And when he wrote these notes, there was no sort of
24 lawsuit pending, was there?

25 A. There was an injury evident.

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1 Q. well, but that injury evident, most of these
2 injuries and nine of the ten injuries that you've had
3 resolve on their own, don't they?

4 A. I didn't have ten injuries.

5 Q. You've had nine temporary injuries and one
6 permanent, correct?

7 A. I'm trying to recall. I don't believe there were
8 that many, no.

9 Q. Do you recall, in one of the depositions that I
10 just showed you, what you said under oath in there was that
11 you had had ten injuries, nine were temporary, one was
12 permanent, from just five minutes ago?

13 A. I don't remember which one.

14 Q. But temporary -- most shoulder dystocia and
15 brachial plexus injuries are temporary and they resolve on
16 their own, don't they?

17 A. They do.

18 Q. And there's no way to know, in the first few days
19 in the hospital, whether an injury is gonna be temporary or
20 permanent, is there?

21 A. No.

22 Q. And if an injury is temporary, there's not going to
23 be a lawsuit, is there?

24 A. I would doubt it.

25 Q. All right. So, when Doctor Giep's writing this

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1 note, he has no idea that he's gonna be sitting in a
2 courtroom in Spartanburg, South Carolina in October of 2017
3 at nine years later, does he?

4 A. I can't answer that question.

5 Q. But his note doesn't matter to your opinion, does
6 it?

7 A. I think he underestimated his traction.

8 Q. There's nothing that Doctor Giep could say in his
9 deposition that would change your opinion that he used
10 35-pounds of traction, is there?

11 A. That's correct.

12 Q. And there's nothing that the nursing staff could
13 say in their testimony that could change your opinion, is
14 there?

15 A. That's correct.

16 Q. So, just so the jury understands, there's exactly
17 one thing that you've used to determine that Doctor Giep was
18 negligent?

19 A. No.

20 Q. And that is the---

21 A. To determine the cause --.

22 Q. There is only one thing that you've used to
23 determine what you believe is the cause of Ashley F
24 injury, correct?

25 A. Yeah.

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1 Q. And that's the injury itself, correct?

2 A. Yes.

3 Q. And there's only one thing essentially that you've
4 used to determine that Doctor Giep used more traction than
5 was necessary and that was the length of the time the
6 shoulder dystocia existed, correct?

7 A. Yes.

8 Q. All right. Now, you had said earlier that you
9 thought Ashley F clavicle was fractured during the
10 delivery, and then you learned that it was actually
11 fractured during her brachial plexus surgery, right?

12 A. Yes.

13 Q. Now -- but you said you did read Doctor Armenta,
14 the surgeon's deposition, correct?

15 A. A long time ago, yes.

16 Q. All right. Well, in your expert opinion, did you
17 consider his testimony that 70 to 80-percent of his patients
18 that have injuries like Ashley F don't end up needing
19 surgery and retain full function?

20 A. I, I don't recall reading it. I don't have any
21 reason to, to dispute --

22 Q. Okay.

23 A. -- a statement like that.

24 Q. Did you consider his testimony that many injuries
25 that injure the entire nerve, which means the sheath and the

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1 axion, repair themselves?

2 A. Yeah, that's true.

3 Q. And did you consider the surgeon's testimony that
4 Ashley F nerves did not repair themselves because she
5 grew a neuroma that prevented that from happening?

6 A. Yes, I considered all of that in, in determining
7 the nature and extent of the injury.

8 Q. And Ashley F was making progress in
9 recovering after she left the hospital, was she not?

10 A. Yes.

11 Q. All right. So, other than Ashley's eventual
12 condition at six months when she had surgery, there's really
13 nothing else different between her injury and one that --
14 and the one that recovers?

15 A. I, I don't know.

16 Q. Okay. All right. Let's talk about some literature
17 for a moment.

18 Okay. The husband -- the research that you and your
19 husband do, a lot of it involves you putting these sensors
20 on testing doctors to see how hard they grip when they're
21 delivering babies, correct?

22 A. I wouldn't say a lot of it. That was like two or
23 three --

24 Q. Okay.

25 A. -- of our experiments.

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1 Q. And you try to correlate that into how much
2 traction is being applied, correct?

3 A. Yes, it was a calibration.

4 Q. And you've never measured a doctor in a case where
5 a permanent brachial plexus injuries like this one has
6 occurred, right?

7 A. That's correct.

8 Q. All right. And, and these devices are not worn in
9 the field, that are not made available to the public, right?

10 A. That's correct.

11 Q. And you don't wear them when you're delivering
12 babies, correct?

13 A. No.

14 Q. And in all of your testing, you've only measured, I
15 think, doctors three times responding to a shoulder
16 dystocia.

17 Is that accurate?

18 A. Yes.

19 Q. Okay. And, in one of those cases, Doctor Gonik
20 used 22-pounds of traction?

21 A. I didn't -- I wasn't involved in that.

22 Q. That was your husband's study with Doctor Gonik,
23 right?

24 A. Yes.

25 Q. And you've read that study, correct?

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1 A. I have.

2 Q. You're familiar with it, right?

3 A. I am.

4 Q. And I think you cited it as a basis of part of your
5 opinion, correct, in this 79 or so articles that you sent us
6 a few days ago, the list had them?

7 A. Yes.

8 Q. All right. And, in that case, Doctor Gonik used
9 22-pounds of traction with one baby, and that baby had a
10 temporary brachial plexus injury, and he used 22-pounds of
11 traction with another baby and that baby had no injury,
12 right?

13 A. Yes.

14 Q. And in another case, you let a resident get -- that
15 had these gloves on get all the way up to 25-pounds of force
16 before you stepped in, correct?

17 A. Yes.

18 Q. And that baby had no injury, right?

19 A. Yes.

20 Q. And this is because they're anatomical differences
21 between babies, right?

22 A. In the Gonik paper, there was a difference in the
23 rate of force, about three times as forceful, in the baby
24 that was temporarily injured. In the case where I took over
25 25-pounds of force, it was clear that there was an issue in

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1 terms of the baby delivering safely. And so I took over.

2 Q. Doctor, I appreciate those answers.

3 My question was, there are anatomical differences
4 between babies, correct?

5 A. There are, but they're not explanations of the
6 cases you've just described.

7 Q. What may injure one baby might not injure another
8 one, correct?

9 A. Yes, within a range.

10 Q. So, the amount of force that might create a
11 permanent injury, the one you had in one baby, might not
12 create any injury at all in another baby, correct?

13 A. I can't talk about the case I had.

14 Q. Let me ask that in a, in a form that you are
15 willing to answer.

16 An injury that creates a mild permanent injury in one
17 baby might not even create any injury at all in another
18 baby, correct?

19 A. That would be unlikely.

20 Q. But possible?

21 A. It's possible.

22 Q. Doctor, let's get back to the point about why
23 shoulder dystocias are so dangerous, and it's because the
24 baby likely isn't getting oxygen when her head is delivered,
25 but her body is stuck due to the impaction of the shoulder,

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1 correct?

2 A. There is likely a decrease in the blood flow
3 through the umbilical cord, yeah.

4 Q. And so the oxygen, oxygenation to the baby and the
5 cord Ph decreases to some degree during the shoulder
6 dystocia, correct?

7 A. Yes.

8 Q. Now, some researches believe you have approximately
9 four minutes before you risk serious brain injury, but you
10 think it's closer to six or eight minutes, correct?

11 A. Yes.

12 Q. All right. And are you aware of two studies, one
13 done by Hope in the UK, and the other done by Ling in China
14 that is documented fetal death in cases of shoulder dystocia
15 before five minutes?

16 A. Yes.

17 Q. Now, it's rare, but it does happen, correct?

18 A. Yes.

19 Q. And so a clinician doesn't know whether that case
20 that they have -- that baby that they're delivering at that
21 moment is going to be the rare case that dies in three
22 minutes or four minutes or if it's one that can last six or
23 eight minutes, do they?

24 A. They can't know that prospectively, no.

25 Q. And, doctor, even you would admit that this -- a

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1 central nervous system injury, an asphyxia, that danger
2 starts at about four minutes, right?

3 A. Yes.

4 Q. All right. And -- because, to some extent, as soon
5 as the shoulder dystocia occurs, the baby starts declining,
6 right, to some extent?

7 A. The standard of care requires protecting the baby
8 from any injury, either to the limb or to the central
9 nervous system, during a shoulder dystocia. They --
10 priorities shift at around four minutes because, in the
11 first four minutes, the risk of asphyxia is low while the
12 risk of injury to the brachial plexus with improper,
13 improperly performed delivery techniques, most specifically
14 traction if it's lateral and forceful, increases the risk of
15 brachial plexus injury.

16 Q. Doctor, I appreciate all that, but that was not my
17 question.

18 My question was, during a shoulder dystocia, the baby's
19 condition is declining to some degree, correct?

20 A. It is.

21 Q. And with Ashley F , she already had reduced
22 oxygenation from between 8:05PM to 8:11PM, correct?

23 A. No, we don't not -- we do not know that.

24 Q. So, is it your opinion that, more likely than not,
25 that when her fetal heart rate declined at 8:05 and was in

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1 the 90s and there was a deceleration, that that was not
2 evidence of reduced oxygenation?

3 A. Instantaneously, yes, but not continuous and not
4 into the shoulder dystocia.

5 Q. My question though, doctor, is from 8:05 to 8:11,
6 she had reduced oxygenation, correct, more likely than not?

7 A. I disagree.

8 Q. We don't know what was going on between 8:14 and
9 8:18 because we don't have a good tracing, do we?

10 A. Correct.

11 Q. And that's through no fault of Doctor Giep or any
12 of the nurses, is it?

13 A. I guess I don't have an opinion on that.

14 Q. All right. So -- but, doctor, wouldn't you admit
15 that there's a sense of urgency to deliver Ashley because,
16 even before the shoulder dystocia, there was at least a
17 concern by the doctor and the nurses that she wasn't getting
18 sufficient oxygen?

19 A. No, I disagree with that.

20 Q. So, you---

21 A. -- like we discussed earlier.

22 Q. So, you disagree with the nurse's testimony and
23 Doctor Giep's testimony that they were concerned about her
24 oxygenation between 8:05 and 8:11?

25 A. I did not see them say that. He was concerned that

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1 she wouldn't deliver on her own in a timely fashion. That,
2 to me, is an, a -- assistance with maternal explosive
3 efforts. There's a reason for doing the vacuum.

4 Q. Well, doctor, let's move forward then.

5 We know that, when she was born, she had reduced
6 oxygenation levels, don't we?

7 A. No, she didn't.

8 Q. Well, doctor, she was born blue, was she not?

9 A. Most babies are.

10 Q. She was born blue at one minute and she was still
11 blue at five minutes, was she not?

12 A. Her Apgars were five and seven. Those are the --
13 the one minute Apgar is not indicative of oxygenation. It's
14 indicative of a need for some stimulation to encourage the
15 baby to take breaths and Apgars of seven or more, which she
16 had at five minutes, are normal.

17 Q. Doctor, let me hand you Defendant's Exhibit 6 so
18 you can have the record actually in front of you.

19 Ashley F color, at one minute, was registered as
20 a zero out of two, was it not?

21 A. Yes.

22 Q. And, at five minutes, her color was registered at
23 zero out of two, correct?

24 A. I don't have the Apgar scores --.

25 Q. And you can look at Defendant's Exhibit 1 if you'd

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1 like to see that as well.

2 A. Yes.

3 Q. All right. And that is indicative of low oxygen
4 content, correct?

5 A. No.

6 Q. Doctor, I'd ask you to turn to Page 31 of your
7 deposition, please. Turn to Line 2 once you get there.
8 Tell me when you're there.

9 I asked you the question, when you were under oath,
10 said can we agree the first minute of life she was blue?
11 What was your response?

12 A. Yes.

13 Q. And I said can we agree still in the fifth minute
14 of life she was blue.

15 What was your response?

16 A. Peripherally. Not centrally.

17 Q. All right. Can you then move to Line 18 please?
18 I asked you okay. What is blue indicative of?
19 Nothing?

20 What was your response?

21 A. To Line 18?

22 Q. Line 20. My question is on Line 18 and 19.
23 What is blue indicative of?
24 Nothing?

25 What was your response on Line 20?

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1 A. Okay. I don't see where you're -- on the same
2 page, on Page 31?

3 Q. Excuse me. Page 33.

4 On Line 18 on Page 33, I asked you what is blue
5 indicative of?

6 Nothing?

7 What was your response then under oath?

8 A. Low oxygen content. Not lack of oxygen.

9 Q. So, I just asked you the question is Ashley F
10 being blue at five minutes indicative of low oxygen content.
11 You said yes. In your deposition a year ago you said that's
12 what blue is indicative of.

13 So, which one is it?

14 A It's indicative of low oxygen content. It's not---

15 Q Thank you.

16 A ---indicative of a lack of oxygen.

17 Q. These Apgar scores that we're talking about in
18 Exhibit 6, these determine the condition of the baby in the
19 first minute and the first five minutes of life, correct?

20 A. Yes.

21 Q. And they're done by doctor -- they're not done by
22 Doctor Giep, correct?

23 A. That's correct.

24 Q. They're done by the NICU nurse. In this case,
25 Amber Dowlis, correct?

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1 A. Yes.

2 Q. And they're reported very clearly there on Exhibit
3 6, aren't they?

4 A. Yes.

5 Q. And at one and five minutes, Ashley F had
6 what's called low tone, correct?

7 A. Yes.

8 Q. And at one minute, it was a one, and, at five
9 minutes, it was also a one, correct?

10 A. Yes.

11 Q. And what does that mean to you?

12 A. It's a part of a normal pattern with an Apgar of
13 seven total.

14 Q. Now, at, at one, it means that she does not have
15 full active motion. She has some flexion extension, but
16 she's not completely flaccid, correct?

17 A zero indicates flaccid, correct?

18 The body -- the baby is limp, right?

19 A. Yes.

20 Q. And a two score means that the baby has active,
21 full motion, correct?

22 A. For tone or movement?

23 Q. For tone.

24 A. Tone just means exactly that. It means the degree
25 of which you, I guess, resist motion or have -- demonstrate

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1 muscle contraction.

2 Q. Doctor?

3 A. One of her arms was injured.

4 Q. Doctor, look at Exhibit 1 for me please.

5 A. Exhibit 1?

6 Q. It's probably under the Task Force report you have
7 there.

8 A. Okay.

9 Q. And there's a scale on Exhibit 1 for Apgar scores,
10 correct?

11 A. Yes.

12 Q. And muscle tone, under zero, it says flaccid,
13 correct?

14 A. Yes.

15 Q. And under one, it's says some flexion/extension,
16 correct?

17 A. Yes.

18 Q. And two, it says active motion, correct?

19 A. Yeah.

20 Q. And so she got a one at one minute, and a one at
21 five minutes meaning, at both of those stages, she had some
22 flexion and extension, correct?

23 A. Yes.

24 Q. And that is more evidence of respiratory
25 depression, correct?

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1 A. No.

2 Q. Doctor, could you please turn to Page 35 of your
3 deposition. Excuse me. Turn to Page 34 please.

4 I asked you the question, Ashley's muscle tone is one
5 minute---

6 Q. I'm sorry.
7 where are you reading?

8 Q. Page 34. Line 18.

9 A. Okay.

10 Q. Ashley's muscle tone at one minute and muscle tone
11 at five minutes, how do you qualify that?

12 Your response was what?

13 A. It was a one.

14 Q. Very -- and I said okay. What does that mean to
15 you?

16 What was your response?

17 A. There's some tone, but it's not normal tone.

18 Q. And then I asked the question, you just told me
19 that her one and one minute -- one at five minutes was not
20 indicative of respiratory depression, but when I asked you
21 this a year ago, I said what is that normal tone indicative
22 of, in your opinion?

23 What was your response?

24 A. Again, respiratory depression.

25 Q. So, is it evidence of respiratory depression like

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1 you said a year ago or is it not like you're saying here
2 today?

3 which one is it?

4 A. Well, the question that's written, I obviously
5 didn't hear it correctly because you said what is normal
6 tone indicative of, and it would certainly not be indicative
7 of respiratory depression. So, I was likely unclear on what
8 you were asking me.

9 Q. Doctor, how many depositions have you done in your
10 career?

11 A. I don't know.

12 Q. Hundreds?

13 A. Probably less than a hundred.

14 Q. Probably close to less than a hundred.

15 At the end of a deposition, you have the ability to
16 request what's called errata sheet, do you not?

17 A. I do.

18 Q. Did you in this case?

19 A. I don't remember.

20 Q. And in an errata sheet, you're able to review the
21 transcript and correct any errors, are you not?

22 A. I am.

23 Q. And, in this case, you did not correct any errors
24 whatsoever, did you?

25 A. Not, not after I gave this deposition, no. But as

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1 I made this here, it's clearly not a correct answer to that
2 question as transcribed.

3 Q. Doctor, Ashley F breathing and her reflexes
4 were also not fully normal at one minute, were they?

5 A. At one minute?

6 Q. The one minute.

7 A. No.

8 Q. All right. Would you agree or disagree that, even
9 though Doctor Giep delivered Ashley F after one to two
10 minute shoulder dystocia, she was born in some distress?
11 Would you agree with that?

12 A. Yes.

13 Q. And you don't think Doctor Giep, during this
14 delivery, was using no care or acting recklessly, do you?

15 A. No, I do not.

16 Q. Okay. Let's first talk about the ACOG report.
17 You're a member of ACOG, right?

18 A. I am.

19 Q. All right. It's a well respected organization,
20 isn't it?

21 A. Yes.

22 Q. How many doctors went into drafting that report?
23 Do you know?

24 I count 12.

25 A. Well, I was gonna say 12.

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1 Q. Okay. Twelve.

2 And those are all well respected researchers, aren't
3 they?

4 A. Yes.

5 Q. And I think there's a biomechanical engineer, a
6 pediatrician, and a neurosurgeon, and several rehabilitation
7 physicians that went into drafting that report, correct?

8 A. Yes.

9 Q. And there are a number of professional
10 organizations ranging from other OB-GYN organizations to
11 pediatrics to pediatric neurologists and even in other
12 countries that have endorsed that publication, correct?

13 A. Yes.

14 Q. And you've read that entire report, correct?

15 A. I have.

16 Q. And it's not fraudulent, is it?

17 A. No.

18 Q. It's not false, is it?

19 A. No.

20 Q. And none of the researchers there purposefully
21 publishing any inaccurate, false, or fraudulent information,
22 are they?

23 A. No.

24 Q. And you've not written to ACOG to criticize any of
25 that report, have you?

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1 A. I haven't.

2 Q. Okay. And that's, that's something that people do,
3 don't they?

4 If they see literature, for instance, in your past,
5 you've seen literature that you disagree with, and so you've
6 written in to publications to criticize it, correct?

7 A. On two occasions.

8 Q. All right. But you didn't do that with this
9 publication, correct?

10 A. No.

11 Q. All right. You said that you don't think that that
12 publication agrees with any of your opinion, but one of the
13 things the publications says is, because of the nonlinear
14 behavior of tissues, such as nerve tissue, an estimate of
15 the force needed to cause a nerve rupture can not be
16 directly established, right?

17 A. Yes.

18 Q. And you don't think that statement contradicts the
19 opinions you've given here today?

20 A. No.

21 Q. Okay.

22 A. I've actually said that you can't measure it
23 directly.

24 Q. Let me give you another one.

25 You don't believe that a child can have a permanent

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1 injury to a posterior shoulder without physician traction
2 being a factor, correct?

3 A. Yes.

4 Q. You claim it's never been reported, right?

5 A. Correct.

6 Q. And that's important.

7 This isn't a posterior or shoulder injury case, this is
8 an anterior shoulder case, but that's important because if
9 the---

10 A. I'm sorry. I don't -- I'm not following what you
11 just said.

12 Q. I just said that this case, Ashley F case, is
13 not a posterior shoulder case.

14 It's an anterior shoulder case more likely than not,
15 right?

16 A. More likely than not, but I don't know.

17 Q. But posterior shoulder research is important
18 because, if the posterior shoulder, being the bottom
19 shoulder, can be permanently injured before the doctor can
20 even reach the head to apply traction, those injuries would
21 have a cause other than physician traction, wouldn't they?

22 A. No, you can't have a permanent injury that occurs
23 before the doctor can reach the, the baby's head.

24 Q. Doctor, would you turn to Page 28 of this Task
25 Force report and you've read this, right?

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1 A. Yes.

2 Q. That area right under the bullet points, and tell
3 me, isn't that exactly what that discusses, the fact that a
4 posterior shoulder injury occurs before the doctor can apply
5 traction?

6 It seems to indicate that those injuries are the cause
7 other than physician traction.

8 Isn't that what that describes?

9 A. No, that's not how I read that.

10 Q. Okay.

11 A. During a posterior shoulder impaction, it's not
12 talking about an injury, at the level of a sacral
13 promontory, it's not possible for the clinician to apply, by
14 extraction forces, that are often put forth as a cause of
15 injury because the head has not delivered, but that's not
16 when the injury occurred.

17 Q. So, you don't take that as meaning that the fact
18 that there are posterior or shoulder injuries that are
19 caused by that mechanism, before the physician can reach the
20 head, is indicative there may be cause for brachial plexus
21 injuries other than physician traction?

22 You don't take that meaning that?

23 A. Not permanent ones. No, that you're mixing up a
24 whole bunch of different things. I don't --.

25 Q. Do you---

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1 A. I don't disagree with this statement, but it is, it
2 is vague at best. The cause of a permanent injury would not
3 occur before the head delivers.

4 Q. You're aware---

5 A. And it doesn't talk about permanent versus
6 temporary, and it actually doesn't talk about what's put
7 forth as a cause of what kind of injury.

8 Q. Doctor, you're aware of medical research that
9 exists that supports the position that persistent or
10 permanent brachial plexus injuries can occur without
11 shoulder dystocia, right?

12 A. Yes, they can.

13 Q. And you're aware of research that says that,
14 correct?

15 A. Yes.

16 Q. And you're -- and there's research that exists that
17 says that a mom's pushing can produce 30 to 40-pounds of
18 force pushing the baby down the birth canal, correct?

19 A. It can, but it doesn't deviate the head more than
20 45-degrees from off axis.

21 Q. And there are studies, doctor, that conclude that
22 permanent brachial plexus injuries can occur even when there
23 is no shoulder dystocia, right?

24 A. We just said that, yes.

25 Q. Okay. And defendant's expert, Doctor Chauhan, has

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1 written several of the articles, has he not?

2 A. He has.

3 Q. Are you familiar with those articles?

4 A. Yes.

5 Q. Now, this idea that a permanent brachial plexus
6 injury can occur, even when there is no shoulder dystocia,
7 even came up among your studies, did it not?

8 A. That's correct.

9 Q. And, in that study, you found that 90-percent of
10 cases of permanent injury involved a shoulder dystocia, that
11 ten percent of them, and I think that was just one single
12 case, happened in the absence of documented shoulder
13 dystocia, right?

14 A. That's correct.

15 Q. Okay. And so your explanation for that was that
16 there was a shoulder dystocia that was not documented,
17 correct?

18 A. Correct.

19 Q. But you never went to the doctor and asked them
20 whether there was a shoulder dystocia that he failed to
21 document, did you?

22 A. No.

23 Q. Tell me if my statement is accurate, that the
24 position of the Task Force report and the doctors that --
25 and, and the writing that's in there, is that physician

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1 traction absolutely can be one of the causes for injuries
2 like Ashley F , right?

3 A. Yes.

4 Q. They also write that injuries like Ashley F
5 can be caused by a combination of gentle traction and the
6 maternal forces of labor?

7 A. Not like Ashley F . They don't say that
8 anywhere.

9 Q. You don't believe that that publication says that?

10 A. No.

11 Q. Okay. would the authors of that publication know
12 better than you as to what that says?

13 A. I would assume so but it's not -- I would challenge
14 you to find it.

15 Q. would you agree then, at the very least, that
16 permanent brachial plexus injuries can be caused by a
17 combination of maternal forces of labor and gentle traction?

18 A. I wouldn't call it gentle.

19 Q. Ordinary traction.

20 A. Permanent, permanent, but it would be mild.

21 Q. Okay. Do you agree that the, that Task Force
22 report says that permanent brachial plexus injuries can be
23 caused simply with the maternal forces of labor in the
24 absence of physician traction?

25 A. I would need to see what the sentence was.

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1 Q. You don't recall whether that Task Force report---

2 A. I don't think that---

3 Q. ---says that or not?

4 A. No, I don't think it says that about permanent
5 injury.

6 Q. Doctor, you would agree with me that you and your
7 husband's expert witness business depends a lot on there not
8 being 100 percent absolute proof that permanent brachial
9 plexus injuries like Ashley F can be caused without
10 physicians using stout traction?

11 A. I, I don't agree.

12 Q. So, if there was a videotaped delivery showing that
13 there was absolutely no traction applied to a baby's head,
14 and that baby developed a permanent brachial plexus injury
15 like Ashley F, that would you -- have no affect on
16 50-percent of your income and 30-percent of his income?

17 A. I, I don't -- no, it wouldn't.

18 Q. You think you would still be able to testify in
19 cases filed just like this?

20 A. I think I would have to review each case for its
21 specific circumstances and resultant outcome.

22 Q. Doctor, if there was a case of a permanent brachial
23 plexus injury that involved a rupture, and there was a
24 definitive video of that birth showing that the doctor
25 applied absolutely no traction at all, would you then change

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1 your opinion?

2 A. I would have to see the video.

3 Q. And a video like that would be incredibly rare to
4 exist, wouldn't it?

5 A. I would think so.

6 Q. And, in fact, with temporary injuries, there's only
7 been one video like that that exists today, right?

8 A. I don't know.

9 Q. Well, you wrote a paper on it, didn't you?

10 A. I did.

11 Q. You wrote a paper and, in that case, there was some
12 speculation that temporary injuries could occur in the
13 absence of physician traction, but there was no definitive
14 proof yet, right?

15 A. Well, I mean the proof was in that video.

16 Q. I'm talking about before the video, doctor.

17 A. I, I don't understand the question then.

18 Q. There was some indirect research that, that
19 insinuated that temporary injuries could exist in the
20 absence of physician traction, but there was no definitive
21 proof, was there?

22 A. Correct.

23 Q. But with this one in a million video where the mom
24 said I don't want any traction applied during my birth, and
25 a definitive video showing, proving, without a doubt, there

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1 was no traction used in the delivery, now everyone accepts
2 that temporary injuries can occur in the absence of
3 physician traction, correct?

4 A. Correct.

5 Q. But we don't yet have a video like that for
6 permanent injuries like Ashley F , do we?

7 A. No.

8 Q. All right. Doctor, let's wrap this up.

9 This entire idea that only nerves that have stretched
10 50-percent will rupture, that's what is the basis behind
11 your opinion that Doctor Giep applied 35-pounds of traction
12 at a 45-degree angle, correct?

13 A. No.

14 Q. Well, doctor, it's your belief that nerves that are
15 stretched to 50-degrees will always rupture or greater than
16 50-degrees will always rupture, isn't it?

17 A. 50-degrees?

18 Q. I mean 50-percent. Excuse me.

19 A. No.

20 Q. It is not your opinion that a brachial plexus nerve
21 that is stretched, stretched in excess of 50-percent at a,
22 at a 45-degree angle I guess will always rupture?

23 That's not your opinion?

24 A. No.

25 Q. Is it your opinion that Ashley F nerves

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1 stretched more than 50-percent and that's why they ruptured?

2 A. Yes.

3 Q. And is it your opinion that nerves, brachial plexus
4 nerves like Ashley F , don't always rupture at a
5 greater than 50-percent stretch?

6 A. I'm sorry. Say that again.

7 Q. Sure.

8 Is it your opinion that Ashley -- that, that brachial
9 plexus nerves at C5, C6, C7 can stretch greater than
10 50-percent without rupturing?

11 A. They can.

12 Q. They can?

13 A. Sure. They have to stretch at least 50-percent in
14 order to rupture.

15 Q. But if they can rupture at a much less stretch,
16 that means it would cause -- take much less force to rupture
17 them, correct?

18 A. No.

19 Q. Well, we'll get to that in just a second. Let's go
20 back to this.

21 So, is it your opinion that Ashley F nerves must
22 have stretched more than 50-percent to rupture?

23 A. More likely than not, yes.

24 Q. Now, when you deliver the baby that had the
25 permanent brachial plexus injury, you believe that that

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1 baby's nerves stretched only 50-percent, correct?

2 Correct?

3 A. I can't talk about that case.

4 Q. I'd ask you to turn to Page 82 of your deposition,
5 please.

6 A. Sorry. Eighty --?

7 Q. 82?

8 A. 82.

9 Q. Line 10 please.

10 I asked you the question, and your injury that was a
11 permanent injury but was not a rupture, did that require
12 50-percent stretch?

13 Your response was yes.

14 Did I read that accurately?

15 MR. HENSHAW: What line is that please?

16 MR. WEATHERLY: Line 10 to 13.

17 MR. HENSHAW: Of Page 82?

18 MR. WEATHERLY: Yes.

19 A. I can't talk about that case.

20 Q. Did I read that accurately?

21 A. I can't talk about that case.

22 Q. So, the difference between a permanent injury that
23 was not a rupture and a rupture can be as little as the
24 difference in 50-percent and just greater than 50-percent.

25 Is that accurate?

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1 A. No.

2 Q. Well, I'm confused because your case, where you
3 claim you were not negligent, had a 50-percent stretch and
4 Doctor Giep's case where he is negligent just had a "more
5 than 50-percent stretch."

6 That's the only difference, isn't it?

7 A. We're talking about what's a minimum, and you're
8 making it sound like a maximum.

9 Q. Well, doctor, there are---

10 A. So, I don't agree with you.

11 Q. You have no idea how much more than 50-percent
12 Ashley F nerves stretched, do you?

13 A. No, all I know is that it had to be at least
14 50-percent.

15 Q. Because, at 50-percent, it breaks, right?

16 A. Yes.

17 Q. And so if it's only 50-percent, apparently it
18 doesn't break, but if it's greater than 50-percent it
19 breaks?

20 A. No. No, this is sort of rudimentary rules of
21 logic. Just because a -- one sentence -- just because A
22 follows B doesn't mean B follows A.

23 Q. Well, doctor, your testimony---

24 A. If what we have is a nonconducting nerve, in
25 stretched nerve injury, for that to happen, it had to have

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1 been at least stretched beyond 50-percent of its original
2 length. That's all I can say about that.

3 Q. But, in your case---

4 A. We start with the basis that there is a rupture.

5 Q. But in your case, where there was a 50-percent
6 stretch, you were not negligent, correct?

7 A. I can't talk about that case.

8 Q. Now, you determined that Ashley F brachial
9 plexus nerve stretched greater than 50-percent simply by
10 looking at the operative report from the procedure done by
11 the plastic surgeon in Texas, correct?

12 A. Yes.

13 Q. There's nothing measured during her birth that led
14 you to that conclusion, correct?

15 A. Correct.

16 Q. Nothing in her -- in Ashley F records at the
17 hospital that led you to that conclusion, correct?

18 A. That's correct.

19 Q. Nothing in the witness testimony that leads you to
20 that conclusion, correct?

21 A. That's correct.

22 Q. Nothing in the birth record that leads you to that
23 conclusion, correct?

24 A. Correct.

25 Q. Nothing in the nurses' deposition that leads you to

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1 that conclusion, correct?

2 A. Correct.

3 Q. And, in your opinion, if there had been some nerve
4 function in Ashley F , C5, C6, and C7 nerves, Doctor
5 Giep wouldn't have been negligent in this case, correct?

6 A. I'm not sure I can answer to that yes or no.

7 Q. Doctor, please turn to Page 69 of your deposition,
8 please.

9 I asked you the question in the deposition, everything
10 in this case -- starting with Line 1. Everything in this
11 case being exactly the same, except when you receive the
12 operative or when you received an EMG from Doctor Armenta,
13 and it says that a surgery was not necessary, that the, that
14 this was some nerve function in C5, some nerve function in
15 C6, some nerve function in C7. There was a residual deficit
16 but surgery was not required and it did not indicate a full
17 rupture. You asked me, and all the maneuvers and the amount
18 of time and all that, and I told you all the same.

19 What was your answer?

20 A. That he could have met the standard of care.

21 Q. Thank you.

22 Doctor, you don't know the failure rate of a healthy
23 baby's nerve, do you?

24 A. No.

25 Q. And what, what might rupture one baby's nerves

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1 might not rupture another baby's nerves, correct?

2 A. That's correct.

3 Q. Even in the same baby, some nerves might be
4 uninjured while other nerves are injured, correct?

5 A. Yes.

6 Q. There is no literature that tells you exactly how
7 much force it takes to rupture a brachial plexus nerve, is
8 there?

9 A. No.

10 Q. And none of your data comes from direct observation
11 of live babies, does it?

12 A. No.

13 Q. It all comes from cadavers or animals or
14 biomechanical models, correct?

15 A. Yes.

16 Q. And the other researchers have---

17 A. The same would be true with the other researchers.

18 Q. Sure, and that's what I was gonna say, doctor.

19 To be fair, all the other researchers have used this
20 indirect evidence and come up with a conclusion that it
21 takes far less stretch to injure a baby's brachial plexus
22 nerves, haven't they?

23 A. That was not their conclusion, no.

24 Q. For instance, Doctor Grimm in Michigan, Doctor
25 Gonik's new research partner, she claims that it only takes

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1 18-percent stretch to rupture a baby's brachial plexus
2 nerves, doesn't she?

3 A. No, she's citing the range that was found but not
4 the median.

5 Q. Okay. But she -- the median is not what's
6 important. It's the minimum for a case like this that what
7 can rupture a baby's brachial plexus nerves.

8 So, if Ashley F brachial plexus---

9 A. You're saying that. I don't agree with that.

10 Q. Doctor, if Ashley F brachial plexus nerves
11 could be ruptured at 18-percent, they would take far less
12 traction than 35-pounds to rupture, would they not?

13 A. Not necessarily.

14 Q. But mighten they?

15 A. I, I think that's just an improper hypothetical
16 question.

17 Q. Well, it may be an improper hypothetical question,
18 doctor, but if it takes 18-pounds of force to, or, excuse
19 me, if it -- if Ashley F brachial plexus nerves only
20 have to stretch 18-percent of their original length to
21 rupture, it might take far less than 35-pounds of force to
22 rupture them?

23 A. I don't think that's true. I mean you're talking
24 about the elasticity of nerves. You would need more
25 traction. It might only stretch 18-percent in, in a small

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1 minimum number, but it may still require a lot of force
2 depending on its elasticity. So, I don't think you can make
3 that conclusion that it would take far less force.

4 Q. It might take, it might take the same force --

5 A. To rupture.

6 Q. -- but it might take a lot less, right?

7 A. No, I don't think that's necessarily normal.

8 Q. There's no circumstance---

9 A. And certainly not true from the data you're citing.

10 Q. Doctor, there's no circumstance where a nerve that
11 takes 50-percent stretch to rupture would take more force
12 than a nerve that takes 18-percent stretch to rupture?

13 A. That's not true. That's not true. It would depend
14 on the elasticity, right?

15 I mean just think of, of silly puddy.

16 All right. The thinner piece that's more elastic, you
17 pull, force, and it, it stretches more than 50-percent of
18 its length. The same amount of force in a much stiffer
19 thing of clay only manages to stretch it to 18-percent but
20 that force is the same. You can't switch the corollary.

21 Q. But you will admit it might take less?

22 A. I don't think that we know that. I don't think
23 that's ever been shown in any of the data that you're
24 citing. So, I don't agree with you.

25 Q. Okay. Doctor, well, let's get back to your claim

Deposition of Edith Gurewitsch

1 that it takes greater than 50-percent stretch of nerve to
2 rupture?

3 A. On average.

4 Q. And 35-pounds of force to create that stretch.

5 You claim to be using data in applying scientific
6 principles to come up with that opinion, right?

7 A. That's correct.

8 Q. And you claim that, by using these principles, your
9 conclusion should be fairly precise, shouldn't they?

10 A. I never said that.

11 Q. So, your opinions are not precise?

12 A. No, they are more likely than not. Within a
13 reasonable degree of medical certainty.

14 Q. You're certainly not guessing or speculating, are
15 you?

16 A. No.

17 Q. And any scientist using your scientific principles
18 should be able to reach the same conclusions on the amount
19 of stretch Ashley's nerves stretched during delivery,
20 shouldn't they?

21 A. No, reasonable scientists disagree all the time.

22 Q. So, you don't think that your findings in how much
23 stretch Ashley's nerves must have stretched to
24 rupture, that's not reproducible by other scientists?

25 A. Oh, sure, it is.

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1 Q. And you would expect other experts, using the same
2 formulas that you're using, using the same scientific data
3 that you're using, to come up with the same opinions,
4 wouldn't you?

5 A. Not necessarily.

6 Q. You don't think so?

7 A. No.

8 Q. So, if your husband's opinions in this case are
9 20-percent different than yours, that wouldn't concern you?

10 A. No.

11 Q. Thank you, ma'am. I have no further questions.

12 THE VIDEOGRAPHER: Sir?

13 MR. HENSHAW: Yes, thank you.

14 THE VIDEOGRAPHER: Are we finished?

15 MR. HENSHAW: No. Unless the doctor wants to take a
16 break.

17 Are you okay?

18 THE WITNESS: I'm okay.

19 THE COURT REPORTER: Do you mind if I take one minute
20 just to flip more paper in?

21 MR. HENSHAW: Absolutely. Sure. Let's go off the
22 record then.

23 THE VIDEOGRAPHER: The time is 6:24. We are going
24 off-the-record.

25 (Pause.)

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1 THE VIDEOGRAPHER: The time is now 6:27. We are now
2 back on the record.

3 REDIRECT EXAMINATION

4 BY MR. HENSHAW:

5 Q. Doctor Gurewitsch, in the field of medicine, is it
6 standard methodology to, to look at examples of actual body
7 tissue in order to determine the cause of a disease or other
8 cause of illness or cause of death?

9 A. Yes.

10 Q. So, for an example, when a pathologist does an
11 autopsy to determine the cause of death, he is specifically
12 going into the body to look at the organs, the tissues, to
13 look at what had previously -- what is the result of what
14 previously happened in order to determine that cause of
15 death.

16 Is that correct?

17 A. That's what they're attempting to do, yes.

18 Q. All right. So, in the methodologies that, that you
19 have referred to today, is that consistent with the
20 methodologies of determining medical causation?

21 A. Yes.

22 Q. Now, in this particular case, do we have a
23 permanent injury to the C5, C6, C7, and C8 nerves of Ashley
24 F ?

25 A. Yes, in terms of the required reconstruction, it

Deposition of Edith Gurewitsch

1 was limited to C5, C6, and C7. C8 required removing the
2 scar.

3 Q. And was it limited to just one side of her body,
4 the left side?

5 A. Yes.

6 Q. Now, you were asked extensively about questions of
7 lack of oxygen and whether or not she had had lack of oxygen
8 earlier in the labor.

9 Doctor, based upon your experience, training, and
10 knowledge, if a child is going to suffer injury because of
11 lack of oxygen, is it usually limited to just one area of
12 the body like the left shoulder?

13 A. No.

14 Q. Is it usually system wide?

15 A. Yes.

16 Q. Is it called -- is it what is usually called
17 global?

18 A. There's a lot of terminology, but it wouldn't be
19 confined to one area, no.

20 Q. And is there any evidence that there was any damage
21 done to the brachial plexus nerves of Ashley F ' right
22 shoulder?

23 A. No.

24 Q. So, in and of itself, if you look at what lack of
25 oxygen usually does and look at what happened to Ashley

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1 F , do you have an opinion, to a reasonable degree of
2 medical certainty, as to whether the brachial plexus
3 injuries that she sustained was caused by lack of oxygen?

4 A. Yes, I have an opinion. No, it was not.

5 Q. Is it more likely that the injuries that she
6 sustained were the result of a -- some type of pulling and
7 stretching of those nerves?

8 A. Yes.

9 Q. Now, is this simply based upon the research that
10 you and your husband have done or are there other
11 researchers who have also looked at the question of what can
12 cause a permanent brachial plexus injury?

13 A. Actually, we haven't done the research on actual
14 brachial plexus nerves. So, it's all on -- based on
15 existing literature from other authors.

16 Q. From other authors?

17 A. That's correct.

18 Q. Peer reviewed authors?

19 A. Yes. Textbooks.

20 Q. Going back for how long?

21 How many years?

22 A. Since the 1800s.

23 Q. Since the 1800s?

24 A. Yes.

25 Q. Now, is it -- would it be fair to say that, if a

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1 doctor uses traction, that it pulls the baby's head, but
2 only pulls the baby's head enough so that it does not cause
3 any brachial plexus injury, that that's within the standard
4 of care?

5 A. More likely than not, yes.

6 Q. Okay. Is it fair to say that, more likely than
7 not, if a doctor, in delivering a baby, pulls the baby's
8 head, uses traction, so as -- that, when the baby is born,
9 there is a temporary injury to the brachial plexus nerves,
10 but then that temporary injury resolves, is not a permanent
11 injury, that that's not considered to be a deviation of
12 standard medical care in most circumstances?

13 A. It -- usually. Usually not.

14 Q. Okay. And -- but if a doctor, in applying traction
15 to the baby's head, causes, pulls to such a degree that it
16 causes permanent injury to the baby's brachial plexus
17 nerves, at least in a situation where it causes injury to
18 each of the nerves that make up the brachial plexus, all
19 five of them, is that more -- most likely to be because the
20 doctor used more pressure than was necessary to deliver the
21 child under those circumstances?

22 A. It depends what the circumstances were.

23 Q. Well, I understand. But in the circumstances where
24 the baby can be freed up with McRoberts and suprapubic
25 pressure and the babies own turning within one to two

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1 minutes.

2 A. I'm not following the question.

3 Q. Well, I'm just trying to determine at what point do
4 we say, in the field of medicine, that a doctor has used too
5 much traction, too much force in the application of
6 traction?

7 A. It depends on the circumstances surrounding that
8 delivery.

9 Q. Okay. But in circumstances such as Ashley F
10 situation where all five nerves sustained injury after
11 the---

12 A. That's, that's an after effect.

13 Q. Oh, okay.

14 A. That's not the circumstances of the delivery.

15 Q. All right. Okay. All right. Well, thank you.

16 Circumstances that the doctor quickly diagnoses that
17 there is shoulder dystocia after the turtle sign and begins
18 to implement the maneuvers of the McRoberts and suprapubic
19 pressure, and suprapubic pressure, and within one to two
20 minutes the baby is delivered, under those circumstances
21 where the child suffers permanent injury, is it most likely
22 because unnecessary pressure was applied?

23 A. That would depend on the nature and extent of the
24 injury.

25 Q. All right. And, and given the extent of the

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1 injury, being all five nerves being implicated with injuries
2 here, four of them being described as ruptured and one of
3 them being described as stretched to the point where scar
4 tissue formed and developed a neuroma, would that, most
5 likely, in your opinion, be because there was unnecessary
6 pressure applied to this baby's head?

7 A. Under those circumstances, yes.

8 Q. And that would be a deviation from standard medical
9 care in your opinion.

10 Is that correct?

11 A. Yes.

12 Q. Now, doctor, you were asked about this booklet from
13 the American College of Obstetrics -- Obstetricians and
14 Gynecologists Neonatal Brachial Plexus Palsy.

15 A. Yes.

16 Q. And you're familiar with that book?

17 A. I am.

18 Q. And, in fact, you, you have several articles cited
19 by this very booklet.

20 Is that correct?

21 A. That's correct.

22 Q. For example, at Page 86 in Appendix A, Number 25 is
23 Allen, R.H., Gurewitsch, E.D., Temporary Erb Duchenne Palsy
24 without Shoulder Dystocia or Traction to the Fetal Head, a
25 publication of obstetrical -- Obstetrics and Gynecology,

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1 2005. That's one of your articles.

2 Is that correct?

3 A. That is.

4 Q. And that's cited by this booklet, Neonatal Brachial
5 Plexus Palsy.

6 A. Yes.

7 Q. Also cited is Gurewitsch, Donithan, and Stallings,
8 Moore, Agarwal, and Allen, Episiotomy Versus Fetal
9 Manipulation, in Managing Severe Shoulder Dystocia, a
10 Comparison of Outcomes, which was published in the American
11 Journal of Obstetrics and Gynecology in 2004.

12 A. Yes.

13 Q. And that's also one of your articles?

14 A. Yes.

15 Q. And there are other articles throughout this
16 publication that, that cite your publications for purposes
17 of their inclusions?

18 A. Yes.

19 Q. Now, in this appendix is included Appendix A of
20 this publication published by the American College of
21 Obstetricians, Obstetricians and Gynecologist is a pamphlet
22 called Shoulder Dystocia of the Royal College of
23 Obstetricians and Gynecologists, Green Top Guideline Number
24 42, Shoulder Dystocia, and that's a British pamphlet of
25 their organization of obstetricians?

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1 A. Yes.

2 Q. And that cites two articles by you as well?

3 A. Yes.

4 Q. At Page 79, the Appendix A talks about management
5 of shoulder dystocia, and, black letters, it states routine
6 traction in an axial direction can be used to diagnose
7 shoulder dystocia, but any other traction should be avoided.

8 A. Yes.

9 Q. Is that, in any way, different than what you stated
10 to be the standard of care today?

11 A. No, it's not. It's the same.

12 Q. And is, in fact, that the standard of care that is
13 followed not only in Britain but in America?

14 A. Yes.

15 Q. At Page 81 of Appendix A, in talking about the --
16 how should shoulder dystocia be managed, it states, at Page
17 81, the woman should be layed flat and any pillows should be
18 removed from under her back. With one assistant on either
19 side, the woman's legs should be hyper-flexed.

20 Is that what you were describing earlier today as being
21 the -- is that the McRoberts maneuver?

22 A. It is.

23 Q. Okay. If the woman is in the lithotomy position,
24 her legs will need to be removed from the supports and
25 that's the -- is that consistent with what you understand

Deposition of Edith Gurewitsch

1 should be done?

2 A. Yes.

3 Q. Routine traction, (the same degree of traction
4 applied during a normal delivery) in an axial direction
5 should then be applied to the fetal head to assess whether
6 the shoulders have been released. That's what the British
7 organization says should be done.

8 Is that the standard of care in America as well?

9 A. Yes.

10 Q. And was it the standard of care in 2008?

11 A. Yes.

12 Q. And that's a situation where the doctor does not
13 apply any more traction than would normally be necessary had
14 the baby not had shoulder dystocia at all.

15 Is that right?

16 A. That's correct.

17 Q. And, and the doctor should not move the baby's head
18 downward so significantly that it can cause stretching of
19 the nerves within the neck.

20 Is that right?

21 A. Axial means along the axis of the spinal column.

22 Q. Just keeping it straight?

23 A. That's correct.

24 Q. Let the baby's head come, come on out straight with
25 the body?

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1 A. Keeping, keeping the head lined up with the baby's
2 body.

3 Q. All right. And that's the standard of care?

4 A. Yes.

5 Q. And since the 1800s, have we known that if a doctor
6 fails to meet these guidelines, then he, unnecessarily, runs
7 the risk of stretching the baby, baby's nerves on one
8 shoulder or the other and causing a brachial plexus injury?

9 A. I don't -- I can't answer about unnecessary cause
10 you're not including any circumstances.

11 Q. All right. I'm sorry.

12 But, but that if he does not keep the baby's head in an
13 axial direction or in, in -- and, and use routine traction,
14 which means the same degree of traction applied during a
15 normal delivery, then the doctor runs the risk of causing
16 injury to the brachial plexus nerves on one side of the
17 baby's body?

18 A. It can cause injury on both sides if you change
19 direction.

20 Q. Okay. But, but---

21 A. But otherwise, yes.

22 Q. When we talk about this nerve injury to the
23 brachial plexus, are we actually talking about simply how
24 much the nerve gets stretched?

25 A. No.

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1 Q. We're not?

2 It's not a matter of stretching the nerves?

3 A. It is a matter of stretching the nerves.

4 Q. And in terms of the injury -- in terms of causing
5 injury is -- are we concerned that we will stretch the
6 nerves and cause injury?

7 A. Yes.

8 Q. And so -- and the -- is the permanency of the
9 injury usually or most likely determined by how much the
10 nerves were stretched?

11 A. More often than not, yes.

12 Q. Doctor, do you have an opinion, to a reasonable
13 degree of medical certainty, as to whether Ashley F
14 C5, C6, C7, and C8 nerves were stretched to the point that,
15 during the delivery, to the point where it caused her to
16 have permanent injury?

17 A. I'm sorry. I don't understand the question.

18 Q. Do you have an opinion, to a reasonable degree of
19 certainty, as to whether or not the stretching of Ashley
20 F nerves during her delivery most probably caused her
21 to have permanent injury to those nerves?

22 A. Yes.

23 Q. Do you have an opinion, doctor, as to whether it
24 was necessary for Doctor Giep to stretch those nerves to
25 that degree as to cause permanent injury to her brachial

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1 plexus nerves?

2 A. Yes, it was.

3 Q. So, it was necessary for him to stretch those
4 nerves that, that far?

5 A. To cause an injury like that?

6 Q. Right.

7 A. Yes.

8 Q. But was it necessary for him to do that in order to
9 deliver her?

10 A. No.

11 Q. Do you have an opinion as to whether she most
12 likely could have been delivered without stretching those
13 nerves to that extent?

14 A. Yes.

15 Q. And what is that opinion?

16 A. That, that it -- this injury could have been
17 avoided.

18 Q. Just to ask about these Apgars. You were asked
19 about muscle tone.

20 If a baby has a head injury that affects their shoulder
21 and their arm, can that be -- is, is that something that can
22 have the appearance of a muscle tone problem?

23 A. Yes.

24 Q. So, when the nurse downgrades Ashley F for
25 muscle tone on the Apgar scoring, would it be correct to do

Deposition of Edith Gurewitsch

1 that if, if there was a brachial plexus injury?

2 A. Yes.

3 Q. You were asked about the fetal heart tone
4 monitoring strip and what it showed about the baby's
5 heartbeat, and about the circumstances prior to the baby's
6 delivery.

7 Was there anything on that fetal heart tone monitoring
8 strip that would medically justify the amount of traction
9 Doctor Giep applied to Ashley F after he diagnosed
10 shoulder dystocia?

11 A. No.

12 Q. Was it a -- did the fetal heart tone monitoring
13 strip indicate that he needed to apply so much traction that
14 he could cause injury to the brachial plexus in order to
15 deliver her?

16 A. No.

17 Q. In the moments -- in the, in the minutes, the two
18 minutes that followed his diagnosis of the shoulder
19 dystocia, was Doctor Giep facing an emergency of, of such
20 gravity that it was going to, within that period of time,
21 involve either death or serious bodily injury?

22 A. No.

23 Q. When you were asked about the amount of traction he
24 applied being 35-pounds, you actually have stated, in your
25 opinions, that he most probably used an amount of traction

1 in excess of 35-pounds.

2 Is that correct?

3 A. Yes.

4 Q. So, 35-pounds, something in excess of 35-pounds,
5 but an unknown amount is what was problem -- most probably
6 used by him.

7 Is that your opinion?

8 A. That it was at least that much.

9 Q. Okay. And, under these circumstances, would you
10 expect a reasonably competent obstetrician to use that much
11 traction to deliver the child?

12 A. Under these circumstances?

13 Q. Yes, ma'am.

14 A. No.

15 Q. And that would be your opinion to a reasonable
16 degree of medical certainty?

17 A. Yes.

18 Q. Doctor, that's all the questions I have. Thank
19 you.

20 THE COURT: Okay. Ladies and gentlemen, I think that
21 will take us to the conclusion of the day. So, we will
22 resume in the morning beginning at 9:30.

23 Keep in mind, again, during the overnight recess, no
24 discussions about the case with anybody in any fashion. No
25 research. No investigation. Do have a good evening.

Treva Flowers - Direct examination
by Mr. Henshaw

1 Mr. Lovell?

2 MR. LOVELL: I'm sorry, judge?

3 THE COURT: You have no other designations?

4 MR. LOVELL: No, sir, that was it.

5 THE COURT: Okay. All right. Bring them in.

6 (WHEREUPON, the following takes place within the
7 presence of the jury.)

8 THE COURT: All right. The jury is present.

9 You may proceed.

10 MR. HENSHAW: Thank you, Your Honor.

11 We would call Treva Flowers please.

12 TREVA FLOWERS, being first duly
13 sworn, testified as follows:

14 DIRECT EXAMINATION

15 BY MR. HENSHAW:

16 Q Mrs. Flowers, please state your full name.

17 A Treva Charese Flowers.

18 Q All right. Pull that microphone up just a little bit
19 so that it gets closer to your mouth and we can hear you a
20 little bit better.

21 Restate your name please.

22 A Treva Charese Flowers.

23 Q I think that's a little bit better. Thank you.

24 A You welcome.

25 Q Mrs. Flowers, where do you live?

Treva Flowers - Direct examination
by Mr. Henshaw

- 1 A Simpsonville, South Carolina.
- 2 Q And where in Simpsonville do you live?
- 3 A 9 Scotts Bluff Drive.
- 4 Q Who lives there with you?
- 5 A My husband and my two children, Ashley and Josiah.
- 6 Q And who is your husband?
- 7 A Tristan Flowers.
- 8 Q And this is Mr. Flowers sitting over here next to you?
- 9 A Yes, it is.
- 10 Q And you've mentioned two children.
- 11 That would include Ashley?
- 12 A Yes.
- 13 Q And Ashley is how old now?
- 14 A She's nine years old.
- 15 Q And just had her birthday?
- 16 A Yes.
- 17 Q And you mentioned another child.
- 18 A Josiah, her brother, who will be four in December.
- 19 Q All right. And what -- when was Josiah born?
- 20 A December 30th, 2013.
- 21 Q All right. And do they get along?
- 22 A Sometimes.
- 23 Q Now, are you employed?
- 24 A No, I'm not.
- 25 Q Where did you -- where were you born?

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by Mr. Henshaw

1 where did you grow up?

2 A I was born here in Greenville, South Carolina that --
3 that's where I spent most of my life. I moved away for the
4 first time in, I believe it was, 1999. Tray and I, my
5 fiance at the time, went off to college in Florida. So,
6 that's my first time moving away.

7 Q where did you go to schools here?

8 A Elementary school, I started out at Alexander
9 Elementary School, which is in Greenville.

10 Q okay.

11 A Middle school, Tanglewood Middle School, Carolina High
12 School. About a year after that I started Greenville
13 Technical College, and I went there for about three years
14 and finished, but after -- let's see. After about a year of
15 that schooling, I enrolled in ITT is where I met my husband,
16 1996.

17 Q ITT where?

18 A Technical -- in Greenville.

19 Q okay.

20 A ITT Technical Institute, Institute in Greenville.

21 Q All right.

22 A I met, then at the time, boyfriend.

23 Q All right. So, when you started higher education after
24 high school, what was your intent?

25 what kind of degree were you trying to get or what were

Treva Flowers - Direct examination
by Mr. Henshaw

1 you trying to get into?

2 A Electronics engineering technology, and that's -- I did
3 receive an associates degree, Associate of Arts. I'm sorry.
4 Associate's of Science Degree in Electronics Engineering
5 Technology, and---

6 Q Where did you get that?

7 A ITT Technical Institute.

8 Q Okay.

9 A And after that, like I said, we moved to, moved to
10 Florida and with intent on getting a Bachelor's Degree in
11 Telecommunications Engineering Technology, and we both
12 received that about a year later.

13 Q And so have you been able to utilize that degree or
14 those degrees?

15 A I have. I have. My, my first job from the Associate's
16 Degree, I got a job at Robert Bosch in Anderson where I was
17 a lab technician for the engineers. And when we moved to
18 Florida, I got a job -- while we were in school in Florida,
19 I got a job working at Siemens Information and
20 Communications, I believe it was networks, ITNT, ITN,
21 working as another lab technician.

22 Q Okay. And where else have you been employed?

23 A Let's see. Once I graduated from ITT in Florida in
24 2000, I joined the military about maybe two months later,
25 and that's where I spent four and a half years in the

1 military.

2 Q Okay.

3 A And, after the military, I got out and I got a job at
4 BMW Manufacturing and briefly, after that, I taught at ITT
5 Technical Institute as an adjunct instructor for maybe six
6 months. And that was my last place of employment, ITT and
7 BMW.

8 Q All right. Now, when you were in the military, where
9 were your assignments?

10 A My first assignment, basic training, was Fort Sill,
11 Oklahoma. My first assignment was Monterey, California at
12 the Defense Language Institute, and, let's see, after
13 that -- I think I was out there about a year and a half.
14 After September 11th, I came up on orders to transition to
15 Germany. So, I spent about three years in Germany, and I
16 was also deployed Iraq for about six months, and then
17 redeployed back to Germany for the remainder of my duty.

18 Q All right. Where were you in Iraq?

19 A I was in Kirkuk, Iraq.

20 Q And was that a war zone?

21 A Yes, it was.

22 Q Okay. What was your assignment there in Kirkuk?

23 A I was actually a part of the Post Office. Our mission
24 was to set up the first Post Office in the sector, and
25 that's, that -- that's primarily what we done. I worked in

1 postal, postal operations my entire, entire military career
2 plus or minus some other duties.

3 Q And how long were you there in Kirkuk?

4 A About six months.

5 Q Now, so, you came back to the States.

6 What was your relationship with Mr. Flowers during
7 that, during that period of time?

8 A It was a good one.

9 Q Well, I understand it was a good one, but were y'all
10 still engaged or not engaged or did you not know?

11 A Unfortunately we weren't engaged, but we were still on
12 good terms as friends.

13 Q Okay.

14 A And we, and we, we got back together. So, yeah.

15 Q All right. So, when did you get married?

16 A We got married May 27th, 2006.

17 Q Okay. And was he employed by the time you -- when you
18 were married?

19 A Yes, sir.

20 Q And what kind of work was he doing?

21 A He was working at Spartanburg Regional Hospital. No,
22 excuse me.

23 At the time we were married?

24 Maybe he was still -- he maybe -- he, he may have been
25 still with Siemens cause he worked for Siemens for a long

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by Mr. Henshaw

1 time, and then I think he got hired on at the hospital. My
2 timing may be a little bit off but---

3 Q Okay.

4 A It was one of the two.

5 Q So, how long was it after you were married that y'all
6 started looking to have a baby?

7 A About a year.

8 Q And did things go as planned?

9 A It did.

10 Q And you got pregnant?

11 A I did.

12 Q And this was your first baby?

13 A First one.

14 Q And that turned out to be Ashley?

15 A Yes.

16 Q Okay. Now, let's talk about your pregnancy. Just let
17 us understand what you went through.

18 You got pregnant and how did you find out?

19 Home test?

20 A No, sir, not a home test. We were actually at the
21 doctor's office at -- I think -- I was trying about nine
22 months to conceive and it just wasn't happening. So, my
23 husband and I discussed getting tested. He -- it was easier
24 to get him tested first we were told. So, we got him
25 tested, and before we even got his results back, I was going

1 to get tested. And while I was there to get tested, I
2 performed urinalysis, and as soon as they checked it, I was
3 pregnant. So, we never even got his results back before I
4 find out I was pregnant, but he, he was good anyway. So --.

5 Q Okay. So, did you have a doctor already or did you
6 have to seek out a doctor?

7 A I was actually going to Doctor Brenda Adams-Hudson and
8 she's our, she's our family physician. I was going to her,
9 but when I found out I was pregnant, she told me I needed to
10 find an OB-GYN. And that's, that's when I sought out Doctor
11 Ashley Fowler.

12 Q Okay. And what, and what practice was she in at that
13 time?

14 A Spartanburg & Pelham OB-GYN.

15 Q And it was already being known as Spartanburg &, &
16 Pelham at that time?

17 A It may have been Village at Pelham at the time.

18 Q Okay.

19 A Yeah.

20 Q And so about how far along were you when you first saw
21 Doctor Fowler at Spartanburg & Pelham?

22 A Oh, not far at all. Maybe a couple weeks.

23 Q Okay.

24 A If, if I remember.

25 Q And so how did the pregnancy go under, under her --

1 under the management of Spartanburg & Pelham?

2 A It was well, you know. It was, from, from what I
3 understand, normal. It was, it was --.

4 Q Now, did you understand that you had just simply be
5 seeing Doctor Fowler the -- every time you went to, to the
6 doctor's office or did they rotate you through the various
7 doctors in the practice?

8 A I was rotated through the various doctors in the
9 practice.

10 Q And you understood that?

11 A Initially, I thought she was gonna be my only doctor,
12 but once I chose her, then it was explained I would be seen
13 by other doctors because it's a group and I was okay with
14 that.

15 Q And did you understand that one of the reasons for that
16 was so that, in the event that another doctor had to cover
17 at -- during your labor and delivery, you would have some
18 familiarity with the doctor?

19 A That's correct.

20 Q All right. Did you see Doctor Giep during your course
21 of office visits at Spartanburg & Pelham?

22 A I, I did see him.

23 Q Okay. And, as far as you know, through most of the
24 pregnancy, did everything go okay?

25 A It did.

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by Mr. Henshaw

1 Q Now, we have already heard, and it's in evidence, that,
2 at some point, you were diagnosed with gestational diabetes.

3 Is that correct?

4 Is that to your understanding as well?

5 A That's correct.

6 Q And approximately when was that?

7 A Oh, I was several months pregnant. I'm not sure how
8 far along, but it wasn't at the beginning.

9 Q Okay. And so, once you were diagnosed with gestational
10 diabetes, what were you told about it?

11 What was the plan?

12 A I was told that gestational diabetes could cause an
13 enlarged baby, and that I would have to manage my diet --
14 well, manage the diabetes with diet and exercise. That's,
15 that's all I remember though.

16 Q And, and -- and is that the way it went from that
17 points on in terms of the gestational diabetes diet, excuse
18 me, diet and exercise?

19 A It did.

20 Q Did you ever have to take any type of Insulin?

21 A No, sir.

22 Q Or any other type of medications related to the
23 gestational diabetes?

24 A I did not.

25 Q Okay. Did you keep all your appointments?

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by Mr. Henshaw

1 A I did.

2 Q Did you do everything that the doctors told you to do
3 during the pregnancy?

4 A Yes, I did.

5 Q And what were the plans as you got close to delivery?

6 A Could you be more specific?

7 Q well, yes.

8 what were the plans in terms of what hospital you would
9 go to, how you would get there, how you'd be admitted, that
10 sort of thing?

11 A Okay. I'm sorry. The plan was -- well, we had already
12 packed our bag, and the plan was to go to Spartanburg
13 Regional Hospital. I think it was Spartanburg Regional
14 Hospital at the time. And my husband was gonna take me and
15 that's pretty much how it happened.

16 Q well, were you preadmitted?

17 Do you know?

18 A I -- you know, I think I was.

19 Q Okay.

20 A I think so.

21 Q So, it was just a matter of you showing up when you
22 needed to show up?

23 A Yes.

24 Q Okay. And when did that happen?

25 A October 7th, it was some time after midnight. I

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by Mr. Henshaw

1 don't, don't remember the exact time, but I was asleep and I
2 felt the urge to go to the bathroom. So, as soon as I stood
3 up, fluid flowed and, at the time, honestly, I wasn't sure
4 if it was actually my water because I did have the urge to
5 go to the bathroom, but there was no effort on my part to
6 release. So, I assumed it was my water.

7 And I woke my husband up and I said, Tray, I think my
8 water broke, and he said are you sure? He said how you
9 know? And I said, well, I'm standing in fluid. So, I went
10 to the bathroom. He said oh. He jumped up and he's like
11 oh, let me call the doctor. And I can't remember if I
12 called or he called.

13 But I went to the bathroom, you know, cleaned myself up
14 and we hurried out the door -- but let me, let me back up.
15 I, I did talk to Doctor Fowler and she said okay, I'll meet
16 you at the hospital, and then we hurried out the door. And
17 once we got there, I remember checking in at the, the desk
18 in the -- on the labor, labor and delivery floor, and they
19 put me into a small room and hooked me up to the necessary
20 equipment for monitoring and I stayed there. It seems like
21 a couple hours.

22 Q So, from what I take from your testimony is, is that,
23 at home, both of y'all were just cooling, calm, and
24 collected, and no, no excitement at all?

25 A I think he was more nervous than I was.

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by Mr. Henshaw

1 Q And so -- but he did get you to the hospital?

2 A He did fast.

3 Q All right. And you got in and they confirmed that your
4 water had broke?

5 A Yes.

6 Q And that you were gonna be delivering?

7 A Yes.

8 Q And how far off -- how far was this from your due date?

9 A My actual due date was October 11th. So, four days.

10 Q All right. So, you were essentially full term?

11 Is that your understanding?

12 A Yes.

13 Q And had there been any discussions about any concerns
14 about what would need to be done once you got to the
15 hospital in your earlier meetings with Doctor Fowler or any
16 of the other doctors?

17 A Any concerns about what would be done?

18 Q Right.

19 I mean was -- were you, were you -- did they consider
20 you to be too big?

21 Did they consider you to be okay?

22 What was the -- what was your understanding about how
23 things would probably go once you got to the hospital?

24 A Everything -- so, everything that I remember was
25 normal. There was no---

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by Mr. Henshaw

- 1 Q Was it planned to be a vaginal delivery?
- 2 A Yes.
- 3 Q And you understood that?
- 4 A I did.
- 5 Q Okay. And this is your first baby?
- 6 A Yes.
- 7 Q So, you got there, the nurses confirmed that your water
- 8 had broken, you were gonna be having a baby?
- 9 A Yes.
- 10 Q All right. What kind of room did you go into?
- 11 A Initially it was just -- it was pretty small, but just
- 12 a regular bed, a TV, and they brought in the -- I think the
- 13 monitoring machine. It was just a basic room. Maybe had a
- 14 chair.
- 15 Q Okay. And so did you see Doctor Fowler?
- 16 A Eventually I did.
- 17 Q All right. And she examined you?
- 18 A She did.
- 19 Q Did she indicate that there was any particular concerns
- 20 about you going forward and delivering the baby vaginally?
- 21 A No concerns.
- 22 Q Do you know whether they put you on any kind of
- 23 medication to induce your labor?
- 24 A Not, not right away they didn't.
- 25 Q Did they ever?

1 A They did. Once I moved, they, like I said, eventually
2 they moved me to the labor and delivery room where I would
3 actually have Ashley, and they expressed to me that they
4 were going to induce my labor because I was progressing kind
5 of slowly to their opinion. And, at some point, I was given
6 the medicine to induce.

7 Q Did you know that you were gonna have a little girl?

8 A I did.

9 Q And, and was that because of ultrasounds that had been
10 done?

11 A Yes.

12 Q Do you know how many ultrasounds they did over the
13 course of your pregnancy?

14 A At least three.

15 Q And did, did any of the doctors ever express any
16 concerns about what the ultrasounds had shown?

17 A No.

18 Q How many times did you see Doctor Fowler that day?
19 Do you remember?

20 A I don't recall exactly, but I know it was two. I
21 remember she checked me initially for -- to, to see how far
22 I had dilated and I remember seeing her again before she
23 left to let me know her shift was over.

24 Q All right. She came in and saw you?

25 A She did.

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by Mr. Henshaw

1 Q Did she explain to you that another doctor would be
2 taking over?

3 A Yes, she -- yes.

4 Q And did she explain who the doctor was?

5 A She didn't know.

6 Q And so approximately what time was it that she left and
7 came to see you to let you know she was leaving?

8 A It was in the evening time. I don't remember exactly
9 the time, but it was in the evening when she came by last.

10 Q And, by that time, were you in the labor and delivery
11 room?

12 A I was.

13 Q And, by that time, were you being induced with
14 medication?

15 A I had already been induced, yes.

16 Q Now, who was there that evening with you?

17 A That evening, I had a lot of family members. My --
18 both my in-laws were there, my sister-in-law, my sister, my
19 mother, my cousin, her daughter. I think my niece was
20 there. Maybe that was it. My husband, of course. But
21 maybe that was it.

22 Q Did -- were they all in the room with you?

23 A Not at one time, no, sir. They would, they would take
24 shifts --

25 Q Okay.

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by Mr. Henshaw

1 A -- and all, but I did see all of them at some point but
2 not --.

3 Q What about your husband, did he stay in the room with
4 you?

5 A Absolutely.

6 Q Okay. And so, as far as you knew, how did your labor
7 progress?

8 A Slowly. It, it, it progressed pretty slowly. It
9 seems, seems like forever. Like I, I said, I'd gotten there
10 after midnight and then I didn't deliver until 8:20 the --
11 that same time. So, it was, it was fairly long.

12 Q Okay. Was that -- did anybody express any concern to
13 you about the fact of, of the pace of your labor?

14 A Only when they told me they were gonna give me
15 something for induction and---

16 Q Okay.

17 A ---that --.

18 Q Who told you and what did they say?

19 A One of the nurses, they -- she just said we're gonna
20 give you something to help further along the process and
21 that was it.

22 Q Okay. So, Doctor Fowler leaves.

23 Do you immediately see Doctor Giep or was it later that
24 you saw Doctor Giep?

25 A No, it was later. Some time around 8:00ish when I saw

1 him.

2 Q Okay. What were the circumstances when he came into
3 the room?

4 A Well, I was already -- I started pushing. Within the
5 seven o'clock hour, I started pushing. One of the nurses
6 instructed me to push, and I, at some point, I told him I
7 felt pain and they said okay, let me give you another
8 epidural, and they called for a doctor to come. But I -- it
9 was a while before the -- I got the second epidural.

10 Q So, you had an epidural earlier?

11 A I had an epidural early and they told me it wore off.
12 So, they give me a second one. Well, that, that one never
13 took because, when they instructed me to push again, I still
14 felt pain.

15 Q When you say that one never took, you're talking about
16 the second epidural?

17 A The second epidural, I never felt a difference in the
18 pain I had before.

19 Q Now, was Doctor Giep in the room when you were first
20 instructed to push and you said you had pain?

21 A No, sir.

22 Q What about after the epidural, the second epidural was
23 administered, were you still being asked to push?

24 A I was.

25 Q Was he in the room at that point?

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by Mr. Henshaw

1 A He was not.

2 Q Okay. And had you seen him or any other doctor after
3 Doctor Fowler had left?

4 A Only the anesthesiologist if -- I'm not sure if they're
5 doctors, but someone came in to -- they gave me something in
6 my vein after the second one didn't take.

7 Q Okay.

8 A And that was, to my understanding, it was a doctor.

9 Q So, do you know how many pushes you made before you saw
10 Doctor Giep?

11 A It was a couple. I don't remember exactly.

12 Q All right. When you were asked to push, were you in
13 stirrups?

14 Had they put you in -- put up stirrups yet?

15 A I don't remember.

16 Q Okay. And so approximately how many times did you push
17 before Doctor Giep came in?

18 A Approximately at least two or three. I don't, I don't
19 remember exactly honestly.

20 Q Do you -- did the nurses inform you that they were
21 getting ready to call the doctor?

22 Do you remember that?

23 A I don't remember her saying we need to call the doctor.
24 I don't remember that. I remember her leaving or she, she
25 left my bedside. I don't know if she left the room or she

1 just, you know, went to a corner, but she saw me before the
2 doctor had come in.

3 Q Okay. Did the nurses make any examination of your
4 pelvic area at any point that you remember?

5 A Not that I remember.

6 Q So, were they saying anything to you about whether they
7 could or could not see the baby's head beginning to crown?

8 Did you ever hear that?

9 A I did hear somebody say oh, this baby has a lot of
10 hair. So --.

11 Q And was that before or after Doctor Giep came in?

12 A Before.

13 Q Okay. So, then did Doctor Giep arrive in the room?

14 A At some time he did.

15 Q Tell us what you remember from that point.

16 A Oh, I remember seeing Doctor Giep walk in the room, and
17 he immediately came to my bedside, and started telling me --
18 and I remember a couple nurses saying push, push, and I know
19 I had one at my right side, one at my left, and the doctor
20 and my husband's at my left side. But I just remember
21 people saying a lot, to just push, push. They just kept
22 saying push. So, that's---

23 Q Okay.

24 A That was my job. I was pushing.

25 Q All right. And were you aware of what was happening

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by Mr. Henshaw

1 down below in terms of the baby's head being born or
2 anything like that?

3 A I knew eventually she was coming. They saw the hair.
4 So, I, I kind of knew she was coming, but --.

5 Q All right. But other than that, did you know when the
6 head was born?

7 A No.

8 Q Were you aware or were you made aware that there was
9 any problem delivering the body?

10 A No.

11 Q That wasn't something that you knew about?

12 A No, it wasn't actually mentioned.

13 Q All right. Was there anything unusual that happened
14 during the baby's birth that you remember or what seemed
15 unusual to you?

16 A You mean after she came out?

17 Q No, before she came -- got completely born.

18 A The only unusual thing I noticed, at some point, that
19 Doctor Giep had a -- some type of monitor around his neck,
20 and I remember him calling somebody. I don't remember what
21 he said, but -- and then a nurse got -- it appeared that she
22 got on my bed, but she was -- she's -- her body was higher
23 than my husband, and he stands 5'11". He was next to my
24 bedside.

25 So, to me, it seems like she was on my bed and she was

1 pressing on my stomach really, really hard. I thought that
2 was unusual.

3 Q Okay. Do you recall having your legs put into stirrups
4 at any point?

5 A Yes, they were in stirrups at some point.

6 Q Okay. Do you recall whether they were ever moved out
7 of the stirrups into another position?

8 A They were. They were brought back behind me -- back
9 behind me.

10 Q Okay.

11 A Yes.

12 Q And did you do that on your own or were you assisted in
13 having your legs brought back?

14 A Oh, no, I was assisted by two people.

15 Q Okay.

16 A One person was---

17 Q Do you know who they were?

18 A There was a nurse over here and I'm not sure who
19 grabbed the other one. There's a nurse on our bed. I
20 really couldn't see who had the other one.

21 Q Okay.

22 A So --.

23 Q Do you recall being able to see Doctor Giep?

24 A At that point?

25 Q During that period of time when your legs are back and

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by Mr. Henshaw

1 the nurse is pushing.

2 A The nurse is on my stomach. If -- I couldn't really
3 see him because the nurse was blocking my vision. She was
4 in front of me.

5 Q Okay.

6 A I couldn't really see him.

7 Q All right. Do you recall him saying anything?

8 A No.

9 Q And were you, in any way, knowledgeable that you were
10 in the middle of a birthing complication?

11 A No.

12 Q That was not known to you?

13 A It wasn't known. At least I didn't assume that.

14 Q Okay.

15 A So --.

16 Q Did you know that Doctor Giep cut you?

17 A After the fact I knew.

18 Q But while it was actually happening, were you aware of
19 that?

20 A No.

21 Q And there wasn't any pain associated with that
22 apparently?

23 A No, I couldn't feel anything.

24 Q Now, were you aware when the baby was born?

25 A Yes.

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by Mr. Henshaw

1 Q And before the baby was completely born, were you aware
2 of any of the maneuvers that Doctor Giep was performing with
3 his hands?

4 A No.

5 Q Okay. Do you have any way of knowing how much traction
6 that he used or didn't use in the, in the delivery of
7 Ashley?

8 A I don't know.

9 Q That's not something that you were in a position to
10 know?

11 A No, that's not my area of expertise.

12 Q All right. So, Ashley is born and what did you know
13 about her in the moment or moments right after she was born?

14 A I, I kept remember -- I kept listening for her to cry,
15 and, a couple minutes later, I did hear that. They brought
16 her over to my bedside. I got a quick glimpse at her and
17 they took her out.

18 Q Okay.

19 A That's about all.

20 Q And did they allow you to hold her at that point?

21 A No, they didn't.

22 Q Okay. Do you -- did you know why they weren't allowing
23 you to?

24 Did you expect them to let you hold her or not?

25 A Absolutely. I expected that.

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by Mr. Henshaw

1 Q And did they tell you why you were not being allowed to
2 hold her?

3 A No.

4 Q Were you able to see her arms and legs?

5 A No, she was swaddled.

6 Q Okay. So, you didn't get to count her fingers and
7 toes?

8 A No.

9 Q And what do you remember happening next?

10 A I remember Doctor Giep was still at the -- he was still
11 attending to me at the bottom, and I do remember having to
12 be sewn or stitched and it took a while. And then I was
13 given something for pain. Said I was gonna be in a lot of
14 pain. And the next time I woke up I was in my private room.

15 Q Okay.

16 A That's what I remember.

17 Q All right. And do you know what day it was when you
18 woke up in your private room?

19 A When I woke up, it was still the same night, but closer
20 to midnight.

21 Q All right. And was anyone there with you?

22 A My husband was there.

23 Q Okay. And when's the first time you saw a doctor after
24 you woke up?

25 A Shortly after I woke up Doctor Giep came in.

1 Q Okay. And did he talk to you?

2 A He talked to my husband and I both.

3 Q And do you recall what he said?

4 A He said there was some complications and I remember
5 three words. I remember shoulder dystocia, Erb's palsy, and
6 brachial, brachial plexus. And that was, that was about --
7 he said it was -- he had trouble getting her out because her
8 left shoulder was stuck against my pelvis bone.

9 Q Okay.

10 A And, after that, I just kind of zoned out because I
11 mean it was just -- that was hard to hear.

12 Q These three words, had you heard those words before?

13 A No.

14 Q Did you know what they meant?

15 A Not at all.

16 Q Did he explain what they meant?

17 A I don't remember.

18 Q Okay. So, how did you do for the rest of the night?

19 A I was torn up. I was still in a lot of pain. I was
20 emotional cause I hadn't had a chance to see my kid, and --
21 but, after he left, Tray and I were able to go to see her in
22 the neonatal intensive care unit for the first time, and it
23 was -- it was tough.

24 Q Why?

25 A When I saw her, she had some bruising on her face.

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by Mr. Henshaw

1 She's real, real greased up from the ointment they had put
2 on her. She had tubes -- well, excuse me, stickers, which
3 appeared to be -- I think I asked. They said they were
4 monitors on her head. She had oxygen in her nose. She had
5 a feeding tube. She was bandaged up and swollen, and she's
6 just laying there.

7 And I was -- that's -- I counted her fingers and toes.
8 Everything was fine, but it was, it was tough. It was tough
9 looking at her, but that's my baby.

10 Q Now, were you able to observe anything about either of
11 her arms?

12 A I saw, I saw her left arm bandaged, but I didn't know
13 why. Yeah, I, I didn't know why right away, and I think, at
14 some point, someone came over, either a nurse or a doctor,
15 and, you know, they, they explained to us that she endured a
16 lot of trauma, and that they was securing her arm so that,
17 so that it wouldn't cause for further damage, but that
18 was -- it was tough watching her just laying there.

19 Q How long did you stay in the hospital?

20 A I, I stayed an extra day. So, maybe three days at the
21 most.

22 Q How long did Ashley stay in the hospital?

23 A She was in there two and a half weeks.

24 Q Okay. And did you understand why she was in there?

25 A Yes.

1 Q And what was that?

2 A Well, they were trying to get her oxygen level back to
3 normal, and, like I say, she, she was on a feeding tube most
4 of the time, and she had to have occupational therapy while
5 she was in NICU. So, the therapist would come by at least
6 once a day and---

7 Q And what was the occupational therapy -- therapist
8 doing?

9 Do you know?

10 A Well, she was, she was exercising her arm because they
11 told us that she had some paralysis in her arm, and they
12 were trying to, you know, just keep it moving in hopes that
13 she gets some movement in it before she left, but she never
14 did.

15 Q Were you able to---

16 A She had---

17 Q ---see the arm without bandaging while she was still in
18 the hospital?

19 A I don't, I don't remember.

20 Q Okay. But what about when you got home?

21 Obviously, was that a situation where you could take
22 the bandages off and see for yourself what was going on with
23 the arm?

24 A Yes, when I got her home, she didn't have any bandages,
25 but what we had to do -- she, she -- we had to keep her arm

1 pinned to her, to her -- either her side or across her, her
2 belly to keep from it just falling because it was completely
3 limp other than just a tad bit of finger movement, which
4 didn't come till later though. We had to pin it so that she
5 wouldn't cause further damage to it if I answered your
6 question correctly.

7 Q All right. Let me put up a photograph here and ask you
8 about it.

9 A Okay.

10 Q Do you recognize this picture?

11 A Yes.

12 Q And tell us approximately when it was taken.

13 A At that time she was still in the hospital. I want to
14 say she was still in the hospital because I remember the,
15 the little shirt she had on. That was one of the first
16 shirts given to us by I think, I think my mother-in-law gave
17 her that shirt, and she was still in NICU at that time. So,
18 maybe a couple days old and see her, her left wrist is
19 bandaged because---

20 Q Right here?

21 A Yes, it's bandaged with that pin because---

22 Q This is the pin right here?

23 A Yes, it's connected to that and her shirt to keep her
24 arm from banging along her side causing further damage.

25 Q And do you recognize this photograph?

Treva Flowers - Direct examination
by Mr. Henshaw

1 A I do.

2 Q And when was approximately this taken?

3 A That was her first surgery. We were out in Texas and
4 that was right before she was six months old.

5 Q Well, I actually meant for you to probably look at this
6 picture. Let's see.

7 A Oh. Oh, we were at home then. She was maybe a month,
8 or a couple -- well, she was more than a couple weeks, but
9 between two and a half weeks and a month old.

10 Q All right. And was this the usual way that she would
11 hold her, her hand and wrist --

12 A Yes.

13 Q -- on the left side at that point?

14 A Yes.

15 Q Did that change up until the time you went to Texas?

16 A It actually got worse than that.

17 Q As time went on?

18 A As time went on it got worse.

19 Q Were you instructed on how to do any type of exercises
20 or therapies on the wrist, or arm, or shoulder?

21 A Before surgery?

22 Q Yes, before you went to Texas.

23 A We were instructed to do some stretching, range of
24 motion, just gentle movement, in, out, you know, up, down.
25 Just gentle range of motion movement.

Treva Flowers - Direct examination
by Mr. Henshaw

1 Q And did, did that seem to cause things to improve or
2 not?

3 A I really can't, really can't say.

4 Q Okay.

5 A Because she never really -- the only movement we ever
6 saw was fingertips.

7 Q Okay.

8 A So, really no change. It's -- her arm eventually
9 became rotated like this --

10 Q All right.

11 A -- before surgeries. So --.

12 Q As, as the months wore on?

13 A Yes.

14 Q Now, was she able to pull the arm in at the elbow?

15 A No.

16 Q Did she seem to have any movement in her shoulder?

17 A Not that I remember.

18 Q Okay. And what about the arm itself?

19 Did she use it in any way similar to the way she was
20 using her right arm and hand?

21 A No.

22 Q So, did you seek out medical help for these conditions
23 related to her left shoulder, arm, wrist, and hand?

24 A We did.

25 You mean outside of therapy?

Treva Flowers - Direct examination
by Mr. Henshaw

1 Q well, yes.

2 I mean what, what type medical -- what kind of medical
3 help did you look for?

4 A We were actually referred to Charlotte at the -- I
5 think it's called Carolinas Medical Center in Charlotte.

6 Q All right. Who made that referral?

7 A Doctor Giep referred us to Doctor Maureen Nelson in
8 Charlotte because she specialize in kids with these type
9 injuries. And while we were there, she told us about Doctor
10 Armenta out in Houston, Texas, and the fact that they hosted
11 a clinic about twice a year for kids with these type
12 injuries, and she invited us to the clinic when the doctors
13 came down. And we were introduced to Doctor Armenta at that
14 time.

15 Q Where was that?

16 A That was in Charlotte. We had to drive to Charlotte to
17 go meet them --

18 Q All right.

19 A -- at the clinic.

20 Q So, you first met with Doctor Nelson?

21 A Yes.

22 Q And how many visits did you have with her before you
23 were introduced to Doctor Armenta?

24 A Oh, numerous.

25 Do you want a number?

Treva Flowers - Direct examination
by Mr. Henshaw

1 Q Well, I mean---

2 A I---

3 Q Was it more than one or was it just the one visit and
4 then you met Doctor Armenta?

5 A No, it's more than twice.

6 Q All right.

7 A More than twice.

8 Q Did she actually undertake any treatments before Doctor
9 Armenta became involved?

10 A She instructed us on therapy and we just continued with
11 therapy up until we met Doctor Armenta.

12 Q What did the therapy involve?

13 A Range of motion and stretching.

14 Q Where was it done?

15 A Initially, I did a lot of it at home, but she's had
16 several people who did therapy with her. We were set up
17 with BabyNet at Spartanburg Regional initially and -- excuse
18 me. After she was born, we went to Spartanburg Regional for
19 therapy for maybe a month, and then BabyNet got involved and
20 started coming to our home. So, I did therapy with her at
21 home. The BabyNet came in with occupational and physical
22 therapy into our home, and --.

23 Q All right. So, then, through Doctor Nelson, you were
24 introduced to Doctor Armenta.

25 Is that right?

Treva Flowers - Direct examination
by Mr. Henshaw

1 A That's correct.

2 Q And that, that took place in Charlotte?

3 A It did.

4 Q But he was actually located in Texas?

5 A In Houston, Texas, yes.

6 Q Okay. And what did you understand was his working
7 relationship with Doctor Nelson?

8 A They worked together to treat the kids with brachial
9 plexus and other type of injuries related to or with a
10 similar, similar injuries.

11 Q Did he undertake an examination of Ashley?

12 A He made an assessment, yes, a physical assessment of
13 her when he saw her.

14 Q And then did he advise you as to what he thought could
15 be done?

16 A Yes.

17 Q You---

18 A He did.

19 Q Was your husband also involved in that?

20 A Yes, he was there.

21 Q And what did you understand from him or what were his
22 proposals to you as to what could be done?

23 A Well, he was saying, with Ashley's injury, typically it
24 would require surgery to repair the nerve damage that was
25 caused, and he said that the best time to do it is before

1 the baby is six months of age. And we were excited because
2 he told us he had some, some really good results and we, you
3 know, we agreed that that was a fair, a fair thing to do.

4 Q After, after you met him or even before you met him,
5 did you check him out?

6 A We did. My husband did a lot of research. I mean he
7 was, he was really good about finding out what shoulder
8 dystocia, all those, all those three terms I mentioned, he
9 did a lot of research. I mean he's my backbone in it to
10 help kind of get things tied up. He was the driving force
11 behind it all because I, I just -- I couldn't -- he, he was
12 the one that, that helped.

13 Q Okay. So, were you satisfied that Doctor Armenta could
14 do the job if you let him?

15 A Absolutely. Absolutely.

16 Q So, what plans were made?

17 A Well, it happened kind of fast. Short minute, notice.
18 We made arrangements to have surgery set up. I believe it
19 was within the month of him telling us that she needed it
20 because we wanted to act fast, and he say he wanted to get
21 it -- Doctor Armenta said he wanted to get it while the
22 nerves are still kind of fresh, before they just go, you
23 know, I guess completely -- I don't know. He, he wanted us
24 to do it while the baby was still young before she started
25 to get older is what he said.

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by Mr. Henshaw

1 So, we made plans to go out there and we flew and she
2 was scheduled for surgery I think the following day. And
3 they -- I think the surgery lasted oh, more than eight
4 hours, and it took so long that everybody in the hospital
5 waiting area went home. Even the receptionist. I mean she
6 went home.

7 My, my husband and I were sitting in the waiting room
8 just worried because I mean we were left with a phone, and
9 we didn't know how to get in contact with the doctors. But
10 eventually the doctors came out and they were like, they
11 look like they were exhausted because the surgery took
12 longer than they expected because, once they, once they got
13 inside, they realized it was worse than they had
14 anticipated.

15 So, they repaired what was there and then---

16 Q Was Doctor Armenta one of the doctors that came out to
17 see you?

18 A Yes.

19 Q And what did he explain?

20 A He explained that there's a lot of damage. He said he
21 had never seen an injury like this before, and that -- he,
22 he said it was the worse one he had seen. And he said that
23 one of her nerves was ripped from the spinal cord and he
24 used the, the, the medical terms. But the way he explained
25 it so I could understand, he said it was -- one was ripped

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by Mr. Henshaw

1 and some were torn or were stretched, and he mentioned C5,
2 6, 7, 8, T1.

3 He called out all these nerves and I had no clue what
4 he was talking about, but he explained that there's a lot of
5 scar tissue, and he had to remove that, and he put cadaver
6 tubing in it, cadaver sheeting, to help regenerate some of
7 the nerves that were severed, and that she's gonna be okay.

8 Q Okay. When was the first time you were able to see
9 Ashley after that surgery?

10 A We saw her shortly after. Yeah, shortly after. It was
11 that same night.

12 Q How long did you stay in the hospital with her?

13 A Oh.

14 Q Or how long did she stay in the hospital?

15 A At least two or three days if --.

16 Q And then where did you go?

17 Back home or to another facility or what?

18 A No, after we left Texas, we went back home and I
19 remember following up in Charlotte with Doctor Nelson so
20 that she could check Ashley's incisions and report back to
21 Doctor Armenta that, you know, she was doing fine and stuff.
22 So, we were back and forth to Charlotte a lot with Doctor
23 Nelson since she was primary contact with Doctor Armenta.

24 Q Let me show you some pictures.

25 Do you recognize this picture?

Treva Flowers - Direct examination
by Mr. Henshaw

1 A Yes.

2 Q And when was this taken?

3 A We were still in NICU. I'm sorry. Ashley was still in
4 NICU at that time.

5 Q This is after she's born?

6 A Yes, that's after she was born.

7 Q All right. Well, I'm, I'm looking for a picture after
8 she left the hospital in -- maybe this is a better picture.

9 Is this in Texas?

10 A Yes, that was in Texas after her first surgery.

11 Q Okay. So, is this when she's about ready to leave or
12 so?

13 A No, not exactly. We were just -- her dad was giving
14 her a ride around the hospital in the wagon. It's just to
15 try to, you know, give her a change of environment from the
16 hospital room.

17 Q All right. So, she's got a bandage on her left upper
18 arm, and she's got some type of wrapping around her chest
19 and abdomen.

20 What -- what's going on there?

21 And then she's got a bandage on her wrist as well.

22 What, what all is going on here?

23 A Okay. The band -- the waistband is to help keep the
24 side bands, like the, the upper armband --

25 Q Okay.

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by Mr. Henshaw

1 A -- and the lower armband. They all are -- they're
2 velcro. So, the purpose was to help keep her arm stabilized
3 because she had, she had an incision here.

4 Q An incision -- and tell -- and you need to---

5 A On her neck.

6 Q You need to tell us, when you point to that, what are
7 you pointing to?

8 A Her neck. The left side of her neck, she had an
9 incision right below the lower part of her ear, and it sort
10 of made an S-shape all the way down to -- close to her
11 armpit.

12 Q All right.

13 A Okay. So, the purpose of the bandages was to stabilize
14 her arm during healing.

15 Q All right. Now, I'm not sure that we asked Ashley to
16 point out any scarring like that yesterday.

17 Does she still have a scar there?

18 A She does, but it's very minimal.

19 Q All right.

20 A You can't hardly see it.

21 Q Okay. Now, is this a picture from Texas?

22 A It is.

23 Q And what does this show us?

24 A Okay. Before she had the bandage we showed you
25 previously, they just wrapped her kind of in a Ace bandage.

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by Mr. Henshaw

1 That was right after surgery. That was probably like the
2 next morning. And the leg has a bandage on it because
3 Ashley had to have -- let's see. One -- she had to have
4 three incisions on the, the left leg to remove nerves to
5 repair the nerves in her brachial plexus.

6 So, she has an additionally -- she has four scars from
7 that surgery, that one surgery alone, to help repair the
8 nerve damage. She had---

9 Q And, at this point in her life, how do those scars
10 appear?

11 A They're beautiful. They're beautiful.

12 Q All right. So, are they scarring that, that you would
13 consider disfiguring or, or not?

14 A No, I actually have to look for the scars---

15 Q Okay.

16 A ---and they're very pretty.

17 Q All right. And she -- it looks like she's got
18 something on her right-hand.

19 Is that right?

20 A Ah, she does. See, Ashley sucks she -- she sucked her
21 fingers for a long time, and if I understand correctly, they
22 put that on there because she had to have IV in that arm,
23 and they didn't want her putting her fingers in her mouth
24 and just try to -- so she wouldn't disconnect the tube that
25 was in her. It just kind of covered it up.

1 Q Okay. Just so we can see what you might be referring
2 to.

3 A Uh-huh. (Affirmative).

4 Q Is this a picture of her with her two fingers in the
5 mouth?

6 A Yes.

7 Q So, you came home and were you trying to see when
8 something might be happening because of the surgeries that
9 had been done in Texas?

10 A Yes.

11 Q And how long was it before you saw what you thought
12 might be an effect from the surgery?

13 A Let's see. She had to wear the bandages for about six
14 weeks. So, after we removed the bandages, movement became
15 almost instantaneously. I remember changing her diaper. I
16 had her laying on my bed and her arm was at her left side,
17 and she raised her forearm about an inch off the bed. And
18 oh, I yelled for Tray and we come in and we were so excited.
19 That -- that is the best thing we've ever seen other than
20 her being born.

21 It -- oh, it just gave us hope. It gave us more -- we
22 were, we were motivated. We wanted more. We wanted more.
23 So, wow, that -- that's one of the best things I had ever
24 seen.

25 Q So, what happened after that in terms of her progress

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1 with that arm?

2 A Therapy became more aggressive. Like I said, she
3 already had -- she was having OT and PT. Well, during the
4 time of her healing, no therapy. But after bandages were
5 removed, we were instructed to have therapy, and we had
6 therapy at least -- OT twice a day. I mean, excuse me,
7 twice a week and then physical therapy was coming in.

8 So, we had, I believe, therapy was three times a week
9 for several months after that, and each time -- well, as
10 time went on, she made progress meaning that instead of just
11 an, just an inch, we got 2-inches and then we got 3-inches
12 and we got just a little bit of elbow flexion. Pardon me if
13 I'm using the wrong term. But her arm would -- she begin to
14 move her arm just inward. She could bend her elbow a
15 little.

16 We were just motivated by that. So, there's a lot of
17 home therapy. I would incorporate therapy into play
18 exercises. Every toy I bought for her had to be something
19 that motivated that arm movement. So, I mean we, we just
20 went hard at it. We went hard at it.

21 Q And did you feel like you had progress?

22 A Absolutely.

23 Q Now, in regard to other areas of Ashley's development,
24 did she appear to develop without difficulty in terms of
25 speaking and other milestones that babies are expected to

1 meet?

2 A Yes, we only had to incorporate speech therapy. I
3 remember a speech pathologist coming through some time
4 during the first year because he wanted to initiate, I
5 guess, swallowing exercises. Like I say, she had a feeding
6 tube when she was in NICU. She had swallowing issues during
7 that time, and, for some reason, they wanted to continue to
8 make sure that she strengthened these muscles here so that,
9 you know, she could -- I guess so, so they could develop
10 better.

11 Q All right. And -- but the speech therapy was how she
12 speaks.

13 what about just being able to speak?

14 Did she begin to speak within the year?

15 A Oh, she did. She used -- she used a couple words. Ma.
16 I mean she was fine. Ma ma, da da. She was fine.

17 Q What about crawling?

18 Was she able to do that?

19 A She never crawled. She had her own version of crawl.

20 Q And what was that?

21 A She sort of got down on one, one knee and -- okay. She
22 got down on her right knee and her left leg, with her foot
23 planted on the floor, she scooted her body across the floor
24 kind of -- just kind of dragging her right leg, and that was
25 her way of crawling.

1 Q What about sitting up?

2 A Eventually she sat up finally. We had some core
3 strengthening that we had to work on because there was
4 weakness on the left side. So, we had to incorporate, you
5 know, exercises to try to strengthen her core muscles
6 because of her balance was a little off for a while. Well,
7 eventually she began to set up, sit up okay.

8 Q What about standing up or standing only?

9 A That was a challenge. So, she started walking around
10 14 months, but she, she, she was okay. After she got
11 moving, she was on the go.

12 Q Okay. So, has she gone to school -- starting school at
13 the same age as most other children start?

14 A Yes.

15 Q And how has she done in school?

16 A Very well.

17 Q And when you say very well, what does that mean?

18 A Academically?

19 Q Yes, ma'am.

20 A Honor Roll. She's in gifted and challenged program now
21 as a third grader, but she's always made the Honor Roll.
22 She loves school.

23 Q Does she have friends?

24 A Yes, a lot of friends.

25 Q And how do you feel that she's coping with the -- well,

1 before I get to that.

2 Tying her shoe, she said that she can tie her shoe.

3 When did she learn to tie her shoe?

4 A Age three.

5 Q Okay. And was that difficult for her or not?

6 A Not really. It was a challenge at first because the,
7 the wrist was always kind of retracted, kind of bent inward
8 toward her forearm, but she figured out a way to do it
9 herself. She figured out a way to make it work for her, but
10 she would watch her dad and I tie her shoes. She actually
11 ties her shoes the way her dad ties his shoes, which is two
12 bunny ears first. She didn't pick up the way I taught her,
13 but she picked up the way her dad ties his shoes, and she
14 just kept working and working until she got it.

15 She was three years old and I mean it's to the point
16 that she got in kindergarten. She was tying the other kids
17 shoes. So --.

18 Q Now, you mentioned that she had friends. I asked her
19 yesterday about, you know, how -- what happens when people
20 stare at her and then I asked her how her friends treated
21 her.

22 What have you observed about other peoples' reactions
23 to, to Ashley and, and the situation with her arm?

24 A Wow. It, it started early on. I remember we were
25 getting Christmas pictures made, and I saw someone staring

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by Mr. Henshaw

1 at her because, the Christmas pictures, she had on a little
2 short red dress, and we didn't have it pinned to her, to her
3 dress. So, it just kind of hung there and I saw people
4 looking and whispering. And I -- as time went on, I, I
5 noticed more adults looking than kids.

6 So, it doesn't really bother her when she see adults
7 looking at her. It's just the kids that constantly just
8 Ashley, what's wrong with your arm? why is it like that?
9 Can you do this?

10 And she doesn't express to -- she tells me that she
11 doesn't -- she try not to let it bother her while she's in
12 school. But when she gets home, she shuts down. I mean
13 when -- I can tell when something has gone wrong when she
14 gets in the car cause I can see that -- I can see the tears
15 in her eyes and she, she's -- it's like she's been holding
16 in all day and she can't wait till she get home to let it
17 all out.

18 So, she, she just kind of hold it in, but I have caught
19 her in her room several times just screaming, just ranting,
20 just uh, like just screaming so loud, and I'm like Ashley,
21 what's wrong, baby? what's wrong?

22 And she's like nothing. I don't want to talk about it.
23 And when I -- eventually I have to let -- I have to let her
24 come around, you know, just kind of get it out, get calmed
25 down, and, once we talk about it, the problem was some kid

1 either said something to her or she just feel really bad
2 about something that she couldn't do at school.

3 Like in gym, she has alternate exercises. I mean she
4 expressed to me that she feels real bad being the only kid
5 that has to do an alternate exercise, but her teachers makes
6 her feel really good about it. You know, they, they let her
7 just do whatever she can tolerate, and they all understand
8 what's going on. But it's, it's the kids and they probably
9 don't mean any harm about it. I mean kids are kids.

10 But it bothers her to the point that she's coming home,
11 and I caught her just, just, just hitting her arm hard as
12 she can. And I said baby, why are you doing that? She said
13 I wish I was never born, you know. I -- why do I have to
14 have brachial plexus injury? She gets angry and it, it
15 bothers---

16 Q She, she, she knows that term, brachial plexus?

17 A Absolutely. I -- when she could talk and respond to me
18 in a way that I knew -- when we could hold conversation,
19 get -- intelligent conversations, I taught her that term.
20 So, four or five years old -- she's five, she started asking
21 questions. I'm not gonna lie to her. I let her know, baby,
22 there's this brachial plexus injury. This is what you have
23 and I explained to her what happened when, when she was
24 coming out. And five years old, she got questions and I'm
25 giving her the answers.

1 And when I tell her -- if the kids ask her, I said
2 baby, tell them. She got -- I passed kids I pass all day.
3 I said if they want to know, I said spell it out to them.
4 So, let them know what it is so they can go and read it for
5 themselves.

6 Yeah, got to educate kids these days. So, I educated
7 my daughter on it.

8 So, yes, she knows what happened to her. She, she
9 knows and it's, it's, it's to the point for her,
10 emotionally, I know that I'm gonna have to get her some
11 help. I asked her, but, right now, she says no, I'm fine.
12 I don't need help cause we pray a lot. I mean that's our
13 way of dealing with it. We just pray and pray for those
14 kids that have understanding and their parents and all the
15 other adults out there who, who don't understand what these
16 injuries are.

17 And it's all about bringing awareness to the community
18 because a lot of people just don't know.

19 So, they stare. And it, it bothered me for a long
20 time, and sometimes it, it -- it still bothers me, but I can
21 address it now. I couldn't address it before without being
22 angry. So, she, she's the same way, but she holds her --
23 she holds it out -- she holds it in all day, but when she
24 gets home, she lets it out.

25 Q Now, what does she -- from your position or standpoint

1 as her mother, what are you observing that she is having
2 problems with in terms of that arm and hand and wrist?

3 A You mean physically?

4 Q Yes. Yes, ma'am.

5 Can she move it -- can she move her -- all five
6 fingers?

7 A She, she can move the fingers, but the issue is the
8 fact that her wrist is bent anywhere, and she can't really,
9 she can't really pick up anything with it. She still needs
10 help putting a belt on. She's kind of got zip, you know,
11 zipping her clothes okay, but sometimes she might need help
12 putting a certain shirt on.

13 I taught her how to button and zip. I taught her how
14 to dress when she was three years old. She started day care
15 when she was three. So, I, I taught her -- my -- her
16 therapist and I taught her how to dress herself as much as
17 we could with that injury.

18 Q Okay. And can she get herself dressed now?

19 A She can get herself dressed now. She might need help
20 buttoning some pants at times, but I'm kind of selective as
21 to what type of clothes I buy her.

22 Q Have you had to make any modifications to her clothing?

23 A Absolutely. I use to make her belts. Recently I made
24 her a belt, but I made it too small for her. But I use to
25 make -- when she was younger, before she actually learned

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1 how to put the, you know, the belt with the buckle with the
2 little stick in it, before she learned how to use that, I
3 made her some belts at home with just the, the snap in
4 buckle. And then I had some with just the loops on it that
5 I made for her because that seemed to be easier to put on.

6 I use to put little ponytail holders inside her, inside
7 of the hole of her pants so that she could fasten it around
8 the button on her pants because, with kids with brachial
9 plexus injuries, it's difficult for them to button, but it's
10 easier if you have a snap on your pants because they can
11 snap it with one hand. But if you have a button, I find
12 that it's difficult to button with one hand when you're,
13 when you have an injury. I tried it myself, you know.

14 So, I put a little bow on that, on that -- in the hole
15 of her pants so that she could pull it and fasten it around
16 the button. And the spaghetti strap shirts, I have to put
17 a, like a ribbon in with that because it falls off her
18 shoulders. For those shirts that I can't adjust, even some
19 shirts that I can, I have to tie some straps that won't fall
20 off her shoulders. Even her dresses.

21 They don't make clothes for brachial plexus kids. So,
22 at home, you have to find ways to make it work for them.
23 So, that's what I did.

24 Q Are you still having to do that or has she progressed
25 to the point now where she can handle these situations on

1 her own?

2 A I still have to tie the shirts. We haven't had any
3 issues with pants because I try not to buy her jeans that
4 button. She wears a lot of leggings. She -- things that
5 she can just pull on, and she pulls her clothes on with one
6 hand. She doesn't -- she can't -- as much as she tries, she
7 has problems pulling her pants up with both hands. So, she
8 can do a lot of things, but it's with her right arm.

9 Q Is she aware that you're making these accommodations
10 for her condition or, or is that something you just sort of
11 keep to yourself and---

12 A No, she knows. She, she picks out -- she picks out
13 some of the stuff and we designed her belts, and she picks
14 out -- she picked -- picks out the ribbon colors for her. I
15 mean it's part of her outfit. So, she's, she's a part of
16 it.

17 Q What about her hair?

18 Is she able to, to manage that on her own or do you
19 have to help her with that?

20 A Primarily, I have to help her but she surmised me about
21 a year ago. I said Ashley, I was like who platted your
22 hair? She said I did. And because she can raise her left
23 arm on this side this far, even though her arm is bent, she
24 managed to plat her hair and I didn't see her do it, but she
25 said she did it.

1 She just couldn't get the right side, and I mean it
2 stayed together for a couple hours. Then it came loose
3 but -- cause she couldn't -- she can't get it really tight.
4 She has attempted to put ponytails in her hair. She can't
5 do it tight, but she does -- but she does the best she can.
6 She tries. She'll try anything.

7 MR. HENSHAW: Just one moment please.

8 (Pause.)

9 Q That all the questions I have at this time. Thank you.
10 Please answer any questions the defense counsel may have.

11 THE COURT: Mr. Lovell.

12 MR. LOVELL: Thank you, Your Honor.

13 CROSS-EXAMINATION

14 BY MR. LOVELL:

15 Q Good morning, Mrs. Flowers.

16 A Good morning.

17 Q I've just got a few questions. I want to kind of back
18 up to the delivery time.

19 Now, you were asked some questions earlier about the
20 rotation of the doctors.

21 You understood that the reason that you saw every
22 doctor in the practice was because you didn't know exactly
23 when you would go in for delivery.

24 So, it might be that Doctor Fowler was on-duty or
25 Doctor Giep or any of the other physicians at the group,

Treva Flowers - Cross-examination
by Mr. Lovell

1 right?

2 A Yes.

3 Q And you were okay with that?

4 A Yes.

5 Q I'm sorry. Pull that a little close just so we can
6 hear you.

7 And Doctor Giep saw you some number of times, and
8 the -- while you were going through the pregnancy, right?

9 A Yes.

10 Q And you were comfortable with him when you saw him?

11 A Yes.

12 Q Okay. And when you saw him in the hospital on the
13 night of your delivery, he came in to the room after the
14 nurses had done something and, and said come in or some of
15 the or in some way or another he came in the room to see
16 you, right?

17 A Yes.

18 Q And I want to kind of make sure I've got an
19 understanding because you told us about two rooms.

20 The first you were in when you got there was just sort
21 of a smaller room and then they moved you to the labor and
22 delivery room, right?

23 A Correct.

24 Q And on that one, you were in a bed that was adjustable,
25 up, down, left, right?

Treva Flowers - Cross-examination
by Mr. Lovell

1 A On that one, you mean the first room?

2 Q The delivery room. Labor and delivery.

3 A Oh, labor and delivery. I was on a, a bed with
4 stirrups.

5 Q Okay. Do you recall the bed also being lowered where
6 your bottom end was sort of lower than the upper end?

7 A I don't, I don't remember.

8 Q Don't remember?

9 A No.

10 Q Do you remember everything about that, that night?
11 I'm sure it was probably busy.

12 A You, you---

13 Q All the things that were going on that night, you can't
14 remember every detail about it?

15 A I can't remember every detail, no, sir.

16 Q But when Doctor Giep came in the room, he went down to
17 the end, business end I'll call it, the end where the baby
18 was coming out, right?

19 A Right.

20 Q And so as you're there, you have your legs in the
21 stirrups, and he's down on that end and I think you
22 mentioned some family members were in there.

23 Your grandma was in there, Mrs. Bowen?

24 A Well, just my mother and my husband at that time.

25 Q And then, when the baby started coming out, Doctor Giep

Treva Flowers - Cross-examination
by Mr. Lovell

1 stayed down at the business end?

2 A Right.

3 Q And the nurse got sort of up on your body doing what we
4 now have been calling suprapubic pressure. I think you've
5 heard that before.

6 A Uh-huh. (Affirmative).

7 Q And that kind of blocked your view of what was going on
8 down where Doctor Giep was, right?

9 A Uh-huh. (Affirmative).

10 Q Is that a yes for her?

11 A I'm sorry. Yes.

12 Q Court reporters have a hard time taking down uh-huh and
13 hu huh.

14 A Uh-huh. (Affirmative).

15 Q Okay. So---

16 A I'm sorry.

17 Q And I apologize for saying that.

18 But when Doctor Giep was actually doing whatever he was
19 doing down there, you couldn't see him?

20 Fair enough?

21 A That's fair.

22 Q And I'm gonna go back to the epidural thing cause I was
23 a little confused.

24 You mentioned the anesthesiologist came in and did an
25 epidural at some point after you got into that labor and

1 delivery room, right?

2 A Right.

3 Q And that involved putting a needle in your back?

4 A Right.

5 Q And hooking it up to some bag with medication in it,
6 right?

7 A Um.

8 Q Or it was---

9 A I remember a needle going in my back.

10 Q The second epidural you talked about, they didn't come
11 do a whole new needle, did they?

12 A In my back they did.

13 Q They re-dosed it at that point with the same needle or
14 a different needle?

15 A I had my back -- I mean he was behind me.

16 Q Okay. After the second epidural, and when you were
17 actually delivering Ashley, you couldn't really feel what
18 was going on on the business end?

19 A No.

20 Q So, the cutting that Doctor Giep did with an
21 episiotomy, you couldn't feel that?

22 A No.

23 Q And what he was doing with his hand or what the, the --
24 how the baby was moving, you couldn't feel any of that
25 either?

Treva Flowers - Cross-examination
by Mr. Lovell

1 A No, I couldn't.

2 Q Okay. And after you woke off, and this is all after
3 the delivery -- well, let me back up. You mentioned
4 something.

5 When saw Ashley in the delivery room after she had been
6 delivered, the NICU nurses were the ones that were taking
7 care of her at that instant?

8 A I'm assuming that's who that was.

9 Q Doctor Giep was still down finishing the delivery, the
10 delivery part, right?

11 A Yes.

12 Q Which included, I guess, delivering the placenta and
13 then sewing up your episiotomy and those things?

14 A Yes.

15 Q Okay. When you saw Ashley, was it a minute or so
16 before you heard her actually make a cry out?

17 A Uh-huh. (Affirmative).

18 Yes.

19 Q Thank you.

20 Later that night, when Doctor Giep came and talked to
21 you and your husband after you had woken up and you were
22 sort of back in the room, and he talked to you about what
23 had occurred, he explained the injury that Ashley had
24 suffered, right?

25 A I don't remember him explaining the injury.

Treva Flowers - Cross-examination
by Mr. Lovell

1 Q You said he used terms shoulder dystocia, brachial
2 plexus, and---

3 A Yeah, I'm sorry. Yes, he used those terms, yes.

4 Q Okay. So, he didn't hide anything about what had
5 occurred in that?

6 A No.

7 Q Okay. You then stayed in the hospital a few days and
8 Ashley a couple weeks, two and a half weeks?

9 A Yes.

10 Q And then y'all all, at that point, were able to bring
11 her home?

12 A Yes.

13 Q And you had mentioned physical therapy and occupational
14 therapy coming in and helping you and Ashley.

15 was the last time you had either of those around 2011
16 for her when they came to your home and did it?

17 A The home -- let's see. The last home visit we had
18 was -- I'm not sure of the exact date for a home visit, but
19 the last therapy she had was in 2015.

20 Q So, a year, two years ago, plus or minus?

21 A Plus or minus.

22 Q And I assume she's doing exercises, as you told us, on
23 her own with your help now?

24 A Yes.

25 Q And it sounds like she tries to pretty much do whatever

Treva Flowers - Cross-examination
by Mr. Lovell

1 she can within her abilities with that arm as far as at the
2 gym, jungle gym with the kids, at school, and things of that
3 sort, right?

4 A Yes.

5 Q Would you say, from your experience -- your
6 observations of her, that she's learning how to accommodate
7 and do things within the abilities that she's got with her
8 arm in the condition it's in?

9 A She's still learning, yes.

10 Q And over the years, now I think you said she was --
11 turned nine two days ago, three days ago?

12 A Yes.

13 Q She's beginning to learn more and more of these
14 accommodations and things as she gets older and older?

15 A Yes, I -- I'm trying to teach her as best I can.

16 Q And I assume Mr. Flowers helps you with that too
17 helping her learn to do things?

18 A He does.

19 Q And y'all have a good family support. I -- obviously,
20 I think they help out a lot on that---

21 A Yes.

22 Q ---too as well?

23 You were asked questions by plaintiff's counsel about
24 her learning and abilities.

25 She hasn't had any -- you've had no doctor say that

Treva Flowers - Cross-examination
by Mr. Lovell

1 she's had any kind of a brain injury or problem like that as
2 a result of her birthing, right?

3 A Right.

4 Q She's -- as far as you know from the testing and all
5 that, she may be ahead of a lot of kids that are her age?

6 A She is.

7 Q Is that right?

8 And you continue to see Doctor Giep in the office there
9 for some period of time even after the delivery for a year
10 or so, two years maybe?

11 A No, a couple months.

12 Q A couple months for him that you continued to go to the
13 practice for a period of time?

14 A No.

15 Q Okay. The last -- they would call you and check on
16 Ashley though?

17 A Who would call and check on Ashley?

18 Q The office.

19 A No, not that I recall.

20 Q You don't recall having conversations with Doctor Giep
21 or people at his office on how Ashley was doing?

22 A To check on her, I don't recall.

23 Q Okay. It could of happened and you just can't remember
24 now?

25 A No, I don't recall that.

1 Q And you mentioned that Doctor Giep referred you up to
2 the doctors in Charlotte to help take care of Ashley's---

3 A Yes.

4 Q ---arm issue?

5 All right. That's all. Thank you very much, ma'am.

6 A You're welcome.

7 MR. HENSHAW: No, no further questions, Your Honor.

8 THE COURT: All right. Thank you. You may step down.

9 All right. We'll take a break. I'll ask the jury to
10 please go to your jury room. Don't discuss this case. I'll
11 bring you back after that break.

12 (WHEREUPON, the following takes place outside the
13 presence of the jury.)

14 THE COURT: We'll be in recess 15-minutes.

15 (WHEREUPON, a short recess was taken at this time.)

16 (WHEREUPON, an operative report was marked as
17 Plaintiff's Exhibit No. 5. A diagram was marked as
18 Plaintiff's Exhibit No. 6. Two operative reports were
19 marked as Plaintiff's Exhibit Nos. 7 and 8. The above
20 exhibits were received into evidence at this time.)

21 MR. HENSHAW: Your Honor, with agreement of defense
22 counsel, we've placed into evidence Exhibits 5, 6, 7, and 8.
23 They include three operative reports that were referenced in
24 doctor -- as referenced in Doctor Armenta's deposition. We
25 showed the video yesterday, and as well as an illustration

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1 that was also part of that deposition.

2 So, these are four exhibits that are now added to the
3 evidence from plaintiff's counsel.

4 THE COURT: Okay. You in agreement, Mr. Lovell?

5 MR. LOVELL: Yes, sir, Your Honor.

6 THE COURT: All right. We ready for the jury?

7 MR. HENSHAW: Yes, sir, Your Honor.

8 THE COURT: Bring them in please.

9 (WHEREUPON, the following takes place within the
10 presence of the jury.)

11 THE COURT: Mr. Henshaw.

12 MR. HENSHAW: Thank you, Your Honor.

13 We call Tristan Flowers to the stand.

14 TRISTAN FLOWERS, being first duly
15 sworn, testified as follows:

16 DIRECT EXAMINATION

17 BY MR. HENSHAW:

18 Q Mr. Flowers, please state your full name.

19 A Tristan Tyrone Flowers.

20 Q All right. And be sure to speak up so we can all hear
21 you.

22 okay?

23 A Okay.

24 Q Where do you reside?

25 A In Simpsonville, South Carolina.

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by Mr. Henshaw

- 1 Q And who resides there with you?
- 2 A My wife and two children.
- 3 Q And what -- where were you born?
- 4 A In Andalusia, Alabama.
- 5 Q How old are you?
- 6 A I am 45-years old.
- 7 Q And were you raised there in Alabama?
- 8 A Until my junior year in high school when my parents
- 9 moved to Greenville, South Carolina.
- 10 Q And you finished up high school there?
- 11 A Yes.
- 12 Q At what high school?
- 13 A At Eastside High School.
- 14 Q And, after high school, did you have any further
- 15 education?
- 16 A I later, right after high school, I joined the United
- 17 States Marine Corp.
- 18 Q All right. How long were you -- did you serve?
- 19 A Four years.
- 20 Q And where were your assignments?
- 21 A In Jacksonville, North Carolina, in Cherry Point, North
- 22 Carolina where I was detached -- attached to the 22nd Marine
- 23 Expeditionary Unit, which, at that point, I was assigned to
- 24 naval ships and we toured the Mediterranean Sea.
- 25 Q All right. You were part of what type of squad?

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1 A I was a part -- I was in radio and microwave
2 communication, which I was attached to the Embassy Team, and
3 what happens -- what we did is, anytime an American citizen
4 was in a country and they did not feel safe, they were
5 responsible for getting to the American Embassy, and our job
6 was to get them from the American Embassy to -- back to a
7 naval ship or to a safe location.

8 Q All right. And what year did you finish your military
9 service?

10 A In 1994.

11 Q 1994?

12 A Yes, sir.

13 Q And once you completed your military service, what did
14 you do then?

15 A I moved back to Greenville, South Carolina where my
16 parents were living and started ITT Technical Institute.

17 Q And what type of degree did you seek there?

18 A There, electronic engineering degree, Associate's
19 Degree in Electronic Engineering.

20 Q Did you get that?

21 A Yes.

22 Q And did you use it to get employment?

23 A Yes, I went to work for Siemens Communications where
24 then I was a -- I moved to Atlanta, Georgia and worked at
25 the world headquarters of Coca-Cola in Atlanta.

Tristan Flowers - Direct examination
by Mr. Henshaw

- 1 Q For Siemens?
- 2 A For Siemens.
- 3 Q How long?
- 4 A About two years there in Atlanta.
- 5 Q Okay.
- 6 A And I was currently dating my wife, Treva.
- 7 Q Okay.
- 8 A And moved back to Greenville. I thought I was gonna
- 9 move back to Greenville, and once Siemens management
- 10 realized I was back in Greenville, they then sent me to
- 11 Columbia, South Carolina to work for BlueCross BlueShield.
- 12 Q All right. And how long did you stay with Siemens
- 13 overall?
- 14 A I stayed with Siemens approximately nine years.
- 15 Q Did you finish up working -- I mean -- with them
- 16 working down at BlueCross BlueShield in Columbia?
- 17 A I wanted to go back to school, and they worked me a
- 18 lot. So, I told them I was gonna quit and go back to
- 19 school. So, they gave me my resume -- I mean my resignation
- 20 back and found me a job in Orlando, Florida where I could
- 21 continue my education there. So, they gave me a job working
- 22 out of my home in Orlando, Florida.
- 23 Q And what's the significance of Orlando, Florida?
- 24 A Because ITT Technical Institute was there and I wanted
- 25 a degree, a Bachelor's Degree in Telecommunications.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q All right. And so you went to Orlando, Florida?

2 A Yes.

3 Q And did you get the degree down there?

4 A I did complete my Bachelor's of Science Degree in
5 Telecommunication.

6 Q And stayed with Siemens?

7 A Yes.

8 Q while you were down there?

9 A That is correct.

10 Q So, what did you do next?

11 A After completing my degree in Florida, we decided, my
12 wife and I, or at the time my fiance and I decided to move
13 back to Greenville, and I continued to work at Siemens while
14 I was in Greenville. While I was in Greenville, a friend of
15 mine told me about a position at Spartanburg Regional, and I
16 applied for it and they, they hired me at Spartanburg
17 Regional.

18 Q So, when did you start at Spartanburg Regional?

19 A This is, I think, in 2002.

20 Q And how long did you stay at Spartanburg Regional?

21 A About nine years.

22 Q And what were your responsibilities while you were
23 there?

24 A I was responsible for their telecommunications.

25 Anything to do with their voice or phone communications, all

Tristan Flowers - Direct examination
by Mr. Henshaw

1 of their telecommunications I was responsible for.

2 Q Okay. So, do you have any medical training?

3 A No.

4 Q So, while you were at Spartanburg Regional, you weren't
5 there for any purposes to actually administer treatments or
6 make diagnoses or anything like that?

7 A No.

8 Q Is that right?

9 A No.

10 Q You basically worked on their telephone system?

11 A That is correct.

12 Q And what about their other communication systems?

13 A That was other -- anything to do with communications or
14 telecommunications, their video systems, any IT equipment
15 that interfaced with communications at all.

16 Q I -- IT?

17 A Information technology.

18 Q Okay.

19 A I would sometimes work on a lot of different things
20 when it came to information technology.

21 Q All right. So, you left there in what year?

22 A Approximately 2011.

23 Q All right. So, Ashley was born on October 7th, 2011.
24 Is that right?

25 A That is correct.

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by Mr. Henshaw

1 Q while you were still an employee of Spartanburg
2 Regional?

3 A That is correct.

4 Q Tell us about that.

5 Did you and your wife want to get pregnant, get
6 pregnant?

7 A Yes.

8 Q Okay.

9 A Well, she did. Yeah, we did.

10 Q Now, you have a son from a previous relationship.
11 Is that right?

12 A That is correct.

13 Q And what is his name?

14 A His name is Hakeem Devonte Flowers.

15 Q All right. And just so we can know, you -- Hakeem,
16 does he -- when he was born, did he have any complications?
17 Does he have any physical problems, ailments, anything
18 like that?

19 A No.

20 Q In fact, he's an athlete.

21 Is that right?

22 A Yes, he was a, a all American receiver and he played at
23 N.C. State.

24 Q Okay. And he's how much older than Ashley?

25 A He's currently 24.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q Okay. But was he living with y'all at the time that
2 she was born?

3 A Yes.

4 Q Now, and you have a third child.
5 Is that right?

6 A That is correct.

7 Q And that's a son as well?

8 A Yes.

9 Q And what is his name?

10 A Josiah Flowers.

11 Q Okay.

12 A Well, Tristan Josiah Flowers.

13 Q All right. And how old is Josiah?

14 A He is three.

15 Q Three.

16 And as far as, as he's concerned, does he have any
17 physical disability, ailments, anything such as that?

18 A No.

19 Q Is he gonna be an all American too?

20 A We're working on it.

21 Q Now, let's talk about Treva's pregnancy with Ashley,
22 and concentrate on it for a few questions.

23 You wanted to get pregnant, and once you found out she
24 got pregnant, did, did you participate in helping her find
25 an obstetrician who would be able to manage the pregnancy

1 and deliver the baby?

2 A Yes, we, we looked at several different doctors, and I
3 asked people I work with and we decided on Doctor Giep.

4 Q All right.

5 A Well, I said -- not Doctor Giep. The practice that
6 Doctor Giep's affiliated with, Spartanburg Regional OB-GYN.

7 Q All right. And once, once Treva started going to the
8 practice for management of her pregnancy, did you
9 participate?

10 A Yes.

11 Q Did you go to the office visits yourself?

12 A Yes.

13 Q How many did you go to?

14 A All of them.

15 Q Okay. Were you aware that, in that practice, the
16 patients are expected to rotate through the different
17 doctors who work in the practice?

18 A I learned that while attending the visits.

19 Q And was that okay by you?

20 A Yes.

21 Q Did you understand that you, you might not know
22 particularly which doctor would actually be there to deliver
23 the baby once that time came?

24 A That is correct. I did understand that.

25 Q And was that okay with you as well?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Yes.

2 Q Did you meet Doctor Giep?

3 A In one of the visits I think I did remember him coming
4 in visiting with us, but it was several different doctors.
5 So, in the visits, I did meet him.

6 Q Okay. Now, as, as far as you knew, as the expectant
7 father, did the pregnancy seem to be going well?

8 A Yes.

9 Q Did, did there come a time where you learned that
10 Mrs. Flowers had gestational diabetes?

11 A Yes.

12 Q And how did you learn that?

13 A In one of the visits they explained what gestational
14 diabetes is, and my wife and I discussed on how to manage
15 that. She did a great job at managing it and making sure
16 she did not do anything incorrect.

17 Q All right. And, and did she manage it with her -- by
18 just simply regulating her diet?

19 A That is correct, diet, and, I think, exercise.

20 Q And, as far as you knew, from that point on when she
21 was seen by the doctors, were they -- did they seem to be
22 okay with the way that she was progressing in her pregnancy?

23 A That is correct. They -- things seemed normal.

24 Q All right. Any other complications that came up while
25 she was pregnant that you became aware of?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A No.

2 Q We've been told that her due date was October 11, 2008.
3 Were you aware of that?

4 A That is correct.

5 Q And were plans made between you and Treva as to how you
6 were gonna handle that when the day came?

7 A Yes.

8 Q And what were the plans?

9 A We packed a bag. I drove the route that -- the route
10 to get to the hospital all different times. I, I, I drove
11 to Spartanburg Regional every day for work. So, I went -- I
12 would drive in the mornings so I knew what traffic was like
13 in the morning and at five o'clock, but I didn't know what
14 the traffic was at, you know, twelve o'clock during the day
15 or at, you know, ten o'clock at night. So, I tried that a
16 couple different times to ensure, see which is the best way
17 to go.

18 We packed a bag. I think she had her bag with her
19 stuff and I had my bag with my stuff.

20 Q Okay. Were -- you were gonna check in too?

21 A Yes. Well, I was there to support.

22 Q Okay. Now, so, October 7 comes?

23 A Yes.

24 Q Actually October 6th I take it?

25 A That, that is correct.

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by Mr. Henshaw

1 Q Y'all went to bed?

2 A Yes.

3 Q And some time a little bit after midnight Treva gets up
4 and says it may be time?

5 A That is correct.

6 Q All right. So, what -- tell us a little bit more
7 detail about that.

8 A Well, I remember her waking me up and saying I think my
9 water broke. Me being a guy, I asked well, how do you know
10 that, and she says cause I'm standing here in water or
11 fluid. At that point, I think we kind of -- reality set in.
12 So, we started to prepare to go to Spartanburg Regional.

13 Q Okay.

14 A And so---

15 Q And---

16 A ---we, you know, we grabbed everything. She grabbed
17 her bag. I forgot my bag and we got in the car and went to
18 Spartanburg Regional.

19 Q All right. And did you make it in plenty of time?

20 A Yes.

21 Q All right. So, what happened when you got there?

22 A They checked us in. We went in through the entrance
23 that they had already informed us that we were suppose to
24 take the entrance you pull up. You call on the intercom.
25 They let you in. You go park and then they took her in,

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by Mr. Henshaw

1 and, like she said earlier, to a small room where the nurses
2 and different medical personnel would come in and check on
3 her.

4 Q All right. So, at some point, did Doctor Fowler arrive
5 on the scene?

6 A Yes.

7 Q And do you remember approximately when that was the
8 first time?

9 A I do not remember the exact time. I just remembered
10 seeing her and thinking okay, she's here, you know, cause
11 we'd already discussed different doctors. You know, like
12 the different doctors that would come through, and, in my
13 mind, I'm thinking well, you know, she gets to see the
14 doctor that she sees, you know, that she originally went to.

15 Q Okay. Doctor Fowler indicate any particular problems
16 or unusual, anything unusual about what was happening during
17 the labor?

18 A No, no issues or no problems.

19 Q Did you see Doctor Fowler again?

20 A Yes, we saw Doctor Fowler several times.

21 Q All right. And on any of those occasions did she
22 indicate that there was any, any concerns out of the
23 ordinary for a labor and delivery?

24 A No, there was no concerns.

25 Q From what you could observe as -- well, first of all,

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by Mr. Henshaw

1 were you in the room the entire time, most of the time, or
2 just part of the time?

3 A I was in the room the entire time except for maybe
4 going to get a soda or to the bathroom, you know. Well, I
5 didn't, you know, cause the bathroom was there. I think I
6 went and got chips and a soda or something, but I stayed
7 there the whole time.

8 Q All right. Who else was in the room on a constant
9 basis that day?

10 A The first room or the second when she moved to the
11 labor and delivery?

12 Q Well, explain that.

13 Now, how long -- approximately how long was she in the
14 first room?

15 A She was in the first room a pretty good while. You
16 know, from -- I, I can't remember the exact time. I just
17 remember she was in her room, and they moved her to another
18 room.

19 Q Okay.

20 A So --.

21 Q Did you understand that they were moving her from say
22 an examining room to a labor and delivery room?

23 A Oh, I knew we were in the labor delivery room when we
24 got there with all the -- cause it was obvious we had all
25 the equipment.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q The first room or the---

2 A No, the, the second room.

3 Q The second room?

4 A Yeah.

5 Q And the first room is more of an examining room where
6 she was seen by the nurses?

7 A Correct.

8 Q All right. And so she gets to the labor and delivery
9 room?

10 A That is correct.

11 Q And did you know enough about the hospital setup to
12 know that, at that hospital, if it's gonna be a vaginal
13 delivery, they pretty much put the woman in the labor room
14 and let her stay there?

15 A That is correct.

16 Q while she labors?

17 A That is correct.

18 Q All right. And that's what -- and that's what Treva
19 did?

20 A That is correct.

21 Q Everything seemed to go okay as far as you were
22 concerned?

23 A That is correct.

24 Q was she having any unusual pains or anything like that
25 that she was expressing to you?

Tristan Flowers - Direct examination
by Mr. Henshaw

- 1 A Not at that point.
- 2 Q All right. Did y'all plan for her to have an epidural?
- 3 A Yes.
- 4 Q And did she get one?
- 5 A Yes.
- 6 Q Did it seem to help?
- 7 A Yes, the, the first one.
- 8 Q The first one did?
- 9 A The first one.
- 10 Q All right, sir. So, the day wore on and she still
- 11 hadn't delivered?
- 12 A That is correct.
- 13 Q That cause any concern to you?
- 14 A No, because really this is my first time being in the
- 15 delivery room or going through the whole process the first
- 16 time. The first time I wasn't there in the, you know, when
- 17 my son, my son was born.
- 18 Q Okay. And were the nurses saying anything to you that
- 19 caused concern to you?
- 20 A No.
- 21 Q So, at some point, did Doctor Fowler arrive and
- 22 indicate that she was going off-duty and another doctor was
- 23 coming on?
- 24 A Yes.
- 25 Q And approximately when was that?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A It was in the evening. I don't want to speculate the
2 exact time, but it was in the evening I know some time after
3 5:00PM.

4 Q All right. And do you recall anything that she said at
5 that point?

6 A She said a doctor would be relieving her, and I don't
7 remember if she gave the name of the doctor. I just
8 remember her saying a doctor would be relieving her.

9 Q And did it seem as though everything was going
10 according to plan?

11 A That is correct.

12 Q All right. So, after that, what happened next that was
13 of any significance to you?

14 A The next thing I remember -- well, after Doctor Fowler
15 left, you know, the nurses started -- it, it -- trying to
16 find the best way to explain it. The process continued and
17 my wife, you know, was pushing and, you know, they were
18 preparing to have a baby.

19 Q Now, she -- was she pushing the whole time during the
20 whole day or did there come a point where she just started
21 pushing?

22 A No, it was a point where she started pushing.

23 Q Now, did she do that on her own or did -- was she
24 instructed to do that?

25 A No, she was instructed to do that.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q By whom?

2 A By one of the nurses.

3 Q All right. Was the doctor in there when that first
4 instruction came to push?

5 A No.

6 Q All right. But did, did you understand that, when the
7 nurse made the instruction to push, that the nurse was
8 identifying your wife as having reached the maximum point of
9 the dilatation of her cervix?

10 A I didn't understand what exactly was happening. I mean
11 they were -- the nurses would come in and talk and speak to
12 my wife about different things on what was happening and how
13 far along she was, but I didn't understand exactly what they
14 were explaining. But I knew it was -- and they were saying
15 this is expected, this is normal. So---

16 Q Okay.

17 A ---once I heard that, I was fine. I mean I was fine.

18 Q All right. Did you understand that, by telling your
19 wife to push, it meant that the nurses had identified that
20 the cervix was as open as it, as open as it could expect to
21 get?

22 A Yes.

23 Q And that the baby's head would be emerging from that
24 opening soon?

25 A Yes.

Tristan Flowers - Direct examination
by Mr. Henshaw

- 1 Q And with pushing, it would help move the head along?
- 2 A Yes.
- 3 Q All right. Were you in a position where you could
- 4 observe the baby's head coming through the birth canal?
- 5 A No.
- 6 Q Where were, were you located?
- 7 A I was standing at her left shoulder.
- 8 Q Okay. Looking back toward her feet?
- 9 A Yes.
- 10 Q So, did they put her into stirrups?
- 11 Did they convert the bed and put up -- put stirrups up
- 12 and then put her in stirrups?
- 13 A At some point she was in stirrups.
- 14 Q All right. Was Doctor Giep in at the time that they
- 15 put her in stirrups?
- 16 A No.
- 17 Q So, when she began to push, who all was in the room
- 18 that you can remember?
- 19 A My -- the nurses and my mother-in-law.
- 20 Q All right. And where was the mother-in-law?
- 21 A She was sitting kind of to the side of the bed.
- 22 Q Okay.
- 23 A You know, to the side of bed.
- 24 Q Did she stay in the entire time?
- 25 A She left out at some point but she didn't stay. You

Tristan Flowers - Direct examination
by Mr. Henshaw

1 know, she was there, but I remember her leaving at some
2 point.

3 Q Were there other family present in the hospital?

4 A They were in the hospital, but not in the room.

5 Q And where were they?

6 A They were in the waiting room.

7 Q Okay.

8 A The waiting room.

9 Q All right. Was anybody keeping them informed as to the
10 progress of the labor during the day?

11 A My mother-in-law at -- during the labor, you know, at
12 some point she went out and informed them but not really.

13 Q Okay. So, did there come a point when Doctor Giep came
14 into the room?

15 A Yes.

16 Q And was he ready to deliver at that point or did they
17 have to glove and gown him or what did you observe?

18 A I observed -- I remember the nurse calling for a doctor
19 several times, and then Doctor Giep came in and went to
20 work. I don't remember him gloving up or anything, and I'm,
21 I'm pretty sure -- well, I don't want to speculate. He came
22 in and went to work as far as delivering the baby. He went
23 straight to the bottom of the bed and started working.

24 Q All right. And was Treva's legs up in stirrups at that
25 time?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Yes, when he walked in the room.

2 Q And did he stand between her legs?

3 A Yes.

4 Q Okay. Could you tell what he was doing?

5 A No.

6 Q Okay. From where you stood?

7 A From where I was standing, I couldn't see exactly what
8 he was doing.

9 Q Were you able to see his hands?

10 A No.

11 Q Were you able to see his face?

12 A Different times I could, but I -- I mean I could see
13 him as he was working, his, his head, yes.

14 Q Okay. So, were you aware about the baby's head coming
15 out of, out of the vagina and being born, the head being
16 born?

17 A I, I did not know at the time the head was out.

18 Q Okay. And were you aware that Doctor Giep encountered
19 a complication known as shoulder dystocia?

20 A I was not aware that he encountered shoulder dystocia.
21 I didn't know what it was at that time, but when he came in
22 and went directly to work, he appeared to be stressed.

23 Q Okay. And why, why do you say that?

24 A Cause he went straight to work. I mean, you know, it
25 wasn't a conversation of hey, how you doing, you know, nice

Tristan Flowers - Direct examination
by Mr. Henshaw

1 day or anything like that. He went directly to delivering
2 the baby.

3 Q All right. Were you aware that he used a vacuum
4 extractor at some point?

5 A No.

6 Q Did you know anything about the vacuum extraction
7 process?

8 A No.

9 Q So, in terms of any tools that he used, in terms of
10 what he did with his hands or how he positioned his hands,
11 were you able to observe any of that?

12 A No.

13 Q Okay. You could just simply see his face and he seemed
14 to be working?

15 A Correct.

16 Q All right. Did he indicate that he was encountering a
17 complication?

18 A No.

19 Q So, tell us what you do know about those moments while
20 the baby was being born.

21 A At some point I remember the nurses saying -- telling
22 my wife or one of the nurse grabbing one leg, and from what
23 I can remember, another, another leg was up. I can't
24 remember if I had the leg, but I remember another nurse
25 up -- it appeared to be a stool, but she was taller than me.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 She appeared to be in the bed, trying to get in the bed
2 working on my wife's stomach area.

3 Q Okay. And, and could you tell what she was doing?

4 A I couldn't tell what she was doing. She was pushing or
5 doing something there at my stomach -- my wife's stomach
6 area.

7 Q Okay. And did you understand that that was because of
8 a complication?

9 A No, I just knew, from my understanding of what I could
10 gather, something was not right.

11 Q All right. So, were you getting concerned at that
12 point?

13 A Very concerned. Go ahead. I'm sorry.

14 Q Well, it sounded like you wanted to---

15 A Well, what I was gonna say is what made me more
16 concerned is because I was in information technology.
17 Doctor Giep was wearing a Vocera badge, which I help
18 installed, and I---

19 Q What, in fact, what is a Vocera badge?

20 A A Vocera badge is a little -- basically looks like a
21 little small cell phone. It's about that long and about
22 that wide.

23 Q Now, the court reporter can't---

24 A Oh.

25 Q ---can't take down your, your---

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A It's about a inch wide and about 4-inches long.

2 Q Okay.

3 A Black. Has a button it -- and it -- it's used --

4 doctors or nurses use it, mostly, mostly doctors, to reach

5 personnel when they need someone and he pressed the button

6 on his Vocera badge requesting NICU nurses.

7 Q All right.

8 A He did that once. They did not appear. He did it

9 again, and, shortly after that, they came in. By me working

10 in IT or information technology, I helped install that and I

11 knew that, in NICU, which is ICU for kids.

12 Q Intensive care unit?

13 A Intensive care unit for kids. Well, something was not

14 right for him to call them.

15 Q Okay. So, he used the Vocera badge and he made a call

16 and that caused you concern because of your knowledge from

17 your employment there?

18 A That is correct.

19 Q All right. So, what else can you tell us that you

20 recall about those moments during the birthing process, if

21 anything?

22 A Just her legs being up and her pushing and the nurses,

23 you know, there beside the bed pushing and the, the,

24 that's---

25 Q Were you able to see the baby come out?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A I did not see her come out the birth canal.

2 Q All right. Did you see the baby after she came out?

3 A Yes, when she came out, I saw Doctor Giep give the baby
4 to the NICU nurses.

5 Q Okay. And were you able to see anything about the baby
6 that gave you an indication as to the baby's condition?

7 A No.

8 Q Were you able to see the baby's arm?

9 A No.

10 Q Were you able to see the baby's color?

11 A Yes.

12 Q And what was the color?

13 A It was blue.

14 Q And---

15 A She was -- my daughter was blue.

16 Q Okay. And what did, did the -- when he handed off the
17 babies -- the baby to the nurses, what did they do?

18 A They started what I understood as working with my
19 daughter. They swaddled her and was doing some other things
20 and I heard her cry.

21 Q Okay.

22 A So, at that point, you know, I, I took a deep breath
23 and they swaddled her and---

24 Q Swaddled her meaning they?

25 A In the, the -- swaddled is a way you fold the baby in a

Tristan Flowers - Direct examination
by Mr. Henshaw

1 blanket, you know, to keep them warm or basically they fold
2 the blanket around the baby.

3 Q Okay. Did that prevent you from being able to see the
4 baby's arms?

5 A Correct.

6 Q And/or legs or---

7 A That is correct.

8 Q Okay. And what did they do next?

9 A They took the baby and just placed her beside my wife's
10 head like, you know, like just quick and then they took --
11 they left out the room.

12 Q Okay. And was that what you'd expected?

13 A No, not at all.

14 Q What had y'all expected once the baby was born?

15 A I thought my wife was gonna get a chance to hold the
16 baby, you know, and, you know, kind of enjoy the moment, but
17 that didn't happen.

18 Q Now, while y'all were still in the labor and delivery
19 room, did Doctor Giep give any kind of explanation as to
20 what had happened?

21 A No, not while we were in the labor, labor and delivery
22 room. He continued to work on my wife.

23 Q All right. And when he finished working on your wife,
24 did he give any explanation while y'all were still there?

25 A No.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q Did you follow the baby down into the NICU?

2 A No.

3 Q Okay.

4 A I stayed with my wife.

5 Q Now, so, I take it she was transported up to a regular
6 room in the hospital?

7 A That is correct.

8 Q And were y'all given any information once you arrived
9 there about your baby?

10 A Yes, we were --.

11 Q What were you told?

12 A We were in the room. My wife was there. She was
13 sleeping. Then, later that afternoon or later, you know,
14 some time later after the -- we were in the room, Doctor
15 Giep came in and sat down with us and started to explain
16 about shoulder dystocia. Well, I shouldn't say explained.
17 He, he told us that -- about shoulder dystocia, Erb's palsy,
18 and the brachial plexus.

19 Q All right. Well, tell us as much as you can remember
20 as specifically as you remember it about what he said.

21 A I remember him saying that he never wanted to
22 experience that again, and he explained that, you know, that
23 he talked about shoulder dystocia, Erb's palsy.

24 Q Had you heard that term before?

25 A No, never before.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q And what did he tell you about it?

2 A It was when the child's shoulder gets caught on the
3 mother's pelvic bone and that's what was explained at that
4 time.

5 Q Okay. Did he explain what he had to do in order to
6 free the baby from being caught on the mother's, on the
7 mother's pelvic bone?

8 A No, he did not.

9 Q You were about to say he explained Erb's palsy?

10 A Yes.

11 Q What did he explain about that?

12 A It's -- Erb's palsy was and shoulder dystocia -- it --
13 Erb's palsy is a form of shoulder dystocia or well, you
14 know---

15 Q At least that's what you understood?

16 A That's what I understood.

17 Q Okay. And he explained -- did he use the term brachial
18 plexus?

19 Do you remember that?

20 A I don't remember that exactly. I do, I do remember
21 shoulder dystocia and Erb's palsy.

22 Q All right. Did he indicate to you that nerves were
23 involved in this?

24 A No.

25 Q And did he indicate that there would be a need to be

Tristan Flowers - Direct examination
by Mr. Henshaw

1 any particular treatment of your baby as a result of this at
2 that time?

3 A No.

4 Q When did that happen?

5 A Well, while he was there, he informed us that he was
6 going to refer us to Charlotte.

7 Q And was that that same evening that he came and had
8 that discussion with you?

9 A I don't remember exactly when he referred to -- us to
10 Doctor Nelson, but, at some point, he referred us to Doctor
11 Nelson in Charlotte.

12 Q While you were still in the -- while your wife was
13 still in the hospital?

14 A Yes.

15 Q And she was in the hospital for about three days?

16 A Yes.

17 Q And did he explain why he was making the referral?

18 A Because she had experienced shoulder dystocia.

19 Q Now, had you had an opportunity to see your baby by
20 that time?

21 A No.

22 Q Not before he, he told you about Doctor Nelson?

23 A No.

24 Q It was -- so, before you saw your baby he told you
25 about Doctor Nelson?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Yes. Well, well, let me correct that. We were in the
2 room and we hadn't seen the baby before Doctor, Doctor Giep
3 came in.

4 Q All right.

5 A That's what it was.

6 Q But, but what I'm trying to understand is we know he
7 can't -- based on your testimony, he came into the room and
8 he said that he had encountered shoulder dystocia?

9 A That is correct.

10 Q And he explained that term and he explained Erb's palsy
11 to you?

12 A That is correct.

13 Q And, and you had not seen the baby by that point?

14 A That is correct.

15 Q And you've testified that, at some point, while you
16 were in the hospital, he made -- he said I want you to go
17 see Doctor Nelson in Charlotte?

18 A That is correct.

19 Q Had you seen the baby by that point?

20 A I do not remember.

21 Q Okay. When you did see the baby, where did you see the
22 baby?

23 A It was in NICU.

24 Q Did they bring the baby up to your room?

25 A No.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q So, you had to go down and see the baby?

2 A I wheeled my wife over in the wheelchair to the NICU to
3 go see the baby.

4 Q Was she allowed to hold the baby then?

5 A No, the baby, at that point, was still in a, you know,
6 bed or some -- we could not touch the baby---

7 Q Okay. And---

8 A ---at that point.

9 Q And were you able to, to observe anything about your
10 baby's condition?

11 A There was a lot of devices hooked up, connected to my
12 daughter. I, I just remember seeing a lot of devices hooked
13 up to my daughter.

14 Q Were you able to see her arm?

15 A Not at that point cause she was still swaddled.

16 Q Okay. Now, was she being seen by a pediatrician or a
17 neonatal specialist while she was in the NICU?

18 A She was being seen by nurses and other doctors. I
19 don't know exactly who they were.

20 Q Did you have any discussions with the nurses or the
21 doctors about your baby's condition?

22 A Later on I did. While she was in NICU, yes.

23 Q Okay. And did they ever explain to you about shoulder
24 dystocia or any problems that your daughter was having with
25 her shoulder?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Not at that point. They were more concerned with
2 making sure she was stable and making sure she was okay.

3 Q Okay. But, at some point, did they talk to you about
4 her arm?

5 A Yes.

6 Q And while you -- while she -- the baby was still in the
7 hospital?

8 A That is correct.

9 Q What did you learn from them?

10 A That sometimes, with shoulder dystocia, they don't have
11 movement in their arm, arm, but later, you know, it, it --
12 they don't really know, you know, from my understanding.
13 They just tell you sometimes the child does not have
14 movement in, in their arm.

15 Q All right. And when you say they didn't know, does
16 that mean you don't know whether the movement's gonna return
17 or, or going to emerge on its own or, or not emerge on its
18 own?

19 A That is correct.

20 Q All right. That's what you understood?

21 A That's what I understood.

22 Q And it was a wait and see?

23 A That is correct.

24 Q So -- but did they make any referrals to other doctors
25 for treatment of the shoulder?

Tristan Flowers - Direct examination
by Mr. Henshaw

- 1 A No, they did not.
- 2 Q But Doctor Giep did?
- 3 A That is correct.
- 4 Q And he was specific?
- 5 A That is correct.
- 6 Q And was Doctor Nelson?
- 7 A That is correct.
- 8 Q Did you follow his advice?
- 9 A Yes.
- 10 Q And when did you first see Doctor Nelson?
- 11 A I think maybe after she was released from NICU.
- 12 Several months later we went to see Doctor Nelson.
- 13 Q All right. And Doctor Nelson did what?
- 14 A She evaluated Ashley and said okay, you know, she
- 15 confirmed she did have shoulder dystocia, and then I
- 16 remember the brachial plexus at that cause I started to
- 17 research more and try to figure out what was actually wrong.
- 18 Q Okay. Did you understand -- did you learn, through
- 19 your research, that this was a problem with nerves in her
- 20 shoulder?
- 21 A That is correct.
- 22 Q Okay. And did you talk with Doctor Nelson and get
- 23 confirmation of your research?
- 24 A That is correct.
- 25 Q So, did Doctor Nelson come up with a plan?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Doctor Nelson then informed us about Doctor Armenta in
2 Houston, Texas and informed us about the clinic that he --
3 so many times a year, a couple times a year, he will come to
4 Charlotte, North Carolina to see kids with injuries like
5 Ashley.

6 Q All right. And, as a result of that, did you look into
7 Doctor Armenta's -- Doctor Armenta?

8 A Yes.

9 Q What did you do?

10 A I did research via the Internet. I also spoke with
11 other parents that had seen Doctor Armenta, other parents
12 who have not seen Doctor Armenta, and I read up on Doctor
13 Armenta and Doctor Bergeron.

14 Q Okay. And did you feel like you had some choices?

15 A Yes.

16 Q And what did you understand your choices to be?

17 A There were other clinics or other surgeons of
18 brachial -- that, that, that treated kids with brachial
19 plexus. One being in Philadelphia. And out of choices I, I
20 had, I decided to go or my wife and I decided to go with
21 Doctor Armenta.

22 Q All right. Did you have a meeting with Doctor Armenta
23 before he did the surgery?

24 A Yes.

25 Q Where did that take place?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A It was in Charlotte, North Carolina.

2 Q And what was done at that, at that meeting?

3 A He evaluated Ashley and he also instructed Doctor
4 Nelson of some things to, to do, and he explained to us what
5 sometimes needed to happen to try to correct the brachial
6 plexus injury.

7 Q Did he make a recommendation at that time?

8 A I don't -- I think he did. Yes, he did make a
9 recommendation for surgery.

10 Q And what -- for surgery?

11 A Yes.

12 Q And did y'all make a decision immediately or did you
13 wait?

14 A It wasn't immediately. I wanted to research it more,
15 but we did make a decision soon after that for the surgery
16 cause we had to make a decision quick because, with brachial
17 plexus injury in kids that, newborns, you want to have that
18 surgery early versus later while the nerves are still
19 growing and active.

20 Q All right. Did -- and did you relate that back to
21 Doctor Armenta in some way --

22 A Yes.

23 Q -- that you wanted to go forward with the surgery?

24 A That is correct.

25 Q And you did go forward with the surgery?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A That is correct.

2 Q And that took place in June of 2009.

3 Is that right?

4 A April.

5 Q April.

6 A Yes.

7 Q What, what location?

8 A In Houston, Texas at Hermann Memorial Children's
9 Hospital---

10 Q All right.

11 A ---in Houston, Texas.

12 Q And we've heard your wife's testimony about going out
13 there and how you waited.

14 Anything that you can add to the circumstances of that
15 surgery?

16 A I do remember waiting in the waiting room. You know,
17 they started out that morning. It was a very long surgery.
18 Like my wife said earlier, we were the only ones in the
19 waiting room. So, there were cause for concern cause Doctor
20 Armenta initially told us the surgery would take only a
21 couple of hours. And then, after that passed and other
22 parents left, the hospital personnel left, we were the only
23 ones there that literally cut out the lights on us in the
24 waiting room. Had to turn the lights back on.

25 A nurse did come to a partition like behind the desk

Tristan Flowers - Direct examination
by Mr. Henshaw

1 behind a glass and stick a phone out there, and said hey,
2 we'll be in contact with you. They're still in surgery.

3 Q Okay. Was that cause for concern?

4 A Very. I was very concerned at that point.

5 Q All right. And was that concern relieved at some
6 point?

7 A The phone did ring later, and I answered it and they
8 told us, you know, that the surgery was over and Doctor
9 Armenta and Doctor Bergeron would be out shortly.

10 MR. HENSHAW: All right. Your Honor, for the
11 information of the Court and the jury, in evidence are all
12 the medical records of, of Ashley F , and, in addition
13 to that, we've marked for identification -- we've, we've
14 marked and placed into evidence the operative reports as
15 well as an illustration that was done in Texas concerning
16 the nerves that were operated on, and they're in these books
17 and individual documents.

18 THE COURT: Okay. Thank you, sir.

19 MR. HENSHAW: Thank you.

20 So, how did Ashley progress after she had the surgery?

21 A You know, there we couldn't see, at that time, what
22 was -- you know, cause she was bandaged up. Once everything
23 was over with in Texas, they sent us home. She stayed
24 bandaged for six weeks, and then, when she removed my wife
25 or well, when we went to see Doctor Armenta -- not, I'm

1 sorry, Doctor Nelson in Charlotte, she removed the bandage,
2 bandage and the stitches and we came home.

3 well, I remember my wife being in the room with my
4 daughter, and calling and screaming and saying, you know,
5 and I run in and we saw slight movement. We really thought
6 we won the Super Bowl. You know, we were running around the
7 house and celebrating because we, first time, seeing
8 movement in her arm.

9 Q What kind of movement did you see?

10 A It was just slight. I mean, you know, it was -- she
11 didn't raise her arm, but she just, you know, tried to move
12 her arm.

13 Q Now, up until that point in time, was it obvious that
14 the left arm and hand were -- and the wrist were different
15 than the right arm, hand, and wrist?

16 A Yes.

17 Q And can you explain to us how you saw it?

18 A It was turned like awkward or her, her palm was turned
19 out before she had the surgery, but, after she had the
20 surgery, it straightened up. So, it was straight like a,
21 you know, beside her. It wasn't rotating in.

22 Q Did, did you have any understanding from Doctor --
23 talking with Doctor Armenta or Doctor Nelson, Nelson as to
24 why the arm would change its configuration that way?

25 A No, but the nerves -- understood that the nerves, due

1 to the nerves being -- having issues or being severed,
2 that's why they were -- it was that way.

3 Q All right. And they were injured?

4 A That is correct.

5 Q Okay. Nobody ever told you they had been severed.
6 Is that correct?

7 A No, no, that's mine.

8 Q Okay.

9 A Yes, sir.

10 Q Now, so, following that surgery by Doctor Armenta, what
11 type of treatments did Ashley receive?

12 A A lot of therapy. My wife did an outstanding job at
13 giving our daughter therapy every day as much as you could.
14 When the therapist, occupation and physical, would come by
15 the house, she would make sure she understood exactly what
16 they were doing and do the same thing or, or find out extra
17 things that she could do to assist Ashley in her therapy.

18 Q Now, up until the time she became pregnant, had, had,
19 had Treva been working?

20 A Yes.

21 Q And did she stop because of the pregnancy?

22 Did she stop working because of the pregnancy?

23 A Yes.

24 Q She stayed, continued to work?

25 A She continued to work until she had Ashley.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q All right. And then what happened in terms of her
2 employment?

3 A She was no longer employed after that. I wanted to
4 ensure that she had all the time she needed to do what was
5 best for our daughter.

6 Q And, and before Ashley was born and had the
7 complication of pregnancy, what was your plan for Treva
8 going back to work?

9 A After six months, I figure okay, six months, that's
10 plenty enough time. You know, she'll be back to work, but
11 she never went back to work after that but, you know, we
12 planned for her to be out.

13 Q Now, was -- did Ashley's condition, continuing
14 condition have anything to do with whether Treva did or did
15 not go back to work even after six months?

16 A Yes.

17 Q In what way?

18 A Because with all the therapy and to provide the correct
19 therapy, I don't see how she was able to work and do that
20 because she was either gonna have to take her to therapy or
21 the therapy person, the therapy personnel will come by the
22 home. With all the appointments, it was either not take
23 Ashley and she go back to work or stay there with Ashley and
24 get the proper care.

25 Q All right. And was that discussed in your family --

Tristan Flowers - Direct examination
by Mr. Henshaw

- 1 A Yes.
- 2 Q -- as to what needed to be done?
- 3 A Yes.
- 4 Q And the decision was not to go back to work?
- 5 A That is correct.
- 6 Q Now, did you see improvement in Ashley's arm?
- 7 A Yes.
- 8 Q And what did you see?
- 9 A She would move -- try to move it. You know, she
- 10 started doing different things. She would, you know, move
- 11 her fingers more. She would reach for stuff and she was
- 12 figuring out ways to do things that she wanted to do. Like
- 13 she may do it different, but she finds a way to do it.
- 14 Q Okay. And what about, what about crawling?
- 15 A She never crawled. She stooped.
- 16 Q Okay. Sitting?
- 17 A Yeah, she would sit. She -- her balance was off
- 18 because it was like she didn't, you know, she didn't really
- 19 know her arm was there. You know, for her, the way it was
- 20 explained to me by a therapist is that we're going with both
- 21 arms and we know they're there. She never knew her arm was
- 22 there. So, she had to learn that she had an arm there. So,
- 23 sitting sometimes, she would be off balance you know. So,
- 24 she had to learn how to sit correctly.
- 25 Q Okay. What about pulling herself up or standing only?

Tristan Flowers - Direct examination
by Mr. Henshaw

1 A Therapy is what helped with all of that. It's the,
2 it's the therapy that teaches the kid how to do those normal
3 things that other kids just do.

4 Q Did she walk in the, in the usual timeframe for babies?

5 A Yes. Yes, sir.

6 Q And did you -- did -- could you tell whether her arm
7 affected that?

8 A Yes, I mean she was off balance, but she walked.

9 Q Okay. So, there came a second surgery?

10 A That is correct.

11 Q Is that right?

12 And who performed that?

13 A Doctor Armenta.

14 Q And where was that one done?

15 A That was in Houston, Texas also.

16 Q And why was it done?

17 A That was done to help kind of straighten her cause kids
18 with brachial plexus will try to -- will overcompensate and
19 turn, turn back in where it was already straight, you know,
20 either -- the first surgery helped straightened the arm
21 correct, but then the shoulder tries to overcompensate. So,
22 you have to straighten it -- straighten -- help straighten
23 the kid back up.

24 Q And, from your point of view, how did that surgery go?

25 A Very well.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q And, and did you see or notice a difference after it
2 was completed and she recuperated from the surgery?

3 A Yes.

4 Q And what did you notice?

5 A That she was straighter and that she was getting more
6 movement and, you know, trying to raise her elbow and her
7 arm.

8 Q All right. And approximately when was that surgery?
9 Do you remember?

10 A It was February of, I think, 2011.

11 Q What about a third surgery?

12 Did she, did she undergo a third surgery?

13 A That is correct.

14 Q And where was that?

15 A That was in Houston, Texas also.

16 Q Who did it?

17 A Doctor Armenta.

18 Q And what was that surgery for?

19 A That was on her wrist, wrist and that is because her
20 wrist is so called hooked and that's my term. That's not a
21 medical term, but it's hooked. So, it was tried to
22 straighten her wrist.

23 Q All right. And what did you observe about her wrist
24 after that surgery and she recuperated?

25 A Well, once Doctor Armenta did the surgery, he realized

1 it was a lot of scar tissue. So, originally that surgery
2 was going to be like a nerve transfer, but once he was
3 there, and during the surgery, he realized there was a lot
4 of scar tissue. So, he said he just removed the scar tissue
5 hoping it would correct on its own, you know, so that he
6 wouldn't have to so call waste a nerve because she may need
7 another surgery later.

8 Q Did you go into that surgery with the understanding
9 that his plan was to transplant or graft a nerve into the
10 wrist?

11 A That is correct.

12 Q And, and he came out and had to report to you that he
13 wasn't able to accomplish that?

14 A That is correct.

15 Q Did -- what did you notice after Ashley had that
16 surgery?

17 A She stayed in a splint for a while so called like a,
18 like people with carpal tunnel wear. My wife would put
19 pretty stuff on it and decorate it so she would, you know,
20 wear it, but she would try to move her wrist more --

21 Q All right.

22 A -- after that surgery.

23 Q Now, did these surgeries leave any scars?

24 A They did, but Doctor Armenta did an outstanding job at
25 trying to disguise the scar. Actually, when we attend the

1 United Brachial Plexus Camp, several other parents have seen
2 Ashley's scars and wanted to know who performed her
3 surgeries, and we've actually recommended Doctor Armenta and
4 they, you know, I don't know what they did after that point,
5 but I've recommend him to several other parents.

6 Q All right. Now, what is the camp you attend?

7 A It's a United Brachial Plexus Camp. It's a camp that
8 was -- that kids or personnel or adults also -- kids and
9 adults with brachial plexus injury attend. It's held every
10 two years. Originally it was held in Potosi, Missouri,
11 about an hour outside of St. Louis. This past July or this
12 past August, I'm sorry, it was in Daniels, West Virginia.

13 Q And how many camps have you attended?

14 A Three.

15 Q And so that's over the last six years?

16 A Yes.

17 Q And what, what types of benefits or activities does the
18 camp provide?

19 A For us, it was life changing because Ashley got a
20 chance to see other kids who had the same injury as she has.
21 They talk about different things. They have round tables
22 for fathers where I got a chance to meet with nothing but
23 fathers who have kids with brachial plexus. My wife gets to
24 attend a meeting with mothers. You get to meet other people
25 who are experiencing what you're experiencing.

Tristan Flowers - Direct examination
by Mr. Henshaw

1 Q And has that been of any benefit to you?

2 A Oh, definitely, definitely because you learn what to
3 expect. You get a chance to even -- like I like to attend
4 the -- what they call round tables with the teenagers. You
5 have a panel of teenagers to tell you what they're
6 experiencing, how they're gonna experience it, when they're
7 gonna experience it like for girls when it comes to prom and
8 dating and, you know, the pain. Like right now, Ashley's
9 not experiencing a lot of pain, but when she gets older---

10 MR. LOVELL: Objection, Your Honor.

11 Q Yeah.

12 MR. LOVELL: I think he's getting into---

13 Q You can't go into what, what you learned that may
14 happen in the future.

15 A Okay.

16 Q But you can tell what the subjects were.

17 A The subject there is that what -- the kids explained to
18 me what to expect later in life.

19 Q All right. Now, have you observed that this has been
20 of any benefit to Ashley to go to those camps?

21 A Oh, yes, it's helped her self-esteem because she gets
22 to talk to other kids who are experiencing what she's
23 experiencing.

24 Q Have you noticed whether Ashley has any emotional
25 issues that might relate to -- that, that do relate -- that

Tristan Flowers - Direct examination
by Mr. Henshaw

1 you believe relate to her arm?

2 A Oh, yes. Yes.

3 Q And what are they?

4 A Sometimes I've caught her getting upset with her
5 brother, asking why---

6 Q Her older brother or her younger brother?

7 A Her younger brother. Asking why, excuse me, does he
8 have use of both of his arms and she doesn't.

9 Q Any other issues that, that you have observed?

10 A Her hitting her arm. Having to explain to her what's
11 wrong with her. So, trying to educate her on what the issue
12 is or what her injury is.

13 Q Now, we've placed into evidence Exhibit 1, which is a
14 summary of the bills that are related to Ashley's injuries
15 to her arm.

16 Have you -- have you had a chance to see that?

17 A I have.

18 Q And I'm not gonna ask you to go through and read it
19 off, but if you'll go to the, the end of it.

20 What, what is the total?

21 A \$610,364.48.

22 Q Thank you.

23 Just one minute, Your Honor, please.

24 (Pause.)

25 MR. HENSHAW: Your Honor, that's all the questions I

Tristan Flowers - Cross-examination
by Mr. Lovell

1 have at this time.

2 Mr. Flowers, please answer any questions defense
3 counsel may have.

4 A Okay.

5 THE COURT: Mr. Lovell.

6 MR. LOVELL: Thank you, Your Honor. Very briefly.

7 CROSS-EXAMINATION

8 BY MR. LOVELL:

9 Q Good afternoon.

10 A Good afternoon.

11 Q Good morning still or afternoon maybe now, Mr. Flowers.

12 A couple of points going back to the delivery---

13 A Okay.

14 Q ---at the time. You told us about the period of time
15 y'all were in one room and then transferred to labor and
16 delivery.

17 Your wife was in labor for 17, plus or minus, hours?

18 A Correct.

19 Q And, during that time, she was having contractions well
20 before they said push, push and all of that, right?

21 A Correct.

22 Q And they kind of started not so strong and got sort of
23 crescendo stronger and stronger as the day went on?

24 A Correct.

25 Q You mentioned your mother-in-law.

Tristan Flowers - Cross-examination
by Mr. Lovell

1 That's Mrs. Bowen?

2 Is that her name?

3 A Correct.

4 Q She was at the hospital as well.

5 You told us about where you were, but, from your
6 prospective, it's fair to say you really couldn't see what
7 was going on on the business end where Doctor Giep was?

8 A That is correct.

9 Q You didn't see the baby's head crowning or the baby's
10 head deliver or anything until Doctor Giep had the baby out
11 and was handing her off to the intensive care people, right?

12 A That is correct.

13 Q And when Doctor Giep came in, I mean he went down and
14 started working on delivering your child, right?

15 A That is correct.

16 Q Okay. And he worked the whole time he was there?

17 He wasn't cutting up with anybody or doing anything of
18 that sort?

19 A That is correct.

20 Q When you saw the nurses you mentioned getting sort of
21 up on the stool and begin pressing on the area of your
22 wife's stomach, were their hands underneath the bedsheets or
23 whatever?

24 Could you see where they were actually pushing her or
25 were they hidden from your view by something?

Tristan Flowers - Cross-examination
by Mr. Lovell

1 A They was pushing on her abdomen where I couldn't -- you
2 know, I didn't look exactly.

3 Q Okay. But you knew, at that point, something unusual
4 was going on with the delivery?

5 A That is correct.

6 Q In your mind, was it sort of this is sort of an
7 emergency scenario?

8 A I don't know if I would say an emergency, but something
9 was wrong.

10 Q After the baby was fully delivered and handed off to
11 the, to the NICU nurses, you mentioned that she was blue in
12 color?

13 A Uh-huh. (Affirmative).

14 Q Is that a yes for her?

15 A That is correct.

16 Q And also that there was a period of time where she
17 wasn't making noise or crying, right?

18 A That is correct.

19 Q But eventually the nurses stimulated or did whatever
20 they did and the baby started crying?

21 A That is correct.

22 Q And I assume that was a big relief for you?

23 A That is correct.

24 Q Ashley was 7-pounds 11-ounces, right?

25 A That is correct.

Tristan Flowers - Cross-examination
by Mr. Lovell

1 Q And that wasn't -- the doctor said that's not
2 abnormally big for a baby, right?

3 A That is correct.

4 Q And, as I understood, you saw Doctor Giep in the
5 hospital before your wife went home, or however many times
6 that was, and then you also went with her to a couple of the
7 visits at his office after she got home, right?

8 A That is correct.

9 Q And, in those visits, Doctor Giep would always ask you
10 guys how Ashley was doing, right?

11 A That is correct.

12 Q And he expressed concern about how, how your baby was
13 doing after the delivery, right?

14 A When we went to the visit.

15 Q The camps you told us about, you mentioned they were
16 every two years.

17 So, they started when Ashley was four years old?

18 A I don't remember the first one exactly we went to. She
19 was three or four if I'm correct.

20 Q So -- and then when she was about six or seven and now
21 this summer y'all went to one?

22 A Yes.

23 Q And she is found those kind of help her with her
24 self-esteem as you've talked about?

25 A Everything.

Tristan Flowers - Cross-examination
by Mr. Lovell

1 Q Okay. And she's there with other people, not just kids
2 I guess, who have similar types of, of brachial plexus
3 injuries and different problems that they've had for things?

4 A That is correct.

5 Q I got one last question. I have a picture that I've
6 marked as Exhibit 15.

7 MR. HENSHAW: No objection, Your Honor.

8 THE COURT: Okay.

9 Q Do you recognize that?

10 A Yes.

11 Q Tell me about when it was taken. I'm, I'm not sure on
12 that.

13 A That was taken in this year.

14 Q Okay. There's a bunch of people in there. I'm just
15 gonna ask. I can see you. This is Ashley and your wife's
16 in the middle.

17 Correct?

18 A Yes.

19 Q And is that Josiah?

20 A Yes.

21 Q who's the other lady?

22 A That's my sister-in-law.

23 Q Was this at some family event?

24 A This was at a family event, yes.

25 Q Was this before or after y'all went to the camp this

Tristan Flowers - Cross-examination
by Mr. Lovell

1 summer?

2 A This is before.

3 Q Thank you.

4 Your Honor, we move Defendant's 15 into evidence.

5 MR. HENSHAW: No objection, Your Honor.

6 THE COURT: It's admitted.

7 (WHEREUPON, Defendant's Exhibit No. 15 was received
8 into evidence at this time.)

9 MR. LOVELL: That's all I've got. Thank you.

10 THE COURT: Anything else?

11 MR. HENSHAW: No, Your Honor. Not with this witness.

12 THE COURT: Okay. You may step down. Thank you.

13 THE WITNESS: Thank you.

14 MR. HENSHAW: Your Honor, that completes the
15 plaintiff's case.

16 THE COURT: Ladies and gentlemen, that is all the
17 testimony or other evidence to be offered by the plaintiff
18 at least in the case in chief. I've got some matters I'll
19 need to address with the lawyers and it's a good time for us
20 to break for lunch now. So, we will do that.

21 Keep in mind the case is not over. So, don't discuss
22 it. Don't do any research. No investigation.

23 Do have a good lunch. Please report to your jury room
24 at 2:30, 2:30 this afternoon. Have a good lunch.

25 (WHEREUPON, the following takes place outside the

1 presence of the jury.)

2 THE COURT: Motions or other matters to address.

3 MR. LOVELL: Yes, Your Honor.

4 On behalf of Doctor Giep and Pelham Spartanburg OB-GYN,
5 we move for directed verdict on the claims of negligence in
6 this case.

7 Judge, this case is, according to all of the evidence
8 we've heard, falls within the exception to the standard of
9 care for obstetrical emergencies stated at Code Section
10 15-32-230. That code section, Your Honor, states that, in
11 actions involving medical malpractice claim arising out of
12 the care rendered in the genuine emergency situation
13 involving an immediate threat of death or serious bodily
14 injury to a patient receiving care in an obstetrical suite,
15 no physician may be held liable unless it is proven that the
16 physician was grossly negligent.

17 The three precursors to that are that the defense must
18 show, as the precursor, that the baby or the -- in this
19 case, I guess the baby, the patient, was not medically
20 stable and was in immediate threat of death or immediate
21 threat of bodily injury. And in -- there's a couple of --
22 there's really only one case really that's talked about that
23 in any detail. It's the Richland Memorial case at 350 S.C.
24 589.

25 There's also an unreported case, Gordon versus

1 Goldstein, and the cites are there, it basically states that
2 when that's -- evidence has been produced by the defense in
3 terms of the affirmative defense, the plaintiff then has the
4 burden of proving that the doctor exercised gross negligence
5 in the care of the case.

6 We've met our burden of proof through their expert of
7 the precursors. Doctor Gurewitsch, who testified yesterday,
8 testified, in several places, and I'll just quote them, Your
9 Honor, at one point she was asked a question about shoulder
10 dystocia.

11 It's not predictable, is it?

12 Q. And there's no doubt this is a medical emergency we
13 have now?

14 Yes.

15 Talking about shoulder dystocia.

16 She also testified, Your Honor, that the question was
17 asked, we will talk in a little bit about how long she
18 was---

19 THE COURT: Well, excuse me just a minute.

20 Give me that quote.

21 This is a quote from her deposition?

22 MR. LOVELL: Yeah, I'm looking at the transcript.

23 THE COURT: And you said there's no doubt and she said
24 yes?

25 MR. LOVELL: About medical emergency, yes, Your Honor.

1 Let me go back and read it for you.

2 THE COURT: Does that mean she agreed or she disagreed?

3 MR. LOVELL: She agreed it was a medical emergency.

4 THE COURT: Okay.

5 MR. LOVELL: Yes, sir.

6 And then the question was asked, but there's no doubt,
7 for a shoulder dystocia baby, can have a serious brain
8 injury or can die as a result of a shoulder dystocia,
9 correct?

10 A. It can.

11 Q. Babies do die from shoulder dystocia, don't they?

12 A. They can.

13 And the question was, and that's because, when the head
14 is delivered but the body is not yet delivered, the baby is
15 not getting oxygen, correct?

16 Her answer was it may not be getting oxygen.

17 Q. All right. And there's no doubt, in this case
18 through the actions of Doctor Giep, that Ashley F
19 avoided brain damage any even death, didn't she?

20 A. Yes.

21 And finally, Your Honor, the question was asked, would
22 you agree or disagree that, even though Doctor Giep
23 delivered Ashley F after a one to two minute shoulder
24 dystocia, she was born in some distress?

25 would you agree with that?

1 A. Yes.

2 And you don't think Doctor Giep, during this delivery,
3 was using no care or was acting recklessly, do you?

4 A. No, I do not.

5 So, Your Honor, we've met the precursor of showing
6 there was a medical emergency, the baby -- that the baby was
7 not medically stable as she just stated, that the baby was,
8 at the point of shoulder dystocia occurrence, in immediate
9 threat of serious bodily injury and/or death, and also that
10 the doctor, their own expert's testimony, wasn't reckless or
11 grossly negligent and that's the standard that would be
12 applied in this case.

13 It's a medical, obstetrical emergency. He's held to a
14 level of gross negligence. Gross negligence has been
15 defined, and I've got a case of Pilot Industries versus
16 Southern Bell, but also the Richland Memorial case
17 referenced it, that South Carolina Courts have recognized
18 gross negligence is only when the defendant has failed to
19 exercise even a slight degree of care, which would be, in
20 essence, exercising no care. She testified he did not
21 exercise no care and was not reckless.

22 So, we've met the burden of proving that we have
23 established that this doctor is held to a standard of gross
24 negligence, and that that standard was at least met in this
25 case through their own expert's testimony.

1 So, we move for directed verdict on the case in chief
2 on that ground.

3 THE COURT: What other grounds do you have?

4 MR. LOVELL: Your Honor, on the damages that have been
5 sought in the case, plaintiffs have alleged in the complaint
6 they requested future medical expenses, future hospital or
7 caretaking expenses, presumably for parent or children, and
8 also loss of income, presumably future.

9 There's been no evidence of any future medical expenses
10 that might be incurred. There was some testimony about
11 potentially a surgery that could occur, but there's no
12 evidence of what it would cost that the jury could rely upon
13 to other than speculate to determine any amount of any of
14 these alleged future damages. So, we would move for a
15 directed verdict on that ground, Your Honor.

16 And they have also pled a claim of punitive damages,
17 which requires clear and convincing evidence of gross
18 recklessness, willful, wantonness, that degree of oppression
19 that suggests a conscious indifference to the consequences.
20 I think, through the testimony of their own expert, that
21 doesn't exist in the case.

22 So, we move for directed verdict on the punitive
23 damages claim as well.

24 THE COURT: Is that it?

25 MR. LOVELL: That's it, Your Honor.

1 THE COURT: Okay. Mr. Henshaw.

2 MR. HENSHAW: Your Honor, addressing the defense under
3 Section 15-32-230, defense counsel has not given you a
4 complete explanation of that statute. It does apply in
5 certain situations involving emergencies in obstetrical and
6 surgical suite, and that's indicated by Section A. And that
7 is the only part that he believes is applicable to this
8 case.

9 But the two other sections of that statute, B and C,
10 are also applicable and indicate that the gross -- first of
11 all, it is, it is not a complete immunity. It -- when it
12 does apply, it only applies as to simple negligence or
13 provides a qualified immunity for simple negligence, but not
14 for gross negligence, and -- but even though immunity does
15 not apply under Subsection B where there has been prenatal
16 care by the practice, and we believe that those two sections
17 are intended by the Legislature to be read together such
18 that, in a situation like this where there has been a
19 continuing management of the pregnancy and the patient is
20 now in the labor and delivery room under the care of the
21 practice that managed the pregnancy, the defendant does not
22 get the benefit of the qualified immunity.

23 But more than that, Your Honor, is Subsection C, which
24 says that the limitation on physician liability established
25 by subsections A and B, whether you read them together or

1 whether you read them independently of each other, shall
2 only apply if the patient is not medically stable and in
3 immediate, in immediate threat of death or in immediate
4 threat of serious bodily injury.

5 That certainly was not the case when she was in the
6 obstetrical suite. She was there all day and there's no
7 indication, from any evidence, that indicated that she was
8 in immediate threat or the baby was in immediate threat of
9 death or immediate threat of serious bodily injury, and, in
10 fact, our expert was asked that question.

11 In the two minutes that it took to release the body
12 from the pubic bone and deliver the baby, was the baby --
13 was there a risk of death or serious bodily injury, and our
14 expert responded to that and said no. That would come later
15 and frankly would not come until there was a colloquy
16 between defense counsel about how long that would be but --
17 and a dispute as to whether it was four or six minutes
18 because Doctor Gurewitsch indicated that it would be six
19 minutes and the defense wants to prove or claim that it's
20 four minutes.

21 Either way, it doesn't apply in this case because
22 everybody's in agreement that the baby's head was -- that
23 the -- that if there was risk attached to shoulder dystocia,
24 it happened and was eliminated within two minutes before
25 there was a significant risk of death or bodily injury.

1 Now, the fact that the doctor then created the injury
2 in the way that he went on to -- and created significant
3 bodily injury because of the way that he twisted the baby,
4 that was by his own, that was by his own actions and conduct
5 and not because of a condition that it -- that he had to
6 take over for and try to manage once it occurred.

7 So, Your Honor, the statute should not be actually even
8 applied here given the language of the statute and the way
9 that it should be interpreted.

10 As to the other reasons or basis for directed verdict
11 as to punitive damages, defense counsel is correct that the
12 expert of the plaintiff did indicate that she did not find
13 gross or -- well, I think she was asked more specifically
14 about reckless, wanton, willful misconduct. But even
15 assuming that, that the definitions for those would be the
16 same for gross negligence, then I'm not willing -- I would
17 not necessarily agree that they are, but, but assuming that
18 they are the same definitions, based on a conscious
19 disregard, yes, and the expert did indicate she did not find
20 that, but that's not for the expert to determine.

21 It's for the jury to determine, and the case law, in
22 South Carolina, is, is that a finding of gross negligence,
23 at least in most cases, is reserved as a question of fact
24 for the jury and it's for the jury to determine.

25 In this case, it would be a reasonable inference that a

1 doctor who has his hands on the baby and is making a
2 conscious effort to deliver this baby is in a position to
3 know whether he is or is not -- in fact, we heard testimony
4 about the amount of traction and what doctors perceive as
5 the amount of traction, and, and also the lateral traction
6 of the baby's head so that it pulls the nerves away from the
7 spinal cord and stretches them. But he's in a position to
8 know whether he is doing that. It is, therefore, he's in a
9 position to be conscious of it, and the fact that he went
10 ahead and did that, when there was no good reason to do
11 that, could be the basis for a finding of conscious
12 disregard and a basis for punitive damages.

13 The defendant can't have it both ways. He can't come
14 into Court and say I -- this happened because I had to apply
15 so much traction to get the baby out that I could not avoid
16 this injury to the baby's nerves. First of all, he never
17 said that he did that, but that is implied in terms of the
18 way the defense is constructing its defense in that look how
19 much force it can take to get the baby out, and what a
20 doctor has to do in a situation that we want to call an
21 emergency.

22 And, and so, if that's what the doctor did is that he
23 made a conscious decision, but he wants to say it was within
24 the standard of care, there's, then there's no evidence that
25 you -- that he made that decision consciously, and, in fact,

1 he's written that he only applied a small amount of traction
2 or reasonable traction in this case in order to get the baby
3 out, but he doesn't deny that he used traction.

4 On the other hand, they want to suggest that it wasn't
5 the traction at all that caused this injury. It was this
6 irrepressible contraction force caused by the uterus, uterus
7 that they're calling the maternal forces of labor, and they
8 want to say that that is what caused injury to the baby's
9 brachial plexus. And, of course, that is highly disputed by
10 our experts who, number one, say there that's not possible
11 and, number two, who, who clearly say that the only reason
12 that this baby had the injuries that she did was because of
13 the traction forces applied by the doctor.

14 So, that would be a question of fact for the jury to
15 determine. So, we feel that there is a basis for the Court
16 to allow the jury to consider punitive damages.

17 Your Honor, I say that at this directed verdict stage.
18 I may -- I would reserve -- I do reserve the opportunity to
19 make a different decision about that after the defense
20 rests.

21 THE COURT: I'm satisfied you're gonna make that
22 difference sitting here too.

23 MR. HENSHAW: Well, well, that's what usually happens
24 in these cases, Your Honor, as you well know.

25 THE COURT: Oh, it's appropriate.

1 MR. HENSHAW: So, you know, I, I make the argument now,
2 but I do want to tell you that, as we hear the defense, we
3 very well may come back to the Court and say we, we agree
4 and will take out the punitive damages. But I do want to
5 give you a basis that, at this point, you should allow it
6 to -- either take it under advisement or allow it to go
7 forward.

8 THE COURT: All right. Let me ask you this.

9 Is it your view that the jury could make a
10 determination as to the deviation from the standard of care
11 without expert testimony?

12 MR. HENSHAW: Without that expert testimony?

13 THE COURT: Yes, sir.

14 MR. HENSHAW: I don't think so in this case.

15 THE COURT: All right.

16 MR. HENSHAW: I don't think this is a case of common
17 knowledge.

18 THE COURT: All right. You're saying this is a case of
19 common knowledge?

20 MR. HENSHAW: I said I don't think that this is a case
21 of common knowledge.

22 THE COURT: All right. Well, if they can't determine
23 if the defendant was negligent without expert testimony, how
24 can they determine whether or not he was grossly negligent
25 without expert testimony?

1 MR. HENSHAW: Because it's not a -- because this --
2 it's a question of the standard of care and what the doctor
3 did to -- and, and what the doctor did in regard to that
4 standard of care and how he did it.

5 THE COURT: Well, I know that but, but what I'm saying
6 is the jury has to consider the expert testimony in deciding
7 if the doctor was negligent.

8 MR. HENSHAW: Yes, sir. No -- well, I -- may I?
9 I'm sorry. I interrupted you, Your Honor.

10 THE COURT: Yes, sir, go ahead.

11 MR. HENSHAW: Your Honor, what my understanding our
12 Courts have said is, is that, in most cases of medical
13 malpractice, an expert is required to help the jury
14 pursuant, I think, to Rule 701 as to scientific principles
15 and standards of care.

16 How a doctor does his job pursuant to the standards of
17 care, that can be within common knowledge, but I mean,
18 generally speaking, you know, when I'm saying it's not a
19 matter of common knowledge as to, you know, it would not be
20 a case of common knowledge. That's not to say that there
21 are certain things that, that would be within a juror's
22 common knowledge, and I think that, whether or not he has a
23 conscious disregard or whether he does, does not have a
24 conscious disregard, does not require expert testimony.
25 That's something that the jury has to determine.

1 Once they understand -- they have to -- the expert has
2 to be there to help them understand what the standard of
3 care is, but I don't think the expert has to be there to
4 tell them whether it's a conscious disregard.

5 THE COURT: So, you're, you're telling me that the
6 expert doesn't have to say that he deviated from the
7 standard of care in some particular?

8 MR. HENSHAW: He has to say that much.

9 THE COURT: Okay. He---

10 MR. HENSHAW: Cause he has to explain what the standard
11 of care is.

12 THE COURT: I understand.

13 And -- but, but you're saying also that the expert has
14 to explain to the jury why there was a deviation because
15 they can't determine that.

16 MR. HENSHAW: I think that's correct. I do think---

17 THE COURT: Well, certainly in this case.

18 MR. HENSHAW: I think that's correct, Your Honor.

19 THE COURT: All right. Well, if, if you have to have
20 an expert to convince them that he was negligent, and they
21 can't determine negligence without that expert testimony,
22 then how can I determine if he was grossly negligent without
23 that expert testimony?

24 MR. HENSHAW: Because it depends upon his -- because,
25 once they understand from the expert what the standard of

1 care is and how the doctor deviated from it, I think that
2 they can determine whether or not that was a conscious
3 disregard.

4 THE COURT: Okay. I got you.

5 All right. Anything else?

6 You want to respond to him?

7 MR. LOVELL: Just one thing on that.

8 Their own witness testified though that, in her
9 opinion, the doctor underestimated the forces as most
10 obstetricians do not consciously disregarded anything.

11 So, I think you're right, Your Honor. They don't have
12 expert testimony that can support a claim for punitive
13 damages.

14 THE COURT: Well, it could be---

15 MR. HENSHAW: And I don't disagree with that, Your
16 Honor.

17 THE COURT: All right. It could be made a lot easier,
18 and I understand a lot of the questions asked of that
19 witness, and there might of been some asked about being
20 reckless, but was there actually one that asked her if he
21 was grossly negligent or not?

22 MR. LOVELL: It was phrased did he exercise no care,
23 which is the converse of slight care, and slight care is
24 gross negligence, and she answered he didn't not answer --
25 not exercise no care.

1 How about that?

2 THE COURT: So, he must of exercised at least slight
3 care.

4 MR. LOVELL: At least care.

5 THE COURT: All right.

6 MR. LOVELL: Some degree of care.

7 THE COURT: Okay. I'm gonna read the statute during
8 the break. I didn't have it. So, I'll rule on it after
9 lunch.

10 MR. LOVELL: Thank you, Your Honor.

11 Court's in recess until 2:30.

12 (WHEREUPON, Court was in recess for the lunch hour.)

13 THE COURT: I've got some more cogitating to do on
14 motions. So, I'll just take them under advisement. At the
15 present time, we'll proceed and then I'll let you know when
16 I've decided it.

17 MR. LOVELL: Thank you, Your Honor.

18 MR. HENSHAW: All right, Your Honor.

19 Your Honor, before we begin, we have what amounts to a
20 motion in limine based upon review of some of the documents
21 that defense counsel intends to use if -- with the next
22 witness.

23 He proposes to publish certain portions of a treatise
24 called Neonatal Brachial Plexus Palsy, and assuming that he
25 lays the appropriate foundation, I mean he's, he's gonna be

1 allowed to do that. I have no problem with that. It's the
2 way in which he intends to do it where he has taken excerpts
3 and blown them up on boards and wants to use those to
4 publish those certain portions to the jury.

5 Mr. Lovell's showing you now one of those.

6 THE COURT: Okay.

7 MR. HENSHAW: Your Honor, I'm---

8 THE COURT: You're not, you're not -- are you intending
9 to introduce it or just use them for demonstrative purposes?

10 MR. LOVELL: Just demonstrative. The witness will---

11 THE COURT: While the witness is testifying?

12 MR. LOVELL: ---lay the foundation. He'll talk about
13 the statement. I'll hold it up.

14 THE COURT: Okay.

15 MR. LOVELL: When we're done with it, we'll move on.
16 It doesn't get introduced into evidence.

17 THE COURT: Okay.

18 MR. HENSHAW: Well, I would refer the Court to Rule
19 803, subsection 18 in regard to learned treatises, which
20 basically -- which says, to the extent called to the
21 attention of an expert witness, upon cross-examination, or
22 relied upon the expert witness in direct examination,
23 statements contained in published treatises, periodicals, or
24 pamphlets on a subject of history, medicine, or other
25 science, or art established as reliable authority by the

1 testimony and admission of the witness or by other expert
2 testimony or by judicial notice. If admitted, the
3 statements may be read into evidence, but may not be
4 received as exhibits. This rule is in addition to any
5 statutory provisions on this subject.

6 In my understanding of that rule is, Your Honor, you
7 can publish -- once the witness, even on direct examination,
8 acknowledges this as an authority, reliable authority, then,
9 if he wants to publish portions of it, he can do that, but
10 he can only do it by reading. He can not do it by
11 demonstrative evidence or otherwise.

12 THE COURT: I don't agree with that.

13 MR. HENSHAW: All right, sir. That's my objection and
14 that's what I note to the Court.

15 THE COURT: Okay. Anything else?

16 MR. LOVELL: No, sir.

17 THE COURT: All right. Bring the jury in.

18 Oh, wait. We got to move these things so the jury can
19 get by.

20 MR. LOVELL: I am sorry, Your Honor.

21 THE COURT: How about taking those things there and
22 lean them up against that podium for the mean time?

23 Good.

24 Who's the first witness you're gonna have?

25 MR. LOVELL: Doctor Chauhan, Your Honor, and he is

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1 seated right here.

2 (WHEREUPON, the following takes place within the
3 presence of the jury.)

4 THE COURT: Good afternoon.

5 As you know, the plaintiff has rested in their
6 presentation. So, we're now gonna proceed with evidence to
7 be offered by the defendant.

8 Mr. Lovell.

9 MR. LOVELL: Your Honor, we call Doctor Suneet Chauhan
10 to the stand please.

11 DOCTOR SUNEET CHAUHAN, being first
12 duly sworn, testified as follows:

13 DIRECT EXAMINATION

14 BY MR. LOVELL:

15 Q All right. Doctor, if you'll pull that microphone
16 close so we can hear you, and would you introduce yourself
17 to the jury?

18 Tell us your name.

19 A Yes, sir, my name is Suneet, S-U-N-E-E-T, last name
20 Chauhan, C-H-A-U-H-A-N.

21 Q Thank you, Doctor Chauhan.

22 Tell us what kind of a physician you are.

23 what type of medicine do you practice?

24 A I initially started out as a general OB-GYN and then I
25 went to additional training in Mississippi to specialize

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1 just in high risk pregnancy. So, I don't do GYN anymore. I
2 take care of pregnant women who have some kind of
3 complications.

4 Q Tell us a little bit about your education and your
5 training and your experience that led you to be a high risk
6 pregnancy doctor.

7 A I did my undergraduate outside Philadelphia. Then went
8 to medical school at Thomas Jefferson in Philadelphia after
9 which I joined the Navy. I did my initial training at
10 Portsmouth Naval Hospital in Virginia. I was with the
11 Marine Corp for two years at Camp Lejeune in North Carolina.

12 After my training as an OB-GYN in the Navy, I served as
13 a general OB-GYN at the United States Naval Hospital, Naples
14 Italy, as a general OB-GYN. After about eight years, six
15 months of service to the United States Navy, I was honorably
16 discharged and I went to Mississippi to do two years of
17 training just taking care of high risk pregnancy that ended
18 in '92, and I've been high risk pregnancy doctor since 1992.

19 Q And where do you currently practice medicine in this
20 high risk area?

21 A Currently I am stationed at UT-Houston, which is in
22 Houston Campus. It's one of the University of Texas campus
23 in Houston.

24 Q All right. And how many years have you been working
25 there?

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1 A Almost four years, sir.

2 Q Are you involved in any teaching of medical students or
3 doctors in training?

4 A Yes, sir. So, we start off medical students, third
5 year, fourth year medical students who are interested in
6 OB-GYN, and then I'm also involved with education of 12, 12
7 times four, 48 residents who want to become general OB-GYN,
8 and then we have fellows like my training in Mississippi.
9 So, we have three fellows at each year. So, a total of nine
10 fellows who want to grow up to just do high risk pregnancy.
11 So, I teach from medical students to all the way to fellows.

12 Q Now, are you also involved in teaching in any other
13 subjects besides high risk pregnancy?

14 A I have become adjunct professor in -- Rice University
15 is right next to UT-Houston. I am in their biomedical
16 engineering department. So, currently I'm working with the
17 biomedical engineer. These are engineers who are interested
18 in biomedicine. So, I help them with their research related
19 to OB.

20 Q When you say OB, what do you mean by that?

21 A So, one of the things I'm working with the Ph.D. and
22 the biomedical engineering is trying to objectively measure
23 how far the head goes down during delivery, how much
24 traction we use. We are also working with them in this
25 postpartum hemorrhage or bleeding too much after delivery,

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1 and we are gone to Africa with them to try to improve the
2 outcome in Africa using bioengineering modeling.

3 Q Now, doctor, although you practice down in Texas, have
4 you ever practiced in other states?

5 A Yes, I have, sir.

6 Q Where?

7 A After my fellowship, I was in Peoria, Illinois.
8 Subsequently I was at Medical College of Georgia in Augusta
9 after which I moved to Spartanburg. I was at the
10 Spartanburg Regional Medical Center for seven years after
11 which I moved to Wisconsin and then Norfolk, Virginia, and
12 now Texas.

13 Q Now, in the seven years you were here in Spartanburg
14 practicing medicine, what type of patients were you helping
15 out?

16 A So, I was a high risk pregnancy. So, I did maternal
17 fetal medicine, and I use to take call, up to three to four
18 calls at night, where I practiced as a general OB-GYN at
19 nighttime.

20 Q Which hospitals were you doing this at here in the
21 Spartanburg area?

22 A Only at the Spartanburg Regional Medical Center.

23 Q Were you ever on any staff positions or administrative
24 positions with Spartanburg Regional?

25 A No, I was just the director of maternal fetal medicine.

1 There were two of us and about four stenographers and
2 multiple ancillary staff of nurses.

3 Q Now, when you were here in Spartanburg, did you know my
4 client, Doctor Giep?

5 A Yes, I did. His office was above our floor, and we
6 literally back -- my backyard was connected to his backyard.

7 Q And did you know his, his father, his brother, some of
8 the other doctors over in his practice group?

9 A I knew his father. He was, not to get too Asian, but
10 he was like a father figure. He advised me when we moved
11 here. I admired him immensely. I met his younger brother.
12 I think I was leaving when his younger brother was coming or
13 starting. I think there was a brief overlap. Maybe a few
14 months. But I knew Giep and I admired his father immensely.

15 Q Now, with this relationship that you've had with Doctor
16 Giep and knowing his father and his brother, is that, in any
17 way, affected the opinions you've given or you're gonna give
18 us here that you formulated about the care that Doctor Giep
19 rendered in this particular matter?

20 A It honestly has not because every opinion I have, I
21 know sounds nerdy, is usually backed up by publication, by
22 research either in America or from other countries or from
23 national guidelines or national things. So, it's not just
24 my opinion. Everything I would say will have a reference or
25 a citation of an articles. So, these are the kind of

1 objective truth.

2 Q And, doctor, I may of missed it, but I think I forgot
3 that.

4 where did you attend college and what degree did you
5 get there?

6 A In my undergraduate degree was at liberal arts college
7 outside of Philadelphia called Arcadia, and my major were
8 chemistry and biology. My medical school was at Thomas
9 Jefferson in Philadelphia.

10 Q And you told us about your residency.

11 That was in -- when you were in the Navy program?

12 A Affirmative.

13 Q All right. What was your final rank there in the Navy?

14 A When I was discharged in 1992, I was a Lieutenant
15 Commander in the Navy or a Major in the Army.

16 Q So, how many years have you been practicing as an
17 obstetrician delivering babies, whether they be high risk or
18 otherwise?

19 A I finished my OB-GYN training at Portsmouth Naval
20 Hospital in 1990. So, I've been delivering babies since at
21 least 1990 if you include my two years training as OB-GYN
22 since '86.

23 Q And are you board certified?

24 A Yes, I'm board certified both in OB-GYN and in high
25 risk pregnancy, maternal fetal medicine.

1 Q And have you had to recertify since you got initially
2 board certified in those areas?

3 A Yes, sir. So, these years everyone has to be board
4 certified -- recertified. That includes taking -- reading
5 OB-GYN and MFM or high risk pregnancy articles, about 20,
6 meet subject, doing the multiple choice questions. You
7 submit it to the computer and they grade you.

8 Q We know you're licensed in Texas.

9 What other states are you licensed to practice
10 medicine?

11 A I was licensed in South Carolina, Mississippi,
12 Illinois, Virginia, and Wisconsin.

13 Q And I asked you about your hospitals you worked at
14 here.

15 What, what ones are you practicing at there up in the
16 Houston?

17 A So, Houston does more deliveries than any other city in
18 America. We literally go to ten hospitals. Currently now I
19 am going to five hospitals. So, depending on the day of the
20 week, we go to different hospitals. I take care of high
21 risk pregnancy primarily during daytime. At least two to
22 four times a day I'm on labor and delivery in one of the
23 biggest teaching centers, the main hub, and I'm on call
24 three times in -- three times a month, two weekdays, and one
25 24-hours on the weekend when I'm on call actually doing the

1 delivery.

2 Q So, you're delivering babies yourself?

3 A I was on call this Sunday.

4 Q So, of all these other things, do you do research and
5 investigation type activities as a doctor?

6 A The main reason for me to move to Houston was Houston
7 is one of the 12 centers in America which does research in
8 conjunction with 11 other institution (sic) where -- and I
9 also, to be humble opinion, one of the best OB research
10 center in America. I'm the head of that research. We call
11 in principal investigators. So, I'm the principal
12 investigator to do NIH research at UT-Houston.

13 Q What does NIH mean?

14 A National Institute of Health and Bethesda.

15 Q Okay. How many babies would say you've delivered over
16 your years?

17 A And this is a reasonable estimate, but it is, it is an
18 estimate, I would say seven, eight thousand.

19 Q And how many say last ten years?

20 A I'm averaging about 150, a hundred less. So, ten times
21 a hundred, 150.

22 Q Per year?

23 A Yes, sir.

24 Q Now, are you familiar with the medical complication
25 that we've all heard about called shoulder dystocia?

1 A Yes, I am.

2 Q And are you familiar with what is considered in the
3 field of obstetrics to be the way that most physicians, most
4 competently trained obstetricians, would manage and react to
5 a situation where a patient develops shoulder
6 dystocia during a delivery?

7 A Yes.

8 Q And that's what we kind of call the standard of care.
9 Are you familiar with that?

10 A Yes, sir.

11 Q All right. And, in 2008, which was the time that this
12 baby was to deliver, are you familiar with the standard of
13 care required of obstetricians when faced with a shoulder
14 dystocia?

15 A Yes, I was.

16 Q How many times have you personally -- well, first,
17 let's -- have you personally, in your many deliveries that
18 you've told us about and encountered shoulder dystocia
19 during a delivery?

20 A We had one this Sunday.

21 Q So, how many times, over the course of your career,
22 have you seen that you think?

23 A So, the national rates are anywhere in the country,
24 it's about one out of a hundred deliveries. So, if you have
25 a hundred babies born in any hospital, you'll encounter it

1 one time. Because I take care of high risk pregnancy, it
2 may be higher. So, I would say at least one, if not more
3 than one percent of all deliveries.

4 Q So, would that be in excess of 50 to a hundred?

5 A I wouldn't be surprised with that.

6 Q Now, another issue that we've heard about in this case
7 involves fetal heart rates, and what's been termed as
8 deceleration.

9 Is that something you're familiar with as an
10 obstetrician?

11 A I'm -- not only am I familiar with it, matter of fact,
12 when I was in the Spartanburg Regional Medical Center, I was
13 invited to write the national guideline on fetal heart rate
14 monitoring at that time. So, not the current one, but the
15 one before. These are the national guideline of fetal heart
16 rate monitoring during labor.

17 Q All right. And, doctor, let's talk about the
18 management of shoulder dystocia.

19 When it's got an element of some decreased fetal heart
20 rate, are you familiar with the, the management of that
21 scenario similar to what happened with this delivery?

22 A Yes, I am.

23 Q Are you familiar with how most obstetricians, in
24 general, would manage those conditions when they occur in a
25 delivery such as what was faced with Doctor Giep or with

1 this patient?

2 A Yes, I am.

3 Q Are there any publications that you've been involved in
4 that deal with this complication of brachial plexus palsy in
5 newborns, in babies?

6 A While I was still at Spartanburg Regional, I wrote one
7 of the largest series of brachial plexus incidents and we
8 have written several publication of brachial plexus. Now I
9 think we have over 20 publication on shoulder dystocia or
10 brachial plexus. We were invited by ACOG, which is American
11 College of OB-GYN, to write what I think is the best
12 synthesis english literature on the topic brachial plexus at
13 that time.

14 Q And what is that particular document called?

15 A It's called Neonatal Brachial Plexus Palsy.

16 Q And was that one that you were one of the authors or
17 participants in that study?

18 A I was both an author and an active participation --
19 participant in the actual editing of the whole book.

20 Q Before we get into that, but I just want to ask you a
21 few basic things.

22 You were retained to -- by my office to look at this
23 particular case and the information about this -- Doctor
24 Giep's care of this patient and this baby, correct?

25 A That is correct.

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1 Q Did you review all of the medical records from
2 Spartanburg Regional that related to Doctor Giep's care of
3 the baby, both he and Doctor Fowler, while she was there in
4 the hospital?

5 A Yes, I did.

6 Q Did you review the prenatal records from Spartanburg &
7 Pelham OB-GYN prenatal care when she was pregnant up until
8 the time she went to the hospital?

9 A Yes, I did, sir.

10 Q And have you reviewed the medical records from the
11 doctors that treated Ashley F after she left the
12 hospital at Spartanburg Regional and the various therapies
13 and surgeries and things of that sort?

14 A I'm not an expert on children and actual brachial
15 plexus in the children, but I am -- know that she did have
16 three surgeries. Matter of fact, it was in the same
17 hospital where I'm currently employed at. So, I know she
18 had surgery, but I'm not an expert on brachial plexus in
19 children.

20 Q When you say you're not an expert on brachial plexus in
21 children, you mean surgery on brachial plexus?

22 A Affirmative.

23 Q Okay. Are you -- do you have expertise in the area of
24 what can cause those types of injuries in babies, in
25 children?

1 A That is my area. So, how does pregnancy, labor, and
2 afterbirth, any component of that, lead to or is associated,
3 linked with cause brachial plexus, that is my area of
4 interest.

5 Q But when it comes to the things such as what Doctor
6 Armenta did with the surgery to attend to and improve the
7 function, is that outside of your area of medicine?

8 A Absolutely.

9 Q Okay. So, with regard to the things you reviewed, did
10 you also review the medical -- I mean -- I'm sorry, the
11 depositions that were taken in the case including that of
12 Doctor Giep, of the nurses that were involved in the labor
13 and delivery process, both Mr. and Mrs. Flowers, the
14 grandmother that was deposed in the case, along with all the
15 various expert witnesses that were deposed?

16 A Yes, I have.

17 Q And from the medical records you reviewed, the
18 depositions that you reviewed, did you get a good
19 understanding of what occurred with the delivery, not only
20 just the deliver, but from the time of the pregnancy all the
21 way through the delivery with regard to this child and, and
22 the services that Doctor Giep rendered?

23 A Yes, I have a, I have a pretty good understanding, yes,
24 sir.

25 Q Were all of those materials that you were provided

1 helpful to you in assisting you to come to some conclusions
2 about the standard of care exercised by Doctor Giep?

3 A Yes, they were.

4 Q And what -- from the prospective of what an
5 obstetrician could do, what's your understanding of what the
6 standard of care is that's required of him?

7 A The standard of care is what most doctors or most
8 clinicians in similar situation would do in the United
9 States given the similar circumstances.

10 Q And, doctor, do you feel that your education, training,
11 experience, and your knowledge of this case would help our
12 jury in kind of understanding the process of this delivery,
13 whether the standard of care was exercised, and also what
14 might of been potential causes of the injuries suffered by
15 this child?

16 A Yes, it should.

17 Q Now, let's talk about your research in the area of
18 brachial, brachial plexus injuries in neonatals, in babies.

19 How many years have you been involved in doing that
20 type of research?

21 A I think my very first publication on this was when I
22 was still in South Carolina. So, that was, I think, if I
23 remember correctly, around 2005 is when it was published.
24 So, let's say 2003. So, I've been working on it since 2003.

25 Q Okay. And, in addition to that, during this time, have

1 you also been delivering the babies and doing the things
2 that you told us about earlier?

3 A One of my thing or my wife says is I do research
4 instead of reading or doing crossword puzzle or watching
5 football. So, that's my hobby. That's what I do at home in
6 the evening and the morning.

7 MR. LOVELL: Your Honor, at this time, we move --
8 tender Doctor Chauhan as an expert in the area of obstetrics
9 and brachial plexus injuries and management of children who
10 present with shoulder dystocia and fetal distress during a
11 labor and delivery.

12 THE COURT: Any objection?

13 MR. HENSHAW: Oh, no objection as to his qualifications
14 as an expert as an obstetrician in regard to the standards
15 of cares, but given what he has said here today and
16 elsewhere about his knowledge of, of nervous system or
17 particularly, in particular the brachial plexus part of the
18 nervous system, I do not think that he is qualified to
19 address the causes of brachial plexus injury.

20 THE COURT: Overrule the objection.

21 Q The various studies that you have done, the research
22 you have done, has that been published in any peer
23 reviewed -- I mean doctor reviewed publications?

24 A So that 20 plus articles we mentioned, I mentioned
25 before on shoulder dystocia and/or brachial plexus, these

1 are all peer reviewed, which means that, once you write the
2 manuscript, you send it to the journal. The editors of the
3 journal send it to two or three people who are clinicians
4 and/or researchers. They comment on it, edit it, criticize
5 it, gives it thumbs up or down. They may ask for revision
6 and, subsequently, it gets published if it gets thumbs up.
7 So, that's call peer reviewed process.

8 Q And are you also familiar, from your research and your
9 study in this area with other peer reviewed and published
10 materials from other countries, not just here in the United
11 States, on dealing with brachial plexus injury and its
12 causes?

13 A At, at least twice we have summarized the literature.
14 So, you can get on what we call PubMed and look at
15 everything published on the topic of brachial plexus in the
16 English language. You can pull all the article (sic) and I
17 call it synthesize. You can take all the data and put it in
18 a simple table. We have done at least that twice.

19 Q Now, doctor, from all of your research and your
20 understanding in this area, is there an understanding you
21 have about the percentage of cases of brachial plexus injury
22 in babies in all of those studies that were not associated
23 with the occurrence of a shoulder dystocia event where the
24 shoulder gets stuck on a -- one of the maternal bone
25 structures?

1 A Yes, I have.

2 Q What are -- is your understanding of that?

3 A So, the simple way to -- please forgive me if I try --
4 I'm not trying to be too simplistic. Let's imagine there
5 are ten babies born with brachial plexus today at any
6 hospital. If they're ten babies born with brachial plexus,
7 over four, less than five, so, four and half will have no
8 shoulder impacted. So, in ten case of brachial plexus, four
9 and a half approximately will have no difficulty by the
10 clinician, it could be a midwife or a doctor, in delivering
11 the shoulder.

12 So, the baby comes out and there's no difficulty with
13 delivery of the shoulder and the baby still has brachial
14 plexus. So, it's about four out of ten, four and a half out
15 of ten.

16 Q And of that four and a half out of ten, is there a
17 percentage of those children that have this brachial plexus
18 injury without shoulder dystocia that is deemed to be
19 permanent?

20 A Yes. So, permanent, for us, means that the difficulty
21 moving the arm has lasted at least for one year after birth.
22 So, that's our limits of one year after birth, the baby, the
23 child can not move the affected arm to the -- like the other
24 arm. The chance of that is two out of ten. So, two and a
25 half out of ten, which last for more than year, will not

1 have any documented shoulder dystocia problem.

2 Q I'm gonna go to the ACOG, American College of
3 Obstetrics and Gynecology Task Force.

4 How many other doctors were involved in that process in
5 the production of that particular report?

6 A So, in this, I believe there were about ten of us in
7 different discipline. So, they were high risk pregnancy
8 doctors, there was a neonatologist, and there was a
9 biomedical engineer. There was a neurosurgeon. So,
10 initially were invited. Then it was -- I think it's one of
11 the most extensively peer reviewed, not only by other
12 doctors, but other society on this topic. I'm not aware of
13 any document which has undergone more extensive review or
14 critical appraisal than any other publication on this topic.

15 Q In the earlier testimony I think from Doctor Allen, he
16 indicated that, in the past, he had worked with a Doctor
17 Bernard Gonik.

18 Was Doctor Gonik involved with the ACOG publication?

19 A Yes, he was one of the coauthors of this document.

20 Q In your opinion, is that report that came from the
21 American College of Obstetrics and Gynecology Task Force, is
22 that a reliable source on the subject of brachial plexus
23 injuries both with and without the occurrence of shoulder
24 dystocia during a delivery?

25 A At that time, it was the most comprehensive, exhaustive

1 synthesis or summarizing all the publication. Since its
2 publication, I'm not aware of any publication which has
3 contradicted the summary or the finding of this. To me, it
4 is currently still the most reliable source of information
5 on brachial plexus in English language.

6 Q And is that an authoritative source and text of
7 information?

8 A I'm not aware of anything which is more authoritative.

9 Q In, in your opinions that you've formulated with regard
10 to this case, and the injury suffered by this child, and the
11 care rendered by Doctor Giep, did you rely upon the ACOG
12 report and the contents of that to arrive at your opinions?

13 A Yes, because what's in there is part of my Lexicon or
14 my -- call it my memory. I may not know word-for-word or
15 verbatim, but that has become part of me cause I was
16 literally involved from time zero in editing it extensively
17 and having reviewed it and talked on the topic.

18 Q I'm gonna show you what's been marked as Exhibit 8
19 previously, doctor, and I've got the last page.

20 Now, is that a copy, a xeroxed copy of the Task Force
21 report we've been talking about?

22 A Yes, sir.

23 Q And what's the official title of it that's printed on
24 that?

25 A It's called Neonatal Brachial Plexus Palsy, and

1 underneath the logo of the ACOG, the American College of
2 Obstetrician and Gynecologist.

3 Q About how many pages is that document, the substantive
4 part of it?

5 A I would say over a hundred to a hundred and ten.

6 MR. HENSHAW: Your Honor, I need to inquire.

7 That's been marked as Exhibit 8 or has it been
8 introduced?

9 MR. LOVELL: For record purposes only, Your Honor. I'm
10 not moving it into evidence at this point.

11 MR. HENSHAW: Okay. I mean as long as it---

12 THE COURT: It's marked as a Court's Exhibit for use by
13 the witness while he's testifying, but it will not be
14 submitted to the jury.

15 MR. HENSHAW: Thank you, Your Honor.

16 Q I want to move to talking about, at this point, the
17 delivery of the child.

18 As far as this, the prenatal course with this
19 particular child doctor, was there anything about it, in
20 your opinion, that was out of the ordinary or not well
21 managed according to whatever the standard of care required
22 under this patient's conditions?

23 A No, sir, the prenatal care or the care before delivery
24 was more than adequate. I would say it was very good in the
25 sense they diagnosed the diabetes during pregnancy,

1 gestational diabetes. As you said earlier, they did a
2 wonderful job of controlling it, checking the sugar, getting
3 the ultrasound, making sure the baby was not too big. So,
4 the prenatal care from the first visit to the last visit was
5 done very well.

6 Q And in terms of how babies are born, once Mrs. Flowers
7 arrives at the hospital, her water has now broken, and in
8 terms of the stages of labor, how do y'all, doctors, divide
9 that up?

10 A So, before birth, we like to keep it simple. So, call
11 it the Stage 1. So, from regular contractions. So, if you,
12 if you -- forgive me. This, this is how I teach my medical
13 students.

14 This is the birth canal. This is the baby or the water
15 bag. So, this is zero centimeter. You start contracting.
16 Then it opens up. Once you get to ten centimeter, that's a
17 Stage 1. So, this is Stage 1. So, the baby is come from
18 here, the birth canal has opened up. It's now
19 10-centimeters and then the mother starts pushing, and the
20 baby -- when the baby's completely born, that's the Stage 2.

21 So, from 10-centimeter to the actual birth is a Stage 2
22 delivery of the placenta or the afterbirth is a Stage 3.
23 So, one, two, three.

24 Q And in the course of this baby's development during the
25 prenatal stage up until the time Mrs. Flowers gets to the

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1 hospital, was there ever any need to or consideration of a
2 C-section based upon baby's size or baby's condition?

3 A No, a C-section should not have been done in this case
4 prior to the onset of the labor. There was no indication.

5 Q Was the baby of a size that normally would be
6 susceptible or capable of a vaginal type delivery, the
7 natural way?

8 A More likely than not, overwhelmingly, based on all the
9 information available at the onset of labor, the baby should
10 have born vaginally without any complication.

11 Q From your review of the medical records in that first
12 stage of labor that you just described, was it uneventful?

13 A Yes, it was.

14 Q And why do you say that?

15 A In the sense that the -- admittedly, the labor was
16 17-hours and I'm not trying to minimize the pain. The fetal
17 heart rate tracing was doing fine. Her vital signs were
18 fine, and she progressed or the cervix dilated at a normal
19 rate. Though 17-hours is a lot, from OB's point of view,
20 that was a normal progression of labor and fetal well being
21 while she was -- so before she started pushing.

22 Q Okay. And then before we start talking about the
23 pushing part, which I think you called the second stage?

24 A Yes, sir.

25 Q Is that right?

1 I want to ask you some questions about brachial plexus
2 injuries in general.

3 Can you explain to us, and from your understanding, the
4 different ways that brachial plexus injuries can occur in a,
5 in a neonate or a baby?

6 A So, I'm going to start with the least common and go up.

7 So, usually -- so, we talked about the anterior
8 shoulder. Anterior shoulder is what faces the roof or the,
9 excuse me, the bladder bone. So, you can get those injury
10 quickly, a brachial plexus in the posterior.

11 So, even though this shoulder, the back shoulder, the
12 one facing the bottom or the floor is not stuck against the
13 bladder bone, you can still get it and this is even before
14 the doctor has touched the head. So, there's a suggestion
15 that the doctor doesn't even have to touch the head to get a
16 brachial plexus. So, that's one.

17 The second one, we originally said, you know, they're
18 also that when a woman has a C-section, so during a
19 C-section, there's no way the bladder or the shoulder gets
20 stuck behind the baby's bladder bone is when you're
21 delivering without any impaction of the shoulder, you can
22 still get brachial plexus.

23 The third one is as we mentioned before. About four
24 and a half out of ten brachial plexus have no shoulder
25 dystocia. That's been shown in American studies. We

1 recently showed it. It has been shown from countries
2 outside United States. The very first report, if I remember
3 correctly, actually came from Libya.

4 So, other OB-GYN in other countries have shown that you
5 can have brachial plexus without shoulder dystocia in the
6 last one, or the more common one, let's say five out of six,
7 five and a half out of ten happen in conjunction with
8 shoulder dystocia.

9 So, those are the four. The dock -- in the back bone
10 without any impaction, Cesarean delivery without shoulder
11 dystocia, and the last thing, with shoulder dystocia.

12 Q In the ones where there's no shoulder dystocia that
13 occurred during the delivery, but the child has a brachial
14 plexus injury discovered after the baby's delivered, what
15 causes that?

16 A So, our understanding of what or how or what we
17 hypothesize of what is happening is so, when the head is
18 there, it lets the baby breathe, 7-pound, 8-pound, or
19 10-pound bad. It has to go from here to come out.

20 It takes force. Well, now, you can say well, this is
21 only so many centimeter, but the head has to navigate
22 through the birth canal and come out. That takes a lot of
23 force. If you think about it, to push about an 8-pound
24 through part of your body, and I've asked -- people have
25 always said a kidney stone. Imagine pushing an 8-pound

1 kidney stone. It takes a lot to bring the baby out.

2 During the process of getting the baby out, you can
3 have other traumas beside brachial plexus. You can even
4 rupture the uterus. So, there's a lot of force being
5 generated, and once the shoulder hits, so the head is coming
6 out and the shoulder hits the bone, so the head is coming
7 out in this, authors have suggested that they -- stretch.
8 So, the head is coming out where the shoulder is struck.

9 In this case, without being stuck, the compression of
10 the uterus is one of the thought process of what caused this
11 brachial plexus injury without shoulder dystocia.

12 Q Now, doctor, you've been talking about how the babies
13 come down and then I've got a diagram here that, for
14 discussion purposes, I've marked as Exhibit 10.

15 Can you, with the Court's permission, come down and
16 explain to us sort of how the baby moves down through the
17 body?

18 THE COURT: Yes, he can, but now, you got a court
19 reporter over here.

20 You understand that?

21 THE WITNESS: Yep.

22 Q So, what you got to do, doc, is you need to stand over
23 on that side.

24 THE COURT: And keep -- let's do this.

25 Can you move -- go ahead and leave that right there for

1 now.

2 If you'll move that?

3 Yeah, and if you'll move that podium back towards the
4 table?

5 MR. LOVELL: Got you. Thank you, Your Honor.

6 THE COURT: All right. Now, you can turn that. Kind
7 of square it up. Well, let's have him -- I don't want his
8 back to the court reporter. Square that up with the jury.
9 Move this way.

10 All right. Now, I want him on the side where you're
11 at.

12 MR. LOVELL: Where I'm standing now, right.

13 THE COURT: And I want the court, I want the court, the
14 court reporter to be able to see your face as you speak.

15 THE WITNESS: Yes, sir.

16 THE COURT: Okay.

17 Q And I got a little pointer thing that might make it a
18 little easier. So, you stand like about right where I am so
19 she'll have an eyeball view of you and you can use this as a
20 pointer.

21 Will that work?

22 THE COURT: You can move that up closer if you need to.

23 MR. LOVELL: Okay.

24 Q Come on down now, doc.

25 A Yes, sir.

1 Q So, stand about here.

2 A (Witness complies.)

3 Q So, what -- the question I had asked, doctor, was can
4 you explain to us sort of -- if this diagram -- well, is
5 this helpful in explaining how the baby moves down through
6 the birthing process when a shoulder dystocia has not
7 occurred.

8 A Yes, it is. So---

9 Q So, explain that to us.

10 A So, you know, as doctors can't remember, so we use to
11 come out with a pneumonic device. My pneumonic device was
12 head, feet -- I know it's misspelled -- this is spelled --
13 but e-d-i-f-e-e.

14 So, engagement is when the head has occurred about
15 here. So, this is the, the prominence of the spine. So,
16 this is where the head is coming down. Sir -- so then the
17 first is engagement. So, the head has engaged and then the
18 decent. So, now the head is coming down, and then there is
19 a flexion so that the head is flexing in. So -- because if
20 the head is stayed stretched, it doesn't come out. So, it
21 has almost like to do a little bit of tucking, flexion, and
22 then internal rotation.

23 So, internal meaning while it's still inside the mother
24 it has to tuck in and rotate. So, it does internal
25 rotation. Then it is going to do a little bit of extension.

1 So, from tucking in, now it's the baby's head is going to
2 tuck out, and then extension, and then, once it comes out,
3 it's going to do external rotation, and then the last thing
4 is expulsion. So, the baby actually is getting pushed out.
5 So, it's called head feet.

6 Q Now, to stop you briefly, doctor, you mentioned over
7 here -- you stand over there and I'll just stand here and
8 make -- talk loudly.

9 At this point, which you said is what the extension?

10 A Extension and external rotation.

11 Q Is the baby still inside the mother?

12 A Yes, it is.

13 Q And as the baby is coming down the birth -- and I use
14 the word birth now.

15 Is that the right word?

16 A (Witness nods affirmatively.)

17 Q The birth canal, is it always in the same alignment,
18 head, shoulders, and the rest of the body?

19 A No, because to squeeze -- literally the baby is
20 squeezing. So, it's literally -- as you -- you know how you
21 move the furniture when you're trying to get to the door?

22 So, you have to kind of rotate and move. Your baby has
23 to do the same thing through the birth canal.

24 Q And the forces that you were talking about a few
25 moments ago that get applied by -- during this process,

1 where are they coming from?

2 A So, the way I look at it, so, this is the uterus or
3 what I call the baby's -- where the first room and the
4 baby's like this. So, this contracts. So, the whole room,
5 all these muscles around here, they all contract and they
6 literally push the baby out.

7 Q And as the baby is moving down the birth canal and
8 doing these different twistings or whatever you've described
9 it, are the forces that are getting pushed upon the baby's
10 body by the uterus reacting upon whichever part of the body
11 of the baby is touching different other structures?

12 A Yes. So, the force comes all through the body because
13 the baby has to come out. So, anything, the bone, the
14 clavicle bone has been known to get broken. Leg bone broken
15 during the birthing process. We've had skull fracture and
16 brachial plexus is one of the other things. So, the fact
17 that the baby can get trauma during coming out is a known
18 phenomena not only to brachial plexus but just about every
19 part of the body.

20 Q And in these lower two parts of our diagram, the baby's
21 head, is it now outside of the mother's body?

22 A Yes. So, this is -- so now the baby's head is
23 literally coming out. So, this part is visible. So,
24 anyone, attendant or grandmother, would be able to see that.
25 Mother wouldn't see it and the doctor will so. Now just the

1 head is out. Rest of the body is still inside the birth
2 canal.

3 Q Is -- now, I look at this one though, the one that's
4 marked E on our exhibit here, it looks like the baby is sort
5 of looking downward as opposed to sideways.

6 What -- what's going on there?

7 A So, babies, when they come out, they often look down.
8 So, we call it occiput -- this is the occiput bone anterior.
9 That's up there and they look down. So, that is one of the
10 more common way when the baby's come out. They can be
11 looking down sideways, this way. Once in a blue moon, be
12 looking up, but this is a very common way for the baby to
13 come out.

14 Q And, in this case, which way was Baby Flowers coming
15 out?

16 A My understanding is O-A. So, some -- akin to this.
17 Something like this.

18 Q Now, in the last view here, we see the baby has -- is
19 looking towards us.

20 How does that happen?

21 A So, it can have external rotation. So, either when the
22 baby -- imagine this is the baby and this is the head. This
23 is the face looking down. Either it can turn or with the
24 doctor helps. It can turn. But when the mother is pushing,
25 it can turn sideways. So that is known phenomena.

1 Q And is that what normally transpires between this point
2 and this point, the baby is turning a little to the
3 sideways?

4 A Yes.

5 Q Okay. Thank you, doctor.

6 Go back to the stand.

7 A (The witness returns to the stand.)

8 Q Now, doctor, we've talked about shoulder dystocia and
9 our jury has seen some diagrams that talk about it. I hate
10 to ask you to get down again.

11 Can you briefly come down and let's talk on shoulder
12 dystocia?

13 A (The witness comes down from the stand.)

14 Q As we looked at the cardinal normal movements, can you
15 explain to us what shoulder dystocia is, and, and we're
16 really talking about the anterior, the upper shoulder in
17 this case, correct?

18 A That is correct.

19 Q Can you show us, on this diagram, sort of how that
20 happens?

21 A Yes, sir.

22 Q And, again, if you'll stand far back so the court
23 reporter can hear -- and see your face and hear you.

24 A So, in this case -- so, these are the doctor's hand.
25 So, this is when the head is literally come out of the birth

1 canal. So, these are the doctor's hands and then this time
2 you do not know whether there's a shoulder dystocia. So, it
3 looks like a normal head has come out.

4 When you try to deliver the baby, so with gentle
5 traction, so, the head is out and you put the head just like
6 this, you move slightly down that, most of the time,
7 overwhelming majority of the time, the anterior shoulder,
8 the one to the roof or the one to the bladder bone, the
9 shoulder will just come out and then the whole baby comes
10 out. Once you deliver the anterior shoulder, the one facing
11 the roof, the whole baby comes out.

12 When you have a gentle traction, the baby -- the
13 shoulder doesn't come out and the baby doesn't come out.
14 That's the moment you know you have anterior shoulder.

15 So, this is the shoulder. This is the bladder bone or
16 symphysis. This shoulder has impacted. So, the way I look
17 at it, if this is the shoulder, it's stuck behind the bone.
18 And so it will not move and this is a diagram of brachial
19 plexus when it -- so, the baby's coming this way. This is
20 stuck. There's some thought process that that process tried
21 to -- and then this is trying to move the shoulder out. If
22 the shoulder is stuck, we try different things.

23 One of them is you can move the shoulder, dislodge the
24 shoulder by turning it towards the chest and this is a
25 doctor's hand or a clinician's hand attempting to do that.

1 Once you dislodge this shoulder against the bladder bone,
2 the rest of the baby comes out.

3 Q In this maneuver, are you attempting to turn the
4 shoulder towards the baby's chest?

5 A Yes. So, this, this is the bone that's stuck. You can
6 go like this. So, you can twist. You bring it to where
7 it's inside the child's sternum or the midline and then you
8 can decrease this way.

9 Q You call this, I think, the, the bladder bone.
10 Is that the pubic symphysis?

11 A Yes, symphysis pubis. So, this is the bone right here,
12 pubic symphysis.

13 Q Thank you. Take a seat.

14 A Yes, sir.

15 (The witness returns to the stand.)

16 Q Now, doctor, in the last say ten years or so in the
17 medical community, has there been a -- any changes in the
18 thoughts about what causes brachial plexus injuries in
19 babies who are born with that condition?

20 A Yes, there has been a gradual progression or changing
21 in the thought process of the possible causes of brachial
22 plexus, yes.

23 Q And, and what has been that shift or change?

24 A One of the earlier paper, when someone reported that it
25 can happen with posterior shoulder was one of the reported

1 or wake-up call let's say. Then there were multiple
2 reports, not only from United States, but other countries
3 that they were reporting on brachial plexus without shoulder
4 ever getting stuck. Then there were reports of C-section
5 associated brachial plexus.

6 It was the combination of the three which made us, not
7 me, but other investigators, propose the concept that the
8 mother's forces, explosive forces, plus the impaction and
9 the head coming down can lead to brachial plexus palsy.

10 Q Does the condition of the baby, prior to that very end
11 when the head is come out, but, you know, prior -- before
12 the crowning, I'll just use that, does the condition of the
13 baby -- is there any thought in, in the research or in your
14 opinion about the condition of the baby having a factor upon
15 development of the brachial plexus injury?

16 A There are reports out there that the baby, if let's say
17 the tone isn't good or the baby has some other thing going
18 on or the baby is not at the optimum, then it takes less to
19 injure the same brachial plexus.

20 Q And how does that -- I mean explain the, the, the
21 science or whatever behind that?

22 A So, the way I look at it is, during any process,
23 anything we do, we playing sports or anything, we can get
24 injured. When we are not at our best, it takes less to get
25 injured. So, if you're not in a good shape, imagine and we

1 played, I don't, flag football, tennis, or whatever, if
2 we're not in a good shape or let's say we have a bad cold
3 and do something, it takes lower threshold to get injured is
4 the simple way I conceive of it.

5 Q And in babies who are suffering from a depression in
6 fetal heart tones, does that affect the, the strength of the
7 brachial plexus complex to resist injuries from the birthing
8 process?

9 A And there are publications which it state that that is
10 a truth statement.

11 Q And why is that?

12 A To me, it's the similar process. Babies who are not
13 adequately oxygenated, it's like -- I always call it, you
14 know, when I get a cold, if I get a cold, it takes less for
15 me to get even more injured. So, that's the way I think of
16 it in my mental image.

17 Q Now, doctor, in -- when a shoulder dystocia occurs and
18 is recognized by the doctor, and, you know, the baby's not
19 coming out after the head is delivered, is there a danger to
20 the, to the baby at that point in time?

21 A Yes.

22 Q All right. What are those dangers?

23 A So, the moment you realize that the shoulder of the
24 baby's not coming out, it is a moment where everything
25 freezes and everyone will say well, it will be over in a

1 minute, but you do not know. I am personally aware of
2 broken neck. I'm personally aware of babies dying on --
3 while they're shoulder dystocia. I'm personally aware of
4 brain damaged baby, and, of course, of brachial plexus.

5 So, it can be spectrum of no problem with shoulder
6 dystocia to permanent brain damage, the baby dying while is
7 still inside -- half of -- just the head out and a permanent
8 brain damage. So, it's a whole spectrum and, at that
9 moment, you do not know which way this will end up.

10 Q And at the time that the dystocia is recognized, does
11 the physician know how long it will take to resolve the
12 dystocia before the remainder of the body or the baby is
13 delivered?

14 A I wish we did. There is in way, at the moment you
15 encounter shoulder, to see well, it's one minute, two
16 minute, three minute, four minute, five minute. There is no
17 way any clinician, using any sophisticated anything, can
18 tell how long it will take before it's resolved.

19 Q And, doctor, is there a thought amongst the people that
20 do what you do on how long the brain injury can begin to
21 occur in a case of a shoulder dystocia where there's no
22 fetal distress prior to the actual head delivering?

23 A So, one of the numbers we just throwing around, four to
24 five minutes. Let's say four, five, six minute is in a
25 general healthy population. So, that's "the average" but,

1 as you know, average doesn't apply. It can be as soon as
2 two minutes. Some children do fine even after six, seven
3 minute.

4 So, those -- the average is four to five minutes or
5 some say four to six. Some people have put it at two
6 minutes though some babies do fine even after seven, eight
7 minutes.

8 Q And in a baby like Ashley F , did you see where
9 her heart rate changed from -- before Doctor Giep even got
10 involved to the time of the delivery?

11 A Yes, I did, sir.

12 Q What happened there?

13 Tell us.

14 A So, usually the heart rate is around 110 to 160. So,
15 110 is the lower limit, 110 beats per minute is what we call
16 it, but then it dropped to 90 and then it kept dropping and
17 kept dropping for several minutes. So, that suggestion
18 that, for whatever reason, the heart, which is our best
19 approximate assessment of baby being oxygenated because, if
20 your heart isn't beating, you're not oxygenating. As is
21 simple thought process in our mind, is the baby's heart rate
22 is down, way below what it should be normally while it was
23 normal for hours and hours.

24 Q And how many minutes, approximately, was the baby's
25 heart rate down before the dystocia event?

1 A I think several minutes, eight minutes, nine minutes.
2 I mean I would have to look at the minute, but it was not a
3 minute of a difference. For several minute before the
4 vacuum was applied.

5 Q So, when the baby's head delivered in this case, did
6 the fact that her heart rate had been lowered in that 90
7 range for that number of minutes, did that put her at a
8 higher risk of potential serious bodily injury or, or even
9 potentially death than the baby wasn't experiencing those,
10 but had the same shoulder dystocia?

11 A So, shoulder dystocia alone is a sentinel event or a
12 major event, which is linked with cerebral palsy on top of
13 it. If you have a normal heart rate, even for several
14 minutes, that has to weigh in on the clinician's mind that
15 he or she has less time to resolve the shoulder dystocia,
16 cause even with the healthiest babies, some babies, within
17 two, three minutes, can have suffering. Once you start the
18 heart rate at normal for let's say even five, ten minutes,
19 then your clock is already set in before the shoulder
20 dystocia.

21 Q So, at the time of the dystocia event, was Ashley
22 F , the baby, was she medically stable given the heart
23 rate changes?

24 A No, Ashley was not stable even before the vacuum was
25 placed. Ashley was absolutely not. It's almost additive.

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1 So, the heart rate is abnormal, which is a risk factor for
2 potentially brain damage. Once you have shoulder dystocia,
3 now you have just multiplied, not multiply for whatever
4 reason, now it has multiplied the problem. Now you have two
5 major risk factor for baby.

6 Q At the time of the dystocia event, when it was
7 recognized by Doctor Giep, was the baby, Ashley F , at
8 immanent risk of serious bodily injury or even potential
9 death at that point in time?

10 A Absolutely.

11 Q And when you as an -- when an obstetrician encounters a
12 shoulder dystocia, what's the primary goal?

13 A The primary goal is to deliver the child without
14 excessive injury to the child and/or the mother.

15 Q And are there certain maneuvers that y'all, as
16 obstetricians, commonly use in trying to accomplish that
17 goal?

18 A Yes, we have several maneuvers we do to release the
19 shoulder.

20 Q And kind of walk us through what the standard maneuvers
21 that most obstetricians in general utilize when they
22 encounter a shoulder dystocia?

23 A So, the first one, and it's actually called Doctor
24 McRoberts who happened to be where I am just by coincidence,
25 you take the -- both knees, if, if I'm pretend mother, and

1 take the knees and bring them backwards. So, the knees of
2 the mother go towards the shoulder.

3 So, that's putting the legs back. That increases the
4 distance between the back bone and the symphysis or the
5 bladder bone. So, instead of being this, now it's bigger.
6 So, the shoulder may come out. That's called McRoberts
7 named after Doctor McRoberts from Houston.

8 If that doesn't work, then we have what we call
9 symphysis or suprapubic pressure. So, right on the bladder
10 bone or symphysis. You -- a nurse or one of the clinician
11 would push down with the hope of moving the shoulder to this
12 side. So, the shoulder is stuck like this. You press on
13 the side and the shoulder comes under the bone.

14 Q Are they pressing the, the actual bone?

15 A No, it's right adjacent to the mother's bone. So, what
16 you're doing is trying to press the shoulder to go under the
17 bone.

18 Q And is that normally done when the mother is having a
19 contraction?

20 A It can be. Some people do it with contractions. Some
21 people wait without the contractions, but it is done after
22 McRoberts usually.

23 Q And is McRoberts usually done with a contraction or
24 without a contraction?

25 A And McRoberts is done as soon as you recognize. Some

1 people, these days, just deliver McRoberts and, at that
2 point, decide. But as soon as you recognize shoulder
3 dystocia, you put the leg back up. If that doesn't resolve
4 it, within seconds you start suprapubic pressure.

5 Q And what other techniques do most obstetricians use
6 besides McRoberts and suprapubic pressure?

7 A So, those are the first two. Then the third one is you
8 can reach inside and actually bring the posterior arm, the
9 arm which is on the floor, so, the top one is stuck. The
10 one to the floor, you can actually go in, pull it out, or
11 extraction of the posterior arm we call it. Once you take
12 the posterior arm, the shoulder just presses down and
13 there's more space. It falls below the symphysis or you can
14 push, with the hand, the doctor can push the anterior
15 shoulder forward or, if that doesn't work, then this one.

16 So, you try to -- what you're trying to do is compress
17 the shoulder one way or another is what you are really
18 trying to do.

19 Q And, doctor, from your review of the information, the
20 medical records, the depositions, did you get an
21 understanding of the maneuvers that Doctor Giep used in this
22 particular delivery of Ashley F ?

23 A Yes, I did.

24 Q And have you -- I put together a video or have put
25 together a video that demonstrates those.

1 Have you reviewed that video before coming in here
2 today?

3 A Yes, I have.

4 Q And does it accurately depict what you understand to be
5 the maneuvers that Doctor Giep utilized in his deliver of
6 this child?

7 A Yes.

8 Q And would that be helpful in you explaining, in your
9 mind, showing the video, what the maneuvers were?

10 A I'm more than happy to.

11 MR. LOVELL: Your Honor, I have the video ready to go
12 and we've shown that and I'll let him talk about it.

13 And, doctor, I'm gonna hand you a laser pointer. I'm
14 gonna play it up here hopefully.

15 A May I come down?

16 Q Yeah, if you need to step down over here so you can see
17 it.

18 THE COURT: Let's do this.

19 You see, doctor, that microphone in front of you?

20 Yeah, the white---

21 THE WITNESS: Yes.

22 THE COURT: If you'll stand and just behind it, have it
23 directed between you and the screen. Stand just behind it
24 and kind of project your voice upward.

25 THE WITNESS: Yes, sir.

1 THE COURT: Then everybody should be able to hear.

2 THE WITNESS: Yes, sir.

3 (The witness comes down from the stand.)

4 MR. LOVELL: I apologize, Your Honor. I had it on but
5 it shut it itself off. It should fire right up. There it
6 is.

7 So, can you dim the light just a little so it's a
8 little bit easier to see?

9 (WHEREUPON, the bailiff complies.)

10 THE COURT: Mr. Lovell, how about moving that---

11 MR. LOVELL: I'm sorry, Your Honor.

12 THE COURT: ---down a little bit?

13 Q Doctor, I'm starting the video at this point, and you
14 tell me when to stop it and I will. I'd like -- what I'd
15 like for you to do is to explain to the jury the -- what's
16 happening as this progresses forward.

17 A If you do -- can I just stop for one second just if you
18 don't mind?

19 I'm going to orient.

20 Q Yes, sir.

21 A So, this is what I call the bladder bone. I, I try to
22 keep it simple. So, this is the symphysis or the bladder
23 bone. Here is the shoulder. Here is the head. This is way
24 before the head is coming out. This is the back bone. This
25 is the posterior shoulder and this is the supine. Mother is

1 supine, what we are looking at.

2 So, this is before the head has come out and before the
3 shoulder dystocia is right here.

4 Q And I'm gonna ask a really stupid question, but you
5 mentioned earlier that, you know, towards the roof.

6 would that be that way---

7 A Yes.

8 Q ---and this way?

9 A So, this is the anterior shoulder and that's the roof.
10 On what you can see on this side is the posterior and this
11 is the bottom or the floor.

12 Q So, I'll start the video, doctor. You tell me when to
13 stop it. It's two minutes plus or minus. So --.

14 A So, this is the uterine wall, and this is what
15 contracts all around. So, this is muscles, which is going
16 to contract and push. This is just to orient you, the
17 placenta, and this is the bladder bone. I'm gonna call it
18 the bladder bone cause the bladder is right there.

19 So, now the head is -- and the baby's coming down
20 because everything is contracting. So, the head is
21 descending.

22 Go ahead please.

23 Now, the head -- stop please.

24 So now the head is -- so, it came down and now it's a
25 little extended. So, the doctor can see this. There's no