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THE STATE OF SOUTH CAROLINA
In the Supreme Court

S.C. SUPREME COURT

APPEAL FROM BEAUFORT COUNTY
Court of Common Pleas

Diane Schafer Goodstein, Circuit Court Judge

Unpublished Opinion No. 2018-UP-221 (S.C. Ct. App. filed May 30, 2018)
Appellate Case No. 2015-002466
Case No. 2012-CP-07-03782

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

Petitioner,

v.

CasePro, Inc.,

Respondent.

Appendix: Volume 6

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- 1 Q And the people at that hospital that granted you
2 the privileges, did it consist of doctors who practiced
3 in the specialty of emergency medicine?
- 4 A Yes.
- 5 Q And I assume maybe other specialties, as well?
- 6 A Correct.
- 7 Q And you came after that. In your years in the E.R.
8 there, were you working with triage and treatment nurses
9 there at Hilton Head Hospital?
- 10 A Yes.
- 11 Q Every day?
- 12 A Every day.
- 13 Q And in your period there, were you also treating
14 patients who came in with all kinds of issues?
- 15 A Yes. That's the practice of emergency medicine.
- 16 Q Including psychiatric challenges.
- 17 A Yes.
- 18 Q When you came to the Beaufort Naval Hospital, for
19 the reasons you've already told us, were you given
20 privileges there?
- 21 A Yes.
- 22 Q And I think you told us that was in 19 -- what
23 year?
- 24 A It was 1989, I believe.
- 25 Q And every year that you were there, until you left

1 the Beaufort Naval Hospital, were your privileges
2 renewed for the next year?

3 A Yes. That's generally how it's done.

4 Q I understand there was a period of time when the
5 government changed the rules about people who worked
6 there had to be U.S. citizens, and you weren't working
7 there while you were getting your citizenship, right?

8 A Yes.

9 Q Other than that period, were your privileges
10 continually in place at Beaufort Naval Hospital?

11 A Yes.

12 Q Your privileges to work in the emergency
13 department.

14 A Yes.

15 Q Did you also work at other parts of that facility
16 during those many years you were there?

17 A In the very beginnings, the emergency department
18 was combined with an acute care clinic or an urgent care
19 clinic. So, the physicians that worked in the E.R.
20 sometimes rotated. We worked also in the urgent care.
21 We had different shifts, so we kind of went between one
22 and the other.

23 Q So, you might be an emergency clinic doctor at one
24 shift, and they may shift you over to the urgent care
25 clinic another.

1 A Yes. But it was the same department.

2 Q Still in the emergency department.

3 A Correct.

4 Q Same privileges apply regardless of whether you're
5 emergency care or urgent care.

6 A Yes.

7 Q You also told us earlier that you worked at the
8 Abbeville area medical center for some period of time in
9 the eighties, correct?

10 A No. The Abbeville work was probably more in the --
11 after 2012, probably.

12 Q How about Coastal Carolina? Was that a 2009 time?

13 A Coastal Carolina was that period of time where I
14 was getting my U.S. citizenship.

15 Q And did you have privileges at that facility to
16 work at the emergency department?

17 A Yes.

18 Q All right. I'm going to move forward a little bit,
19 and then, I'm going to move into the treatment. When
20 you were working at the Naval Hospital in the emergency
21 department, from the time you started, 'til you last
22 worked there, were there certain policies, protocols,
23 and things set forth by the Department of the Navy that
24 governed what you could do or should do in the E.R.
25 during certain situations?

1 A Yes, there were a scope of work that you were
2 allowed to perform, and you had to apply for that.

3 Q Was one of those, when a patient, a military
4 person, presented into the E.R. and expressed I have
5 thoughts of hurting myself or these suicidal ideations,
6 was one of those that you had to have them evaluated by
7 a psychiatric person to determine admission to the
8 hospital for whatever further evaluation might be
9 needed?

10 A I don't think that was a particular specification.
11 I -- I -- I would have to check that, but I believe
12 there was no requirement that you had to consult with a
13 specialist whatever the case were. So, this was on --
14 based on the doctor's decision and doctor's request and
15 his medical training whether he would consult with
16 someone or not.

17 Q But the hospital privileges were issued by the
18 Department of the Navy, not CasePro?

19 A Correct.

20 Q Did CasePro ever give you any input on how to do
21 whatever you did in the E.R. on a day-to-day basis?

22 A Never.

23 Q If you had day-to-day operational issues about the
24 E.R., who did you go talk to?

25 A I would probably go to probably the chief of staff,

1 who was really one of the Navy officers.

2 Q Now, there has been some testimony yesterday
3 elicited to imply that perhaps you aren't a good doctor.
4 I'll just put it out there. We heard a witness talk
5 about you supposedly sleeping too much in the hospital.
6 Were there beds provided for you as an E.R. doctor to
7 rest your eyes if you were working the night shift and
8 it was not busy?

9 A Well, there were -- there were cots or rooms where
10 the patients would be in. If the room was empty, and it
11 was the middle of the night where nothing was going on,
12 and you could only drink so much coffee to stay awake,
13 then, it was, you know, some people would put their feet
14 up and just rest a little bit. That was never
15 discouraged or not allowed.

16 Q That's something you did on occasion?

17 A Certainly.

18 Q And were you ever chastised or reprimanded by the
19 Department of the Navy or anybody else about that issue
20 of putting your feet up every once in a while?

21 A Never.

22 Q With regard to this patient, Mr. Hunt, once you
23 felt there was a need to have some additional input from
24 the psychiatric folks, did you immediately take steps to
25 get them involved?

1 A Yes, I did.

2 Q Lot of questions about the incident back in 2010
3 involving the Marine who allegedly had sepsis. First, I
4 want to ask a little more information. Were you in the
5 process of working up and diagnosing and testing on that
6 patient when he was transferred out to a different
7 facility?

8 A Yes.

9 Q After he left, were you ever advised what happened
10 to that patient?

11 A Yes.

12 Q All right. Were you, when there were
13 investigations done by the Navy, this peer review that
14 we've heard about, were you ever asked by the Navy to
15 come and give your version of what had happened in your
16 treatment?

17 A No, not directly, no.

18 Q Were you ever given an opportunity to gave your
19 version of what had happened in your treatment?

20 A No, not directly, no.

21 Q Were you ever given an opportunity to come in and
22 meet with the peer review people, whether it's Dr. Moore
23 or whoever it was, and say, hey, here's what I was
24 taking when I was seeing this patient; here's why I went
25 down this path, instead of that path; and here's why I

1 think maybe you're wrong about your finding that my care
2 didn't meet to whatever standard you think? Did you
3 ever get that opportunity?

4 A No, I never had any discussion.

5 Q You were asked questions about this abeyance issue,
6 and I'm going to show you a document that's marked
7 Defendant's 23. You mentioned that, after your
8 deposition, you got asked a bunch of questions by
9 Plaintiff's counsel about privileges and whether you had
10 them or didn't have them. You went and did some
11 research about the definition of abeyance. Did you tell
12 us that?

13 A Yes, I did.

14 Q I ask you, do you recognize what's in front of you
15 as Defendant's 23. Don't read it. Don't tell us what
16 it says, but do you recognize what that is?

17 A Yes.

18 Q All right. Is that what you found to be the
19 definition of abeyance as set forth by the Navy?

20 A Yes.

21 MR. LOVELL: Your Honor, we move to admit 23.

22 THE COURT: Any objection?

23 MR. HOYLE: No objection, for what it's worth, your
24 Honor.

25 THE COURT: Very well.

1 ITEM IDENTIFIED AS ABEYANCE DEFINITIONS
2 MARKED DEFENDANT'S EXHIBIT NUMBER 23,
3 ADMITTED AS EVIDENCE.

4 MR. LOVELL: Thank you.

5 BY MR. LOVELL:

6 Q Doctor, just to put this to rest, I'd asked you to
7 look at what I'm putting up here -- and we're going to
8 make it a little bigger, so we can read it.

9 THE COURT: Counsel, I got -- I'm going to stop
10 both of you, and I need to see you for just a moment. I
11 do apologize for interrupting.

12 OFF-THE-RECORD BENCH CONFERENCE, OUT
13 OF HEARING OF JURORS. PRESENT: THE
14 COURT, MR. HOYLE, MR. LOVELL.
15 END BENCH CONFERENCE.

16 BY MR. LOVELL:

17 Q Now, we're back to here the -- organize this a
18 little bit. All right, Doctor, I'm going to read this,
19 and you tell me if this is your reading of the
20 definition of an abeyance was.

21 Says, number 1, abeyance:

22 *The temporary removal of a healthcare*
23 *provider from clinical duties while an*
24 *inquiry into allegations of provider*
25 *impairment or misconduct is conducted.*

1 *Periods of abeyance provide privileging*
2 *authorities the opportunity to review*
3 *allegations while insuring patients safety*
4 *and protecting providers from unwarranted,*
5 *adverse privileging action.*

6 *An abeyance terminates upon a referral*
7 *to a peer review hearing or at the end of*
8 *28 days, whichever occurs sooner. An*
9 *abeyance is not an adverse action, and*
10 *it is non-commutative.*

11 Did I read that correctly, doctor?

12 A Yes.

13 Q Is that what led you to the decision that all of
14 those things that were listed on the LLR application did
15 not apply to you?

16 A Yes.

17 Q And I've written them up here, Doctor. I'm going
18 to put it where you can see it.

19 A Um-hmm.

20 Q I'm not going to make you go look through the
21 document. But the question:

22 *Have any hospital privileges been*
23 *revoked, suspended, restricted, denied,*
24 *voluntarily surrendered, relinquished,*
25 *or relinquished while under investigation*

1 or pending action?

2 Did you determine from all of your investigation
3 after your deposition that none of those applied in the
4 abeyance scenario?

5 A That's exactly what I determined.

6 Q I'll take this down. Since the issues involving
7 Mr. Hunt, have you been notified by the Naval
8 authorities that the actions of you and your E.R. staff
9 were appropriate?

10 A Yes.

11 Q There were questions asked you about your
12 resignation from CasePro in the latter part of 2012.
13 Did that have anything to do with the events involving
14 Mr. Hunt?

15 A It had nothing to do with it. You know, after the
16 determination was made that nothing was done wrong, you
17 know, the Navy asked me to come back to work.

18 Q Your privileges remained in place during that time?

19 A Of course.

20 Q All right. Now let's talk about your involvement
21 in this patient's treatment. We're going to move
22 relatively quickly through this.

23 You had worked with Mr. and Mrs. McDonald, the
24 triage and treatment nurses, on many occasions before
25 Mr. Hunt came in on the 14th, correct?

1 A Yes.

2 Q Good nurses?

3 A Very good.

4 Q When a patient comes into the emergency department
5 and you actually first see them, do you know that -- let
6 me back up. If it's a patient like Mr. Hunt, who's not
7 stationed in Beaufort; he's from some other place; and
8 he has now shown up here at Beaufort Naval Medical for
9 treatment; when he was in the door and the nurses say
10 here's a chart on Mr. Hunt, or whoever it might be; do
11 you have an assumption that they've already reviewed
12 whatever paperwork that he brought to make sure that he
13 is allowed to get treatment at that facility?

14 A Yes. I mean, the Navy is very strict about who can
15 be seen in the -- in the emergency department. And they
16 will always verify their eligibility to be seen there,
17 which, you know, as a physician, I'll see anybody that
18 comes in. I don't care what -- whether they're eligible
19 or not. But the Navy has strict requirements.

20 Q And I don't know that we've really talked about it,
21 but can you explain to the jury when -- do you have a
22 sort of pattern in practice when the patient has
23 presented; has come into the E.R.; nurse McDonald has
24 put them in triage or Treatment Room 4; and now you have
25 spoken with her a little bit about what the patient, you

1 know, is there for and what she's found, do you have a
2 procedure you go through, a standard operating
3 procedure, on how you look at things and what you do
4 before you actually go talk to the patient?

5 A Well, when the nurse notifies me that there's a
6 patient, or I find out that there's a patient waiting to
7 be seen, depending on the situation, I will usually --
8 the nurse will tell me generally what's going on with
9 the patient and if there's any concerns or not. And you
10 know, you'll usually know if it's something that's
11 emergent or non-emergent, whether you have to rush and
12 run -- run and see that patient immediately, or whether
13 you can see that patient after you've seen the other
14 patients. So, you get a general idea of what's going on
15 from the nurse. And then, I would probably look at the
16 chart.

17 Q And when you look at the chart, what's the next
18 step after you've looked at the chart in terms of a
19 patient like this who's presenting for mental health
20 challenges?

21 A Well, I -- I would -- normally, you would walk over
22 to the patient, introduce yourself. Sometimes I will
23 even shake hands. And I think that's a good way of
24 establishing a patient/provider rapport. And you know,
25 just to put the person at ease. Sometimes they're upset

1 because they've been waiting long. So, you try to be
2 professional and establish a rapport with the patient.

3 Q And when you're doing that, walking over,
4 introducing yourself to the patient, are you telling
5 them, hey, I'm Dr. Jansen; I'm the E.R. doctor; I'm here
6 to see you?

7 A Yes.

8 Q And why are you talking to them? And what is the
9 matter? Why don't you just go over and start doing
10 whatever you do?

11 A Well, I -- I mean, this is -- this is normal human
12 reaction. I mean, this is what normal people do. And
13 you want the person to understand that you're there to
14 help them. And you're who you are, you're a
15 professional, and to -- to get the conversation going.

16 Q And while you're doing all of this, are you also
17 looking and assessing the patient's reaction to you
18 coming into the room?

19 A Well, of course. That's part of the assessment.

20 Q Is that important in mental health-challenged
21 patients?

22 A It's very important.

23 Q Why?

24 A Well, I mean, the -- sometimes, patients may not
25 tell you what's wrong, but their actions can suggest

1 what's going on.

2 Q Did you do that with Mr. Hunt?.

3 A Of course.

4 Q Now, I'm going to put up here what is Plaintiff's
5 Exhibit, I believe, 22, which is a compilation of the
6 various notes that you wrote. And I've got -- what's
7 the first page? Do you have it right there in front of
8 you, Doctor?

9 A I'm sure I do. Let me just look.

10 Q Oh, you do have it. All right. You had mentioned
11 that this sheet was called a T-sheet. Can you explain
12 to us what a T-sheet is.

13 A Well, T, stands for Treatment Sheet, and it's
14 various forms that are selected, depending on what the
15 complaint is. If it's a fever in a child or an injury,
16 or, in this case, a psychiatric problem, this sheet is
17 the one that we pull out and fill out.

18 Q And if we look up at the -- underneath the little
19 circled thing, it says, *emergency physician records,*
20 *psyche disorder, suicide attempt, overdose.* Is that the
21 guided sheet, one that's specific to the complaints that
22 might be seen in the patient with any of those
23 presentations?

24 A Yes. I'm sorry. I apologize.

25 Q That's all right.

1 A Yes.

2 Q And is that why you use that particular sheet, as
3 opposed to one with cold or flu or something else?

4 A Yes.

5 Q Now, before you ever got the T-sheet, is that
6 something you pick out or the nurses hands you?

7 A The nurse.

8 Q Okay. When Nurse McDonald hands you the T-sheet,
9 does she ever tell you anything to the effect that she
10 felt like this guy was a risk of injury to you or
11 anybody else, or was going to take off or run off, or
12 anything of that sort?

13 A No.

14 Q But the fact that she gives you a sheet that says,
15 *psyche disorder, suicide attempt, overdose*, does that
16 help you focus some on what you're going to be looking
17 at with this gentleman?

18 A Yes.

19 Q When you talk with the nurse and got the history
20 from her about his being there, to be seen, and to get
21 help, the fact that he's there with Mr. Ray, but there
22 voluntarily, does that tell you anything about his state
23 of mind initially?

24 A Well, it -- it tells you that he's there -- he
25 chose to come there, probably. I mean, he wasn't being

1 restrained in any way. He was, from what I remember, he
2 was sitting calmly next to Mr. Ray. So, that just tells
3 me that the patient wanted to come and be treated.

4 Q Was this the first time you had ever evaluated a
5 patient with mental health challenges like Mr. Hunt?

6 A No.

7 Q How many times do you think in your career you have
8 done that?

9 A Probably hundreds of times. And at the Naval
10 Hospital, we saw recruits with suicidal ideations
11 probably every day.

12 Q Now, when you walked into Bay 4, where Mr. Hunt was
13 sitting, was Mr. Ray in there with him?

14 A Yes.

15 Q And at that point, when you knew from the nurse's
16 notes that he had come for medication refills, but had
17 thoughts of hurting himself, suicidal ideations, and the
18 other things you had seen in the notes, did you think it
19 necessary at that point to get a guard or someone else
20 to secure him in place?

21 A No. There was no indication that was required.

22 Q Did you think, at that point, that it was necessary
23 to consider medicating him or physically restraining
24 him?

25 A No.

1 Q Why not?

2 A Well, there was really no need to do that. I mean,
3 you certainly don't restrain or medicate patients that
4 come in for anything, unless they give you reason to
5 suspect that. I think we would have a lot of lawsuits
6 if we restrained and medicated everybody.

7 Q All right. I want to walk through a few things on
8 your medical history on here, and I want to ask you some
9 general questions about how these forms are used. We
10 see some things are circled; some things have sort of a
11 backslash; and then, some things are left blank. What's
12 the significance of circling something on this T-sheet?

13 A Well, this is my own preference of doing it. Every
14 doctor has their own way of doing it. When you -- when
15 I circle somebody in a section, it means that, that's --
16 that particular item is correct or true. If I -- and if
17 I don't circle anything in that particular line, it
18 means it's not -- if -- if I happen to backslash, it
19 means those particular items are not happening.

20 Q So, like, up here, when you ask chief complaint
21 under the history and physical history of present
22 illness, the HPI, this is what Mr. Hunt was telling you
23 as you're talking to him.

24 A Yes. Or you know, it's probably that and a
25 combination of things with perhaps what I got from Mr.

1 Ray, perhaps what I got from the nurses.

2 Q Okay.

3 A It's a compilation of things.

4 Q So, you circled suicidal thoughts; you circled
5 depression. But I note here, agitated, hallucinating,
6 suicide attempt, and self-injury are not circled. Does
7 that mean those were not things that were existing at
8 the time he had come in or a short time before then?

9 A Yes, that's correct.

10 Q You write in *medication refill*. Is that another
11 thing that you were told by him he's there to get?

12 A Yes.

13 Q Now, the timing of this, you have gradual onset,
14 circled. Is that correct?

15 A Yes.

16 Q But it had been ongoing for several weeks, correct?

17 A Yes.

18 Q But you don't put in here anything. You don't
19 circle sudden onset, intermittent, or constant, right?

20 A That's correct.

21 Q When you're evaluating the patient who comes in
22 with suicidal thoughts and depression, looking for a
23 medication refill, but tells you it's been going on for
24 several weeks, but it came on gradually, does that give
25 you, as a doctor, any sense of the state of mind of the

1 patient at that point?

2 A Well, it suggests that things that have been going
3 on for a long time may be his normal state. And you
4 know, certain medications can cause suicidal ideations.
5 And certain conditions, such as schizophrenia, can make
6 you have suicidal ideations normally, so.

7 Q And when you see that it's been going on for
8 awhile, does that make you a little less concerned that
9 this patient is going to flip out on you or do something
10 other than the way he's been acting since he's arrived
11 at the hospital that day at 1:00 o'clock?

12 A Probably, yes.

13 Q All right. As we go down the form, you marked
14 severe, under severity. When a patient comes to the
15 E.D. and says I have suicidal thoughts or suicidal
16 ideations, does severe always get circled?

17 A I would -- I would think so.

18 Q You note some situational problems you've circled.
19 And there are a lot of things that's not circled, like
20 spouse, parent, son, daughter, significant other, work,
21 lost job, school, legal problems. None of those are
22 circled. But you wrote in specifically:

23 *The patient was dishonorably discharged*
24 *from the military, United States Marine*
25 *Corp, and is appealing that decision.*

1 That's what you were told by Mr. Hunt and/or Mr.
2 Ray?

3 A I believe so, yes.

4 Q All right.

5 *Visiting with grandmother at Beaufort.*
6 *She called Mr. Ray, concerned about his*
7 *depression.*

8 Is that, again, what you were told by one of the
9 two gents that were there?

10 A Yes.

11 Q Now, in your experience with Marines, in particular
12 like Mr. Hunt, when they're being dishonorably
13 discharged, is that something that makes them happy?

14 A Well, I would think they would be very unhappy.

15 Q Okay.

16 A It's very stressful.

17 Q Because right after that, as you were going down
18 this list, you've got current and associated complaints.
19 He's depressed, but he's also, you circled angry.

20 A Yes.

21 Q And would you have done that assessment right after
22 you talked to him and he told you, hey, I'm getting
23 dishonorably discharged, but I'm fighting it?

24 A Most likely.

25 Q All right. Would you expect someone to be a little

1 bit angry when they're talking about that to you?

2 A Yes.

3 Q What you didn't put as a current associated
4 complaint was that he was frustrated or agitated or
5 hostile or paranoid. Were those things you were looking
6 for as you were interacting with him that day?

7 A Yes.

8 Q Did you find any of those four?

9 A No.

10 Q And you backslashed confused and hallucinating.
11 And tell us why you backslashed those two.

12 A I didn't find any of that.

13 Q All right. And so, did you think at that point he
14 was hearing things or seeing things that weren't in
15 reality?

16 A I didn't document that, no.

17 Q In fact, you documented just the opposite, that
18 they're not there, correct?

19 A Yes.

20 Q And that's the backslashing, correct?

21 A Yes.

22 Q You go on to put the suicidal thoughts. And you
23 had a discussion with him about that, correct?

24 A Yes.

25 Q And that's when he also says, after you've had this

1 discussion with him about his dishonorable discharge and
2 how he's fighting that, that he does have thoughts of
3 hurting himself and the thought of hurting others. But
4 you put on here, *but no specific plans*, correct?

5 A Correct.

6 Q I want to ask you some questions about this issue.
7 I made a little chart, Doctor. Can you see that?

8 A Yes.

9 Q Everybody over here see that? I'll stand over
10 here. I want you to help us define some terms. When a
11 patient has what was called suicidal ideation, does that
12 mean they're having some general thoughts of hurting
13 themselves?

14 A Yes.

15 Q All right.

16 A That's true.

17 Q When a patient has thoughts of hurting others, is
18 that some general thoughts of hurting others?

19 A Yes.

20 Q Now, is that different than when someone comes in
21 and says those things, but says I have a plan to hurt
22 myself or a plan to hurt others.

23 A Well, that's the next step up in severity. If
24 somebody has actually a plan, it means it's more
25 dangerous.

1 Q With this gentleman -- and you were asked a lot of
2 questions by Plaintiff's counsel about your notes, and I
3 think you'll see, on the next page, that, at times, he
4 said he had thoughts of hurting himself, and at times he
5 kind of wavered on that. Am I right?

6 A Yes.

7 Q And he wavered to the point where he wouldn't say I
8 really have plans of doing that, correct?

9 A Yes.

10 Q Is that uncommon to see in depressed patients?

11 A It's very common.

12 Q Did he ever, at any point, in the whatever minutes
13 you were with him, or, to your knowledge, before or
14 after you were with him, ever state a plan, an idea of
15 something he had thought out about how he was going to
16 hurt himself?

17 A No.

18 Q Did he ever communicate to you or anybody else in
19 that E.R., to your knowledge, any ideas or plans that he
20 had formulated to hurt anybody else?

21 A No.

22 Q In your assessment of a patient who presents with
23 suicidal thoughts, and at some point during the
24 interview, after you've talk to him about things that
25 make him a little angry, talks about maybe hurting

1 others, at any point there, has he expressed an actual
2 physical manifestation that he's going to go hurt
3 himself or others, or a verbal, telling you, I'm going
4 to go hurt others?

5 A There was no indication of that, no.

6 Q So, I go back to something I wrote here called
7 patients' rights. When a patient comes to a facility
8 voluntarily, who's been cooperative by participating in
9 the process from when he walked in upstairs to the
10 triage and E.R., to the placement in Room 4, and now
11 you're talking with him and evaluating him, who, what
12 we've seen, was never aggressive, combative, hostile, or
13 whatever terms you want to use, does he have certain
14 rights, even though he's stated some suicidal ideations
15 or said I have thoughts of hurting others, but no plans,
16 does he have some rights that you have to honor as an
17 E.R. physician?

18 A Well, he has many rights to privacy, care,
19 compassion, and to, you know, to treat whatever
20 complaints he has. Those are the general rights of a
21 person.

22 Q And does a person in this situation, who's got
23 these things, also have the right to come and go as he
24 pleases in your E.R.?

25 A Yes.

1 Q I'm sorry. I talked over you that time. Is that a
2 yes or no?

3 A Well, I mean, to a certain degree, they do have a
4 right. They can sign -- certain patients can sign
5 themselves out and leave. So, I mean, if they're not
6 demonstrating any obvious risks of self-harm or harm to
7 others, people can sign themselves out and leave. I
8 mean, that's a -- that's a right that everybody has.

9 Q While I'm up here, I'm asking you to explain to us,
10 if you don't mind, we've heard the term, *admission to*
11 *the hospital*, but Dr. Hendelman said this gentleman
12 should be admitted to the hospital.

13 A Yes.

14 Q Can you explain what a voluntary admission to a
15 civil mental health facility like Beaufort Memorial
16 Hospital is, versus involuntary commitment to a military
17 medical facility that we heard earlier in this case
18 about? What's the difference in how that works?

19 A Well, voluntary admission is the patient actually
20 agrees to go to the hospital on their own. They don't
21 confront you. They don't resist you. They say, fine,
22 I'm here for help, I'll go to the hospital and stay
23 there. Involuntary usually applies to people that you
24 feel are -- are dangerous to themselves and to others,
25 and they need to be in the hospital, and for one reason

1 or another, they disagree with that or refuse to go.
2 So, that would be an involuntary commitment, where you
3 fill out paperwork, and legally they're not -- they
4 cannot leave the E.R., the facilities where you're at,
5 and they have to be admitted.

6 Q With regard to Mr. Hunt, when you were having
7 discussions with Dr. Hendelman about admitting him to
8 the Beaufort Memorial facility, and there were calls,
9 however many there were, about bed availability and
10 whether they could take him, was that always under the
11 assumption that this patient was going to continue to
12 cooperate in the evaluation and diagnostic process, and
13 go there voluntarily?

14 A Yes. I mean, the usual idea is that the patient
15 will go voluntarily. And if you feel the need that they
16 have to be in the hospital, and they're refusing to,
17 then, you consider involuntary admission.

18 Q We'll come to that in a second. But when you're
19 going to do a voluntary admission, let's assume, take
20 our time line for it, that, the patient had remained in
21 the hospital after you and Dr. Hendelman had talked, and
22 you walked in, and you said, Mr. Hunt, we think you need
23 to be seen at Beaufort Memorial, in the medical thing;
24 and he said, that's fine, would there still be things
25 you'd have to do in the E.R. at the Naval Hospital

1 before he could be transported over to Beaufort
2 Memorial?

3 A Yes. There's a lot of paperwork that has to be
4 filled out.

5 Q What about lab tests or checking to see if he's got
6 some other physical illness going on before you send him
7 over there?

8 A Now, that commonly is done, and it would really
9 depend on the accepting physician. Often, they require
10 a lot of blood work tests to make sure there's no other
11 medical condition going on.

12 Q If the same scenario had played out, but Mr. Hunt
13 says I'm not going to go, and you have to go through
14 involuntary commitment procedures first, would you ever
15 involuntarily commit a military person to a civilian
16 medical facility?

17 A That's -- it really doesn't matter whether it's
18 military or not. It's voluntary/involuntary goes with
19 civilian and military.

20 Q If you're going to send them to an involuntary
21 commitment, and they don't want to do it, do you have to
22 get some type of a legal process in order to do that?

23 A Yes.

24 Q Is that an order from a judge or somebody of that
25 sort, saying this person must go against their will?

1 A Usually, it's a doctor's decision. And they make
2 the approximate reasoning why this person needs to be
3 committed involuntarily. It's for a short period of
4 time. And I think probably some other people probably
5 need to get involved legally with that, but I don't
6 think it's a judge that initially gets involved.

7 Q But there's some legalities of doing so.

8 A Yes.

9 Q Thank you, sir. Are there degrees of suicidal
10 ideation?

11 A Yes, there are.

12 Q Tell us a little bit about that.

13 A Well, there's vague ideations where somebody says
14 -- can say that, you know, I don't want to live, or, I'm
15 not happy, and I just want to escape. And all the way
16 to, I'm so depressed; I have cancer; I don't want to
17 live; I'm going to kill myself.

18 Q And the same with homicidal ideations, are there
19 degrees of those?

20 A Of course there are.

21 Q Give some ideas of the examples of that.

22 A Well, I -- I gave an example yesterday where, you
23 know, somebody's cut off in traffic and says, I'd like
24 to kill that person, and you know, it's not a serious
25 threat, just angry at the moment. And you know, later

1 the person just kind of realizes the mistake of going to
2 road rage and laughs it off; versus somebody that
3 actually makes plans, and either is in the process of
4 hanging themselves, or purchases a weapon, or things
5 like that.

6 Q Is a plan the important part for you, whether it's
7 a suicidal thought or homicidal thought? The absence of
8 a plan versus the existence of a plan?

9 A That's a very important part of it.

10 Q Let me go back to your chart, Doctor, and ask a few
11 other things. As you did your continued evaluation of
12 this, when you were under the -- excuse me -- current
13 and continuing and associated complaints, you've
14 backslashed suicide attempts, wanted to escape inside,
15 and abraded risk. Why backslash those four areas in
16 there?

17 A Well, because they -- they -- they weren't
18 appearing in that situation.

19 Q So, it didn't appear to you he had other attempts
20 where he had left some physical evidence on his body of
21 having tried to hurt himself?

22 A Correct.

23 Q Over here on the right side, you have some other
24 areas that you looked at. A review of systems, where
25 you're looking at his lungs and his constitution and his

1 neurological and his eyes. Excuse me. Under neuro/
2 eyes, you have a backslash on headache, and nothing
3 checked for visual disturbance. Are those important
4 things to note, when you're looking at a patient with
5 mental health challenges like Mr. Hunt?

6 A Well, you have to really look at the whole patient,
7 but you want to concentrate on specifics problems. I
8 mean, you're not going to be looking at his toe for an
9 ingrown toenail when he's presenting with suicidal
10 ideations. So, you -- you examine the patient, but you
11 specifically look at certain areas that are relevant.

12 Q And if patients are extremely agitated, or in a
13 high mental state of mental distress or whatever, can
14 they experience headaches and visual disturbances that
15 are evident when you're examining them?

16 A It's possible.

17 Q You checked nausea and vomiting, backslash. Can
18 patients who are in a high state of agitation sometimes
19 feel nauseated or like they want to throw up?

20 A It's possible.

21 Q And those are things you look for?

22 A Yes.

23 Q You noted at the bottom that he has alcohol and
24 drug abuse, depression, prior suicide gesture. What's a
25 suicide gesture, as opposed to an attempt?

1 A A suicide gesture is considered a non-serious
2 attempt. It's usually a seeking out or looking for
3 help. For example, somebody that takes five aspirins,
4 and says, you know, I want to kill myself, and that's
5 usually a cry out for help. So, it's a gesture, looking
6 for somebody to help you. An attempt is actually an
7 attempt to kill yourself.

8 Q And the bottom, you were already asked about the
9 medication side, but under the social history, you've
10 got, he's a smoker of about a pack a day. Now, with
11 smokers, sometimes, they get -- if they sit too long in
12 an E.R., waiting for things to be done, and diagnoses,
13 do they like to go out and have a smoke?

14 A Yes.

15 Q And is that something that, absent some plan to
16 hurt themselves or others, you are not against allowing
17 to occur, as long as a patient remains cooperative?

18 A Again, a lot of physicians will allow patients to
19 go out for a smoke. Usually, they don't go by
20 themselves.

21 Q And this patient didn't go by himself, did he?

22 A No.

23 Q Now, I'm going to ask the last question on this
24 page. You've noted on alcohol use, you have he's not a
25 binge drinker. At least, you didn't circle it. But you

1 have alcoholism, and that he's divorced, with a child,
2 right?

3 A Yes.

4 Q The fact that he tells you he has an alcohol and
5 drug problem and alcoholism is something, but in your
6 assessment of him, did it appear that he had abstained
7 from those things for quite some time?

8 A I really couldn't tell.

9 Q He didn't come in with the odor of alcohol or
10 anything, right?

11 A I don't believe he did, no.

12 Q And if a person has got all these other mental
13 health challenges, is it a good thing if they're
14 abstaining from alcohol and not binge drinking? Does
15 that show you they're trying to help themselves?

16 A Well, that certainly is true.

17 Q And that's why you understood that he came there,
18 is he wanted some help getting medications refilled.

19 A Yes.

20 Q And was there anything during this time when you've
21 been talking with him and reviewing systems with him,
22 anything about your interactions with Mr. Hunt that
23 suggested he wasn't going to continue to stay and get
24 the help that he had come there for?

25 A No.

1 Q All right. Thank you, sir. Now, we're going to
2 move into that second page very briefly. Now, these
3 appear to be things where you're actually putting your
4 hands, eyes, stethoscope, some things on the patient,
5 doing a physical exam. Is that right?

6 A No. I'm afraid that's the nurse's assessment.

7 Q I picked up the wrong one. I'm sorry. Thank you
8 for correcting me, Doctor. Let me get the right one.
9 There we go. Is that --

10 THE COURT: Would you identify it. Would you just
11 identify it.

12 MR. LOVELL: Yeah. It's Plaintiff's 22.

13 THE COURT: Perfect. Thank you.

14 MR. LOVELL: And it's -- I don't know the page
15 number. I apologize.

16 BY MR. LOVELL:

17 Q This one, Doctor, that starts at physical exam, and
18 it has some handwriting in the upper right, that's your
19 second page of your note?

20 A Yes.

21 Q The physical exam, when you're dealing with mental
22 health patients, patients that come in with challenges
23 like Mr. Hunt, when you go to do a physical exam where
24 you're going to be touching their body, are there
25 occasions where, when you go to do that, they react to

1 those touches?

2 A Well, certainly. But I mean, as a -- as a
3 compassionate human being, you will tell them that
4 you're going to be examining them. So, they usually --
5 if they refuse to do it, then, that's a different
6 scenario. If they -- you prepare them for whatever
7 you're going to be doing. You don't suddenly draw blood
8 without telling them to do that, so you always prepare
9 patients.

10 Q And Dr. Jansen, I should have asked you this at the
11 beginning. But when you're interacting with a patient,
12 from the minute you walk in and introduce yourself to
13 the minute you leave, are you talking with him during
14 that whole time?

15 A Constantly.

16 Q Why do you talk to him the whole time?

17 A Well, that's the only way that human beings
18 communicate is by talking. And if they're talking, it
19 means they -- they -- they want to be there, probably.
20 I mean, that's an assumption you make.

21 Q And are you saying words to him, explaining to him
22 what you're doing, when you're doing it, and kind of why
23 you're doing it?

24 A Usually, yes.

25 Q And are you talking to Mr. Hunt, or did you talk

1 with Mr. Hunt, as you got to the end of the process to
2 explain to him sort of what to expect to happen next?

3 A Yes.

4 Q We'll come back to that in a second. But as you
5 were doing your physical exam, you did put that he was
6 in moderate distress and he was anxious, correct?

7 A Yes.

8 Q But you didn't put severely distressed or lethargic
9 or obtunded or uncooperative for exam, correct?

10 A Correct.

11 Q And had he been any of those things, you would have
12 circled them?

13 A Yes.

14 Q So, as you're talking to him, and you're telling
15 him what you're doing, and you're touching his body,
16 he's allowing you to do these things, right?

17 A Yes.

18 Q As we go down, you have his eyes, ears and nose,
19 and throat exam to be basically normal, right?

20 A Yes.

21 Q Nothing about looking in his eyes that suggested
22 something unusual or weird was going on?

23 A Nothing was documented to that effect, no.

24 Q I note over here there's something called
25 disconjugate gaze.

1 A Yes.

2 Q And that would be abnormal sometimes in patients
3 who are on medications or having something unusual going
4 on mentally?

5 A Yes.

6 Q All right. Explain to us what that means,
7 disconjugative gaze.

8 A Well, disconjugative gaze means your eyes aren't
9 equally focused. They're off like that, so that could
10 be anything from brain lesions, strokes, tumors, to
11 certain medications.

12 Q In the neurologic and psychological evaluation of
13 him, you noted the depressed affect, and you were asked
14 about it. But he wasn't tearful, hostile, or non-
15 communicative with you at that time, correct?

16 A Let's see here.

17 Q It's under the neuro-psyche exam.

18 A I circled only depressed affect.

19 Q Okay. And again, as you're talking to him, and
20 having this ongoing conversation, are you, again, asking
21 him, do you have suicidal thoughts, as you're going
22 through this, correct?

23 A Yes.

24 Q And you wrote here, he doesn't state them at that
25 time of this process, right?

1 A Correct.

2 Q And I assume this whole process takes a little bit
3 of time; it doesn't just happen like that.

4 A Yes.

5 Q And as you're talking to your patient, Mr. Hunt,
6 going through this process, you keep asking him some of
7 these questions over and over sort of, to judge the
8 validity of his responses?

9 A Yes, that's correct.

10 Q And one of those is, are you thinking of hurting
11 yourself; are you having ideas of suicide.

12 A Yes.

13 Q Just to see at different times what he says?

14 A Yes.

15 Q And in this case, this gentleman even wavered on
16 that, whether he was and he wasn't having those
17 thoughts. Did he not?

18 A That's what's written in the notes, so I believe
19 that's correct.

20 Q And again, when you note below, and you were asked
21 earlier where you wrote, patient doesn't deny nor
22 confirm ideations, right?

23 A Yes.

24 Q Under orientation, you put, he's disoriented to his
25 Social Security Number; doesn't recall it. But he was

1 oriented to where he was, what day of the week it was,
2 who he is, what he's doing, right?

3 A Yes. And I think that was documented in the
4 nursing note.

5 Q Okay. And he was, again, cooperative. He wasn't
6 uncooperative at all.

7 A Yes.

8 Q You did an exam of his sensory and motor nerves and
9 his respiratory system, correct?

10 A Yes.

11 Q All of those things relatively normal?

12 A Yes.

13 Q He wasn't breathing fast, was he?

14 A I don't believe he was, no. And but we can go back
15 to the vital signs, and I think they were -- sure that
16 he was breathing normally.

17 Q And was his blood pressure higher than you would
18 expect for a gentleman of his age?

19 A His blood pressure was normal.

20 Q Was his pulse rate faster than you would expect for
21 a man of his age?

22 A His pulse rate was just slightly above the upper
23 limit of normal.

24 Q Is that abnormal, to see a slight elevation of
25 blood pressure when somebody is sitting in the emergency

1 department being evaluated by a doctor?

2 A No, it's not abnormal at all.

3 Q If he had been in an extremely agitated state, but
4 not showing it, you know, talking to you or telling you
5 about it, would you expect those vital signs to look
6 like what Mr. Hunt's looked like?

7 A No. They would be probably -- but again, not in
8 all cases, but usually, they would be abnormal.

9 Q Much higher pulse rate, higher blood pressure?

10 A Higher pulse rate, maybe elevated blood pressure.
11 You get a release of catecholamines. Probably breathing
12 faster, pacing, you know, things like that.

13 Q And those are things that people can't consciously
14 control. Your body just does it.

15 A Yes.

16 Q And he didn't have any of that, other than a
17 slightly elevated heart rate that could be just
18 associated with things, either being talking to you.

19 A Or not having a cigarette.

20 Q Okay. Skin color look normal?

21 A Yes.

22 Q He wasn't flushed or sweaty or anything like that,
23 correct?

24 A Correct.

25 Q And those would be things, if someone who was in an

1 extremely agitated scenario, you might see a sweaty or
2 flushed appearance?

3 A Yes.

4 Q Is that right?

5 A Yes, that's -- that's correct.

6 Q All right. So, Doctor, you completed all of your
7 examination of him, and at that point, your decision was
8 I think I need to consult with the psychiatry group
9 about what to do with this gentleman, correct?

10 A Correct.

11 Q Was he ever -- was Mr. Hunt ever combative to you
12 at all?

13 A He never appeared to be, no.

14 Q Did he always cooperate with you when you were
15 talking with him, telling him what's going on?

16 A Yes, he did.

17 Q And as you sat there and made the decision you
18 needed to get psychiatric people to evaluate him, did
19 you talk to Mr. Hunt about the fact that, that was going
20 to occur?

21 A Yes.

22 Q Did he, in any way, resist that being the next step
23 of his voluntary participation in this evaluation?

24 A I don't recall him resisting at all.

25 Q If Mr. Hunt had resisted that, would you have made

1 a notation of it?

2 A Most likely.

3 Q Was the gentleman, at any point, exhibiting any
4 signs or symptoms of a delusional disorder while you
5 were in the room with him?

6 A No.

7 Q Active personality disorder while you were in the
8 room with him?

9 A No.

10 Q Psychosis of any sort?

11 A No.

12 Q Was he exhibiting any signs of schizophrenia?

13 A No.

14 Q All right. We're going to talk just briefly about
15 this time line, and I apologize for digging into this
16 one more time. This is something I started with Mr.
17 McDonald, and I've added some things to it, and I
18 apologize in advance for the really poor handwriting.
19 The things that you did, I kind of put in pink
20 underneath.

21 At 1520, your notes showed -- well, I'm sorry, at
22 1510, there was a call from you to Mental Health, asking
23 for a psychiatric tech to come down, correct?

24 A Yes. Correct.

25 Q And we saw from Mr. McDonald, that was also around

1 the time you charted a call to Beaufort Memorial to
2 check on bed availability. If you were thinking that
3 this man might need admitting to the hospital, is it bad
4 for you and the staff there to go ahead and check and
5 see if there's any beds available for him over there?

6 A No, it's not bad.

7 Q Does it save time if you check, and you find out
8 they don't have them, you can go look other places; or
9 if they do, you, perhaps, don't have to?

10 A That would be common sense.

11 Q It would be good patient care to try to expedite
12 the process?

13 A Of course.

14 Q Now, at 1520, you made a second call to the psyche
15 tech area asking where is he, correct?

16 A Yes.

17 Q All right. And Mr. McDonald told us; at 1525, he
18 indicated the psyche tech was evaluating Mr. Hunt. Your
19 note shows that, at 1540, Mr. Manning, the psyche tech,
20 was present, correct?

21 A Yes.

22 Q And then, shortly after that, we heard your
23 testimony yesterday that the psyche tech completed
24 whatever he was doing. Did you have a conversation with
25 the psychiatric tech?

1 A I don't think there was anything of any essence.
2 He was basically going to report to the psychiatrist,
3 and that I would get a call back probably.

4 Q Now, at any point -- I'm going to back up one step.
5 When you were in there creating these two documents that
6 we've looked at, your form, is that a front and back of
7 the same piece of paper?

8 A Yes.

9 Q So, it's not really two separate sheets. It's one,
10 front and back.

11 A Yes.

12 Q Do you have the entirety of the medical chart in
13 your hand when you're doing that?

14 A The only chart that's created in the emergency
15 department, yes.

16 Q So, you would have Nurse Janice's triage record and
17 whatever documents were with that, correct?

18 A Correct.

19 Q And you would have the T-sheet, correct?

20 A Yes.

21 Q Mr. McDonald's form that he's completing, is that
22 something that's at the nurse's desk with him?

23 A Let's see. You mean the nurse's evaluation?

24 Q No, the treatment nurse's chronological sequence of
25 notes that are there in your packet. Let me show it to

1 you here. Doctor, this one, I'll put it up over here.

2 A I see.

3 Q Joe McDonald's.

4 A That -- that -- I don't think that's, necessarily,
5 that's with me. I only have the T-sheet.

6 Q Okay.

7 A That's what I have.

8 Q So, with what you've got, when you go back and see
9 the patient, you complete your things. When Mr. Manning
10 comes to see the patient, do you then hand those to him?

11 A I usually don't hand my paperwork to the consultant
12 or the consulting technician. They have their own
13 paperwork.

14 Q Why wouldn't you let them have yours?

15 A Well, they can ask for it, if they want, but they
16 don't necessarily -- I don't necessarily hand them the
17 form.

18 Q Is it important for the psyche tech to get his own
19 independent gathering of information from the patient?

20 A That's exactly right.

21 Q Okay. So, when Mr. Manning is in there completing
22 his evaluation, when he comes out, does he give you a
23 form, say, hey, here's what I found with regard to the
24 patient?

25 A No. He would take that, whatever information he

1 has, to the psychiatrist.

2 Q And then, he left some time after 1540, but before
3 your phone call to Dr. Hendelman at 1605, correct?

4 A Yes.

5 Q At any point when Psychiatric Tech Manning was
6 there, did he come to you, or to your knowledge, did he
7 tell anyone else, hey, this gentleman doesn't need to be
8 escorted only by Mr. Hunt -- I mean, Mr. Ray; or hey,
9 don't let this guy out; or hey, do anything differently
10 than what you all were doing?

11 A No.

12 Q Even when he came out to go upstairs to see Dr.
13 Hendelman?

14 A No.

15 Q When you made the phone call to Dr. Hendelman,
16 which, according to your time frame, was at 1605, do you
17 remember the words that you all exchanged, as you sit
18 here today?

19 A Well, whatever words were there would be in the
20 notes that I made. I -- I don't recall, exactly.

21 Q At that point, she told you that this patient, it
22 was obvious to her that he needed to be admitted for
23 further work-up and evaluation, right?

24 A Yes.

25 Q Did she say he needs to be a voluntary or an

1 involuntary? Did she specify?

2 A No.

3 Q But at that point, did Dr. Hendelman say to you,
4 make sure this gentleman doesn't leave the E.R. or get
5 somebody down to restrain him; do anything other than
6 what you all had been doing with him?

7 A Nothing to that effect, no.

8 Q And at that point, did you ask Dr. Hendelman to
9 come down and see Mr. Hunt?

10 A Yes.

11 Q Why?

12 A Well, like I said yesterday, when you do a
13 consultation, you want the specialist to at least look
14 at the patient. That's -- that's the way I usually work
15 it, so. The Navy sometimes works it a little
16 differently, so it's -- I -- I think that's reasonable.

17 Q And you knew that you had a patient, at least from
18 your observation, that had had thoughts of hurting
19 himself that were sort of wavering to yes, I'm having;
20 no, I'm not?

21 A Yes.

22 Q So, in your mind, was there perhaps this gentleman
23 with wavering thoughts of suicidal or homicidal issues,
24 and no -- absolutely no plan, who was not combative, not
25 all the restless, agitated, all those things, where, you

1 know, not really giving you all a hard time, was there
2 some question in your mind whether an admission was
3 exactly what he needed?

4 A Well, of course. I mean, mental illness is a very
5 difficult condition to completely and well-diagnose
6 correctly. Even psychiatrists have trouble sometimes.
7 So, I mean, the more help you get in evaluating a
8 patient and his needs and his care and his safety, the
9 better.

10 Q But when she, Dr. Hendelman, tells you, forget all
11 of that; I'm not coming to see him; it's obvious he
12 needs to be admitted; at that point, you're going to do
13 whatever paperwork needs to be to have him admitted.

14 A Correct.

15 Q First, though, would you go down and go talk to Mr.
16 Hunt, and explain to him what had happened with the
17 psychiatric evaluation, and explain the process of
18 voluntary admission, and then, give him the option of
19 going that route? Is that what would have happened?

20 A Well, that's normally what's done, yes. And I
21 would have done that.

22 Q And when you walked out of your evaluation of Mr.
23 Hunt, when you finished, you know, right before you
24 walked out, did you tell him, hey, I'm going to have a
25 psychiatric tech come and see you, and it's possible you

1 may need to be -- go into the hospital, depending on
2 what we find?

3 A I -- I -- I'm pretty sure I said that there's going
4 to be a psyche tech come in to see you. And I don't
5 recall whether I said, you know, he may get admitted or
6 not.

7 Q Okay. But you don't know what Mr. Manning may have
8 said to Mr. Hunt at any point, right?

9 A No.

10 Q Did Mr. Ray, the gentleman who had been with Mr.
11 Hunt since 10:30 or so in the morning, and accompanied
12 him upstairs/downstairs, did he, at any point in time,
13 express to you that he was concerned that something
14 could change with Mr. Hunt, or that Mr. Hunt was acting
15 differently?

16 A No, he did not.

17 Q Do you have any knowledge of Mr. Ray making any
18 comments to that effect to any of the E.R. staff, the
19 Nurses McDonalds?

20 A No.

21 Q If Mr. Ray had said something to you to that
22 effect, would you have done something differently than
23 what was done?

24 A Most likely, that would change the scenario, to
25 some degree.

1 Q Doctor, given your medical evaluation of this
2 patient, including the information that was provided to
3 you by the emergency staff, and your interaction with
4 Mr. Hunt and his wavering on the ideation issue, do you
5 have -- did you have any medical thought or medical
6 reason to justify telling this patient, hey, you cannot
7 leave this E.R. for any reason whatsoever?

8 A No, I did not have an indication.

9 Q He wanted to go out and get fresh air. As far as
10 you were concerned, that was acceptable at the time.

11 A That would have been an option. But again, like I
12 said, in my practice, I -- I personally do not like
13 people leaving the E.R. until their -- their treatment
14 is completed. Although, some people do allow that, but
15 I personally do not like that.

16 Q And the reason you don't like people leaving the
17 E.R. before you've completed your evaluation and made
18 some decision about what happens next is because, if
19 they leave the E.R., and you decide, oh, I need to get
20 this test, or I need to re-evaluate this, you kind of
21 got to go chase them down, and there may be some time
22 wasted in the process. Is that one reason?

23 A Yes.

24 Q And if you happen to have other patients in the
25 E.R., and you know, you're having to stack who you see,

1 if you need to see Mr. Hunt, and he's gone outside for a
2 cigarette, it might delay the time you get to see the
3 other people, right?

4 A Yes.

5 Q But in this case, he's the only patient in the E.R.
6 that day, so we're not worried about other people having
7 to wait while you all track him down, right?

8 A Yes.

9 Q And as far as a need to do other tests or anything,
10 there were no tests that you were going to do, until the
11 decision had been made that he's going to be admitted or
12 not, correct?

13 A Correct.

14 Q And so, that really wasn't a factor in whether he
15 could go in or out to go have a smoke, or get fresh air,
16 or whatever he wanted to do with Mr. Ray.

17 A Correct.

18 Q When you were trying to make a decision, even if
19 it's early on, like when Mr. Ray -- I mean, sorry --
20 when Mr. Hunt was first seen by you, if you have to make
21 a decision whether to chemically restrain him by giving
22 him medication, does that decision have some risk to the
23 patient, if it's not necessary medically?

24 A There's always risk with -- with psychotropic
25 medications.

1 Q So, with most E.R. doctors, when faced with a
2 patient like this one, with the situation you saw when
3 you saw, would a medical restraint be something you
4 would shy away from under those conditions and
5 circumstances?

6 A Well, in this particular case, any restraint was
7 not indicated while I was, you know, seeing the patient.

8 Q And does that include medications that might calm
9 him down or whatever, and physical restraints, such as
10 somebody physically holding him or tying him down with
11 the straps you all can use?

12 A Yes.

13 Q Even though you knew this gentleman was a Marine
14 and capable or trained on how to defend our country
15 through the use of violence, was there anything about
16 his presentation to you that day, and the information
17 that you reviewed or looked in, that suggested to you
18 that he was going to use any of those propensities on
19 anybody that day?

20 A No.

21 Q It was obvious that he needed to be admitted,
22 according to the psychiatrist, and you would follow her
23 instruction, right?

24 A Yes.

25 Q And that would be admitted to have further work-up,

1 people asking those questions about his history, and
2 determining what course of treatment to do, right?

3 A Yes.

4 Q That kind of evaluation could not occur in your
5 emergency department on that day, correct?

6 A No.

7 Q He had to go somewhere, and it couldn't occur in
8 the military facility that day, either, correct?

9 A Correct.

10 Q Because this was a Friday afternoon, late, and
11 those folks all go home over the weekend.

12 A And usually, the patients in that particular
13 situation of Mr. Hunt's are not admitted to the Naval
14 Hospital.

15 Q So, they've got to go somewhere else for all of
16 this follow-up care.

17 A Correct.

18 Q Was it obvious to you that, at least during the
19 time you were with him, Mr. Hunt was going to continue
20 to cooperate with the medical care he was getting?

21 A That would have been the pattern, yes.

22 Q Nothing to suggest that he wasn't going to
23 continue. Is that right?

24 A Correct.

25 Q Was it obvious to you, from your interactions with

1 him, with Mr. Ray sitting in the room for those periods
2 of time, that he was going to continue to cooperate with
3 Mr. Ray in this process?

4 A Yes.

5 Q You weren't there, but we've heard that the
6 gentleman left and went to the restroom. Mr. Hunt did.
7 Came out of the restroom, spoke to Mr. McDonald, who
8 offered him something to drink. He politely said, no,
9 and then, went back to the bed, where Mr. Ray was still
10 in the room, and stayed there for some period. Is that
11 consistent with the pattern of cooperation and
12 participation in his healthcare that you had seen from
13 Mr. Hunt?

14 A Yes, that is.

15 Q Did you have, in your mind, Doctor, any thoughts
16 that, at any point in time, Mr. Hunt posed a serious
17 threat of danger or violence to other people?

18 A No, I did not.

19 Q To himself?

20 A No.

21 Q In your opinion, would any reasonably prudent
22 emergency physician such as yourself, trained in the --
23 competently trained in the practice of emergency
24 medicine, or a nurse working in that department, who's
25 competently trained, determine that, based on all the

1 information that was there with Mr. Hunt, that he posed
2 a serious danger of violence to himself or others that
3 day?

4 A No, he did not.

5 Q Did you have any suspicion that this gentleman, who
6 had been there since 10:30 that morning, had cooperated
7 with the Nurse Smith, and cooperated with Janice
8 McDonald, and had cooperated with you, and had
9 cooperated, presumably, with Mr. Manning and Mr. Ray,
10 and Joe McDonald, was going to run away from Mr. Ray,
11 after walking outside, strip down to his underwear and
12 his socks, run off the base, get in a fire truck and
13 cause harm to other people?

14 A That would have been very unexpected.

15 Q Did you have the benefit of hindsight, a crystal
16 ball, knowing what happened at the time you were
17 treating the patient, and assessing what might happen in
18 the future?

19 A No. I -- I cannot predict the future.

20 Q When you were asked questions yesterday, you know,
21 knowing what you know now, would you do things
22 differently, is that using a crystal ball or hindsight
23 that you didn't have when you were seeing the patient?

24 A Well, that's a very common question you're asked in
25 court, and that's being that Monday night quarterback.

1 And if you know what happened, then, you can start
2 guessing or second-guessing people.

3 Q But back when you were treating this patient,
4 Doctor, from your professional experience as a doctor,
5 treating patients like this before and evaluating them,
6 was there anything in your mind that made it suspicious
7 or made you think that this gentleman might do something
8 to cause serious danger to himself or others?

9 A There was nothing to that effect.

10 MR. LOVELL: Thank you. That's all the questions I
11 have.

12 BY THE COURT:

13 THE COURT: All right. Ladies and gentlemen, we
14 are going to take our morning break. I'm going to ask
15 you to please step to your jury room. Do not discuss
16 this matter or allow anyone to discuss it with you.
17 Remember that show Ally McBeal? Before long, you all
18 are going to be saying it with me. Leave your notebooks
19 and your pads, and we will take about 15.

20 A Judge, do I need to still stick around? Really?

21 THE COURT: We have more cups of water.

22 A As well.

23 THE COURT: You've got to drink them all before you
24 go.

25 A Water. This is like a prison, bread and water,

1 huh?

2 THE COURT: Oh, come on.

3 A But there's no bread.

4 THE COURT: I just warn you not to testify. Don't
5 talk about your testimony during the break. I know you
6 know that by this point. We'll take about 15. You be
7 at ease, too. You go take your break, Ms. Rowe.

8 JURY LEAVES COURTROOM AT 11:00 A.M.

9 BAILIFF: Jury's clear, your Honor.

10 THE COURT: Be at ease. Fifteen, guys, and ladies,
11 and folks.

12 OFF THE RECORD 11:00 A.M.

13 BACK ON THE RECORD 11:35 A.M.

14 BAILIFF: All rise. Court is back in session.

15 THE COURT: Thank you. Please be seated.

16 MR. HOYLE: Good morning, Judge. Just a little bit
17 of forward planning, because I don't think I'm going to
18 need that long with Dr. Jansen. Could we go ahead and
19 talk about the next deposition? We'd like to play Dr.
20 Hendelman, and we have two issues we need to address
21 with you.

22 THE COURT: Okay.

23 MR. HOYLE: It might be easier if we just approach.

24 THE COURT: Yeah, since the jury is coming in.

25 MR. HOYLE: Because it would be nice if we could

1 just hit play.

2 OFF-THE-RECORD BENCH CONFERENCE, OUT OF

3 PRESENCE OF JURY. PRESENT: THE COURT,

4 MR. HOYLE, MR. LOVELL.

5 END BENCH CONFERENCE.

6 BAILIFF: Jury is entering the courtroom, your
7 Honor.

8 JURORS ENTER COURTROOM 11:39 A.M.

9 THE COURT: Oh, I need my witness. There you are.
10 Come on. I'm sorry. Ladies and gentlemen, at this
11 time, we will continue with the Plaintiff's case and the
12 re-direct of Dr. Jansen, as soon as he's able to make
13 his way back. Does he have water? Wonderful. All
14 right. Your witness.

15 MR. HOYLE: Thank you, your Honor.

16 DR. CHRISTIAN JANSEN

17 RE-DIRECT EXAMINATION, BY MR. HOYLE:

18 Q Dr. Jansen, let's begin where prior counsel, Mr.
19 Lovell, began his examination. Do you have Exhibit --
20 Defendant's Exhibit 23 handy?

21 A Yes, I do.

22 Q Okay. And Exhibit Number 23, is this something
23 that you yourself actually obtained from some source and
24 printed onto a piece of paper?

25 A Well, I didn't get this exhibit. This is not mine.

1 Q Okay. Did you yourself actually go, subsequent to
2 your deposition that took place, oh, I think, back in
3 August of 2014, and obtain something substantially
4 similar to the document we have in front of us as
5 Defendant's Exhibit 23?

6 A I read this information. I didn't have actually
7 the paperwork. I just looked it up.

8 Q And where did you look it up, Doctor?

9 A Internet.

10 Q And did you just type in some terms in Google?

11 A Yes.

12 Q And I believe your testimony earlier here today was
13 that you did not believe that this definition contained
14 in Defendant's Exhibit 23 was provided to you back when
15 your deposition took place on August the 18th, 2014. Is
16 that correct?

17 A I don't remember.

18 Q Okay. Do you recall me asking you:

19 *Any reason for you to dispute that*
20 *the Navy defines an abeyance as the*
21 *temporary removal of a privileged*
22 *practitioner from clinical duties while*
23 *an inquiry into allegations that practitioner*
24 *misconduct or professional impairment is*
25 *conducted. Abeyances cannot exceed 28 days.*

1 Do you recall me asking you that?

2 A I don't recall.

3 Q Is there anything that you believe would refresh
4 your recollection as to whether or not I asked you that
5 question at your deposition?

6 A Well, I'll believe you, if you say you asked me, in
7 this situation, I'll believe you.

8 Q In this situation, about this particular question.

9 A Well.

10 Q Okay.

11 A I mean, I have no -- no reason --

12 Q So, if I were to have asked -- if I were to have
13 asked you in that deposition at Page 81 of your
14 deposition transcript, and then, followed up and said
15 that's your understanding of what an abeyance is, you
16 would have no reason to dispute that? Is that what I'm
17 hearing?

18 A No.

19 Q So, with respect to the document that we've been
20 looking at, it's the same definition that I gave you at
21 your deposition, contained within the Paragraph Number 1
22 of Defendant's Exhibit 23?

23 A I'll assume it is.

24 Q So, when I asked you at your deposition whether or
25 not you intended to notify the South Carolina State

1 Medical Board that there was an inaccurate statement
2 contained in your 2011 renewal application, and you
3 responded, *yes, I think that would be a reasonable thing*
4 *to do*, that would be with the full knowledge of the
5 definition of abeyance that has been brought forth into
6 this courtroom today as Defendant's Exhibit 23, correct?

7 A Not correct. I don't recall you having me read
8 this during the deposition. I just don't recall. So,
9 my understanding was that I did not know the definition.

10 Q Okay.

11 A And that's why I answered that question that way.

12 Q All right. Well, Doctor, I don't want to belabor
13 this point, but we just read through a definition that I
14 provided you back in your deposition. Do you recall
15 that testimony a few minutes ago?

16 A Yes. Go ahead.

17 Q And any reason to dispute that, just moments ago, I
18 reminded you that there had been a definition given at
19 your deposition of an abeyance as a temporary removal of
20 a privileged practitioner from clinical duties while an
21 inquiry into allegation that practitioner misconduct or
22 professional impairment is conducted; abeyances cannot
23 exceed 28 days?

24 A I agree with that statement. And Mr. Hoyle, we're
25 kind of going around in circles here. I mean, I may

1 have been wrong in answering that I will contact the
2 Board, because I probably misunderstood something. But
3 the fact of the matter is, my privileges were never
4 removed or reduced at any time, and I checked that.
5 Thus, I think I'm allowed to change my mind when I get
6 more information, and not contact the Board. I think
7 that's very reasonable.

8 Q All right, Doctor. And I think I heard some
9 testimony with respect to prior counsel, Mr. Lovell, as
10 well. Your privileges were in abeyance a second time at
11 the Naval Hospital, correct?

12 A I believe so, yes.

13 Q That was in 2012, after the incident involving
14 Calvin Hunt, correct?

15 A Yes.

16 Q Okay. Doctor, I want to go back to the medical
17 records from that fateful Friday. Can you pull those
18 out of your stack of information.

19 A Yes.

20 Q And Doctor, specifically, I want to direct your
21 attention back to the document you yourself typed up at
22 4:40 p.m., that afternoon. Okay? Let me know when
23 we're on the same page, sir.

24 A I'm here.

25 Q And you actually typed this document yourself,

1 correct?

2 A Yes.

3 Q You didn't dictate it into a Dictaphone, and have
4 someone else type it up; you typed it yourself.

5 A Yes.

6 Q Okay. And you told us that these were your present
7 impressions at 40 minutes past the hour of 4:00, on
8 February 24, 2012, correct?

9 MR. HOYLE: Madam Clerk, can you turn the screens
10 on, so -- all right.

11 BY MR. HOYLE:

12 Q And we looked at some of this earlier about your
13 recollection of a quote from Dr. Hendelman. But I want
14 to direct your attention to the last two sentences that
15 you wrote that day. Okay. Is that reasonable?

16 A Last two sentences, yes.

17 Q All right. We're going to work backwards.

18 Around 1620, --

19 that'd be 4:20 in the afternoon,

20 -- Mr. Ray came back and said patient ran
21 away from him and went out front gate.

22 Is that your understanding of the events of that
23 fateful Friday?

24 A Again, that's what's written by me.

25 Q Okay. So, before that happens, in the sentence

1 before, we have a sentence that says:

2 I --

3 which is presumably, you, Dr. Jansen,

4 -- asked nurses and psyche tech to
5 look for patient, and to notify security
6 and front desk.

7 Is that what's written in that sentence, sir?

8 A Yes.

9 Q So, I want to make sure I understand this
10 correctly. Before Mr. Ray comes back into the emergency
11 room, and makes whatever report that he makes about
12 Kalvin Hunt running away and going out the front gate,
13 you'd already conducted or directed others to start
14 searching for this patient and to notify security and
15 the front desk. Is that correct?

16 A Again, I don't know the exact time frame of this.
17 This is a continuous note written by me. Again, you can
18 see that I asked nurses. I don't have the time exactly
19 when I did that, so I can't tell for certain which came
20 first. At this point, I can't tell you. There's no
21 time stamp there, so I'm -- I'm not sure.

22 Q Well, if Mr. Ray had come back and said that Kalvin
23 Hunt had run off the property, he'd run off the base,
24 he'd gone out the front gate of the hospital, why would
25 you have a psyche tech and the nurses looking for him,

1 and notifying security and the front desk? He's done
2 gone, Doctor. Do you agree with that?

3 A I agree with that.

4 Q So, you will agree with me that, if we read your
5 note, which you typed up at 40 minutes after the hour of
6 4:00 that fateful Friday, that we start with the
7 beginning, with the patient coming into the E.R.,
8 correct?

9 A Yes.

10 Q And your note ends with Mr. Ray coming back into
11 the E.R., and saying that Mr. Hunt's gone, correct?

12 A Correct.

13 Q So, these are kind of in a sequence. Do you agree
14 with that?

15 A Well, it's written in a sequence, of course.

16 Q And so, this is my question, Doctor. If Calvin
17 Hunt was calm, cool, collected, and didn't pose any
18 danger to himself or didn't pose any danger to others,
19 why was it, when you found out that he wasn't within the
20 four walls of the emergency room, did you direct your
21 nurses and a psyche tech to go look for Mr. Hunt and to
22 notify security and the front desk?

23 A Well, if -- if that was exactly what you're
24 reading, it would make sense. If I'm about to do
25 something with a patient, whether to admit him or to do

1 tests, I need him there now. So, I think it would be
2 not unreasonable for somebody to go looking for him.

3 Q Well, what about notifying security? If somebody's
4 in there because they've got the flu, and you're worried
5 that they might need a strep test because they've got a
6 yucky-looking throat, and they go missing, --

7 A Um-hmm.

8 Q -- do you direct your nurses to call security?

9 A Well, if somebody's outside the confines of the
10 building, you're not going to have the nurses running
11 outside looking for them. Security is the one that
12 controls the outside environment of the hospital
13 building, so, that would make sense.

14 Q Now, at this point in time, Edward Ray hadn't come
15 back yet, correct?

16 A Again, that's very possible, but again, I don't
17 know the exact time frame here. I'm just not sure, but
18 let's say yes.

19 Q All right. At this point in time, when you're
20 directing the nurses and the psyche tech to look for a
21 patient and to notify security and front desk, fair to
22 say you don't know if Mr. Hunt's inside, outside, on the
23 base, off the base, or where he is, other than he's not
24 in front of you in the E.R.?

25 A Correct.

1 Q So, let's go back to my question, Doctor. If
2 Calvin Hunt is calm, cool, collected, and doesn't pose a
3 threat of harm to himself or to others, why do you ask
4 for security to go look for him?

5 A Well, several reasons for that. Number one is
6 because security is the only one that can look for him
7 outside the E.R. And number two is, while he was calm
8 and collected when I was seeing him, I don't know what
9 he was doing when he was outside, so I don't know what's
10 going on. So, it's just common sense to get somebody to
11 look for him. Security is the only one that can look
12 for him outside the confines of the E.R.

13 Q Well, then, why did you ask the nurses and psyche
14 tech to look for the patient? Did you think Mr. Hunt
15 was hiding somewhere in that 800-square-foot, itty-bitty
16 emergency room?

17 A Well, he could have been outside the emergency room
18 in the hospital somewhere. Been in the bathroom, in the
19 cafeteria. I mean, it's -- he can be somewhere else.

20 Q You didn't know where he was, did you?

21 A No, I didn't.

22 Q Now, there's been a lot of talk in your examination
23 with prior counsel about a plan. Did I hear some talk
24 about that?

25 A Yes.

1 Q Okay. And I believe you've already told us that,
2 even though Calvin Hunt had starch in his britches and
3 was well dressed and he was generally cooperative, he
4 was poorly communicative. Is that correct?

5 A Yes, that's correct.

6 Q If somebody's poorly communicative, does that mean
7 that they're telling you everything that's going on?

8 A That's exactly what it means, that they're not
9 telling you everything.

10 Q So, is it your testimony here today, before this
11 Court and this jury, that Calvin Hunt didn't have a
12 plan; or is it your testimony that Calvin Hunt never
13 told you that he had a plan?

14 A My notes say that he -- let's see what my notes
15 say. *Suicidal thoughts and thoughts of hurting others,*
16 *but no specific plan.*

17 Q So, what's your testimony, Doctor?

18 A What I said.

19 Q But you agree with me, by your own note, he's
20 poorly communicative, correct?

21 A Yes.

22 Q *I was unable to get sufficient history from him,*
23 *correct?*

24 A Correct.

25 Q *His train of thought was delayed, correct?*

1 A Correct.

2 Q So, we've got somebody with a delayed train of
3 thought who is poorly communicative. Do you agree with
4 that?

5 A Correct.

6 Q Somebody who is on anti-psychotic medications, and
7 hasn't been taking them for some period of time, if
8 they've got a delayed train of thought, and they're
9 poorly communicative, are you able to get the best
10 information about what's going on with that person from
11 that person himself?

12 A I can't get all the information from him, and thus,
13 I was going to consult the psychiatrist. However, from
14 all the indications that I had at the time, there was no
15 threat of danger to the patient or to others.

16 Q And that's why you notified security and the front
17 desk that he was no longer within your E.R., correct?

18 A Well, again, repeating what I said, security is the
19 only person that can check outside the confines of the
20 hospital building. The nurses, the techs, other people,
21 can check inside the building.

22 Q Doctor, there was some testimony earlier in
23 response to questions by prior counsel, Mr. Lovell,
24 about patients coming and going as they pleased. Do you
25 recall that?

1 A Yes. Somewhat.

2 Q And I believe there was some discussions with the
3 help of a flip chart about there being some sort of a
4 right that a patient has. Do you recall that?

5 A That is correct. With certain limitations.

6 Q If Calvin Hunt -- strike that. If it was a safe
7 thing to do, -- and I believe you told us yesterday that
8 your number one duty to a patient is to keep the patient
9 safe, correct?

10 A Yes.

11 Q That would be a patient right, correct? for that
12 patient to be kept safe.

13 A That's an expectation. I don't know if it's a
14 right.

15 Q And certainly, the expectation to keep a patient
16 safe who is expressing suicidal thoughts and homicidal
17 thoughts may require some type of observation or
18 instruction or warning. Wouldn't you agree with that?

19 A Of course.

20 Q And I think I heard this. You never actually told
21 Calvin Hunt that he needed to stay where he was,
22 correct?

23 A No, I did not.

24 Q You never directed any of your nurses to make sure
25 Calvin Hunt stayed where he was, correct?

1 A I don't believe I did, no.

2 Q You never warned Calvin Hunt that, if he left the
3 emergency room, he might act on these suicidal ideations
4 or these homicidal ideations or anything like that,
5 correct?

6 A There was no indication to believe that would
7 happen.

8 Q Okay. But if he has the right to come and go as he
9 pleased, why were you so concerned when you realized he
10 wasn't there?

11 A Well, again, right to come and please [sic],
12 really, we're talking about a person that knows what
13 they're doing exactly. In this case, the evaluation
14 hasn't been completed on this patient. So, I'm not -- I
15 don't know exactly what's going on, but to that -- to
16 that point of the examination, he was not a threat to
17 anyone.

18 Q At this moment in time, if we could freeze time,
19 when you're asking these nurses and the psyche tech to
20 go look for Calvin Hunt, and to notify security and the
21 front desk, at that moment in time, Doctor, did you
22 believe that Calvin Hunt should have been admitted?

23 A Yes, that was the discussion that I had before that
24 with the psychiatrist. So, a decision was made to admit
25 him.

1 Q No doubt in your mind about that.

2 A No doubt in my mind.

3 Q You agree with me that Calvin Hunt really wasn't
4 able to give you a good story as to what was going on;
5 and so, until that was resolved, the safe thing to do
6 was to keep Calvin Hunt under observation, correct?

7 A Yes. That -- that would be my general inclination,
8 correct.

9 Q And not let -- strike that. And not let Calvin
10 Hunt leave, correct?

11 A Correct. This is what I've been repeating over and
12 over to you, that it is my personal treatment and my
13 personal wish that patients do not leave the confines of
14 the emergency room while they're being evaluated. That
15 is my personal preference.

16 Q If you had had actual knowledge on February the
17 24th, 2012, of a question posed as follows: can we go
18 outside for a breath of fresh air, and the we included
19 Calvin Hunt, would your answer to that question have
20 been, yes, no, or something else?

21 A Again, we're theorizing something that never
22 happened. But if you're giving me a theoretical
23 situation, I would probably have talked to the patient,
24 and asked him if he wouldn't mind staying, because we
25 still have some things we need to do, and I'd really

1 prefer if he didn't.

2 Q It wouldn't have been a yes. Is that correct?

3 A Well, that's my -- that's my answer.

4 Q It wouldn't have been a yes, correct?

5 A Correct.

6 MR. HOYLE: Thank you, Doctor. Those are all the
7 questions I have.

8 THE COURT: All right. Yes. Re-cross.

9 MR. LOVELL: Very briefly. Could I get the ELMO
10 back up, please. Thank you.

11 DR. CHRISTIAN JANSEN

12 RE-CROSS EXAMINATION, BY MR. LOVELL:

13 Q Doctor, I'm going to ask you to help me read, in
14 context, this entire note. Not the whole note, but
15 pertinent parts of it. The typewritten one you have,
16 from what's up there on the screen.

17 A Yes. I'll look over there. Go ahead.

18 Q I'm going to back up a couple of sentences, prior
19 sentences, to what was read. And you wrote this sort of
20 at the day of this incident after the patient had left,
21 to kind of put your thoughts on the paper of what
22 occurred, and not necessarily exactly in time wise, but
23 the sequence of how things went. Is that fair?

24 A Yes, it is.

25 Q It says:

1 Dr. Hendelman called back (around 1605)
2 and told me the patient obviously needs to be
3 admitted. I asked her to see patient, but was
4 told it would not change her opinion.

5 I went out of the E.R. office to see
6 patient, and was told that he and Mr. Ray,
7 who appeared to have a good rapport with the
8 patient, stepped out to get some fresh air,
9 and would be right back.

10 In the meantime, I contacted BMH Psyche
11 Floor, and told Nurse Marilyn we had a potential
12 admission. I asked nurses and psyche tech to
13 look for patient, and to notify security and
14 front desk.

15 Around 1620, Mr. Ray came back and said
16 patient ran away from him and went out front
17 gate.

18 Did I read that correctly, Doctor?

19 A Yes, you did.

20 Q So, when you came after -- you came out of your
21 office from talking with Dr. Hendelman, you went and
22 talked to someone who told you that Mr. Ray and the
23 patient had gone out to get some fresh air and would be
24 right back. And then, you went and made a call over to
25 the hospital to tell them you've got somebody that's

1 coming over there, and will be sending him in a little
2 bit, correct?

3 A Let's see. That's, more or less, the sequence of
4 events, yes.

5 Q And after that is when you went and told your
6 nurses and psyche tech, Mr. Manning, who was there, hey,
7 go find my patient; we've got to get the paperwork going
8 to get him out the door, right?

9 A Correct.

10 Q And it wasn't until Mr. Ray came in some period
11 after that and said he took off on me, that the thought
12 ever crossed your mind this guy wasn't going to come
13 back and follow all the instructions that we've been
14 talking about and everything else, right?

15 A Correct.

16 MR. LOVELL: Good enough. Thank you, sir.

17 THE COURT: All right. Is this witness free to
18 leave?

19 MR. HOYLE: Yes, your Honor?

20 THE COURT: Any objection, Mr. Lovell?

21 MR. LOVELL: No objection.

22 THE COURT: You are free to go.

23 A I have a little objection. That picture of mine is
24 very unflattering.

25 THE COURT: Oh. All right. Thank you. We'll make

1 that note. Appreciate it.

2 A Thank you.

3 THE COURT: All right. Call your next witness,
4 please, sir.

5 MR. HOYLE: Your Honor, at this time, Plaintiff
6 calls, by videotaped deposition, Dr. Beverly Hendelman.

7 THE COURT: Very well.

8 DVD OF VIDEOTAPED DEPOSITION OF
9 DR. BEVERLY ELAINE HENDELMAN, COURT'S
10 EXHIBIT NUMBER 9, PLAYING.

11 PAUSE PLAYING DVD OF VIDEOTAPED
12 DEPOSITION, COURT'S EXHIBIT NUMBER 9,
13 OF DR. BEVERLY ELAINE HENDELMAN.

14 MR. HOYLE: Stop it. Stop it.

15 MR. MACKELCAN: Objection, your Honor. This
16 testimony, I don't think it's supposed to be in.

17 THE COURT: Okay. Okay.

18 MR. HOYLE: Clearly, for the purposes of the
19 record, we're just having technical issues, your Honor.

20 THE COURT: Okay. Well, can we repair them? Does
21 the jury need to leave to allow you to repair them?
22 Just let me know what you need to do.

23 MR. HOYLE: I'm informed by Mr. Knowles he can make
24 these additional changes as we sit here.

25 THE COURT: Okay.

1 BAILIFF: Your Honor, the jury would like to stand
2 up.

3 THE COURT: Terrific. Stand and stretch is a
4 wonderful thing, always. Stretch. Wonderful.

5 Are you ready?

6 MR. HOYLE: Yes, your Honor.

7 THE COURT: Go right ahead.

8 MR. HOYLE: Thank you, your Honor.

9 DVD OF VIDEOTAPED DEPOSITION OF

10 DR. BEVERLY ELAINE HENDELMAN

11 CONTINUES PLAY.

12 END PLAYING DVD OF VIDEOTAPED

13 DEPOSITION OF DR. BEVERLY ELAINE

14 HENDELMAN.

15 MR. HOYLE: That ends the deposition of Dr. Beverly
16 Hendelman, your Honor.

17 BY THE COURT:

18 THE COURT: Very well. Ladies and gentlemen, it is
19 now ten minutes until 1:00. It's a good time to take
20 our lunch break. I'm going to ask you to please be back
21 in your jury room and ready to continue with this matter
22 at 2:00 o'clock.

23 Please be mindful not to discuss this matter or
24 allow anyone to discuss it with you. Do not read
25 anything. Do not listen to anything about this matter.

1 That is, radio, television, newspaper, or the Internet.
2 Please do not do any investigation regarding this
3 matter. You must receive all of the information from
4 which you will makeup your minds while court is in
5 session.

6 Also, please be mindful to leave any communication
7 device, cell phone, tablet, or other communication
8 device away from the courthouse. I think I may follow
9 my own admonition. And have a very pleasant lunch. I
10 will see you all at 2:00 o'clock. You need to leave
11 your notes in your seat.

12 JURORS LEAVE COURTROOM 12:54 P.M.

13 BAILIFF: And the jury is clear, your Honor.

14 THE COURT: Anything before we take a break?

15 MR. HOYLE: Nothing from the Plaintiff, your Honor.

16 MR. LOVELL: No, your Honor.

17 THE COURT: Thank you. You all have a pleasant
18 lunch. I'll see you at 2:00.

19 OFF THE RECORD 12:54 P.M.

20 ON THE RECORD 2:09 P.M.

21 BY THE COURT:

22 BAILIFF: All rise. Court is back in session.

23 THE COURT: All right. Anything before we bring
24 the jury out?

25 MR. HOYLE: Nothing from the Plaintiff, your Honor.

1 MR. MACKELCAN: No, your Honor.

2 THE COURT: Jury. Oh, and is the next witness --
3 yes, you're here. Wonderful. Great, great, great,
4 great.

5 MR. HOYLE: Oh, your Honor, one point of
6 housekeeping.

7 THE COURT: Yes.

8 MR. HOYLE: Can you kind of instruct the jury that
9 Ms. Leyimu is going to be reading both questions by the
10 plaintiff and the defendant, just like we're doing on
11 the videotape.

12 THE COURT: Yeah, sure. That's not when that -- is
13 that what is next?

14 MR. HOYLE: That is what is next.

15 THE COURT: Okay. Very well.

16 BAILIFF: Jury is entering. Ready?

17 THE COURT: How are you doing? I'm ready. Come
18 on.

19 BAILIFF: Come on.

20 JURORS ENTER COURTROOM 2:09 P.M.

21 THE COURT: Ladies and gentlemen, it's my
22 understanding that the plaintiff's next witness will be
23 one, also, by deposition. What will be different is
24 that you have benefit of seeing the depositions that
25 have videotape. This one is going to be read. They all

1 have transcripts. Some have videotapes. Actually, most
2 probably do not. But this one is going to be read to
3 you, and it's a little bit like when you have a
4 substitute person in the theater, when they say, ladies
5 and gentlemen, the part of so-and-so this evening will
6 be played by so-and-so. And so, there will be folks who
7 will be reading the questions and the answers. And
8 again, just as in the videotapes, the lawyers have
9 cooperated, and they have put together the questions and
10 the answers that both sides would want from the
11 deposition. So, just know that, while one person will
12 be reading everything, some is from the Plaintiff, some
13 is from the Defendant. Okay? Very well. Come on.
14 You're going to do the reading?

15 WILLIAM TINCKLER: Yes, your Honor.

16 THE COURT: You're going to read the answers?

17 WILLIAM TINCKLER: That's correct.

18 THE COURT: And your name is?

19 WILLIAM TINCKLER: Is William Tinckler.

20 THE COURT: Hello, William Tinckler. How are you?

21 WILLIAM TINCKLER: I'm doing well. Sit up there?

22 THE COURT: Yeah, of course. And this afternoon,
23 you will be?

24 WILLIAM TINCKLER: I will be Arthur Gerard Manning.

25 THE COURT: You will be Arthur Gerard Manning. In

1 other words, that's the person who was deposed, and Mr.
2 Tinckler's going to be reading the answers.

3 You're going to be reading.

4 MS. LEYIMU: Yes, your Honor.

5 THE COURT: Wonderful. Ladies and gentlemen, I ask
6 while you are listening -- I have to plug this in so I'm
7 here. You may, for a moment, not see me, but I expect
8 because I'm plugging this in. Take your seat.

9 MS. LEYIMU: Your Honor, Plaintiffs call next
10 witness, Arthur Manning.

11 THE COURT: Thank you. Yes.

12 ITEM IDENTIFIED AS ORIGINAL HARDCOPY
13 OF DEPOSITION OF ARTHUR GERARD
14 MANNING TRANSCRIPT READ BY MS. LEYIMU
15 AND MR. WILLIAM TINCKLER.
16 END READING OF DEPOSITION OF ARTHUR
17 GERARD MANNING.

18 MS. LEYIMU: And your Honor, that concludes this
19 deposition.

20 THE COURT: Very well. All right. Call your next
21 witness, please.

22 MR. HOYLE: Your Honor, we have some page and line
23 issues that we need to address with your Honor before we
24 play the next deposition.

25 THE COURT: Okay. All right. Ladies and

1 gentlemen, please step to your jury room. We'll use
2 this as our afternoon break. Please do not discuss this
3 matter, or allow anyone to discuss it with you. We will
4 not be long. Kind of like what old Senator Warren and
5 Elizabeth Taylor, you will not be very long. Very well.

6 JURORS LEAVE COURTROOM 2:50 P.M.

7 BAILIFF: Jury is clear, your Honor.

8 OBJECTIONS TO THE VIDEOTAPED
9 DEPOSITION OF LIEUTENANT NURSE

10 ANGELINA DOLORES BRANNON:

11 THE COURT: Okay. I've got my list here. Who are
12 we talking about next?

13 MR. HOYLE: We're going to talk about Angelina
14 Brannon. She is the longest clip that we have left.
15 And it actually seems like the jury is fairly well
16 engaged, so.

17 THE COURT: Okay.

18 MR. HOYLE: I'm calling an audible, and suggest we
19 do her next. And I have a clip sheet, your Honor, with
20 the entire testimony that both sides have designated.

21 THE COURT: All right.

22 MR. HOYLE: In case you need anything in context.

23 THE COURT: Okay.

24 Okay. The first objection, I concur. I sustain
25 it. It's self-serving. I don't know what relevance it

1 has to what her -- or what personal preference has to
2 this litigation, so I respectfully sustain that
3 objection. The next one.

4 MR. MACKELCAN: And your Honor, are you looking at
5 the Defendant's objections first?

6 THE COURT: Yep.

7 MR. MACKELCAN: Okay. Thank you.

8 THE COURT: The second one is sustained. Which, I
9 probably should tell you all, it is Pages 133; 1 through
10 25; and 134, 1 through 23.

11 MR. HOYLE: And the first objection that you
12 sustained took out Page 115, Line 5 through 21. Just
13 trying to make sure we're on the same sheet of music,
14 Judge.

15 THE COURT: These are all out.

16 MR. HOYLE: Good.

17 THE COURT: Okay. So, all right, there's an
18 objection, but we've got a lot of just stuff about Dr.
19 Jansen. And I keep, you know, did you hear this, did
20 you hear that, different instances. Most of them she
21 says no. Some she said yes. And I keep looking for
22 that tie-in. So, did anybody complain to CasePro and
23 say, you must fire this fellow, or anything that
24 indicates that she did not believe, on behalf of the
25 Navy, that the Navy was capable of firing this

1 individual? Can you help me? Because I'm reading,
2 like, a lot of stuff, but it doesn't really have
3 anything to do with what this case is about. Because
4 what I think this information is being elicited for is
5 on the issue of respondeat superior.

6 MR. HOYLE: I don't dispute that, your Honor.

7 THE COURT: Okay. Now, the last -- we may get down
8 to it. Look on Page 63 of the submittal that Defense
9 gave me, Mr. Hoyle.

10 MR. HOYLE: Yes. Yes, your Honor.

11 THE COURT: Because it gets to this question,
12 finally, now:

13 *If the CasePro employees in question,*
14 *including, but not limited to Dr. Chris Jansen,*
15 *really were within the United States Navy*
16 *chain of command, could the commanding officer*
17 *of the Naval Hospital in Beaufort, South*
18 *Carolina, see to it, in 2010, that Dr. Chris*
19 *Jansen no longer treated patients?*

20 *If he was an active-duty medical officer?*

21 *Yes, ma'am.*

22 *Yeah, she could pretty -- she could do*
23 *pretty much anything.*

24 Question:

25 *Not the same story when you are dealing*

1 with a government contractor, correct?

2 No, it's completely different.

3 And you have testified to those
4 differences here today, correct?

5 Yes, that is correct.

6 So that would be --

7 MR. HOYLE: That's the tie-in to the control.

8 THE COURT: Yeah, that -- yes. Yes. Now, let's go
9 up. Okay. You go to Number 12.

10 Will you agree with me that, if CasePro,
11 Incorporated, had terminated the employer
12 of Dr. Chris Jansen back in 2010, when the
13 commanding officer of the United States Naval
14 Hospital of Beaufort made the request, then,
15 Dr. Jansen wouldn't have been working in
16 the E.R. hospital in Beaufort in February
17 24th of 2012?

18 Yes.

19 But is there a backup for that, that there was a
20 specific request made by the commanding officer?

21 MR. HOYLE: We already have the emails from Craig
22 Martin that is in evidence as part of Dr. Jansen's
23 personnel file as to the issue of control.

24 MR. MACKELCAN: Your Honor, Lieutenant Brannon
25 testified that she was not -- she didn't become the

1 department head of the --

2 THE COURT: Until '11.

3 MR. MACKELCAN: Until '11. So, I think, regardless
4 of when she started, it still calls for speculation.
5 But specifically, with regards to that email, she
6 certainly had no involvement with that.

7 MR. HOYLE: But there's testimony that's elicited
8 earlier, your Honor, that I think you reviewed in
9 Defendant's submission that, you know, when you get
10 there in the summer of 2011, what do you hear about Dr.
11 Jansen? Oh, people take me aside, and tell me about
12 this incident involving a dead Marine from sepsis, and
13 there's a dead Marine from meningitis.

14 She is certainly aware of the concerns that have
15 been expressed. She wasn't on that email to Craig
16 Martin sent to Amanda Rutten at Fort Detrick in
17 Maryland, but she knew these concerns, and she also knew
18 it was CasePro, and CasePro alone, that had the ability
19 to make Dr. Jansen get gone. And that's, I think, the
20 point and purpose of this testimony.

21 THE COURT: I'm not going to allow that, and will
22 sustain the objection that was made by Counsel, because
23 it really does call for speculation, really, on two
24 fronts. Number 1, she wasn't there at the time when
25 these events occurred, and the best evidence is what you

1 already have. You already have this gentleman
2 testifying to that.

3 Now, now, I do believe that the wrap-up below is
4 appropriate and admissible. Okay?

5 MR. HOYLE: Thank you, your Honor.

6 THE COURT: Now, take me, then, Mr. Hoyle, back
7 into all these other events. I surely don't want the
8 events where she says I doesn't know anything about
9 that. Those really don't need to come in.

10 MR. HOYLE: Um-hmm.

11 THE COURT: Let's do this. The one that she talks
12 about is the one that appears on Page 60. Look at Page
13 60 of the submittal.

14 MR. HOYLE: Yes, your Honor.

15 THE COURT: It's 154 of the deposition. It's in
16 the middle, beginning at 154, 10. Is that confusing
17 enough?

18 MR. HOYLE: It's confusing enough. This is about
19 the lady -- or, excuse me -- the man with the elevated
20 white blood count.

21 THE COURT: And she doesn't know about that.

22 MR. HOYLE: She doesn't know about that, but she
23 knows about the lady that --

24 THE COURT: And then, move on to 10, she does know
25 about that one. Now, and then, then, here's what

1 concerns me. It doesn't go on to say this occurred and
2 we move to have -- I couldn't fire him; I wanted to fire
3 him for these events; or I could have fired him for
4 these events. So, what we end up with is, we end up,
5 unless you can help me tie that somewhere else, it's
6 just propensity evidence, and it would, therefore, be
7 inadmissible, even under my limited instruction.

8 MR. HOYLE: Let me confer with my co-counsel on
9 that. I may agree with you.

10 THE COURT: Yeah. What I'm looking for is, I'm
11 looking for, this event occurred, and it goes on to say,
12 gee whiz, we wrote CasePro and said, please, whatever.

13 MR. MACKELCAN: Well, your Honor, I think it's
14 important that all of this that you are referring to
15 there happened after the incident involving Calvin Hunt.

16 THE COURT: Don't care. Goes to control. Well,
17 maybe I do care.

18 MR. MACKELCAN: But Lieutenant Brannon is not a
19 CasePro employee.

20 THE COURT: Yeah, maybe I do care. Maybe I --

21 MR. MACKELCAN: Well, she's not a CasePro employee,
22 and so, --

23 THE COURT: Yeah, exactly.

24 MR. MACKELCAN: -- there's no control, and there's
25 no notice to CasePro. It has nothing to do with it.

1 It's purely -- I mean, it's hearsay, really.

2 THE COURT: I absolutely get your point, and what I
3 don't know that I know is, that I think I only have
4 contracts up to the point of these events. I think you
5 are correct. I agree. You are correct that I must deal
6 with the relationship up to the time of these events.

7 MR. HOYLE: The contract between CasePro and the
8 Navy did continue --

9 THE COURT: Yeah.

10 MR. HOYLE: -- past the events involving Calvin
11 Hunt, as did Dr. Jansen's employment for some period of
12 time. I think -- okay, we'll withdraw that testimony,
13 your Honor. We concur with your analysis.

14 THE COURT: And I agree with that, too. I think
15 post -- while my first inclination is to say, well, it
16 goes -- it goes to the issue of control, I really -- I
17 think it does go to the issue of control that's
18 irrelevant, because it's post these events.

19 MR. HOYLE: Okay.

20 THE COURT: Yeah.

21 MR. HOYLE: All right. Your Honor, do you have
22 Plaintiff's objections, as well, up there? Okay?

23 THE COURT: This --

24 MR. HOYLE: Okay.

25 THE COURT: Come with, help me.

1 MR. HOYLE: I apologize.

2 THE COURT: Now, I've got my clips.

3 MR. HOYLE: I like clips. That gives you the
4 context.

5 THE COURT: Yeah.

6 MR. HOYLE: These are all our objections.

7 THE COURT: Wonderful.

8 MR. HOYLE: And we have another copy at our table.

9 THE COURT: No, I don't want to take yours. Just
10 stay here with me.

11 MR. HOYLE: Okay.

12 THE COURT: Tell me the first -- tell me what the
13 first one is.

14 MR. HOYLE: Page 41, Lines 10, through Page 42, 11.

15 OFF-THE-RECORD BENCH CONFERENCE, OUT

16 OF PRESENCE OF JURORS. PRESENT: THE

17 COURT, MR. HOYLE, MS. CASTLEBERRY,

18 MS. LEYIMU, MR. MACKELCAN, MR. LOVELL.

19 END BENCH CONFERENCE.

20 OFF THE RECORD 3:47 P.M.

21 NOTHING ON RECORD ON THIS AUDIO.

22 BACK ON THE RECORD 4:00 P.M.

23 OBJECTIONS TO THE VIDEOTAPED

24 DEPOSITIONS OF DEBORAH MAYO AND

25 TRASIE BRASWELL:

1 THE COURT: Does Plaintiff have any objections on
2 the other two depositions? Mayo and Braswell.

3 MR. HOYLE: I need to confer with my papers. Yes,
4 Judge, we do.

5 THE COURT: Okay.

6 MR. HOYLE: For Deb Mayo, there's going to be a
7 running objection to certain things dealing with legal
8 conclusions. The contract that's now in evidence
9 between CasePro -- I'll stand, your Honor. I'm sorry.

10 THE COURT: That's fine.

11 MR. HOYLE: The contract that is in evidence
12 between CasePro, Incorporated, and Navy Medical
13 Logistics Command, Ms. Mayo's what's known as the
14 contracting officers representative at the Naval
15 Hospital here in Beaufort, and there are a number of
16 questions where she's asked is this what the contract
17 says. And then, she's asked questions, that, by my
18 hearing, we're asking her to interpret that contract.

19 THE COURT: So, where are they written?

20 MR. HOYLE: They are written on Plaintiff's
21 Objections to Defendant's Designation of Deposition
22 Testimony. They are not on that sheet, Judge. I can
23 give you --

24 THE COURT: May I have a sheet? May I have one to
25 take with me this evening?

1 MR. HOYLE: I want to make sure I still have a
2 copy.

3 THE COURT: Because I know I've got -- I've got the
4 Defendant's.

5 MR. HOYLE: We should have handed this up the other
6 day. If we didn't, I apologize.

7 BAILIFF: Jury is ready when you're ready, your
8 Honor.

9 THE COURT: Perfect.

10 BAILIFF: Ready for them?

11 THE COURT: Yeah.

12 MR. HOYLE: Your Honor, I'm going to ask my
13 paralegal to go make us a copy of that.

14 THE COURT: Don't worry about it, if you don't.

15 JURORS ENTER COURTROOM 4:02 P.M.

16 THE COURT: Ladies and gentlemen, at this time,
17 we'll continue the Plaintiff's case. And I believe our
18 next witness is by deposition on video, correct?

19 MR. HOYLE: That is correct, your Honor. At this
20 time, Plaintiffs call, by videotaped deposition,
21 Lieutenant Nurse Angelina Brannon.

22 THE COURT: Thank you so much. Mr. Knowles?

23 DVD OF VIDEOTAPED DEPOSITION OF
24 LIEUTENANT NURSE ANGELINA DOLORES
25 BRANNON PLAYING.

1 PAUSE PLAYING OF DVD OF VIDEOTAPED
2 DEPOSITION OF LIEUTENANT NURSE ANGELINA
3 DOLORES BRANNON; TECHNICAL ISSUES.

4 MR. HOYLE: Technical issues, your Honor.

5 THE COURT: Good.

6 BAILIFF: Can they stretch a little bit?

7 THE COURT: Oh, yeah. That was easy. I thought
8 you were going to say, where's the hot fudge sundae, or
9 something like that.

10 MR. HOYLE: Okay. Your Honor, may we continue with
11 the videotaped deposition? I believe the technical
12 issues have been resolved.

13 THE COURT: Cool.

14 RESUME PLAYING VIDEOTAPED DEPOSITION
15 OF LIEUTENANT NURSE ANGELINA DOLORES
16 BRANNON.

17 PAUSE PLAYING OF VIDEOTAPED DEPOSITION
18 OF LIEUTENANT NURSE ANGELINA DOLORES
19 BRANNON; TECHNICAL PROBLEMS.

20 RESUME PLAYING OF VIDEOTAPED DEPOSITION
21 OF LIEUTENANT NURSE ANGELINA DOLORES
22 BRANNON.

23 PAUSE PLAYING OF VIDEOTAPED
24 DEPOSITION OF LIEUTENANT NURSE
25 ANGELINA DOLORES BRANNON.

1 BY THE COURT:

2 THE COURT: That's the end of the deposition, yes?

3 MR. HOYLE: Thus ends the deposition of Angelina
4 Brannon, your Honor.

5 THE COURT: Ladies and gentlemen, that concludes
6 the work we're going to do for today. And just in case
7 anyone forgot, please do not discuss this matter or
8 allow anyone to discuss it with you. Please, whoever is
9 curious about it at home, please don't let them get
10 upset with you. Let them get upset with the judge. Put
11 it on the judge. Do not do any Columbo. Do not do any
12 research. Do not do any sort of investigation,
13 particularly on the Internet. You must receive all of
14 the information from which you will make up your minds
15 here in court, while court is in session.

16 And also, do not read anything. Do not listen to
17 anything about this case; that is, the radio, the
18 television, newspaper, and, of course, the Internet.

19 Tomorrow morning, we will begin at nine bells.
20 Please leave your cell phone or other communication
21 device away from the courthouse. If you forget, let our
22 bailiffs know, and they will take great care of it until
23 we have our morning break or our lunch break, at which
24 time you can take it somewhere other than the
25 courthouse. And have a very lovely evening. See you in

1 the morning at 9:00.

2 JURORS LEAVE COURTROOM 5:30 P.M.

3 BAILIFF: Jury is clear, your Honor.

4 THE COURT: Very well. Thank you all. Anything
5 before we take our leave this evening?

6 MR. LOVELL: Judge, from a scheduling standpoint,
7 we've got two witnesses coming live, tomorrow. Dr.
8 Oberg and somebody else. We may have to take somebody
9 out of order, if it proceeds at the pace we're going.
10 Just to alert, we won't know until in the morning
11 exactly where we are, but.

12 THE COURT: And there was something in that. You
13 want me to, like, do something?

14 MR. LOVELL: Just to warn you, we may have a
15 schedule issue at the end of the day tomorrow. People
16 that can only come tomorrow afternoon.

17 THE COURT: Oh, my. I think we can probably handle
18 that.

19 MR. LOVELL: Okay. Thank you, Judge.

20 THE COURT: Put our heads together, and we'll
21 figure it out, yes?

22 MR. LOVELL: We're going to work on those
23 depositions tonight, and skim them down, if we can,
24 these videos.

25 THE COURT: Wonderful. I think that's a grand

1 idea. If you can, if you can, this is my position about
2 it, if you can, I know the jury will appreciate it. If
3 it's information that they need to receive, I have
4 absolutely no question that they're happy to receive it.
5 They will receive it.

6 This is one of the -- when you watch this jury
7 panel, they are just being so attentive, and their
8 attitude is wonderful. I am so appreciative that they
9 continue to appear that way and be that way. You need
10 to do what you need to do. If you can, that's great.
11 If you can't, that's okay. That's great, too. And I
12 just express my continued appreciation for all the work
13 that you continue to do, and work together as much as
14 you possibly can. I certainly appreciate it, and I'll
15 see you all in the morning at 9:00.

16 MR. HOYLE: Thank you, your Honor.

17 THE COURT: Yes.

18 **END DAY SIX, TUESDAY,**

19 **OCTOBER 13, 2015, 5:32 P.M.**

20 **BEGIN DAY SEVEN, WEDNESDAY,**

21 **OCTOBER 14, 2015, 9:45 A.M.**

22 **OBJECTIONS AND RULINGS REGARDING**

23 **FIRE TRUCK DASHCAM VIDEO:**

24 BAILIFF: All rise.

1 MR. HOYLE: So, our first witness the Plaintiff
2 will call this morning is Chief Sammy Negrón of the
3 Beaufort-Port Royal Fire Department. And --

4 THE COURT: Why do I sense there's something out
5 there?

6 MR. HOYLE: Oh, there's --

7 MR. LOVELL: There's something out there.

8 MR. HOYLE: There's a pregnant pause in the air,
9 your Honor. One of the documents, it's actually a video
10 --

11 THE COURT: Yeah.

12 MR. HOYLE: -- the Plaintiffs will seek to
13 introduce through this witness --

14 THE COURT: Yeah.

15 MR. HOYLE: -- is dashcam footage from Engine 5 of
16 the Beaufort-Port Royal Fire Department, which recorded
17 the events of February 24, 2012, from the time the fire
18 truck left the station, 'til the time it went to Laurel
19 Hill Apartments, 'til the time it was absconded with,
20 until the time it drove down Ribaut Road, before fatally
21 striking Justin Miller.

22 THE COURT: Okay. And?

23 MR. LOVELL: We have objections to the latter
24 portion of that, that shows the --

25 THE COURT: Impact..

1 MR. LOVELL: -- short period of time where the
2 decedent is seen visible in the video itself, and
3 obviously, the fire truck striking him, or inferentially
4 striking him, because he goes out of view. We think
5 that, that is highly prejudicial on the issues in this
6 case. And the testimony that we heard from the
7 pathologist, who is Mr. Caplan, early on, did not
8 establish that there was any conscious pain and
9 suffering.

10 So, any evidence pre-impact that the Plaintiffs
11 might use to show pre-impact fright and fear and shock
12 is not relevant. (1) pre-impact fright, fear, and
13 shock, is not recognized in our state; and secondly,
14 there's no evidence that this gentleman suffered any
15 conscious pain and suffering even post-impact. So, we
16 think that all of this video, especially the portion
17 relating the visibility to the decedent in that video,
18 is irrelevant to the issues in the case, and highly
19 prejudicial, if allowed.

20 THE COURT: Got it. Let me ask you this question.
21 Mr. Lovell, just to be sure I'm understanding the issue,
22 the concern is the point of impact, yes?

23 MR. LOVELL: Yes, your Honor. I think, in the
24 video -- and Doug can speak more to this. I think, in
25 the video, there is a short period of time where -- I

1 mean, the thing shows the fire truck, and the field of
2 view is relatively narrow. It's not a, you know, broad
3 thing. And there's a period of time, and I don't know
4 the exact number of seconds, where the decedent is seen
5 in the video, and, at one point sort of moving his head
6 this way, and then, he's out of the field of view. And
7 again, I don't know exactly how long that is.

8 THE COURT: Yeah. No, I guess my point is, is, I'm
9 trying to -- cause I got to look at it.

10 MR. LOVELL: Sure.

11 THE COURT: I can't rule on it unless I see it.

12 MR. LOVELL: Yes. Absolutely.

13 THE COURT: So, I'm trying to ascertain is the
14 objection just the conclusion of it? Because, if it is,
15 then, I'll just look at that. Or is it the whole thing?

16 MR. LOVELL: Well, the whole thing, we think, is
17 irrelevant to all the issues, which really are what
18 happened in the E.R. with regard to this patient. And
19 it just shows the things that happened after the E.R.
20 But in particular, we are -- on the issues where you see
21 the decedent in the video, we think, for the reasons I
22 previously stated, that, that is not relevant to any
23 issue, and highly, highly prejudicial.

24 THE COURT: May I ask this question. I want you to
25 do this for me. I want you to take out the end. Just

1 take out the impact. Take that out of it, for the
2 moment, for my question. Okay?

3 MR. LOVELL: Yes, ma'am.

4 THE COURT: Because I'll see that, and I'll
5 certainly hear from the Plaintiff. But let me tell you,
6 on first blush, I'm inclined to agree with you. Okay?
7 So, but let me just -- let me take that out for the
8 moment. Let me ask you to speak to this issue.

9 MR. LOVELL: Yes, ma'am.

10 THE COURT: And again, I may need to look at the
11 whole video. The relevance that it could have in this
12 case has to do with the proximity of time from the time
13 that he was in the emergency room, saying, yes, yes, I
14 have had thoughts of hurting myself and others; and
15 then, this immediately happens there. I mean, and it is
16 immediate. We all know -- I know that now.

17 The question gets to be, what, if any, relevance,
18 does his immediate conduct, after leaving the emergency
19 room, have on the issue for this jury? Was he calm?
20 Was he angry? Was he anxious? Was he somebody I'd love
21 to have come home to dinner? I think one of the
22 witnesses testified to that. In other words, what, if
23 any, relevance, meaning, meaning, what issue which is of
24 consequence would this make it more probable or less
25 probable, in that, it happened immediately after his

1 leaving the emergency room. Because his demeanor in
2 that emergency room, I think, is one of the issues in
3 this case, because we are everything from calm,
4 wonderful, love to have him come home to supper.
5 Everything to angry and agitated; and, I'm kind of
6 scared of him; I am scared of him. So, focus. Help me
7 with that.

8 MR. LOVELL: Your Honor, one flaw in the videotape
9 on the issue of relevancy is, it picks up at a point in
10 time when he's in the fire truck, you know, driving
11 away. There's a gap, a period of time, that, perhaps,
12 the 911 tapes help fill in a little between when he
13 walks out the door of the E.R. with Mr. Ray at whatever
14 time that is, around 4:00 something; walks outside;
15 disrobes partially; does whatever he does to escape from
16 Mr. Ray; and then, goes across the street, into the
17 apartment complex; somehow gets in this fire truck.

18 I agree with you, your Honor, I think there may be
19 some relevance on the time sequence of events. And
20 perhaps the video, up until the point where we were
21 talking about earlier shows how he drove the fire truck.
22 It's not audio, correct? There's no audio.

23 MR. HOYLE: There's no audio.

24 MR. LOVELL: So, we don't know what he's saying, if
25 anything. All we see is how he's operating the motor

1 vehicle.

2 THE COURT: Let me do that. Let me look at it, and
3 let me tell you what, address -- I'm just going to have
4 to see it. I'm going to have to see the --

5 MR. HOYLE: For purposes of the record, your Honor,
6 if I could briefly be heard. The video is seven minutes
7 and, I'm told, about 40 seconds.

8 MR. KNOWLES: No, 7:57.

9 MR. HOYLE: I apologize. I am wrong.

10 MR. KNOWLES: It's almost eight minutes.

11 THE COURT: Precision's a rule.

12 MR. HOYLE: Seven minutes, 57 seconds. In other
13 words, almost eight minutes. Okay.

14 THE COURT: Okay.

15 MR. HOYLE: The fire truck -- the video begins with
16 the crew from Engine Number 5 leaving the firehouse, and
17 then, ends with impact. If I could briefly be heard on
18 my views on why this tape, in its entirety, is relevant.

19 Defendant has asserted comparative fault, on the
20 part of the decedent. I think seeing where the decedent
21 was in relation to the fire truck is certainly relevant
22 to the jury's determination of that issue. I also think
23 the manner in which Calvin Hunt's driving this fire
24 truck, that it may appear that he is intentionally
25 striking certain vehicles and a person may go to his

1 state of mind. I think all of that, with that narrow
2 time frame of eight minutes, goes to the proximate cause
3 burden the Plaintiff must prove as part of her case in
4 chief.

5 But going back to where we begin, with respect to
6 the final moments, in addition to dealing with
7 comparative fault, --

8 THE COURT: Time out. Comparative negligence is in
9 this case?

10 MR. LOVELL: We'll withdraw comparative negligence,
11 your Honor.

12 THE COURT: Okay.

13 MR. HOYLE: I appreciate that.

14 MR. LOVELL: Based on the evidence that we have
15 seen to date, we withdraw it, and it's no longer --

16 MR. HOYLE: With prejudice.

17 MR. LOVELL: Withdrawn.

18 MR. HOYLE: Is it withdrawn with prejudice? I
19 don't want to --

20 THE COURT: Yes, it is.

21 MR. HOYLE: All right. Thank you, Mr. Lovell.
22 Thank you, your Honor.

23 With respect to the testimony from the pathologist,
24 there was testimony that Mr. Miller was conscious for a
25 very, very, very -- he said very three times -- short

1 period.

2 THE COURT: Millisecond.

3 MR. HOYLE: Correct. And at this point in time,
4 those complaints have not been addressed on a directed
5 verdict motion. We do have a survival claim as part of
6 our complaint. I would submit that I believe this is
7 some evidence that could go to whether or not Justin
8 Nicholas Miller was contemporaneously aware --

9 THE COURT: I understand.

10 MR. HOYLE: -- and experiencing neurological
11 activity such that this jury could find conscious pain
12 and suffering as part of a survival claim, if that claim
13 were to go to a jury.

14 THE COURT: I got it.

15 MR. MACKELCAN: Quickly, to respond to that. And
16 you can look. You'll see the video, but I don't believe
17 that the video shows anything after the impact. It
18 doesn't even really show the impact. It only shows him
19 prior to the impact, and of course, South Carolina
20 doesn't recognize pre-impact fear.

21 THE COURT: I'm with you. I got it. And there's
22 no way -- I've got to see it.

23 Would you just tell the jury there is a matter that
24 has --

25 BAILIFF: I already did.

1 THE COURT: You already did? You're so good.

2 MR. HOYLE: And your Honor, I have it on disc. Mr.
3 Knowles can play it. He can do it however your leisure
4 is. If you're going to play it in the courtroom, we
5 would ask our client --

6 THE COURT: Of course.

7 MR. HOYLE: -- to be excused.

8 THE COURT: It doesn't have video [sic].

9 MR. HOYLE: There's no sound.

10 THE COURT: Yeah. You all can just come on up
11 here.

12 THE COURT, MR. HOYLE, MS. CASTLEBERRY,
13 MR. MACKELCAN, MR. LOVELL VIEWING
14 FIRE TRUCK DASHCAM VIDEO AT BENCH.
15 END VIEWING FIRE TRUCK DASHCAM VIDEO.

16 THE COURT: All right. I'm ready to rule. And I
17 have reviewed the video which has been marked for
18 identification purposes as --

19 MR. HOYLE: This will be Plaintiff's --

20 THE COURT: Well, let's do this one as Court's,
21 because, what's going to be shown to the jury is going
22 to be redacted. Okay?

23 MR. HOYLE: Okay.

24 THE COURT: Court's Exhibit?

25 COURT REPORTER: 12.

1 ITEM IDENTIFIED AS UNREDACTED DVD
2 OF FIRE TRUCK DASHCAM VIDEO
3 MARKED COURT'S EXHIBIT NUMBER 12,
4 RECEIVED BY THE COURT.

5 THE COURT: 12. Now, I don't know what evidentiary
6 value there is to the tape in terms of the ride from the
7 firehouse to the apartment complex. I don't know. I
8 don't. I don't know what value there is to that. I do
9 think that to, perhaps, to give some context to it, it's
10 reasonable to have it begin when the firemen park it and
11 get out, just to give the jury some context.

12 They've heard the 911 tape. They understand about
13 being at the apartment complex, but I don't know what
14 evidentiary value it would have prior to that point.
15 But I think that, in fairness to the jury, I think they
16 need to have some context, and I think the way they can
17 get that is by seeing the firemen get out and go into
18 the apartment complex, because they've heard the 911
19 tape.

20 I do believe that there is evidentiary value,
21 because of the -- because these events happened
22 immediately after his leaving the emergency room, and
23 because the testimony at this point varies greatly
24 regarding his demeanor and what I believe a jury could
25 determine was his conduct in the emergency room. So, I

1 think it's relevant. I think it makes his conduct more
2 probable or less probable.

3 I have looked at the point of impact, and here's
4 what you see at the point of impact. Let me, just for
5 the record, say that my law clerk was able to stop it,
6 stop it, stop it, stop it, stop it, so that I was able
7 to see it slowly. I couldn't -- I could not discern as
8 much with it when it was playing at normal speed as I
9 could when he was able to stop it. And I've looked at
10 it twice, three times, and both ways.

11 At the point of impact, what you see is, you see a
12 young man whose face is not facing the fire truck. It
13 is facing directly, but it looks like he's -- he looks
14 like he's fixing to run. And you see his brother, who
15 is across the street, looking back at the events that
16 have occurred.

17 Doing the 403 analysis, when you consider the
18 evidentiary value with regards to survival action, as
19 opposed to what I believe the overwhelming prejudicial
20 effect would be, because you do not see the -- you know,
21 it's the point of impact, unquestionably, but you don't
22 see it. In other words, you can't see his face post-
23 impact to see if there's any evidence of conscious pain
24 and suffering, which is actually what I was looking for.
25 You do not even see the point of impact, but you know

1 it's the point of impact.

2 I think that what concerns me greatly, and what
3 this tape injects into this case, that may be implicitly
4 in this case, but I need Counsel to be very careful not
5 to inject it explicitly in this case, is the brother
6 witnessing this tragedy. And you see him, in this tape,
7 looking at his brother, and looking at this fire truck.
8 I think that would inject passion and prejudice for this
9 jury, and I think it would be difficult for them to
10 isolate that, because it is compelling. So, I believe -
11 - but, but, Counsel, I need you to come back up with our
12 -- who's going to be running it.

13 MR. HOYLE: Mr. Knowles.

14 THE COURT: Because I've got to determine where I'm
15 going to stop it, and because I also think that,
16 evidentiarily speaking, I think that -- I think that it
17 is important for the jury to see him go from the very
18 right-hand lane and turn, and that's where I want it to
19 stop.

20 MR. HOYLE: Your Honor, before -- and I certainly
21 respect your ruling.

22 THE COURT: Yeah.

23 MR. HOYLE: But for purposes of the record, if I
24 could --

25 THE COURT: Yes.

1 MR. HOYLE: -- make a few additional thoughts
2 heard. One of the issues in this case is whether or not
3 Calvin Hunt was, in fact, homicidal that day. The
4 testimony varies. We've had some nurses come into this
5 courthouse and testify that, although one nurse, Janice
6 McDonald, said she was afraid to have Calvin Hunt
7 between her and the door, she didn't think he was
8 homicidal. She thought he was just angry.

9 We've had other testimony here that he did express
10 thoughts of hurting others. I think that is an issue in
11 this case. And I do think the actual point of impact,
12 which shows the taking of a human life, which our
13 solicitor, when he viewed it, and it was after Duffie
14 Stone viewed that videotape, that he and Corporal Perry,
15 who testified earlier in this trial, made the decision
16 to seek an arrest warrant for murder.

17 The Grand Jury of this county saw that videotape
18 when they made the decision to indict Calvin Hunt for
19 murder. Judge Carmen Mullen, before she adjudicated
20 Calvin Hunt not guilty by reason of insanity, saw that
21 videotape, so, in its entirety, as your Honor has seen
22 it as a Court's exhibit here today.

23 So, I do think the actual impact, in addition to
24 perhaps having some evidence to make it more likely than
25 not, or have some evidence in the record of conscious

1 pain and suffering, directly goes to whether or not
2 Calvin Hunt was, indeed, homicidal on that day.

3 THE COURT: Okay. Come on. Thank you.

4 MR. HOYLE: Thank you, your Honor.

5 THE COURT: Okay. You all come and help me figure
6 out where to start it. Talk and -- walk and talk.

7 MR. HOYLE: I'll walk and talk.

8 THE COURT: Thanks.

9 MR. MACKELCAN: And just briefly, your Honor, I
10 don't know that the term *homicidal* has been used, and I
11 do think the document, that testimony has been that
12 there's a distinction between -- Mr. Hoyle used the word
13 *homicidal*; that Calvin Hunt was homicidal. I don't know
14 that there's any testimony thus far in this trial that
15 Calvin Hunt was homicidal. The only testimony is that
16 he had thoughts of hurting others, but no specific plan,
17 and that was only Dr. Jansen.

18 And there's been distinctions raised about the
19 difference between homicidal ideation or thoughts of
20 hurting others, and a plan to hurt others. So, I think
21 that, that is an important distinction in this case.
22 The term *homicidal* has not been used. It's only been in
23 the context of thoughts that Calvin Hunt had.

24 THE COURT: That makes, in my mind, that makes Mr.
25 Hoyle's argument for him. Because, if you maintain

1 that, that's an issue, whether or not this guy was
2 homicidal, then, maybe it needs to come all the way in.
3 Because it's -- it's not -- I mean, that's my concern.
4 When you say that, then, I think you make his argument
5 that I need to let this jury see him pointing this fire
6 truck at this guy and go nail him, go kill him. I mean,
7 that's what concerns me. Because, if you maintain that
8 this was fanciful and it wasn't real, or -- then, maybe
9 I think you've made his argument. Maybe they do need to
10 see it. Because there's no question, but when you look
11 at this video, you can tell that he turns this vehicle
12 from all the way on the right-hand side, to go get a
13 young man crossing the street in the middle.

14 MR. MACKELCAN: No question, your Honor, that,
15 that's what the video shows.

16 THE COURT: Yeah.

17 MR. MACKELCAN: And the testimony has already come
18 in from the trooper that, based on the tire tracks, that
19 the fire truck turned from, I believe he said, the
20 northbound lane to southbound lane, but whatever; but
21 that he had turned and crossed, and intentionally hit
22 him, so I think that, that's already come in.

23 THE COURT: But this is the best evidence of it,
24 Mr. Mackelcan. You know, when you tell me that he
25 really wasn't homicidal, maybe they do need to see it.

1 That's my concern.

2 MR. MACKELCAN: I didn't say that he wasn't
3 homicidal. I just said that, that word wasn't used.

4 THE COURT: I got you. Okay. Let's go back.
5 Let's go back and -- what do you think? You all come
6 look at it, and tell me where you think we need to
7 start.

8 LAW CLERK RYAN LOCKHART: This is turning into the
9 complex now.

10 THE COURT: Come and see what you all think. You
11 all, I need your -- I understand everybody objects. I'm
12 not taking your objection away from you and saying that
13 you've yielded your objection. I just need you to help
14 me decide where to start at. What makes sense?

15 COURT REPORTER: Do you want me to stop?

16 MR. HOYLE: No, no. I want it on the record.

17 THE COURT: Where to begin the tape. Does it make
18 sense to maybe show them pulling into the apartment
19 complex?

20 MS. CASTLEBERRY: Yeah, yeah.

21 THE COURT: I think so.

22 MR. HOYLE: I think so. And we can --

23 THE COURT: Because you can see that this is an
24 apartment complex.

25 MR. HOYLE: I would, also, for purposes of the

1 record, offer the thought that, seeing the fireman drive
2 the fire truck down Ribaut Road, the jury would have the
3 ability to see a different rate of speed that this fire
4 truck's being driven, an appropriate, safe rate of
5 speed, as opposed to be being driven by someone with
6 psychotic issues, who is homicidal.

7 THE COURT: Okay. All right. Okay. I concur.
8 I'll let that -- I'll let it in. And it's -- for what
9 that piece of it is worth, I think that is -- it may
10 have some evidentiary value for comparison purposes.

11 Okay. Now, where to stop. I'm sorry. I know
12 you're -- offensive lineman knees are tough.

13 MR. HOYLE: 7:55, is that what that is, or 7:56?

14 MR. LOVELL: Your Honor, at this point, you've
15 clearly shown his, Mr. Miller's, presence in the road,
16 and preceding this, you see the vehicle go over.

17 THE COURT: I think that's sufficient. I think
18 that's sufficient.

19 MR. MACKELCAN: And it establishes what the
20 Plaintiff says.

21 THE COURT: I want to be sure, though, that this
22 doesn't show the brother -- if we back it up, are we
23 showing the brother's face?

24 MR. LOVELL: I can't see it.

25 THE COURT: I'm very concerned about that for this

1 jury.

2 LAW CLERK RYAN LOCKHART: All right. Let's go back
3 just a little bit. I don't see the brother.

4 MR. MACKELCAN: I think he is in the scene on the
5 left at 7:56.

6 THE COURT: Okay.

7 MR. MACKELCAN: So, I think what we were talking
8 about was stopping it at 7:55.

9 THE COURT: Okay. Okay. Okay. I don't see the
10 brother. Does anybody see the brother?

11 MS. CASTLEBERRY: No, not there.

12 MR. MACKELCAN: No.

13 MR. LOVELL: No, ma'am.

14 THE COURT: Okay. Okay. That's it. That's it.
15 That's the point. What is this?

16 LAW CLERK RYAN LOCKHART: 16:03:27.

17 THE COURT: You don't get the brother?

18 MR. MACKELCAN: That can't be right, though. That
19 time at the top on the video can't be right, based on
20 everything else. But anyway, that's an aside.

21 MR. LOVELL: That's irrelevant.

22 MR. MACKELCAN: Doesn't matter.

23 MR. HOYLE: That's irrelevant at this point.

24 MR. MACKELCAN: It is irrelevant.

25 THE COURT: Yeah, I'm just using it for a point of

1 where to stop.

2 MR. MACKELCAN: I agree. I just noticed it, so.

3 THE COURT: Okay. Is that going to confuse this
4 jury? You all?

5 MR. HOYLE: Can we -- off the record?

6 OFF-THE-RECORD DISCUSSION.

7 BACK ON THE RECORD.

8 THE COURT: I don't think Mom needs to be there for
9 this.

10 MR. HOYLE: No. No, Judge, I concur with that.

11 THE COURT: I wouldn't keep her from being here if
12 she wants to be here, but.

13 LAW CLERK RYAN LOCKHART: It has stopped moving at
14 the bottom as I start and stop it, so I don't know that
15 the time at the bottom's right, but this time should be
16 correct.

17 MR. KNOWLES: Okay. I'll stop it there. So, where
18 are we starting it at?

19 MR. LOVELL: The very beginning.

20 MR. MACKELCAN: The very beginning.

21 MR. KNOWLES: The very beginning?

22 MR. HOYLE: And I just want to clarify, while we're
23 all up here at the Judge's Bench and we're looking at
24 this video on a laptop, --

25 THE COURT: And I'm passing out cough drops.

1 MR. HOYLE: -- is Defendant conceding the Calvin
2 Hunt was homicidal?

3 THE COURT: No. I'm sorry, I --

4 MR. LOVELL: No, no.

5 MR. MACKELCAN: Defendant --

6 MR. LOVELL: Just be quiet.

7 MR. MACKELCAN: Okay.

8 THE COURT: I did not hear that.

9 MR. LOVELL: Correct.

10 THE COURT: I did not hear that. I didn't hear
11 that.

12 MR. HOYLE: Okay.

13 THE COURT: I did not hear that. That's a good
14 question, but I did not hear that. And that's the
15 reason why it gets to this point.

16 MR. HOYLE: Is there a frame of the video that's
17 closer to the targeting that does not show the brother
18 in the field of vision?

19 THE COURT: I don't know, Mr. Hoyle, and I do love
20 good advocacy, but this is where we will stop.

21 MR. HOYLE: Thank you, your Honor. I respect your
22 ruling.

23 THE COURT: Yeah, I know you do. And the reason
24 for it is that this, as you look at it, at this point, I
25 don't -- while I know this jury is very mindful of the

1 absolute tragedy of these events, of all of these
2 events, any closer, I believe, would shift -- would
3 place this jury in a different place, and it becomes, I
4 think, to a point that I would be concerned about the
5 emotional effect on this jury. And I do not want this
6 jury to make its determination based on passion or
7 prejudice. As we know, that's inappropriate.

8 This is a good stopping point. I am satisfied,
9 having looked at the tape now several times, I am
10 convinced that this shows everything that is appropriate
11 and needs to be shown, based on my view of the evidence
12 in this record up to this point. The brother's excluded
13 from view. It is very clear from this vantage point at
14 16:03:27, on this tape, that you can tell that the fire
15 truck has absolutely left the lane of travel, and has
16 traveled over the lane next, and into the medians, and
17 is exiting the median, and going into incoming traffic
18 in order to strike Plaintiff's decedent.

19 So, I am very satisfied with what my ruling has
20 accomplished with the tape at this juncture, noting the
21 Defense's exception to any of it being played.

22 And for our record, Counsel has -- all Counsel, for
23 which I'm grateful, have assisted me in looking at this
24 and trying to fashion an appropriate amount to be shown.
25 But by doing that, the Defense, in no way, in my mind,

1 compromises or otherwise waives their objection to be
2 showing the tape at all. Okay? All right.

3 MR. MACKELCAN: Thank you, your Honor.

4 MR. LOVELL: Thank you, your Honor.

5 THE COURT: All right. Very well. Okay. Good.
6 Can we bring the jury out. Oh, I guess you're going to
7 have to do something with it.

8 MR. HOYLE: Yes, and your Honor, can we clarify the
9 Plaintiff's objections with respect to the truncation of
10 the video are also noted, as well.

11 THE COURT: Most assuredly.

12 MR. HOYLE: Thank you, Judge.

13 THE COURT: And I think they were well articulated
14 throughout.

15 MR. HOYLE: Thank you, your Honor.

16 THE COURT: Yeah.

17 MR. HOYLE: And Mr. Knowles needs some time to --

18 THE COURT: Well, let me just say, Ryan has noticed
19 that, that second where we referred to about where we're
20 stopping it, that second does encompass the actual
21 impact, because a thousand and one. So, you're going to
22 have to be really -- let me just -- are you editing it
23 now?

24 MR. KNOWLES: Yeah.

25 MS. CASTLEBERRY: We'll show it to you.

1 THE COURT: I'll come over there. I'll just come
2 over there. It's so much easier. And just to make
3 sure, let's everybody look and make sure it's stopping
4 where it needs to stop, because, thank you, Ryan,
5 because Ryan says that, in that second, the part we're
6 trying --

7 LAW CLERK RYAN LOCKHART: That's the beginning of
8 27?

9 THE COURT: Yeah.

10 LAW CLERK RYAN LOCKHART: And it's still 27. It's
11 still 27 after.

12 THE COURT: Oh. Yeah. It's the second of 27 where
13 it all occurs.

14 MS. CASTLEBERRY: So, it has to be stopped
15 somewhere before that.

16 THE COURT: The beginning of the 27th second. It's
17 16:03:27. It has to be stopped at the beginning of
18 16:03:27.

19 OFF-THE-RECORD DISCUSSION.

20 BACK ON THE RECORD.

21 THE COURT: Are you ready?

22 MR. HOYLE: Mr. Knowles is apologizing to me. He's
23 not ready. Your Honor, would you like for us to work on
24 some sort of instruction, or will you inform the jury
25 that the videotape ends before its natural conclusion,

1 or something like along those lines?

2 THE COURT: It is what it is.

3 MR. HOYLE: Okay.

4 THE COURT: I mean, it is what it is. And then, I
5 think I'm encouraging them to speculate. And I should
6 let you all speak to it. I mean, if they're not seeing
7 it all, then, I'm encouraging them to speculate.

8 MR. HOYLE: Okay. I'm not -- I guess I'm poorly
9 articulating my thought, your Honor, in that, what I
10 would not want this jury to think is that Calvin Hunt
11 actually stopped and he didn't actually run over
12 anybody.

13 THE COURT: I don't think that's an issue.

14 MR. HOYLE: Okay. If you don't think that's a
15 concern, --

16 THE COURT: I don't think that's an issue.

17 MR. HOYLE: -- then, I will sit down and withdraw
18 that concern.

19 THE COURT: I don't think that's an issue.

20 MR. HOYLE: Okay.

21 THE COURT: So, and let me ask this question. Are
22 you going to be a couple more minutes?

23 MR. KNOWLES: Yes, ma'am.

24 THE COURT: I'm going to run out just and take a
25 comfort break. Wanda, you go ahead and take a comfort

1 break, too.

2 OFF THE RECORD 10:34 A.M.

3 BACK ON THE RECORD 10:47 A.M.

4 BY THE COURT:

5 BAILIFF: All rise. This court is back in session.

6 THE COURT: Okay. Now, we're ready?

7 MR. HOYLE: While we're waiting, why don't we do
8 some housekeeping? Your Honor, we have marked this
9 morning as Court's Exhibit Number 9 the DVD of Dr.
10 Hendelman's testimony, which was played yesterday. We
11 have marked as Court's Exhibit 10 a annotated hardcopy
12 of the deposition transcript of Arthur Manning, which
13 was read here in open court yesterday. And we've marked
14 as Court's Exhibit Number 11 the DVD of Angelina
15 Brannon's testimony, which was played here yesterday.
16 And we would ask that the Court receive all of those as
17 Court's Exhibits 9, 10, and 11.

18 THE COURT: Any objection to any of that?

19 MR. LOVELL: None.

20 MR. MACKELCAN: No objection.

21 ITEM IDENTIFIED AS DVD OF

22 VIDEOTAPED DEPOSITION OF DR.

23 BEVERLY ELAINE HENDELMAN

24 MARKED COURT'S EXHIBIT NUMBER 9

25 RECEIVED BY THE COURT.

1 ITEM IDENTIFIED AS ANNOTATED
2 HARDCOPY OF DEPOSITION TRANSCRIPT
3 OF ARTHUR GERARD MANNING
4 MARKED COURT'S EXHIBIT NUMBER 10
5 RECEIVED BY THE COURT.

6 ITEM IDENTIFIED AS DVD OF VIDEOTAPED
7 DEPOSITION OF LIEUTENANT NURSE
8 ANGELINA DOLORES BRANNON
9 MARKED COURT'S EXHIBIT NUMBER 11
10 RECEIVED BY THE COURT.

11 MR. HOYLE: Your Honor, I think we have up on the
12 screens in the courtroom the final edited version of
13 this video, which will be an exhibit. I believe that,
14 that comports with your Honor's rulings. It does not?

15 THE COURT: No.

16 MR. HOYLE: I'm sorry.

17 OFF-THE-RECORD BENCH CONFERENCE, OUT
18 OF PRESENCE OF JURORS. PRESENT: THE
19 COURT, MR. HOYLE, MS. CASTLEBERRY, MS.
20 LEYIMU, MR. MACKELCAN, MR. LOVELL,
21 MS. SABER.

22 END BENCH CONFERENCE.

23 MR. HOYLE: Your Honor, may I have permission to
24 not touch anything in the jury box, but at least go into
25 the jury box to see the view from this screen? Would

1 you mind?

2 THE COURT: Not at all.

3 MR. HOYLE: Okay. Thank you, your Honor.

4 OFF THE RECORD 10:49 A.M.

5 BACK ON THE RECORD 11:10 A.M.

6 THE COURT: Ready?

7 MR. HOYLE: Ready.

8 MR. MACKELCAN: Yes.

9 THE COURT: The jury, bring them in.

10 BAILIFF: You ready, your Honor?

11 THE COURT: Yes.

12 BAILIFF: Jury is entering the courtroom, your
13 Honor.

14 JURORS ENTER COURTROOM 11:15 A.M.

15 THE COURT: Ladies and gentlemen, ladies and
16 gentlemen, lots of apologies, and I, you know, I am --
17 all I can tell you is that I'm certainly mindful when
18 you are in your jury room. I want you to know that,
19 that is also a part of your jury service. That's why I
20 tell juries that. I have to remind them, because, when
21 we are out here like that, gosh, I try to keep it to a
22 minimum, but I can assure you, the work that we are
23 doing is absolutely necessary, and I certainly apologize
24 to you when you have to stay in your room, and
25 certainly, particularly, for as long a duration as this.

1 But I want you to know that I did hear about the snacks
2 that are in the room. That's all I'm saying. You know,
3 cookies, too. Sun Chips.

4 Without further ado, ladies and gentlemen, we now,
5 at this time, will continue with the Plaintiff's case.
6 Please call your next witness.

7 MR. HOYLE: Thank you, your Honor. At this time,
8 Plaintiff calls Fire Chief Sammy Negron.

9 THE COURT: All right. Yes, sir. Come on around,
10 please.

11 BAILIFF: Come forward to be sworn, please, sir.

12 MADAM CLERK: Do you solemnly swear or affirm that
13 the testimony you give to the Court in this trial shall
14 be the truth, so help you God?

15 FIRE CHIEF SAMMY NEGRON: I do.

16 MADAM CLERK: Thank you. If you'll state and spell
17 your name, for the record.

18 FIRE CHIEF SAMMY NEGRON: Sammy Negron, S/a/m/m/y,
19 N/e/g/r/o/n.

20 THE COURT: Your witness.

21 FIRE CHIEF SAMMY NEGRON

22 DIRECT EXAMINATION, BY MR. HOYLE:

23 Q Good morning, sir.

24 A Good morning.

25 Q I apologize for the delay this morning. We were

1 attending to some business that needed to be taken care
2 of.

3 Can you tell the Court and jury what you do for a
4 living.

5 A I am the fire chief of the City of Beaufort Fire
6 Department.

7 Q And the City of Beaufort Fire Department, does it
8 also provide the fire service to the municipality of
9 Port Royal?

10 A That's correct.

11 Q How long have you been the fire chief here in the
12 City of Beaufort?

13 A For six years, since 2009.

14 Q And how long have you been engaged in the
15 profession of fighting fires and helping people?

16 A Around 20 years.

17 Q And where did you begin that career, sir?

18 A With the City of Beaufort Fire Department.

19 Q So, your entire career as a firefighter, and now as
20 the fire chief, has been here in Beaufort?

21 A That's correct.

22 Q Tell us a little bit about your training. What did
23 you do in order to become a firefighter, and later, a
24 fire chief here in the City of Beaufort?

25 A I became a firefighter while I was in the Marine

1 Corp. During my time off, I would volunteer with the
2 fire department. I became certified through their
3 volunteer training program. And once I terminated my
4 enlistment in the Marine Corp, I was able to -- to get
5 hired by the City of Beaufort Fire Department. And
6 throughout the years, I've become certified in different
7 aspects of trainings in the fire service, from fire
8 suppression, to driving apparatus, to code enforcement,
9 fire marshall investigations. Just, there -- there's so
10 many.

11 Then, in 2009, I was one of five candidates to the
12 position as fire chief, and I was selected as the City's
13 fire chief at that time.

14 Q Now, with respect to being the fire chief, how many
15 men and women do you command with respect to the duties
16 that you've told us about with respect to the fire
17 service here in Beaufort?

18 A Currently, we have 37 firefighters. And 11, 33,
19 firefighters a shift. They work a 24/48 schedule, one
20 day on, two days off. And four senior staff officers,
21 plus, the Volunteer Reserve Corp.

22 Q And how many fire stations are those brave men and
23 women staffing under your command?

24 A Three fire stations.

25 Q And providing 24/7 coverage to this community.

1 A That's correct.

2 Q Okay. Now, those of us who may not have ever had
3 much experience with members of the fire service may
4 kind of think of the job of a firefighter as being
5 related to fighting fire. But in this community, do
6 firefighters do more than that?

7 A We do. We do emergency medical response, which is
8 also referred to as first responder. The basic life
9 support label, meaning we're EMT basics. And we do CPR.
10 We can use -- we can provide the basic first emergency
11 response.

12 Q So, it sounds like, if somebody were to call 911
13 for help here in this community, and they had some sort
14 of medical emergency, in addition to, perhaps, an
15 ambulance showing up, an actual fire truck may show up
16 first? Is that fair?

17 A That's correct. Because of the location of our
18 fire station, of our fire stations, in Port Royal
19 Island, which is where Beaufort is located, there are
20 eight fire stations within the City of Beaufort and the
21 Burton Fire District. Only two -- two ambulances. So,
22 there's a good chance, when someone calls 911, there's a
23 fire station nearby that can render the aid until the
24 paramedics get there.

25 Q And Chief, does the fact that the fire stations are

1 closer to the people suggest that folks may get that
2 emergency medical care quicker, if a fire truck is
3 actually dispatched?

4 A That's correct.

5 Q Okay. And back on February the 24th, 2012, you
6 were the fire chief?

7 A Correct.

8 Q Okay. Let's talk a little bit about how the fire
9 service here in Beaufort and Port Royal worked back in
10 February the 24th, 2012. I've never been inside a fire
11 truck. Not even as a little kid. I missed out on that.
12 How do you start up a fire truck here in Beaufort back
13 in 2012? Walk me through the process.

14 A The fire apparatus that we use today, and use --
15 were using at that time, they don't require a key to
16 start the engine. You simply turn -- there's a battery
17 switch that you rotate to turn. then, there's an
18 ignition switch that you also flip to the on position.
19 Then, you have two buttons that -- that, when you push
20 those, the engine will start at that time.

21 Q So, that sounds like a multi-step process, not as
22 simple as putting a key into a Ford F-150 and cranking
23 it. Is that fair?

24 A That's correct.

25 Q Okay. So, you've got the battery switch; you've

1 got to flip something to on; you've got some buttons
2 you've got to push. At that point in time, back in
3 February of 2012, were you aware of any standard, either
4 here in Beaufort, here in South Carolina, or anywhere in
5 the entire United States, that addressed the issue of
6 whether or not anything else needed to be done with
7 respect to starting up a fire truck?

8 A There were none at that time, and there are still
9 none at this time.

10 Q Okay. Let's talk a little bit about all the
11 systems that are involved in a fire truck. How many
12 different kind of systems did they have on a fire truck
13 back in 2012?

14 A Well, a fire truck will have a power plan, your
15 engine, that, of course, operates the apparatus. The
16 engine would also operate the pump. So, there's an
17 engine, there's a pump, there's a water tank in the case
18 of a -- of a pump or a fire engine. And then, you have
19 a hose, hose bed to carry an assortment of different
20 sizes of hose. Then, you have ladders. And in the
21 different compartments, you have all sorts of tools that
22 we use on -- on the fire scene.

23 Q Do a number of those systems that you just told us
24 about require a connection to some sort of power source?

25 A Yes. Most important, the lights and some of the

1 equipment that we carry have to be connected to a source
2 to -- to charge. For example, we have suction units
3 that we use on emergency call. There -- those are
4 plugged in all the time. We have flashlights. We have
5 radios. We have thermal imager that we use when we go
6 in a building that's on fire, so we can see if there's
7 smoke. And I'm pretty sure there's some others that
8 just don't come to my mind that also have to be
9 constantly provided with -- with a power source.

10 Q Now, if, with respect to the design and build of
11 fire trucks here in this community back in 2012, if the
12 fire truck got turned off, would some of those systems
13 that you just told us about that require a power source
14 continue to work?

15 A Correct.

16 Q Let me make sure I understand that. If the power
17 gets turned off to the fire truck, are some of those
18 systems you just told us about, are they going to work
19 or not work, if the power is cut off?

20 A They would not work. I'm sorry, I misunderstood
21 your question.

22 Q Now, in fact, we're talking about this fire truck,
23 and I can picture it in my mind driving down the street,
24 or maybe seeing it at a community event, but again,
25 never having been inside one, do they have locks on the

1 doors?

2 A No. Ours don't. And -- and the reason for that,
3 locks can be dangerous or detrimental to our operation,
4 either on the fire on ground or emergency scene. I
5 should remind you, the last thing you want to find
6 yourself in, as a firefighter, is locking yourself out
7 of the vehicle, the apparatus, and needing equipment and
8 so on. Therefore, the industry, while they might offer
9 that, it's not a common practice of fire departments to
10 have those in your apparatus. And if you do, you
11 usually don't use them for that purpose.

12 Q Back in 2012, was there any type of policy or
13 standard here, either locally or in South Carolina, or
14 anywhere in the United States, that you're aware of,
15 that said, when a fire truck has left the fire station,
16 and it's off responding to some sort of call, like a
17 medical emergency, that one of the fire service
18 personnel needed to stay with the fire truck at all
19 times?

20 A No, and what drives that is staffing. There's
21 departments throughout the nation, bigger department,
22 bigger cities, that have either some kind of chauffeur,
23 and he stays with the apparatus, because the other four
24 or six guys are out doing whatever. But your average
25 department in the United States, because of budgetary

1 reasons, you can't afford to have so many personnel on a
2 truck. Therefore, when you respond to the scene,
3 everyone on that apparatus, two or three, participate in
4 a medical call, vehicle accident, fire, whatever it is.

5 Q And back in February of 2012, here in Beaufort,
6 South Carolina, what was the typical staffing for, let's
7 just say, Engine Number 5? How many firefighters would
8 be with that rig during a given shift?

9 A There are three firefighters assigned to that
10 station at that time. And -- and that day, there were
11 only two. And the reason for that, someone might call
12 in sick and, or someone is in a class, or leave,
13 vacation, and so on. So, the minimum staffing for
14 Engine 5 at the Port Royal station was two.

15 Q And by that day, you're referring to that fateful
16 Friday in February, February 24, 2012.

17 A That's correct.

18 Q Okay. That's the day that brings us all here to
19 this courthouse.

20 A Correct.

21 Q Okay. And Engine Number 5 is the fire apparatus
22 that sits in the station in Port Royal. Did I hear
23 that?

24 A That's correct.

25 Q So, and you were fire chief that day.

1 A Yes, sir.

2 Q And so, persons working at the fire station in Port
3 Royal, working on Engine Number 5, they reported to you?

4 A Yes.

5 Q Okay. Now, can you tell the Court and jury whether
6 or not there is some sort of camera that is physically
7 mounted on the fire apparatus associated with Engine
8 Number 5?

9 A Yes.

10 Q And what type of camera is actually mounted on this
11 particular fire truck?

12 A The camera in question was installed on -- on this
13 apparatus, and it was a recording unit with cameras
14 inside the cabin, that, once the engineer or the driver
15 of the apparatus, that's what we call the engineer, will
16 turn the -- the apparatus on. It will start recording.
17 Therefore, by the time that the crew is ready to leave
18 the fire station, responding on a call, it will record
19 continuously, until the point that they return to the
20 fire station and turn the engine off, or the system off
21 in the fire truck.

22 Q And in February of 2012, was it the regular
23 practice of the City of Beaufort Fire Department, which
24 also provided fire service to the town of Port Royal, to
25 make these recordings for every run made with respect to

1 Engine Number 5 from the Port Royal station?

2 A Yes.

3 Q And what was the -- just out of curiosity, what was
4 the reason the fire service decided to install this
5 camera on this particular truck? Was it all the trucks
6 in the city?

7 A Yes.

8 Q Okay. So, it wasn't just this fire truck; it was
9 all the fire trucks in the city. Why did you all decide
10 to put these cameras and the recording units on the fire
11 trucks here in the city of Beaufort?

12 A Well, it -- it was my -- my decision that we needed
13 to have those, first of all, operationally. At the time
14 I took over the fire department, we had them in some
15 trucks, and some others didn't have them. And during my
16 career, I experience situations that the firefighters
17 was involved in an accident, or someone called the fire
18 department complaining about the driver driving
19 recklessly down the road. And so, it is a tool. It is
20 a tool to protect their station, the firefighters.

21 But also, it's a tool to protect the city, since
22 that was our -- from the moment that we respond, you're
23 being recorded, and our drivers know that. And we can
24 access that for the purpose of reviewing the footage of
25 how our drivers are responding to calls; are they being

1 cautious; are they slowing down intersections; they are
2 following our SRGs. And but the most importantly, as it
3 turned out, now that they, if an incident happened, we'd
4 have a video.

5 Q It essentially documents, for posterity's sake,
6 what actually happened with particular firefighters in
7 the course of their actual duties for the city of
8 Beaufort and Port Royal Fire Department.

9 A Yes, sir.

10 Q Okay. And can these recording units be tampered
11 with or altered with in any type of way, that you're
12 aware of?

13 A Well, as with any piece of equipment, electronics,
14 it could. But we have a system in place that only
15 personnel that I have designated have access to the --
16 to the data on those cameras.

17 Q And how many people within your fire department
18 have access to that data?

19 A Only one person.

20 Q Sir, I served you a subpoena requesting your
21 attendance at this trial. In response to that subpoena,
22 did you bring with you a disc containing video footage
23 from Engine Number 5, on February 24, 2012?

24 A Yes, I did.

25 Q Okay. And in a moment, we will see a portion of

1 that video that was brought. Chief, let me ask this.

2 We're obviously here today about an incident that took
3 place involving a fire truck. Is that fair?

4 A Correct. Yes, sir.

5 Q What were your firefighters doing when they were in
6 the minutes or immediately before the events that bring
7 us here today? What were they out doing?

8 A They were at the fire station. Just daily routine.
9 And they received a call for a medical emergency at the
10 Laurel Hill Apartments, which is just down from the fire
11 station. So, at the time, they -- they got on the
12 apparatus and responded to the -- to the emergency,
13 which, it's just a very short distance from the fire
14 station on Ribaut Road.

15 Q They were in the course of their official duties.
16 Is that fair?

17 A Correct.

18 Q Serving this community as firefighters on an
19 emergency call.

20 A Yes, sir.

21 Q Okay. And as the fire chief in this community, do
22 you believe that your firefighters associated with
23 Engine Number 5 on that day violated any type of policy,
24 rule, or regulation that exists within your fire
25 department?

1 A None.

2 Q And what about with respect to any type of standard
3 or protocol, or anything that you're aware of, either in
4 this community, in the state, or in the entire United
5 States?

6 A None.

7 Q You believe they were doing what they were supposed
8 to do.

9 A That's correct.

10 MR. HOYLE: At this time, your Honor, like our
11 prior conversations on the record, Plaintiffs would move
12 into evidence Plaintiff's Exhibit Number 23, over the
13 objection of the Defendant, and move to publish same to
14 the Court and jury at this time.

15 THE COURT: All right. At this time.

16 MR. MACKELCAN: I think he just covered that.

17 THE COURT: I think he did, too.

18 MR. MACKELCAN: Okay.

19 THE COURT: Yes. Very well. You may proceed.

20 ITEM IDENTIFIED AS REDACTED DVD
21 OF FIRE TRUCK DASHCAM VIDEO,
22 MARKED PLAINTIFF'S EXHIBIT NUMBER 23,
23 ADMITTED INTO EVIDENCE.

24 MR. HOYLE: And we'll direct the Court and jury to
25 the two monitors permanently affixed here in the

1 courtroom.

2 REDACTED DVD FROM FIRE TRUCK DASHCAM
3 VIDEO, PLAINTIFF'S EXHIBIT 23, PLAYING.
4 END PLAYING REDACTED DVD OF FIRE TRUCK
5 DASHCAM VIDEO.

6 BY MR. HOYLE:

7 Q Chief, we stopped the video that's contained within
8 Plaintiff's Exhibit Number 23. Have you seen the entire
9 video?

10 A Yes, sir.

11 Q After the scene that we just left with in the
12 playing of Exhibit Number 23, what happens?

13 A Then, -- then, on the video, the apparatus impact
14 one of the two pedestrians that were crossing the Ribalt
15 Road.

16 MR. HOYLE: Sir, I very much thank you for coming
17 here today. I thank you for your service to the
18 community. And at this time, I'll ask that you answer
19 any questions that Mr. Mackelcan has for you.

20 A You're welcome.

21 THE COURT: All right. Cross-examination.

22 FIRE CHIEF SAMMY NEGRON

23 CROSS-EXAMINATION, BY MR. MACKELCAN:

24 Q Good morning, Chief.

25 A Good morning.

1 Q Can I ask you a couple more questions about the
2 fire truck. Is it a manual transmission or an automatic
3 transmission?

4 A Automatic.

5 Q Automatic. When the firefighters leave the
6 apparatus, do they put it in park, just like you would
7 with a car?

8 A Correct.

9 Q Okay. And on this particular day, February 24,
10 2012, the apparatus was left running when they went for
11 a medical emergency?

12 A Correct.

13 Q And I believe you said that, that was the standard,
14 regardless of whether it was a fire call or a medical
15 call. Is that right?

16 A Correct.

17 Q When the battery -- I believe you said the first
18 step in the process was turning on the battery. When
19 the battery is turned on, what comes on, on the
20 apparatus?

21 A The apparatus today, contrary to 20, 30 years ago,
22 are -- have a computer on board that just manage all the
23 different systems and components. When you turn the
24 battery switch on, that energizes all those systems.
25 When you turn -- turn the engine switch on, the systems

1 come alive and start communicating. And at that time,
2 the apparatus makes some sorts of alarms or beeps that
3 allow the engineer or the driver to understand that the
4 system checks on the apparatus are complete, and he is
5 now ready to operate the fire truck.

6 Q Would you expect the average person off the street
7 to be able to get into a fire truck and drive it away,
8 the way Mr. Hunt did?

9 A No. And to my knowledge, never happened before.

10 Q So, prior to February 24, 2012, no city of Beaufort
11 or Port Royal fire truck had ever been used by an
12 unauthorized user?

13 A That's correct, and I'll take even that further.
14 There's no record of that ever happening in the nation
15 that result in the outcome we experienced that day.

16 Q That's not something that ever crossed your mind,
17 as the fire chief, that could possibly happen, right?

18 A Correct.

19 Q Clearly, if it was something that had crossed your
20 mind, you would have done something to prevent something
21 like this from happening, correct?

22 A Yes. In our training of fire service, the systems
23 and methods that we have are proven based on history.
24 And what we find quite often is, the way we operate is
25 because, either it happened before, or something failed

1 before. So, yes. Just the way we do things that way
2 that day.

3 MR. MACKELCAN: Thank you. Nothing further.

4 MR. HOYLE: Very briefly, your Honor.

5 THE COURT: Yes. Re-direct? Sure.

6 FIRE CHIEF SAMMY NEGRON

7 RE-DIRECT EXAMINATION, BY MR. HOYLE:

8 Q Chief, Mr. Mackelcan raised the concept of
9 prevention. Did the fire service here in the city of
10 Beaufort, on February 24, 2012, have any knowledge,
11 prior to your men going on that medical call that we saw
12 in the video, that Calvin Hunt had thoughts of hurting
13 others?

14 A No.

15 Q And this particular fire truck, the fire truck that
16 we saw in the video that is Plaintiff's 23, what
17 happened to this fire truck?

18 A You mean, after the fact?

19 Q Yes.

20 A Well, of course, because of the damage, severe
21 damage, it was totaled by the insurance company. And
22 today, it is sitting at the City of Beaufort Public
23 Works, and we just have it covered there. And because
24 we have another apparatus that is identical, we cut off
25 the used parts, and so on, to repair the other one.

1 Q Did I hear correctly that the fire truck was
2 damaged such that it was totaled?

3 A That's correct.

4 Q What was the economic value of that decision with
5 respect to totaling the fire truck?

6 A Well, that particular apparatus costs over
7 \$500,000.00. And at the time of the incident, the town
8 of Port Royal was still making payments. And the
9 insurance money was just enough to -- to pay off the --
10 the apparatus and close the account. And then, we had
11 to purchase a replacement fire truck.

12 Q Chief, I just want to make sure we're clear about
13 something. Did that fire truck have to stay on, on
14 February 24, 2012, when it was parked at the Laurel Hill
15 Apartments, in order for dispatch reasons?

16 A Yes. And if you notice, if the jury notice in the
17 video, when the personnel arrive at the apartment
18 complex, they kind of park to the side. That was (1) to
19 allow the ambulance room enough to park in front of the
20 building; and also, to stay away from traffic. And as
21 you notice in the video, the emergency lights were still
22 on throughout the -- the incident. And the purpose of
23 that was to warn citizens that we were on scene,
24 engaged, responding to an actual emergency, and that the
25 fire truck was there; and for drivers, specifically,

1 coming and trying to manage the parking lot that, be
2 careful.

3 Q You all were trying to keep people safe.

4 A Correct.

5 MR. HOYLE: Thank you, Chief. Those are all the
6 questions I have for you.

7 THE COURT: Re-cross?

8 MR. MACKELCAN: Nothing for this witness.

9 THE COURT: Is this witness free to leave?

10 MR. HOYLE: This witness is excused, with the
11 thanks of Ms. Delaney.

12 THE COURT: All right. Any objection?

13 MR. MACKELCAN: None from the Defendant, your
14 Honor.

15 THE COURT: Very well. Thank you, sir. You're
16 free to go. Please call our next witness.

17 A Thank you, your Honor.

18 MR. HOYLE: Your Honor, at this time, the Plaintiff
19 calls Dr. Terrence Baker to the stand.

20 THE COURT: Okay. Yes, sir.

21 MR. LOVELL: Your Honor, may approach on one brief
22 issue?

23 THE COURT: Sure.

24 BAILIFF: Come forward and be sworn, please, sir.

25 ON-THE-RECORD BENCH CONFERENCE, OUT

1 OF HEARING OF JURORS. PRESENT: THE
2 COURT, MR. HOYLE, MS. CASTLEBERRY,
3 MR. MACKELCAN, MR. LOVELL.

4 MR. LOVELL: It's an ordinary negligence case. we
5 would object under Rule 703 of this witness being called
6 to render expert testimony about standards of care and
7 such, as those are not relevant to the issues. Period.

8 THE COURT: Okay. I don't know what he's going to
9 testify to. So, just --

10 MR. LOVELL: Okay. I'll --

11 MR. HOYLE: And just briefly, for purposes,
12 obviously, we think this witness goes to the question of
13 duty, even in an ordinary negligence case. And I've
14 tried ordinary negligence cases before, and there's been
15 expert testimony elicited in those cases. So, I don't
16 believe that it has to necessarily be a professional
17 negligence case in order to obtain expert testimony.

18 There's also one other issue we need to raise with
19 your Honor. And I'm going to lean in and whisper. I
20 expect there will be some testimony likely elicited by
21 Mr. Lovell about opinions that this witness has about
22 actions and inactions of a party's employee that has
23 been granted summary judgment; that being Edward Ray,
24 the Veterans Affairs Officer. This Court has entered an
25 order granting summary judgment, saying it is a matter

1 of law. There is no liability for the actions and
2 inactions of Edward Ray.

3 When Mr. Baker prepared a report and gave his
4 deposition, for the first part of the deposition, he did
5 not have that information, that the Court had summary
6 judgmented the state Office of Veterans Affairs out. I
7 think it would confuse the jury and confuse the law of
8 the case to elicit testimony at this point in time from
9 this witness about a party that used to be a chair, but
10 is no longer a chair. They're a judicially adjudicated
11 chair.

12 THE COURT: My understanding is that there was no
13 evidence offered in the case one way or the other,
14 because the gentleman had passed away. Do I understand
15 that correctly?

16 MR. MACKELCAN: Yes.

17 MR. HOYLE: If you'll bear with me, Judge.

18 MR. MACKELCAN: That is correct. He passed away
19 before we started taking any depositions.

20 MR. HOYLE: And this is the order entered by Judge
21 Jeff Young. And Judge Young, he makes more conclusions
22 of law.

23 THE COURT: I'll work on this. I'll read this
24 while you all keep going.

25 MR. HOYLE: And my only request would be, if we

1 could get some guidance from the Court.

2 THE COURT: Before he starts.

3 MR. HOYLE: Not before he starts. Before I finish
4 my direct of him.

5 THE COURT: Okay.

6 MR. HOYLE: So, maybe we could take a comfort break
7 at some point --

8 THE COURT: Okay.

9 MR. HOYLE: -- to confer with your Honor. Is that
10 reasonable?

11 THE COURT: Sure.

12 MR. LOVELL: We think it's irrelevant on
13 intervening supervening cause, proximate cause, and the
14 actions of others.

15 THE COURT: Okay.

16 MR. LOVELL: And his opinions also go to
17 credibility as an expert.

18 THE COURT: Okay.

19 MR. MACKELCAN: And your Honor, we were not
20 involved in that particular motion.

21 THE COURT: I understand.

22 MR. MACKELCAN: I think that one of the issues I
23 think you'll read, I don't know, because I didn't
24 participate in preparing that order, is that, Edward
25 Ray, individually, could have been a Defendant. One of

1 the issues was whether he was acting in the scope of his
2 duties as the Veterans Affairs officer. The entity was
3 dismissed, but Edward Ray, there's no ruling on Edward
4 Ray individually.

5 THE COURT: Okay. I understand.

6 MR. HOYLE: I'll state for the record that my
7 understanding of the *Tort Claims Act* is that an
8 individual employee of the state of South Carolina, one
9 that's political subdivisions, cannot be named
10 individually. Period.

11 THE COURT: Okay. Go ahead and start.

12 MADAM CLERK: Do you solemnly swear or affirm that
13 the testimony you give in the trial in this court shall
14 be the truth, so help you God?

15 DR. TERRENCE L. BAKER: I do.

16 MADAM CLERK: Thank you. If you'll state and spell
17 your name, for the record.

18 DR. TERRENCE L. BAKER: Yes, Terrence L. Baker,
19 M.D.

20 DR. TERRENCE L. BAKER

21 DIRECT EXAMINATION, BY MR. HOYLE:

22 Q I think I still have the pleasure of saying good
23 morning to you, Doctor.

24 A Good morning, sir.

25 Q It is good to see you. You have introduced

1 yourself already to this Court and jury, but why don't
2 you tell the jury where you're from.

3 A Yes, I'm from Baltimore, Maryland.

4 Q And what do you do up there in Baltimore, Maryland,
5 Doctor?

6 A I'm a physician.

7 Q All right. How long have you practiced medicine as
8 a physician?

9 A I know I don't look that old, but it's almost 40
10 years.

11 Q I agree with you, sir. All right. So, you've been
12 a practicing physician for 40 years. Why don't you tell
13 the Court and jury about your education.

14 A Yes. My formal education started at Johns Hopkins
15 University in Baltimore, Maryland, at the Homewood
16 Campus. I obtained my bachelor's degree in natural
17 science, which was a pre-med program at Hopkins at the
18 time. Completed that program in '78. Stayed at Hopkins
19 in order to get my finances together for medical school,
20 and obtained a master's degree at Johns Hopkins in
21 developmental disabilities and special education.

22 And having then completed my master's degree and
23 got my funding together, I was able to be accepted to
24 George Washington University School of Medicine in D.C.
25 I completed my doctorate's degree in medicine in '84,

1 and then, was accepted by the Medical College of
2 Virginia, in Richmond, to do advanced training as a
3 resident physician.

4 Q Are you familiar with a term called board
5 certification?

6 A Yes, I am.

7 Q Okay. Tell the Court and jury what a board
8 certification is.

9 A Board certification is where a physician studies a
10 certain area of medicine, like the heart, cardiology, or
11 like emergency medicine or family medicine; and then,
12 sits for an examination. Sometimes it's a written
13 examination. Almost always a written examination, all-
14 day, eight-hour exam of written questions and answers,
15 followed by an oral examination in subspecialties like
16 emergency medicine. We have both emergency medicine
17 oral examination and written examination.

18 Q Do you hold any board certification or board
19 certifications?

20 A I do. I have successfully passed all of the
21 requirements for emergency medicine, family medicine.
22 Added certificate in geriatrics and forensic medicine.

23 Q Is that four of them?

24 A Yes.

25 Q Okay. And I think you told us a little bit about

1 how long ago it was that you became board certified.
2 You've actually done those things, with respect to
3 emergency medicine and family medicine. Did I hear
4 that?

5 A Correct.

6 Q Okay. And have you actually been involved in
7 giving the tests, so that other physicians can become
8 board certified?

9 A Yes. In emergency medicine, I'm actively involved
10 in writing written questions that become part of the
11 examination for the written test for physicians who are
12 looking to become board certified, that is, to take the
13 written test and to demonstrate that they have the
14 minimum necessary knowledge, education, training, and
15 experience to be able to say they are board certified in
16 emergency medicine. So, I actually help to write the
17 written examination.

18 I also am an oral board examiner. That is, I'm one
19 of the physicians who actually sits. And the way we set
20 it up, there's three of us sitting at a table, and a
21 physician who wants to be board certified in emergency
22 medicine will sit down, and we will ask the candidate
23 questions about how to take care of certain medical
24 conditions in the emergency room. And then, there are
25 certain answers that we expect to receive, and we go

1 through that process. It's about a four-hour testing
2 process of give and take between the candidate and the
3 examiners to understand that, that candidate is able to
4 handle common emergency problems.

5 Q All right. Doctor, are you a member of any
6 professional associations?

7 A I am.

8 Q What professional organizations are you involved
9 with?

10 A Well, I mean, I'm a member of the American Medical
11 Association, American Academy of Family Practice, the
12 American College of Geriatrics, the American Academy of
13 Emergency Medicine, and the American Association of
14 Physician Specialists.

15 Q That's a lot of anachronisms, Doctor.

16 A It's a few.

17 Q It's a few. Have you held any offices with any of
18 the professional organizations that you just told us
19 about?

20 A I have.

21 Q Okay. And what offices have you held?

22 A I'm currently the president of the American College
23 of Emergency Physicians, through the American
24 Association of Physician Specialists. I was elected
25 president last year, continued at the request of my

1 colleagues this year. Prior to that, I was president-
2 elect. And prior to that, I was vice president of the
3 Academy.

4 Q Have you held any teaching positions, Doctor?

5 A Yes.

6 Q Tell us about those.

7 A At the -- well, it started when I was at the
8 Medical College, Virginia, in Richmond. I was actively
9 involved in teaching interns and medical students. It
10 continued during the 20 years I practiced here in South
11 Carolina. Following my completion, I came to Conway,
12 South Carolina and Orangeburg, South Carolina, at the
13 request of the federal government. I practiced in
14 Conway and in Orangeburg for -- and some in Columbia for
15 nearly 20 years, prior to being invited to come back to
16 the Good Samaritan Hospital, where I am today.

17 Good Samaritan is a training center. We train
18 residents from a number of hospitals, University of
19 Maryland, Johns Hopkins, George Washington. Plus, we
20 have our own residents, internal medicine residents, in
21 the building, some actively involved in teaching
22 principles of family medicine and emergency medicine to
23 young physicians in training, medical students,
24 physicians' assistants, nurse practitioners from the
25 School of Nursing at University of Maryland, as well as

1 interns and residents from the facilities I mentioned.

2 Q How many hours in a given month do you actually
3 spend in a clinical practice in an emergency room or
4 some other setting, Doctor?

5 A Yes. My practice is -- has been, for quite a few
6 years, 70 to 100 hours a week, practicing in the areas
7 of my board certification.

8 Q Do you hold any privileges at any hospital?

9 A I do.

10 Q Which hospital or hospitals do you hold privileges
11 at?

12 A I currently have privileges at the Good Samaritan
13 Hospital, the Good Samaritan Nursing Center, and Good
14 Samaritan Transitional Care Center.

15 Q And those are all up in Baltimore?

16 A Yes, they're all part of the Good Samaritan campus.

17 Q Okay. And in that campus, how many beds does the
18 emergency room up there have?

19 A The emergency room currently -- we expanded several
20 years ago. We currently are up to 44 beds. We went
21 from 15 to 44 to meet the growing needs of the Baltimore
22 community.

23 Q And in what states are you currently licensed to
24 practice medicine?

25 A Currently licensed in South Carolina, North

1 Carolina, and Maryland.

2 Q Have you published any articles in what's known as
3 the peer review literature?

4 A No.

5 Q Have you ever been qualified to render opinions in
6 a court of law?

7 A Yes.

8 Q Okay. That includes courts in this state?

9 A Yes. Federal and state courts in South Carolina.

10 Q Okay. Have you been qualified to render opinions
11 elsewhere in the United States of America?

12 A Yes.

13 Q Okay. About how many states do you think that is,
14 Doctor?

15 A About 48.

16 Q Well, I'll just ask which two you haven't been to,
17 Doc.

18 A Hawaii and Alaska.

19 Q So, it sounds like, I don't want to foreshadow, but
20 it sounds like you testify a good bit. Is that fair?

21 A A part of my practice, somewhere between ten and
22 twenty percent of my practice, involves chart review and
23 answering questions, either written questions, or
24 questions in person, like today.

25 Q Okay. Now, when you've been here in South

1 Carolina, giving testimony in courtrooms like this one,
2 were those occasions in which you testified for the
3 Plaintiff, meaning the person who brought the lawsuit;
4 or the Defendant, meaning the person defending the
5 lawsuit; or some combination?

6 A Both. In South Carolina, when I have been asked to
7 come and answer questions in front of a jury, or in a
8 deposition setting, it has been both for defendants and
9 for plaintiffs.

10 Q Now, how is it that you came to be involved in
11 forensic work or testifying-type work?

12 A Soon after I arrived in the state back in '88,
13 seems like just yesterday, the South Carolina Board of
14 Medical Examiners put out a postcard, a letter, inviting
15 physicians like myself to become part of peer review.
16 That is, reviewing of medical records and charts in the
17 State of South Carolina for the purpose of looking at
18 complaints and problems that were alleged about
19 physicians practicing here. So, that started in '88.
20 And then, subsequently, some of the -- one or two of the
21 defense insurance -- one of the -- one or two of the
22 insurance companies here in South Carolina asked me to
23 start reviewing charts for them. And then, I think, in
24 '92, the first plaintiff's attorney asked me to actually
25 look at a case on behalf of a patient and a family.

1 Q And currently, today, what's the split of your
2 testifying work between plaintiffs, those bringing the
3 lawsuits, and defendants, those defending the lawsuits?

4 A Yes, it's approximately 60 to 70 percent on behalf
5 of Plaintiffs, that is, families and patients. Thirty
6 to 40 percent on behalf of physicians, facilities,
7 P.A.s, nurse practitioners.

8 Q Do you have any sense of why you tend to offer more
9 testimony on behalf of plaintiffs than it is defendants?

10 A Yes.

11 Q What is that?

12 A In my opinion, the reason I look at more
13 plaintiffs' cases on behalf of patients and families is
14 because I am asked to review cases in which it's not
15 known whether the standard of care was met or not. That
16 is, no one knows, and they're asking for a professional
17 opinion. And so, the attorneys or the patient
18 themselves will ask me to review their file and answer
19 questions. Out of those cases, a number of times,
20 there's actually no standard of care problems. That is
21 that patients and their families and lawyers will send
22 me a file, but the standard of care is met. That is, a
23 physician treated a patient like they should. And
24 there's a misunderstanding, sometimes an untimely death,
25 but not malpractice. And then, the other times that

1 there is malpractice, that is, the standard of care has
2 been violated, and I will explain to the patient, their
3 family, or to the attorney why that is.

4 With defense cases, when a defense firm calls me or
5 a physician calls me, and tells me that they've been
6 named in a suit and they would like me to be their
7 expert, the suit's already been filed, that is, a
8 complaint has already been filed, most of the time. And
9 so, in those cases, my job is to review the file; and
10 then, to answer questions about whether -- whether there
11 was a problem; and if there was a problem, what was it.
12 And if there was no problem, then, to explain to the
13 attorney why there was no problem and why this is a case
14 that should be, you know, vigorously defended.

15 Q Makes sense, Doctor. Can you tell the Court and
16 jury about your experience in dealing with psychiatric
17 patients in an emergency room setting.

18 A Yes. Since I started my training way back at
19 George Washington, evaluating and treating psychiatric
20 patients in an emergency room setting, has been an
21 important part of my work. In fact, the first clinical
22 rotation I did at George Washington actually was in
23 psychiatry. And one of the things that we would do as a
24 young medical student in my third year would be go down
25 to the George Washington emergency room to see patients

1 that were complaining of being upset or disturbed, or
2 having psychiatric complaints and symptoms that needed
3 treated. So, that was actually my first rotation.

4 But subsequently, what I found is, that virtually
5 every day of my clinical practice in the emergency room
6 I treat more -- one or more patients who are
7 experiencing -- they're upset, they're anxious, they're
8 having psychiatric symptoms of some sort that have
9 brought them to the emergency room. Sometimes they're
10 suicidal; sometimes they're not. Sometimes they're
11 homicidal, wanting to hurt somebody else; sometimes
12 they're not. Sometimes they're just upset and anxious.
13 Sometimes they just need their medication back. There's
14 a whole sort of, you know, there's a whole range of
15 signs and symptoms patients present with. To answer
16 Counsel's question is, that is an important part of my
17 emergency room practice, which has occurred virtually
18 every day of my emergency room career.

19 Q And that's something that continues today?

20 A Yes. I -- I believe, tomorrow, when I show up in
21 the emergency room, I believe that I will go through
22 that shift and see one or two or more psychiatric
23 patients.

24 Q So, tomorrow, you'll actually be treating patients
25 in the emergency room up there in Baltimore?

1 A Yes. I have a 15-hour shift tomorrow.

2 Q Okay. Well, we'll try to get you home at a good
3 hour, Doctor.

4 A Well, thank you.

5 Q Now, these folks, the psychiatric patients you've
6 been dealing with for, gosh, sounds about like 40 years,
7 have you dealt with folks who have been in the military
8 who have psychiatric issues?

9 A Yes, I have.

10 Q Tell us about that.

11 A Patients who are either active duty or who have
12 retired, or are on disability with the military come to
13 civilian hospitals, number one. A large number of our
14 patients have service records that are veterans. Some
15 are even active duty, and not able to make it to a
16 military facility. And so, they'll come to see us. So,
17 number one, in civilian life, I regularly see veterans
18 in civilian hospitals.

19 Number two is that, for a number of years, I was at
20 the Dorn Veterans Administration Hospital in Columbia,
21 South Carolina, and was an active member of the
22 emergency department there. I also helped the V.A. to
23 open up two facilities, one over in Sumter, and a 4,000-
24 square-foot facility in Orangeburg, to treat veterans
25 off-campus, so to speak, that is away from Dorn.

1 Q Doctor, are you familiar with the duties of
2 emergency room personnel regarding patients who present
3 with psychiatric problems?

4 A Yes, I am.

5 MR. HOYLE: Your Honor, at this time, Plaintiff
6 moves to qualify Dr. Baker as an expert, qualified to
7 render opinions as to emergency medicine.

8 THE COURT: All right. Is there any voir dire, or
9 is there any objection?

10 MR. LOVELL: Your Honor, we believe, under Rule
11 701, that these issues are irrelevant as it relates to
12 the professional duties owed. This is pled as an
13 ordinary negligence case.

14 THE COURT: Okay. All right. And?

15 MR. LOVELL: Be glad to voir dire him on those
16 issues, if you'd like, your Honor.

17 THE COURT: Go ahead and do your voir dire.

18 MR. LOVELL: Thank you.

19 DR. TERRENCE L. BAKER, VOIR DIRE

20 DIRECT EXAMINATION, BY MR. LOVELL:

21 Q Good morning, Dr. Baker.

22 A Good afternoon, at this point.

23 Q I'll ask you some questions about qualifications
24 and the opinions you've got here today. You would agree
25 with me, would you not, that any of your training,

1 education, and experience in the field of emergency
2 medicine is training, education, and experience you have
3 gained through medical school or professional education,
4 correct?

5 A Yes. And the application of that training, yes.

6 Q And application when you're acting as a
7 professional medical doctor, treating or diagnosing or
8 prescribing medications as a medical physician
9 professional, correct?

10 A Yes, in general. My training actually started as a
11 -- as a EMT was the first level of training I received
12 in medicine. EMT in the District of Columbia;
13 subsequently, medical school, residency; and then, now,
14 today, clinical practice and ongoing, continuing medical
15 education.

16 Q And EMTs are professionals, as well. They have to
17 have specialist training, right?

18 A Yes, they do.

19 Q Now, Doctor, you would agree that the diagnosis,
20 treatment, assessment of a patient who presents, as
21 you've talked about, in the emergency department, to
22 you, as an E.R. doctor, requires you to exercise
23 professional judgment in assessing that patient and
24 determining what level of mental challenge they are
25 suffering that has brought them to the emergency

1 department, correct?

2 A Yes. As a -- as a E.R. physician, correct.

3 Q And when you are looking at a patient who presents
4 for medication refills, and medications that include
5 medications that are of the type that are used to treat
6 psychiatric challenges, the only person that can assess
7 the need for those medications and/or refill them is
8 someone who has been trained and licensed by a state
9 licensing facility in the field of medicine, a doctor.

10 A Correct. Either the physician, nurse practitioner,
11 or P.A. That's correct.

12 Q Professional judgment has to be exercised by those
13 persons in determining whether the medications that have
14 been asked to be refilled are appropriate for the
15 patient, based on the professional assessment and
16 judgment of that medical provider, correct?

17 A Yes, in general, that's correct.

18 Q Average person off the street cannot do that,
19 correct?

20 A That's correct. A layperson from the street would
21 not be able to prescribe professional medications.

22 Q Additionally, when a patient presents and gives a
23 history to a medical provider, be it a nurse in a triage
24 situation, or a treatment nurse in the treatment floor
25 of an E.R., or emergency doctor, those persons

1 exercising or interacting with the patient must exercise
2 their judgment in assessing the patient and taking an
3 accurate medical history. Do they not?

4 A Yes. In general, that's true.

5 Q And that's professional judgment, not lay judgment,
6 right?

7 A That's correct. In that capacity, the individual
8 who is assessing the patient when they present to the
9 emergency room, the entrance, the triage nurse, the
10 first person you talk to, is -- is using professional
11 experience and judgment to ask questions about why
12 you're there. That's true.

13 Q And the treatment nurse in this case, you know Joe
14 McDonald, --

15 A Yes.

16 Q -- he has to exercise his professional training and
17 experience in assessing the patient as he's observing
18 him and making decisions about what to do or not to do
19 with a patient, correct?

20 A Yes, that's what he's been hired to do, and those
21 are the responsibilities he has. That's correct.

22 Q As a professional with medical training and medical
23 experience, right?

24 A Yes. He's a hired professional. That's correct.

25 Q And if there are any policies or protocols that the

1 medical department has set forth, he, as a professional,
2 has to exercise judgment on whether he follows them or
3 not, or whether they even apply to a given patient
4 presentation, correct?

5 A Yes. As someone hired to act in that capacity of a
6 treating nurse back at bedside, the -- the nurse is
7 responsible for understanding the policies and
8 procedures that are in play.

9 Q And all of the things that these nurses, triage and
10 treatment nurses, have to do in interacting with a
11 patient within the four walls of the E.R. require them
12 to exercise their experience, judgment, knowledge,
13 training, everything they've learned as a professional,
14 or any policies and procedures that may apply, as they
15 determine, apply as a professional, using their
16 professional judgment, right?

17 A Yes. That's -- that's the job responsibility, if
18 you will. It's the job assignment.

19 Q To a medical professional.

20 A To a medical professional who's been hired to
21 fulfill those duties.

22 Q And a layperson wouldn't know (a) what the duties
23 are; (b) how to perform them, correct?

24 A In the questions you're asking me today, that's
25 correct, as you would, in general, not want a layperson

1 at bedside when you get brought back to be treated, you
2 wouldn't want somebody off the street, in general, to be
3 there.

4 Q Making decisions, professional decisions, about
5 judgment or what to do with a patient or how to treat
6 them, right?

7 A That's correct. In general, you would not want a
8 layperson doing that.

9 Q And in terms of interacting with the patient and
10 determining what information the patient needs to know
11 about this process that's ongoing, whether it's from the
12 minute he walks in the door, to the history that's
13 taken, to the assessment by the E.R. triage or treatment
14 nurses, to the assessment by the E.R. doctors, to the
15 assessment by a psyche tech, to what's going to happen
16 next, those are all things that the professionals have
17 to use their judgment and skill and training in
18 determining what level of interaction to have with the
19 patient. Do you agree with that?

20 A That's correct. In your hypothetical, that's
21 generally correct.

22 Q And determining how to restrain a patient, if it's
23 even necessary, is something that only a medical
24 judgment can be used, whether it's a chemical restraint,
25 physical restraint, or no restraint at all. That's a

1 medical, professional judgment.

2 A Right. In your hypothetical case, that's generally
3 true.

4 Q Doctor, for the Court's purpose, I would like to
5 show you Exhibit 29, for identification only at this
6 point. Do you recognize that particular document,
7 Doctor?

8 A Thanks. Yes, these are some notes that I put
9 together on the morning prior to my deposition. That's
10 correct.

11 Q And just so it's clear, when you were retained in
12 this case, how long ago was that first, when you first
13 got hired by these folks to serve any function?

14 A Early this year.

15 Q And then, you were deposed. What's the date of
16 that?

17 A September 24, 2015.

18 Q So, ten or eleven months, plus or minus, after you
19 were retained, you were then offered this report the day
20 before my partner took your deposition with a bunch of
21 other people.

22 A Right. These are notes that I made in the morning,
23 as -- as I testified to in my deposition. Notes that I
24 made on the morning, so that I would have facts in front
25 of me, so that I could answer questions with less

1 looking and less error.

2 Q We'll get into all that stuff later on, but I want
3 to ask you to look at Page 2. When you were giving some
4 of the opinions you have, -- and I'm going to ask about
5 the opinions. I just want to ask you about some of the
6 terms you used in talking about the opinions.

7 This is, first, about other folks that are here,
8 but you talk about --

9 MR. HOYLE: Your Honor, I'm going to object. I
10 think we're exceeding the proper voir dire, the
11 qualifications of an expert who's been proffered to
12 offer expert testimony.

13 THE COURT: Let me hear the -- let me hear the
14 question. And please, sir, don't answer the question
15 until I've had a chance to rule on it, please.

16 A Okay.

17 BY MR. LOVELL:

18 Q Opinions you've indicated you put on this report,
19 serving as an expert retained by these folks, you talk
20 about applicable standards of care and duty to provide
21 care to this patient, right? Page 2, next to the last
22 paragraph.

23 THE COURT: I don't think that's for the jury. I
24 don't think that's appropriate voir dire.

25 MR. LOVELL: Okay.

1 BY MR. LOVELL:

2 Q Standards of care are, in your opinion,
3 professional standards of care? That's how you use them
4 in all -- you wrote in your report?

5 A Yes.

6 Q Okay. When you talk about the duty of care
7 required of practitioners under the same and similar
8 circumstances, you're talking about professional
9 standard of care, correct?

10 A Yes. That's one of the things I talked about in my
11 notes, that's correct.

12 Q And you even used the term *national standards of*
13 *care*. You're talking about national professional
14 standards of care, correct?

15 A And national duties, that's correct.

16 Q I'd like you to --

17 MR. LOVELL: Your Honor, that's probably
18 sufficient, for purposes of voir dire.

19 THE COURT: I understand.

20 MR. LOVELL: Thank you.

21 BY THE COURT:

22 THE COURT: All right. Ladies and gentlemen, there
23 is a matter that I must take up outside your presence.

24 I'm going to send you to lunch while I do the work that
25 I must do. And I'm going to ask you to be back in your

1 jury room -- we are going to be a little bit longer, but
2 we've got to get some lunch, too, after we finish our
3 work. I'm going to ask you to back in your jury room,
4 please, at 2:00 o'clock, ready to continue this matter.
5 Thank you so much.

6 Please be mindful, do not discuss this matter. Do
7 not allow anyone to discuss it with you. Don't read
8 anything or listen to anything about this matter, radio,
9 television, Internet. Do not do any investigation.

10 Remember to leave your cell phone or other
11 communication devices away from the courthouse. If you
12 forget, let us know, and our bailiffs will take good
13 care of it until you're able to take it away from the
14 courthouse. Have a good lunch. We'll see you at 2:00
15 o'clock.

16 JURORS LEAVE COURTROOM 12:24 P.M.

17 BAILIFF: Jury is clear, your Honor.

18 THE COURT: Thank you. Okay.

19 I just wanted -- I just took a moment to look again
20 at the *Hardee* case. Now, the concern is that this
21 witness may testify regarding the standard of care. And
22 the reason I excused the jury is, I think it is
23 appropriate that I just simply hear the testimony. I
24 mean, I think we're to that point in this case. And I
25 have, in our conversations, have had conversations with

1 you all both on and off the record regarding these
2 issues and whether or not there is any duty that flowed,
3 either directly or in the nature of the Hardee case, to
4 third parties, to the public, to their own public at
5 large, to Plaintiff's decedent. And I think this
6 particular witness is really -- puts a spotlight on
7 where we are in this case in terms of duty. And so, so,
8 I want to hear the testimony.

9 Let me say that, the mere fact that he is couching
10 the testimony as standard of care, he can say standard
11 of care; he can say carelessness, too. I don't think
12 there's any question in my mind that, contained in a
13 violation of the standard of care of a physician, that,
14 subsumed within that definition has got to be
15 carelessness. It's a lack of due care. And so, it is
16 more complicated to establish a standard of care, and
17 then, say that a doctor, a healthcare professional,
18 violated that standard duty of the standard of care, as
19 opposed to this person was careless. But I'm going to
20 hear the testimony. So, we'll do that now. Okay?

21 MR. HOYLE: Beg 30 seconds, your Honor.

22 THE COURT: Sure. If you all want to take a little
23 comfort break, if everybody needs to take a little
24 comfort break before we start, including our witness, we
25 can do that, too.

1 MR. HOYLE: I think that, that would be
2 appreciated, your Honor.

3 THE COURT: You want to do that, everybody? Let's
4 take a -- we'll take two or three minutes for a comfort
5 break.

6 You, too, but do not, sir, please do not discuss
7 your testimony with anyone.

8 A Thank you.

9 THE COURT: You can take a comfort break, too. All
10 right. We'll take about three.

11 OFF THE RECORD 12:32 P.M.

12 BACK ON THE RECORD 12:47 P.M.

13 BAILIFF: All rise.

14 THE COURT: Thank you.

15 DR. TERRENCE L. BAKER, PROFFER

16 DIRECT EXAMINATION, BY MR. HOYLE:

17 Q Doctor Baker, good afternoon.

18 A Hello. Good to see you, sir.

19 Q The jury has been excused, and at the Court's
20 request, I'm going to ask you a few questions. Before
21 we get into all of the opinions that you have formed
22 with respect to employees of CasePro, Incorporated, I
23 just want to ask you a simple hypothetical.

24 A Yes.

25 Q Okay. Let's assume we've got a man who comes into

1 an emergency room, and he is out of some anti-psychotic
2 medication that he's been previously prescribed. He's
3 not been taking those pills. He indicates that he is
4 both suicidal, and that he has thoughts of hurting
5 others. And the reason he is there in the emergency
6 room is because his family is concerned about him and
7 wanted him to be seen by a doctor.

8 If this hypothetical person were to request
9 permission to leave the emergency room for a breath of
10 fresh air, given your education, training, and
11 experience as a 40-year, emergency room, board-certified
12 physician, what would you tell that person?

13 A I would tell the person no. And then, I would warn
14 or advise the patient of the reason why; that is, the
15 need to keep the patient, the staff, and the community
16 safe until we were able to provide treatment.

17 Q And the duty that you've just articulated, that's
18 something that extends both to the patient and to
19 others. Did I hear that correctly?

20 A Yes. You would need to warn the patient, advise
21 the patient, as well as the staff that was assisting in
22 the care and treatment of the patient. And if there
23 were any family members available, to warn them, also,
24 and the need to advise them of the warning.

25 Q And there's been some talk here today about

1 standard of care and carelessness. Do you believe that
2 the applicable standard of care in your field requires
3 that warning to be made to the patient?

4 A Yes.

5 Q Do you also believe that a medical provider, in
6 breaching that duty to the patient, as well as others,
7 would be careless if he or she did not provide that
8 instruction and warning?

9 A Yes, they would.

10 Q Okay. Now, I know you've looked at medical records
11 in this case.

12 A Yes.

13 Q You've read deposition testimony in this case.

14 A Yes.

15 Q Okay. And focusing on your opinions with respect
16 to the three CasePro employees, Nurse Janice, Nurse Joe,
17 and Dr. Jansen, do you have opinions about these three
18 persons?

19 THE COURT: Let me interrupt you, and so that our
20 record is clear, that is Janice McDonald, Joe McDonald.

21 MR. HOYLE: Yes, your Honor.

22 THE COURT: All right.

23 MR. HOYLE: And Dr. Chris Jansen.

24 THE COURT: Yes.

25 MR. HOYLE: In a photo that he himself identified

1 here yesterday.

2 THE COURT: Yes.

3 BY MR. HOYLE:

4 Q Do you have opinions about these three persons?

5 A I do.

6 Q And what they did or did not do on February 24,
7 2012?

8 A Yes, I do.

9 Q Okay. Let's walk through this. What's your first
10 opinion?

11 A My first opinion is that there was a failure to
12 secure or place the patient, Mr. Hunt, in a secure
13 environment. And a secure environment would be a room
14 free of materials, hazards, things that Mr. Hunt could
15 use to harm himself or harm others. So, there was a
16 failure to secure. There was a failure to disrobe; that
17 is to remove the clothing from Mr. Hunt, so as to insure
18 that there was no weapons or any kind of material or
19 agents that could be used against himself, the staff, or
20 the community, in order to harm himself or harm others.

21 Number 3 is that there was failure to warn Mr.
22 Hunt, that is, to advise Hunt as to the need to keep him
23 safe; to warn him that he would need to be kept in a
24 safe room, that is, in the treatment area that's been
25 designated; to be disrobed; that he would need to be

1 accompanied to the bathroom; and that he would not be
2 allowed to leave the security of the emergency
3 department; for his own safety, the safety of the staff,
4 safety of the staff, and the safety of the community, he
5 would need to be provided with those warnings.

6 Q And let's just think by analogy, Doctor, are there
7 other analogous situations in which a healthcare
8 professional would need to provide a warning or an
9 instruction to a patient not to leave a medical
10 treatment facility that you can think of?

11 A Yes.

12 Q And what would one of those examples be?

13 A Well, the most recent example would be Ebola.
14 Ebola being a potentially life-ending, life-threatening
15 medical condition, readily spread by contact with
16 someone who is infected to somebody who's not, and the
17 patient, leaving the emergency room could readily,
18 quickly infect many others.

19 Q Okay. Are there any other analogous situations
20 that you can think of?

21 A Yes. Another one that occurred a year ago was
22 tuberculosis. A patient with known resistance to
23 tuberculosis, for which there is no cure, was identified
24 by physicians and was sequestered. That is, was warned
25 and sequestered in order to protect themselves, the

1 staff, and others in the community.

2 Q Any others that you can think of as you sit here
3 today?

4 A Yes. A patient under the influence of certain
5 medications, street drugs, alcohol, either alone alcohol
6 or in combination with street drugs. For example, we
7 recently had patients coming in who were under the
8 influence of bath salts, for example. Bath salts is a
9 substance purchased on the street that causes patients
10 to be cognitively impaired. That is, to so disrupt
11 their thinking, so as to be a danger to themselves.
12 They can be so violent as to throw -- literally throw
13 staff around, and they're certainly a danger to not only
14 to company, but any officer that approached them and
15 tried to, you know, secure them. Those patients must be
16 warned and restrained and kept safe.

17 Q And this warning that you believe should be given
18 to patients in the scenarios that you just articulated
19 for us, that's a warning that both benefits both the
20 patient and others? Did I hear that correctly?

21 A The patient, the staff, and the community as a
22 whole.

23 Q The folks within the zone of danger.

24 A Correct.

25 Q Okay. And you believe that medical personnel in

1 those scenarios you just articulated for us have an
2 affirmative obligation to make that warning. Did I hear
3 that correctly?

4 A Yes, they have an obligation or a duty to take
5 those measures, that is, to make the patient safe, and
6 to warn the patient as to what's happening and why it's
7 happening.

8 Q And by doing that, that also protects others.

9 A Correct.

10 Q Now, this duty that you just articulated, do you
11 believe that to be analogous to something referred to as
12 a standard of care that Mr. Lovell's been talking about?

13 A At times, it can be, yes.

14 Q Do you believe that, that duty, if not followed by
15 a registered nurse or an emergency room doctor, could be
16 evidence of carelessness?

17 A Correct, it would be carelessness, and it would be
18 grossly reckless or negligent.

19 Q And that's specifically if the medical provider
20 does not warn the person that they shouldn't leave?

21 A That is correct. That would be grossly negligent.
22 It would put the patient, the staff, and the community
23 at harm's, you know, in harm's way.

24 MR. HOYLE: Your Honor, at this time, I think
25 that's a sufficient examination.

1 THE COURT: I understand.

2 MR. HOYLE: I reserve the right to ask any
3 questions after my friend, Mr. Lovell, examines the
4 witness.

5 THE COURT: Well, I don't know who -- all right,
6 who's it going to be? Ah, Mr. Lovell.

7 DR. TERRENCE L. BAKER, PROFFER

8 CROSS-EXAMINATION, BY MR. LOVELL:

9 Q Doctor, looking at your three analogies that you
10 gave us of ebola, tuberculosis, and the under the
11 influence of street drugs, bath salts, alcohol,
12 whatever; ebola, when a patient presents with that, a
13 medical provider has to assess does this person have
14 signs of symptoms such that we think that they may have
15 ebola, unless a diagnosis has already been made,
16 correct?

17 A Yes, that's correct. Or the patient presents,
18 believing they've been exposed to it.

19 Q And the provider, in that scenario, may, having to
20 exercise their professional judgment, they would have to
21 do that before they ever go warn a patient of the
22 possibility they have this communicable disease that
23 they would potentially spread somewhere else, correct?

24 A Well, I would disagree. These medical conditions
25 are sufficient that warning the patient -- for example,

1 as you know, the news media was filled full of examples
2 of ebola where -- where patients with any exposure, any
3 possible exposure, were warned to stay isolated; and
4 they were either isolated by the community, or they
5 self-imposed isolation.

6 Q Warned to stay isolated. The warning part is what
7 a professional has to -- a doctor, nurse, in our
8 scenario, the McDonalds or Dr. Jansen, would have to
9 decide is this a condition that exists in this patient
10 that I must now warn the patient of something that he's
11 not already aware of, right?

12 A Well, I disagree. Some medical conditions, such as
13 the ones that I mentioned, and including suicide/
14 homicide thoughts, are so obvious, that even a
15 layperson, even a lay person, would recognize. For
16 example, anyone in this courtroom, I believe, would
17 recognize that someone exposed to ebola must be
18 isolated. It's so well-known, it's so well-published,
19 that even a layperson would recognize it.

20 Q You mentioned in your tuberculosis it was a known
21 resistant strain; that's what everybody's worried about
22 the warning preceding?

23 A Yes.

24 Q And the bath salt, obviously, it would be known
25 that they were under the influence of that because of

1 the things you said, it impairs the cognition such that
2 they're so violent as to throw things around. That's,
3 again, a known issue?

4 A It is a known issue, but the -- the risk and
5 symptoms are so well-known in the public that even a
6 layperson would recognize that a person under the
7 influence of bath salts needs to be protected.

8 Q And in this case, -- let me ask you, first, to
9 define something for me. Homicidal, what does that mean
10 as you're using it?

11 A Homicidal, in general, means that you have
12 thoughts, plans, ideas, about harming someone else.

13 Q Thoughts, plans, ideas about harming someone else,
14 that's the focus of homicidal as it relates to what
15 we're doing here in this courtroom and as you're using
16 the term, right?

17 A In general, that's true.

18 Q Suicidal, define that as you're using it in this
19 case.

20 MR. HOYLE: Your Honor, I'm going to object. I
21 don't think -- I think this might have exceeded the
22 bounds of what was permissible at this point in time,
23 asking the witness to define terms that don't
24 necessarily go to whether or not this witness is
25 qualified to offer opinions in the field of emergency

1 medicine.

2 THE COURT: Got you. Go ahead. Okay.

3 MR. LOVELL: Respond to the objection, or ask a
4 question?

5 THE COURT: Keep going.

6 BY MR. LOVELL:

7 Q Define that, suicidal.

8 A Yes. The general term would be suicidal, which is
9 where you have thoughts, plans, ideas to harm yourself.

10 Q And in the case, if the warning that would be
11 required by your testimony to be provided to this
12 patient, Mr. Hunt, would be related to homicidal
13 ideations, or suicidal, because he had both, right? Is
14 that what you're contending?

15 A Yes. The warning would be that -- that the reason
16 we're saying no to leaving the facility, and the reason
17 we're offering treatment is that, number 1, we believe
18 you're a danger to yourself. So, he should be warned
19 that he is a danger to himself. We're concerned that
20 you could be a danger to the staff, and we're concerned
21 -- you would be warned that you can be a danger to the
22 community if you were to leave.

23 Q But doesn't it require the exercise of
24 professional, medically-trained judgment by a nurse,
25 McDonalds plural, or Dr. Jansen, to determine if he

1 does, in fact, have thoughts, plans, and ideas to hurt
2 himself or others?

3 A Well, and in my deposition, I answered that
4 question yes and no. I said, yes, certainly, trained
5 professionals have that knowledge, education, training,
6 experience. But you recall, I also talked about going
7 out on the street and talking to a hundred laypersons
8 about somebody with same or similar symptoms, that is,
9 homicidal or suicidal thoughts. And it was my opinion
10 in my deposition testimony that, that most laypersons
11 would recognize the need to keep the duty, the
12 responsibility, to keep the person safe.

13 Q But you've done no scientific studies that did any
14 interviews of hundreds of people. That's speculation on
15 your part, is it not, Doctor?

16 A I disagree. It's based upon nearly 40 years of
17 treating patients, their families. For example, in this
18 case, Mr. Hunt is in the Naval Emergency Room, in large
19 part, because his grandmother recognized he needed -- he
20 needed assistance, and she's a layperson.

21 Q But not specifically that he had homicidal
22 ideations or suicidal ideations.

23 A But you recognize the need that he needed
24 assistance and to be kept safe.

25 MR. LOVELL: Judge, I think we've covered enough on

1 that.

2 THE COURT: Okay.

3 MR. LOVELL: Thank you.

4 THE COURT: Very well. All right.

5 MR. LOVELL: Thank you, Doctor. I'm sorry.

6 A You're welcome.

7 THE COURT: You go get yourself some lunch. Be
8 mindful, again, though, do not discuss your testimony
9 with anyone. And I'll see you at 2:00 o'clock, please,
10 sir.

11 A Thank you.

12 ARGUMENT AND RULING:

13 THE COURT: All right. Once the Doctor leaves, if
14 you all have any additional argument, I'd be happy to
15 hear from you.

16 MR. HOYLE: Doctor, before you leave, I think Mr.
17 Knowles will probably meet you at the parking lot with
18 your lunch that you requested.

19 A Oh, thank you. Thanks.

20 THE COURT: Oh, that is lovely.

21 MR. HOYLE: I wanted to say that in open court,
22 Judge, so there's no question.

23 THE COURT: Oh, great. What did we get him?

24 MR. HOYLE: Unfortunately -- unfortunately --

25 THE COURT: Stop, stop.

1 MR. HOYLE: Unfortunately, I believe it's Chick-
2 fil-A. We're a little bit tired of it after, I think,
3 about day six.

4 THE COURT: Okay. Yes.

5 MR. LOVELL: Judge, I would just reiterate our
6 argument I started making earlier, that, under Rules, I
7 think 701, 702, 703, in order for this gentleman to
8 testify, there must be some issue in question or fact at
9 issue that his expertise would shed some light upon.
10 He's only here to testify about professional negligence.
11 You can look, from the testimony he just gave us, that
12 all of these failure to warn and the things that he's
13 talking about require the exercise of professional
14 judgment, and this is not pled as a professional
15 judgment case. Otherwise, they would have had to have
16 expert affidavits and such; and thus, his testimony on
17 all these issues is just irrelevant.

18 And so, to allow him to testify would be, (1) an
19 injection into, in front of this jury, issues that have
20 not been pled, and are not relevant. (2) a waste of the
21 Court's time and judicial resources in doing so.

22 And as the doctor just stated that, at times, the
23 duty is analogous to standard of care. And that's the
24 time we're talking about is right now.

25 THE COURT: Okay.

1 MR. LOVELL: So, we think his testimony should be
2 excluded.

3 THE COURT: Got it. All right. Here is my view of
4 this witness's testimony in this case. And I
5 specifically cite two cases, the *Bishop* case and the
6 *Hardee* case. And when you read those two cases
7 together, our courts talk about the fact that a medical
8 malpractice case is a case that can only be brought by
9 the patient, except under extraordinary circumstances.
10 It then follows up with the *Hardee* case. And the *Hardee*
11 case says that, when there is, even in the medical
12 context, a duty to warn, that the duty to warn the
13 patient also flows to the community at large, motorists,
14 in the *Hardee* case.

15 When you look at those cases together, and you look
16 at the fact that South Carolina clearly allows a cause
17 of action under ordinary negligence, and it isn't
18 excluded simply because it arises in the medical
19 context, I believe that this is such a context.

20 This witness intends to, at the end of the day, say
21 that these healthcare professionals owed to this
22 gentleman, Mr. Hunt, a duty to warn him, a duty to warn
23 him. And it happens that this duty to warn does arise
24 within the medical context. Well, if I'm going to talk
25 about -- if I had a police officer, who Mr. Hoyle called

1 or Ms. Castleberry called to testify, and this doctor,
2 these nurses, had a duty to warn this guy when he walked
3 out, no doubt there would be -- there would be an
4 objection, because they do not -- the police officer
5 would not have the requisite knowledge, training, or
6 experience to know what a doctor ought to do and ought
7 not to do, or a nurse ought to do or ought not to do,
8 because it's their lack of knowledge, training,
9 experience.

10 So, when the ordinary negligence arises in the
11 medical context, there's got to be somebody that can
12 testify should that kind of testimony help the jury
13 understand the issues, the evidence, and I think that is
14 what is presented by this witness. He is somebody who
15 can simply say, by virtue of his knowledge, training,
16 and experience, because he's a doc, an emergency room
17 doctor, can just say, yes, this is a lack of due care;
18 this is careless. He doesn't have to say, standard of
19 care, but he can certainly say this is -- it is
20 negligent not to warn this gentleman, who has told these
21 people that he has had thoughts of injuring himself and
22 others. And I believe that no one else -- I don't
23 believe anyone else would be allowed to testify
24 regarding ordinary carelessness, because of the unique
25 environment where the warning should have existed,

1 should have occurred.

2 So, that's what gets us to medical experts.
3 There's nothing magical about them. It doesn't make it
4 a malpractice case because the person who can testify to
5 the carelessness happens to be somebody that's got the
6 knowledge to know whether or not, in this context, it's
7 negligent, it's careless. And it is the duty to warn,
8 not a treatment issue, it a duty to warn, which is
9 certainly what is reflected in the Hardee case. And at
10 the end of the day, I believe that, that is the only
11 duty that I am satisfied that our courts have recognized
12 does extend to third parties, and that is the duty to
13 warn. And the motoring public, the public at large, if
14 you will, obviously, are entitled, pedestrians crossing
15 the street are entitled, to the warning, much as the
16 language says in Hardee, a duty to warn the patient
17 benefits the community, as well.

18 Okay-dokey. Go get some lunch.

19 MR. LOVELL: We'll just take exception to the rule,
20 your Honor.

21 THE COURT: Oh, I know. I know, I know, I know.

22 MR. HOYLE: And as always, we respect your ruling,
23 your Honor.

24 MR. MACKELCAN: And just for clarification, your
25 Honor, he listed three different failures. And number

1 three was the failure to warn. The other two had to
2 deal with actions taken in their capacity as medical
3 providers. They're talking about removing his clothing
4 and putting him in a secure environment free from
5 hazards.

6 THE COURT: Failure to disrobe was to see if he had
7 any weapons on him, to keep, you know, for -- and you
8 know, failure to secure, as I recall, he certainly
9 interwove in all of them, the failure to warn, with the
10 failure to secure and failure to disrobe, so.

11 MR. MACKELCAN: Okay.

12 THE COURT: All right.

13 MR. LOVELL: Thank you, Judge.

14 THE COURT: You all go get some lunch.

15 MR. HOYLE: And your Honor, I hate to be a pest,
16 but we raised --

17 THE COURT: You are a pest.

18 MR. HOYLE: We raised earlier about the summary
19 judgment issue with respect to Edward Ray, and --

20 THE COURT: Oh, the cross-examination. What do you
21 all want to cross-examine him on?

22 MR. LOVELL: I'm sorry? What? I --

23 THE COURT: What do you want to cross-examine this
24 gentleman about?

25 MR. HOYLE: They just want to blame Mr. Ray.

1 MR. LOVELL: Well, he, in his report, has opinions
2 that Edward Ray was negligent in doing a whole laundry
3 list of things, supervising, not doing this, that, and
4 the other with the guy. I think the fact that Mr. Ray
5 -- or Mr. Ray's employer was dismissed because of
6 sovereign immunity. We pled there are supervening --
7 superceding and intervening --

8 THE COURT: I thought you were going to go
9 supercalafragalistic.

10 MR. LOVELL: We've alleged that other acts, both
11 subsequent to the alleged negligence act of our client's
12 intervening proximate cause, superceding intervening
13 cause, these events that led to this death of this young
14 man. And we think that the testimony from this witness,
15 who authored opinions critical of what those people did,
16 and who said those contributed to the events, especially
17 going outside without supervising this guy and all of
18 that, is clearly irrelevant to this case.

19 THE COURT: Go ahead.

20 MR. HOYLE: My two thoughts that are on the tip of
21 my tongue: (1) you made the comment about a police
22 officer can't come in here and say what a doctor or
23 nurse ought to do. While this man treated patients at
24 the Dorn V.A. Center, he's never been a county Veterans
25 Affairs officer. These are folks who, by statute, are

1 appointed solely by our legislative delegation to assist
2 veterans and work in that capacity. I don't know that a
3 medical doctor, even if he is the president of the
4 American Academy of Emergency Medical whatever, can come
5 in here, under our *Watson* standard and under our rules
6 of evidence, and offer an opinion about what Edward Ray
7 should do or should not do.

8 And specifically, going back to *Hardee*, as your
9 Honor has articulated, and I've heard it -- I've heard
10 it, Judge, as you have articulated, *Hardee* clearly says
11 there is at least a duty to warn. And with respect to
12 permitting testimony on that basis, what would Mr. Ray's
13 duty have been to warn? Certainly, under *Hardee*,
14 *Hardee*, again, the dialysis case rises in the medical
15 context. This is a medical doctor. I mean, if Mr.
16 Lovell wants to get him a Veterans Affairs expert and
17 lay that foundation, that might be proper for his
18 superceding intervening cause, but.

19 MR. LOVELL: Your Honor, the doctor, in his
20 affidavit, said that Mr. Ray knew, before Dr. Jansen
21 ever interacted with this patient, from conversations or
22 information that was made available to this expert, that
23 Mr. Hunt had told people he wanted to hurt others, and
24 that Mr. Hunt [sic], with that knowledge, should have
25 done something more to supervise, control, et cetera, et

1 cetera, et cetera. He's got experience. They're
2 bringing him in as an expert. I can put him up and ask
3 him about his opinions. Credibility and weight and all
4 is for the jury to decide. He's equally competent,
5 based on his --

6 THE COURT: Hold that thought just a second.

7 MR. LOVELL: I'm sorry, your Honor.

8 THE COURT: No, I understand where you're coming
9 from. Hold up. I've got to get my cheat sheet.

10 MR. LOVELL: Okay, your Honor.

11 THE COURT: Got to have my cheat sheet, so hold on
12 a minute. Hold on. Now, go with me to the summary
13 judgment order.

14 Now, I want you all to go with me to -- now, let me
15 ask, just ask this question. Tell me your theory, just
16 in general, your theory of liability regarding Mr. Ray.

17 MR. LOVELL: Well, the Plaintiffs alleged in the
18 original complaint, and their expert has testified, that
19 Mr. Ray had a duty to control, supervise, and otherwise
20 warn other people about this gentleman, Mr. Hunt.

21 THE COURT: And they lost that.

22 MR. LOVELL: But that's -- you're asking our
23 position -- that he had a duty to do something to
24 protect others that he assumed, on his own individually,
25 outside of the course and scope of whatever he's doing

1 with the V.A., and that he never did anything about it.

2 THE COURT: Outside the scope of the V.A. Come on.

3 MR. LOVELL: Right. The first thing in the order
4 the Defendants were arguing, hey, he's outside the scope
5 of the V.A.; Plaintiff hasn't proven anything. And so,
6 that whole issue is, he's acting as Mr. Ray, individual,
7 family friend. They allege that he was told by Mr. Hunt
8 at some point around 10:30 in the morning, according to
9 Dr. Baker's, by Mr. Hunt, hey, I got thoughts of hurting
10 myself and others. Again, according to the affidavit of
11 Dr. Baker, when he was interviewed by Nurse Smith, he
12 was told similar information. Never did anything to
13 protect anybody from this dangerous individual with whom
14 he has knowledge.

15 Now, it's for a jury to decide whether that's
16 carelessness or recklessness on his part, under the
17 ordinary care standard, which is what, at this point,
18 we're dealing with. We think that issue goes to
19 intervening proximate cause, because, when Mr. -- we
20 know, from the evidence in the courtroom, the first time
21 that Dr. Jansen had ever made -- that anybody in the
22 E.R. was made aware of thoughts of hurting others is
23 when Dr. Jansen's interviewing this gentleman. So, at
24 that point, Dr. Jansen has knowledge, but Mr. Hunt also
25 has the same knowledge. He's in the room when that

1 interview takes place. He's the one that goes up
2 knowing that, and talks to Nurse McDonald, under that
3 theory, and asks permission may we go outside. He
4 doesn't make any com --

5 And I ask Joe McDonald, anybody ever tell you -- or
6 they asked Joe McDonald, anybody ever tell you this guy
7 had thoughts of hurting himself? Joe says, no. Mr. Ray
8 doesn't say that to Mr. McDonald. And so, I think a
9 jury could determine that Mr. Ray's failure to give this
10 knowledge that he has to Mr. McDonald, before he asks
11 permission to go outside with a guy that he knows is
12 dangerous, or supposedly dangerous, is, in and of
13 itself, a failure to exercise ordinary care for the
14 safety of himself, the staff of the E.R., and the
15 motoring -- the public at large. That's our intervening
16 proximate cause argument, or superceding, whatever the
17 two terms you want to use.

18 So, take Dr. Jansens's interaction and work your
19 way forward, at that point, Mr. Hunt [sic] clearly has
20 the same knowledge that they're being critical -- I
21 mean, Mr. Ray has the same knowledge they're being
22 critical of my people for having, except for, obviously,
23 the McDonalds, who didn't. So, it's the same standard.
24 It's an ordinary negligence standard. Would a
25 reasonably prudent person like Mr. Ray, who has

1 knowledge that this gentleman has said I have thoughts
2 of hurting other people, allow him, escort him, and go
3 with him, outside of the E.R.? That's the question
4 they're saying that, you know, Dr. Jansen had the same -
5 - they're saying he had the same duty at that point
6 because he had the knowledge, that he should have warned
7 the patient. Well, perhaps Mr. Ray should have done the
8 same thing. It's an ordinary care standard. You've
9 said it's not a professional negligence standard, so Mr.
10 Ray is held to the same standard as Dr. Jansen, once he
11 has that knowledge.

12 MR. HOYLE: Your Honor, two brief thoughts. (1) I
13 hold elected leadership roles in both the South Carolina
14 Association for Justice and the American Association for
15 Justice. I'm a trial lawyer, plaintiff's lawyer. And
16 even under my expansive interpretation of *Hardee*, which
17 may be more expansive than other persons in this room, I
18 do not believe *Hardee* creates a duty on a friend to warn
19 them in certain situations that they pose a risk of harm
20 to themselves or others, and make sure that they stay
21 safe, and don't harm others in a foreseeable zone of
22 danger. I don't think that's what *Hardee* says.

23 But more importantly, I want to go back to
24 something that we briefly raised on the very first day,
25 when we all got here to Beaufort after the flooding.

1 And that's, following the entry of this order, actually,
2 within 48 hours of Judge Jeff Young signing his name to
3 this order, looks like on November 6, 2014, the
4 Defendant removed us to federal court. And this is a
5 second time we've went to the courthouse at the four
6 corners of law from here. And at that time, we were
7 removed, because the Defendants alleged that the
8 Plaintiff had fraudulently joined the state Office of
9 Veterans Affairs. The Defendant said, in papers filed
10 in federal court, and they clocked in a notice of
11 removal in this courthouse, they said that we
12 fraudulently joined these people, because we had --

13 THE COURT: That's in these pleadings?

14 MR. HOYLE: Yes. Yes, your Honor.

15 THE COURT: Okay. Go ahead.

16 MR. HOYLE: Said that there was no evidence
17 whatsoever, and that we were just a bunch of crooks,
18 essentially. And you know, we had no plausible basis to
19 get a recovery against the State Office of Veterans
20 Affairs, and we were just a bunch of charlatans, trying
21 to drag this poor company from Texas into the
22 jurisdiction of the State Court of Common Pleas here in
23 Beaufort.

24 And thankfully, Judge Norton, he didn't even hold a
25 hearing on it, but it took him awhile to read all the

1 papers, he said there's no evidence that the Plaintiff
2 and Plaintiff's counsel have engaged in fraud. There's
3 no evidence that anybody's been fraudulently joined, and
4 I'm not going to presume that the Plaintiffs -- or that
5 the Plaintiffs or the Plaintiff's counsel engaged in
6 that fraud, and he sent us right back here.

7 So, I think it's a little disingenuous, and I would
8 even go so far as to state, I think the Defendant is
9 estopped from now coming into this court during this
10 trial and somehow making Edward Ray and the State Office
11 of Veterans Affairs or Beaufort County or whoever the
12 heck it is he worked for, the boogeyman.

13 Either they were disingenuous under Federal Rule
14 11, in their pleadings that they filed in federal court
15 about what the situation was with respect to Judge
16 Young's order; or they're being, I hate to say this,
17 perhaps, less than genuine now, because I don't think
18 they can have it both ways, Judge.

19 And I'll be real honest, at the time, Ms.
20 Castleberry and I argued very vociferously about whether
21 or not we should seek a sanctions order in federal
22 court. We did not. We were content to get our order
23 from Judge Norton, and come right back here, because we
24 knew we'd have twelve people in a box from Beaufort
25 County. But I don't believe, that under our principles

1 of judicial estopped in this state, they're allowed to
2 do what they're trying to do right now.

3 MR. LOVELL: Judge, may I make one comment on that?
4 This judge's order was entered on November the 6th. The
5 affidavit of Dr. Baker, their expert that we're talking
6 about, was authored on September 20-something of this
7 year, a month before this trial, setting forth the
8 issues that he contended were issues that were relevant
9 to this matter, and it's in Defendant's 29, your Honor.

10 So, all of these issues are not issues. This is
11 their expert, writing a report to David Hoyle, saying,
12 here are the things that I think are evidence of
13 negligence in this case. Well, and this is offered by
14 their expert a year -- almost a year after the orders
15 were given. So, are we to now assume that this expert
16 is not coming into court to talk about these very
17 issues? This is the guy that they put up as the expert
18 talking about Mr. Ray.

19 MR. HOYLE: Well, Judge.

20 MR. LOVELL: If they weren't issues in the case,
21 why in the heck are they letting him testify about it?

22 MR. HOYLE: Well, Judge, because I don't write my
23 experts' reports; that's why. I mean, I didn't tell
24 this man what to say. I don't need to. I didn't have
25 to go find somebody who practices on the night shift in

1 North Charleston to be an expert in this case. Instead,
2 I hired Dr. Baker. We gave him the complaint, so he
3 knew who the parties were. We sent him a whole treasure
4 trove of documents, all the depositions, all the
5 documents that had been produced in discovery, so on and
6 so forth.

7 My good friend and colleague, Elizabeth Smith, went
8 up there to Baltimore to attend his deposition, and it
9 wasn't until that deposition that I knew he had some
10 thoughts about Edward Ray. I'll be completely candid
11 with this court and with opposing counsel. I didn't go
12 to that deposition. We were doing, I think, eight
13 depositions that week, and I couldn't be in two places
14 at once. So, Ms. Smith went and covered that
15 deposition. And she called and told me this, and I
16 said, well, huh, that's interesting; I've talked to this
17 man three or four times, and Edward Ray's never come up.
18

19 But regardless, I think that the law of this case
20 is that the State Office of Veterans Affairs is not a
21 party; they're not a proper chair. And I think the
22 Defendant has affirmatively placed, in statements filed
23 in court, and their notice, in removal and subsequent
24 briefs, because they vigorously contested our motion for
25 a remand that there wasn't even a scintilla of evidence;

1 we had no good-faith basis. They kept using that phrase
2 a bunch, no good-faith basis, and, you know, that we
3 should suffer the consequences, and be removed to
4 federal court. So, I don't know why we are hearing this
5 now.

6 THE COURT: I'm waiting from the order from Judge
7 Norton.

8 MR. HOYLE: Can you go print that, Ms. Saber. I'll
9 ask my paralegal to go print it. We don't have it in
10 hard copy box.

11 THE COURT: Okay.

12 MR. HOYLE: But it would have been transmitted back
13 to Ms. Roseneau in April? In late April.

14 THE COURT: Okay. Oh, that's very helpful.

15 MR. HOYLE: It could have been March, Ms.
16 Castleberry tells me. It was either March or April.

17 THE COURT: Okay.

18 MR. HOYLE: If I may be excused, to help my
19 paralegal find the document, that might help expedite
20 things.

21 THE COURT: And I'm worried about you all getting
22 lunch, too. Here's what we're going to do. I got it.
23 I got your positions. You all go get some lunch, and
24 you don't have very long. And then, I'll let you know,
25 too, what I'm going to do. Okay?

1 MR. HOYLE: Thank you, your Honor.

2 OFF THE RECORD 1:29 P.M.

3 BACK ON THE RECORD 2:25 P.M.

4 BY THE COURT:

5 THE COURT: Yes.

6 BAILIFF: Are you ready, your Honor.

7 THE COURT: I've been ready.

8 BAILIFF: Jury is entering the courtroom, your
9 Honor.

10 JURORS ENTER COURTROOM 2:26 P.M.

11 THE COURT: Ladies and gentlemen, just as we were
12 parting, there was a request to qualify this witness as
13 an expert, and he has been qualified as an expert in the
14 field of emergency room medicine. And I want to tell
15 you what that means. And I'm standing because -- I'm
16 just standing because, same reason as you all wanted to
17 stand this afternoon.

18 Ladies and gentlemen, under our rules of evidence,
19 ordinarily, witnesses are not allowed to testify
20 regarding their opinions, but there's an exception, and
21 that's when, by virtue of someone's knowledge or
22 education, profession, and experience, they become an
23 expert in some field, perhaps, or science, typically.
24 And those individuals are allowed to testify regarding
25 their opinions, and the reasons for those opinions, and

1 they can testify regarding their opinions within that
2 area of expertise. And this witness has now been
3 qualified as an expert.

4 I will tell you, in general, and I will certainly
5 give you instruction when I give you the concluding
6 instruction, that expert testimony is given for the
7 purposes of helping you understand the evidence, and not
8 for the purpose of controlling your judgment. And I
9 will give you more instruction, but that's the short
10 version of it. I'll give you the longer version when I
11 give you the concluding instruction on the law.

12 So, I'm now sitting down. Turning it over to you,
13 Mr. Hoyle.

14 MR. HOYLE: Thank you, your Honor. May it please
15 the Court?

16 THE COURT: Yes.

17 DR. TERRENCE L. BAKER

18 CONTINUE DIRECT EXAMINATION, BY MR. HOYLE:

19 Q Doctor, I think I have the pleasure of saying, good
20 afternoon, now.

21 A Good afternoon, sir.

22 Q All right. Just to refresh people's recollection,
23 you've traveled all the way here today from Baltimore,
24 Maryland to offer testimony in this case. You're a
25 board-certified, emergency room doctor, correct?

1 A Yes.

2 Q Okay. Before we adjourned for the lunch hour, we
3 were going through a little bit of your qualifications
4 and your experience. And I just was looking over your
5 curriculum vitae, and I just want to make sure that this
6 Court and jury has the benefit of all of your
7 qualifications.

8 I see something on here that says you are a
9 certified medical director. What is that?

10 A Correct. Being a certified medical director means
11 that I have taken a course of -- an additional course of
12 study, particularly being a director for a long-term
13 care facility, nursing home, residential care, assisted-
14 living-type facilities, and have successfully completed
15 that course work.

16 Q Okay. And you told us earlier about how you will
17 actually be in a 40-something-bed emergency room
18 tomorrow, up there in Baltimore. But I've heard earlier
19 that you've got a number of board certifications,
20 including, I think you said, family practice.

21 A Yes.

22 Q Do you also maintain a private family practice
23 outside of the emergency room setting?

24 A I do.

25 Q Tell us about that, Doctor.

1 A Yes. I have a general family medicine practice.
2 We see several thousand patients a year. It started as
3 sort of an overflow from the emergency room. There were
4 homeless patients and patients without doctors in the
5 emergency room, and that didn't have anywhere to go. We
6 train a lot of physicians in Baltimore, but there
7 continues to be a shortage of primary care, even in
8 Baltimore. And so, it started as sort of a bridge
9 clinic or an overflow clinic. And out of that, it's
10 grown into several thousand patients that myself and my
11 nurse practitioner manage. We have several special-
12 interest patients sent us. For example, we have
13 specialty in wound care and wound healing, difficult-to-
14 heal wounds. We also have special knowledge and
15 training in -- in weight loss. In fact, back in 1998, I
16 started doing weight loss here in South Carolina in
17 Columbia, South Carolina with Physicians' Weight Loss.
18 It created a lot of interest in me, and I continue to
19 work with patients to lose weight today.

20 And we also do some pain management, that is, for
21 our patients who are experiencing pain from various
22 muscle and bone diseases, necks, backs, shoulders, hips,
23 we also use pain management. But just not with
24 medications or with physical or occupational therapy; we
25 also use medical therapeutic lasers to help people cure

1 medical conditions that they've suffered with for years,
2 but that didn't have good solutions.

3 Q Okay. Sounds like you do a lot in your private
4 practice. Is that fair?

5 A Yes. We are a busy private practice, yes.

6 Q All right. And one of things I noticed on your
7 C.V., it looks like you've done some work at the M&T
8 Stadium. What is that, Doctor?

9 A Yes. I've worked as a stadium physician for the
10 Baltimore Ravens, I guess, for about eight years. Also,
11 in Baltimore, we host a lot of big sporting kind of
12 events, Army versus Navy, those type of games, that I
13 also help to staff.

14 Q I asked you earlier today about peer-reviewed
15 articles. And I think you told us you haven't
16 necessarily done any peer-reviewed articles. But have
17 you engaged in professional peer review of other
18 physicians?

19 A Yes.

20 Q Tell us about that, Doctor.

21 A Well, I do that in several ways. (1) at the Good
22 Samaritan Hospital, I'm actually on the Credentials
23 Committee. I was chairman of that committee for many
24 years. And what the Credentials Committee does is, it
25 reviews the knowledge, training, education, of

1 physicians who want to be on staff at Good Samaritan
2 Hospital. So, I'm on the Credentials Committee, and
3 that involves peer review of other doctors, all
4 specialties, to make sure they have the knowledge,
5 education, training, experience to practice at our
6 hospital.

7 Number two is, within our hospital, I also do peer
8 review with the Risk Management Department, where I
9 review possible problems in our own facility with the
10 care we provided, and come up with solutions so that,
11 that doesn't happen again. Or, if nothing happened to
12 -- to verify that, in fact, nothing happened.

13 Next is, I work with State Board of
14 Medical Examiners, too. I did it here in South Carolina
15 for many years. Currently do it in Maryland, which is
16 to review medical records, and to answer questions that
17 the State Board may have.

18 And then, finally, with the American Association of
19 Physician Specialists, as the president of the Academy
20 of the Emergency Physicians, I regularly sit down and
21 review the files of young physicians who want to become
22 board certified in emergency medicine, to make sure that
23 their paperwork and their credentials are in order.

24 Q And on a personal, on an honorary-type basis, I
25 understand you're also an Eagle Scout.

1 A I am.

2 Q And in some of the conversations you and I have had
3 the past couple of days, I understand you recently had
4 the opportunity to meet the Pope.

5 A Yes.

6 Q Tell us about that.

7 A Yes. I had an opportunity to travel to New York to
8 the Madison Square Garden appearance, and to be part of
9 that celebration.

10 Q All right, Doctor. Can you please tell our jury
11 here in Beaufort what you have reviewed in connection
12 with the events that transpired on February the 24th,
13 2012.

14 A Yes. The documents that I've reviewed include all
15 the medical records concerning that day, February the
16 24th, 2014 [sic], in terms of Beaufort medical records.
17 Also, records from that day, February the 24th, 2012,
18 and past medical records of Mr. Hunt concerning multiple
19 visits that he had made throughout the healthcare system
20 prior to that day.

21 Also, looked at something called interrogatories,
22 which is the attorneys ask each other questions prior to
23 the trial. Those are called interrogatories. And so,
24 I've looked at answers from both parties, Defense and
25 Plaintiff's answers to questions they were asked before

1 the trial, called interrogatories.

2 I've also looked at a number of depositions. Dr.
3 Jansen, Craig Martin, Janice McDonald, Koren Pope,
4 Saundra Smith, Deborah Meaut.

5 Q Meaut.

6 A M/e/a/u/t. Sorry. Erik Oberg, who, I believe, is
7 an expert witness, also. Also, Michael Cole. Mr. Mann,
8 who is the psychiatric technician. Also, a motion for
9 summary judgment concerning the Office of Veteran
10 Affairs.

11 Q But did I hear correctly you actually reviewed
12 prior medical records of Calvin Hunt?

13 A I did.

14 Q Okay. And you said these were prior medical
15 records from some sort of system. What system were they
16 from, Doctor?

17 A They were from the -- the military, or the -- they
18 were from the military system of records. I can't think
19 of the -- the official name of that.

20 Q Okay. But something that had been printed off in
21 hard copy? Or you looked at them electronically?

22 A Both.

23 Q Okay. Now, based upon your review of all that
24 information you just told us about, have you formed
25 certain opinions related to Calvin Hunt's elopement from

1 the Naval Hospital Beaufort, which resulted in Justin
2 Nicholas Miller's unfortunate death?

3 A Yes.

4 Q We're going to go a little slowly. Okay? And
5 since you used to live in South Carolina, I know you
6 won't have any trouble with that. Let's walk through
7 those opinions. Okay?

8 A Yes.

9 Q Okay. Can you tell the jury what your first
10 opinion is about the events of that day.

11 A Yes. First, there was a careless disregard for Mr.
12 Hunt when he arrived in the emergency room to protect
13 Mr. Hunt from himself. He should have been placed in a
14 quiet room that was readily observable, and anything in
15 that room that could be used as a weapon to hurt himself
16 should have been removed. So, there was a careless
17 disregard for that responsibility or duty to do that.

18 Secondly, is that there was a second careless
19 disregard to disrobe Mr. Hunt, because, being a Marine,
20 he certainly had the possibility of knives and guns and
21 all sorts of various objects and items that can be used
22 to harm yourself. And when you have a depressed, sad
23 mind that's having thoughts about hurting yourself or
24 hurting others, literally, anything can become a weapon
25 against yourself. So, he was required to be disrobed

1 and put in a gown, a hospital gown, and his personal
2 effects put in bags, labeled properly, and removed from
3 the room.

4 Third, there was a careless regard for allowing Mr.
5 Hunt to wander, Calvin to wander, in the facility. He
6 wandered to the bathroom alone and unsupervised, still
7 fully clothed, unsupervised. Again, a careless
8 disregard for Mr. Hunt's safety, because in the
9 bathroom, many things in a bathroom can become a weapon
10 against yourself or against others. Okay? Everything
11 from the mirror can be broken, to the toilet can be
12 broken. You get the picture. I've even had patients
13 try to drown themselves in the toilet. So, he needed to
14 be supervised and gowned at all times. That supervision
15 could include a sitter, someone specifically assigned to
16 -- from the medical staff of the facility at the Naval
17 Hospital to supervise him at all times.

18 Finally, there was a careless disregard for
19 allowing him to go outside, because, in my opinion, Mr.
20 Hunt was testing the system. That is, testing the
21 healthcare providers, the physician, and Joe McDonald,
22 the nurse. Was testing them to see what they would
23 allow him to do. They allowed him to go to the bathroom
24 unsupervised, fully dressed. Now, he's asking to go out
25 and get a breath of fresh air. He's basically testing

1 the system, and -- and this is something that is well
2 known to physicians like myself; that patients like Mr.
3 Hunt, who are not thinking clearly, who are sad, who are
4 depressed, or having these kinds of thoughts, and when
5 you allow him to go outside, there's something that I
6 have labeled rabbit syndrome, which is that a
7 significant number of patients in this situation,
8 particularly when they've just been seen by someone from
9 the psychiatric department, will run. And that's
10 exactly what happened here. It was careless. It was
11 reckless to allow Mr. Hunt to go outside, essentially,
12 unsupervised, where he ran away, stripped naked, got
13 into the fire truck, and -- and created a death.

14 Q Well, with respect to that last opinion -- and let
15 me back up. All of your opinions that you're offering
16 here today, those are as to the actions and inactions of
17 CasePro, Incorporated, employees.

18 A Correct. Because this is not a malpractice case,
19 as I understand it.

20 Q Okay. And again, Justin Miller was never a patient
21 at the Naval Hospital. That's your understanding?

22 A Yes.

23 Q He was just somebody trying to cross the street
24 while he was out for a walk.

25 A That is correct. That's my understanding.

1 Q Okay. So, with respect to that last opinion you
2 told us about, about it being a careless disregard for
3 safety to allow Calvin Hunt to leave, --

4 A Yes.

5 Q -- what should Joe McDonald have said when the
6 question, can we go outside for a breath of fresh air,
7 was asked?

8 A What should have happened is that Nurse McDonald,
9 Nurse Joe McDonald, should have said, in a calm -- a
10 calm, quiet voice, no, you may not go outside; and then,
11 an explanation, a warning. The reason that I will not
12 allow you to go outside is because you're not feeling
13 well; you're having some thoughts about hurting yourself
14 or hurting someone else; and we're going to get you some
15 help; if you need something to eat or drink, we can
16 provide it; but we're going to get you some help. And
17 there should have been a warning that you need to stay
18 in the room we've prepared for you; we're having a
19 doctor to come and see you; and we will get you help.
20 And Mr. Hunt should have been warned that going outside
21 was -- would be dangerous to himself, the staff, and the
22 community.

23 Q That warning would be specific to the public at
24 large.

25 A Yes.

1 Q Folks walking down the street near the Naval
2 Hospital.

3 A Correct.

4 Q Okay. And the warning that you think, and are
5 testifying here today as an expert in the field of
6 emergency medicine, needed to be given to Calvin Hunt,
7 was that solely for Mr. Hunt's benefit, or solely -- or
8 also for the benefit of others?

9 A It was for the benefit of -- of all parties.
10 First, Mr. Hunt, because, if Mr. Hunt is kept safe by
11 securing him in a quiet room and providing his needs
12 while he waits to be treated, it protects the staff from
13 Mr. Hunt having thoughts and concerns about harming the
14 staff. And it protects the community as a whole, the
15 Beaufort community as a whole, by preventing Mr. Hunt
16 from leaving his quiet, safe environment in the
17 emergency room.

18 Q Do you believe that the failure on the part of
19 Nurse Joe McDonald to provide that warning, as you've
20 articulated in here today, violated a duty owed to Mr.
21 Hunt?

22 A Yes. It was careless, and it violated the duty,
23 the responsibility of Nurse Joe McDonald to keep Mr.
24 Hunt safe.

25 Q And this duty, would it also be an identical duty

1 that would be owed to persons in the general field of
2 danger, those persons walking down Ribaut Road in close
3 proximity to the Naval Hospital.

4 A Yes. Because, if Mr. Hunt is safe, then, the staff
5 is safe and the community is safe. And so, there was a
6 duty to keep Mr. Hunt safe at all times, against himself
7 and against the staff, and against the community at
8 large.

9 Q Now, you've referred to this as a duty, and a
10 failure to follow that duty was careless. I believe I
11 even heard you use the word *reckless*. I know that the
12 next lawyer standing up here at this podium asking
13 questions will ask you about something called the
14 standard of care.

15 A Yes.

16 Q What you're telling us, the carelessness and the
17 recklessness and the failure to provide Calvin Hunt a
18 warning that he shouldn't leave, did that also violate a
19 standard of care?

20 A Yes, it did.

21 Q And all of these opinions you told us about the
22 failure to provide a warning on the part of Nurse Joe
23 McDonald, are all of those opinions rendered to a
24 reasonable degree of certainty, based upon your field of
25 expertise?

1 A Yes, they are.

2 Q Let's talk about somebody else who was there that
3 day. Dr. Jansen. Do you know Dr. Jansen?

4 A Yes.

5 Q You've met him?

6 A Yes.

7 Q Where did you meet him, Doctor?

8 A Previous trial.

9 Q All right, Dr. Jansen. Do you have any opinions,
10 with respect to the failure of the staff at the
11 emergency room, the folks who were in the E.R. working
12 for CasePro, do you have an opinion about Dr. Jansen in
13 connection with the warning and instructions that
14 weren't given to Calvin Hunt?

15 A Yes, I do.

16 Q Tell the Court and jury about that, sir.

17 A First, there was a failure of Dr. Jansen when he
18 walked into the room to examine Calvin that day. There
19 was a failed duty to, number one, make sure that Calvin
20 Hunt was safe. And to do that, there needed to be
21 safety in the room, everything removed that wasn't
22 necessary for the care, which, there wasn't anything,
23 really, other than stretcher and chair that was needed
24 in the room while Mr. Hunt waited.

25 Number two is, Mr. Hunt needed to be disrobed,

1 because, as a physician, neither I nor Dr. Jansen can
2 examine a patient who's fully clothed. You can't
3 examine a patient who's dressed. And so, there was a
4 duty, a responsibility, for Dr. Jansen to instruct Joe
5 McDonald to get Mr. Hunt into a gown, so that he could
6 be examined.

7 There was a failure of Dr. Jansen to do the
8 necessary testing, to order the necessary testing, that
9 was required in order to make sure that drugs or alcohol
10 or something else, something medical, wasn't causing the
11 symptoms of wanting to harm himself or harm the
12 community.

13 There was a failure of duty, carelessness of duty,
14 to inform the staff, Joe McDonald and Janice McDonald,
15 the staff, of the seriousness of the symptoms. That is,
16 once Dr. Jansen went in and examined Mr. Hunt, he came
17 out and he wrote a note, and that, that note
18 demonstrated the seriousness of the signs and symptoms
19 that Mr. Hunt was demonstrating, that is, red flags.
20 They're like red flags, warning flags, flying after his
21 examination as documented in the medical record. And
22 Dr. Jansen should have warned the staff, Joe McDonald,
23 Janice McDonald, and -- and Mr. Mann, when he came down,
24 as to those red flags and the concerns that he had, and
25 the knowledge that he had that Mr. Hunt would be an

1 involuntary admission, that is, that Mr. Hunt would not
2 be allowed to leave the emergency room.

3 Physicians in the State of South Carolina, we have,
4 by law, by license, we have the right to certify a
5 patient like Mr. Hunt as incapable, as unable to make
6 decisions for themselves. And once Dr. Jansen came out
7 of the room, it was clear, because of the red flags,
8 because of the warning flags and signs and symptoms,
9 that Mr. Hunt would be an involuntary admission to a
10 psychiatric facility for mandatory inpatient evaluation
11 and treatment. And there was a requirement of Dr.
12 Jansen to inform his staff of what he was thinking. And
13 also, there was a duty, a responsibility, to warn Mr.
14 Hunt what he was thinking, and what he thought that Mr.
15 Hunt needed.

16 And patients, in my nearly 40 years' experience,
17 respond well to being kept in the loop, that is, being
18 warned as to what I'm thinking, why I'm thinking it, and
19 what it is I'm going to do for them to make them well.

20 Q And you told us a lot of information there about
21 Dr. Jansen, and we'll try and walk through most of that.
22 But let me make sure I understand this. The warning
23 that Calvin Hunt should have been given by Dr. Jansen
24 was that a warning to inform Mr. Hunt he was going to be
25 admitted to some sort of psyche ward, and he needed to

1 stay put?

2 A That would be one purpose of the warning. An
3 additional purpose of the warning would be to define
4 the treatment was going to be provided to Mr. Hunt, so
5 that he was in the loop, and that he knew what was going
6 on, and that he understood why the answer of going to
7 the bathroom alone was, no, you may go to the bathroom
8 with, you know, a sitter, or with -- we call them
9 sitters, but they're essentially someone who simply
10 moves from place to place with the patient to assist in
11 keeping the patient and staff safe, and to prevent
12 elopement. So, there needs to be a supervisor or sitter
13 when he went to the bathroom.

14 But also, it would be to let the staff know when he
15 was teaching Mr. Hunt, he would also be warning the
16 staff of Mr. Mann, Joe McDonald, what was happening and
17 what the plan was to be. And the purpose of that would
18 be to elicit the cooperation of Mr. Hunt. That is, to
19 explain to him why the answer is no, and the care and
20 treatment that we're going to provide to him to make him
21 better.

22 Q I've heard a phrase several times in the past
23 couple of days, something along the lines of patient
24 rights. Have you heard that term before?

25 A Correct. Yes, I have.

1 Q Okay. Is one of the rights of a patient in an
2 emergency room to know what treatment is going to be
3 provided to him or her?

4 A Yes, it is.

5 Q Okay. And following up on that train of thought,
6 Doctor, is it also a patient right for the patient to be
7 informed or warned by the healthcare professional what
8 actions need to be taken in order to keep the patient
9 safe?

10 A Yes. And the reason for those actions, which
11 allows the patients to have a peace of mind, even
12 patients confused, patients who are homicidal, suicidal,
13 want to kill themselves, hurt others, even those
14 patients understand the instruction. They understand a
15 plan that is put to them.

16 Q And I believe you told us that the first duty that
17 Dr. Jansen owed to Calvin Hunt was the duty to keep him
18 safe.

19 A Yes.

20 Q And there's been some testimony by Dr. Jansen here
21 in this very courtroom that, that is the number one duty
22 owed by an E.R. physician to a patient. Do you concur
23 with that?

24 A It is. All patients, but particularly patients
25 that can't look after themselves, that is, patients who

1 have a change in their thinking; they're not thinking
2 accurately; they're thinking of harming themselves;
3 they're thinking of hurting themselves; they can't make
4 good decisions for themselves. So, the team, the
5 healthcare team, the provider, the physician, needs to
6 assist in keeping that patient safe by making good
7 decisions for them.

8 Q And that duty to keep the patient safe, in this
9 case, Calvin Hunt, if Calvin Hunt had been kept safe
10 within the emergency room, would persons outside the
11 emergency room also have been kept safe?

12 A Yes. Staff and persons outside the E.R. would be
13 kept safe.

14 Q So, just like what we were talking about with Nurse
15 Joe McDonald, are all the duties and breaches thereof
16 that you've been telling us about here today by Dr.
17 Jansen, are those duties that he breached that flow not
18 only to Calvin Hunt, but also to persons within the
19 foreseeable zone of danger?

20 A Yes.

21 Q And do you believe that those duties existed on
22 February the 24th, 2012, with respect to Dr. Jansen and
23 this patient and the public at large?

24 A Yes.

25 Q Those opinions you've articulated, are all of those

1 to a reasonable degree of certainty within your field of
2 expertise?

3 A Yes, they are.

4 Q Now, you talked a little bit about some red flags,
5 and I've been making this little board as we've gone
6 along today. Thankfully, we only had three people that
7 were working for CasePro in the emergency room that day.
8 Otherwise, I would have had to have gotten a bigger
9 board. But can you see it, Doctor? I'm trying to
10 figure out the best way to do this.

11 A If the Judge will allow me to scoot back, I can see
12 it and the jury.

13 Q Okay.

14 THE COURT: Certainly. Certainly.

15 A Okay. Okay.

16 Q Let's talk about the red flags that you see, based
17 on the information that these persons who were working
18 for CasePro that day knew about Calvin Hunt. We'll
19 start with the first person in the emergency room that
20 saw Mr. Hunt, the triage nurse, Nurse Janice. What red
21 flags are there with respect to her?

22 A Well, first off is, the past medical history is
23 known to Janice McDonald at triage. Triage is the front
24 desk when you first come into the emergency room. The
25 first person you often meet is the triage nurse. Triage

1 nurse's responsibility is to take information about why
2 you're there and past medical information that's related
3 to why you're there.

4 And so, we know that Janice McDonald, that day,
5 documents for us that there is a significant -- that Mr.
6 Hunt, Calvin Hunt, has a significant past medical
7 history of depression; he has a past medical history of
8 post traumatic stress syndrome; he has a history of
9 anxiety; he has a history of suicidal thoughts and
10 attempts in the past. He is being court marshaled for
11 an altercation with superiors, and even, perhaps, an
12 assault of an officer, a superior officer.

13 And so, the history of drug use, history of
14 excessive alcohol use, all of which, trouble sleeping,
15 history of psychosis, that is, not thinking correctly,
16 that is having periods of times where his thoughts are
17 disturbed, and he's not thinking accurately, all of that
18 is past medical history for which Mr. Hunt has been
19 previously treated, and are part of those red flags that
20 I mentioned.

21 Q All right. So, we've got some red flags from the
22 past. And Doctor, do you know, from your review of
23 everything you told us about a few minutes ago, the
24 depositions and records and everything, do you know
25 whether or not the triage nurse, Nurse Janice McDonald,

1 reviewed Calvin Hunt's past medical records?

2 A It's my understanding that she had access to it,
3 and -- and reviewed it, at least in part.

4 Q In a cursory way.

5 A Yes.

6 Q Okay. Any other red flags with respect to Nurse
7 Janice you want to tell us about, or should we move on
8 to her husband?

9 A Well, with Nurse Janice, the only other thing
10 that's not on your board, but very important, is, if you
11 actually look at her note from that day, she found signs
12 and symptoms that were additional red flags. Past
13 medical history is wonderful, but that's the past.
14 Current, what are we looking at today, is very
15 important.

16 Q All right, Doctor. I hate to interrupt you, but I
17 want to get you back to Baltimore tonight.

18 A Thank you.

19 Q So, we're looking at a triage record filled out by
20 Nurse Janice.

21 A Yes.

22 Q And it's two pages. Do you want to talk about the
23 first page, the second page, or both pages?

24 A On the second page, at the -- the -- we can talk
25 about both pages, but what I'm talking about to the jury

1 right now is that left, lower corner. Yes, correct.

2 And what we have there, is we have what we call review
3 of systems, and there's certain systems that are checked
4 off. And the -- the patient is suicidal, the patient is
5 depressed. The patient is -- may I see this for just a
6 second?

7 Q Absolutely.

8 A The patient has flat affect and a depressed mood.

9 Q And those are red flags, Doctor?

10 A Yes.

11 Q All right, sir. And were there any other red flags
12 on the other page of the triage record that Nurse Janice
13 McDonald filled out?

14 A The other red flag is that the patient's heart rate
15 was elevated, and the patient had an elevation in
16 temperature. The heart rate above 100 is significant,
17 because that would go along with what -- with what was
18 seen later, which is some agitation, some
19 aggressiveness, some instability in behavior.

20 Q So, when we talked about what you knew from a
21 review of the past, the vital signs from, oh, looks like
22 about 17 minutes past the hour of 2:00, on February 24,
23 2012, those would be current, present red flags.

24 A Yes. Also, the medications on the page you're
25 looking at, the medications also correlate with the past

1 diagnosis. That is, these are medications used in
2 patients who are depressed, moody, anxious. These are
3 medications that go along with those diagnosis.

4 Q Okay. Depressed and moody.

5 A And he has not been on those medications recently.
6 He has run out, and he has not been on them.

7 Q Is it concerning that there's no quantification by
8 Nurse Janice McDonald as to how long it's been since Mr.
9 Hunt, or Calvin, was on his depressed and moody
10 medication?

11 A Yes. So, there's no indication of when he was on
12 his medication last. Also, there's no quantification of
13 many of the feelings that Mr. Hunt's having. When did
14 he start having these feelings, how long had that been
15 going on, when did they start, those type of basic facts
16 that just take a few seconds to elicit, to get from the
17 patient. But that type of information is not reported,
18 and we don't know.

19 Q And why would it be important to have those, what
20 you just called basic facts?

21 A The reason the basic facts are important is, it
22 gives you some idea of the longevity of the problem.
23 Did Mr. Hunt start having thoughts of hurting somebody
24 today, or has he been having these feelings for a week
25 or two? There's a big difference.

1 Q All right, sir. Let's talk about Nurse Joe
2 McDonald. Can you see that from where you are?

3 A Yes, I can. Yes, I can.

4 Q Okay. So, Nurse Joe McDonald knew a few things
5 about Calvin Hunt that day. What, if any of those,
6 would you tell us would be red flags for him as a
7 treatment nurse?

8 A Red flags, again, would be angry, Post Traumatic
9 Stress Disorder, alcohol and drug use, and dependency in
10 the past, perhaps even more recently.

11 Q Okay. And what's the significance of PTSD for
12 someone presenting with these kind of symptoms in an
13 emergency room?

14 A Patients with Post Traumatic Stress Disorder are
15 unpredictable in many ways, particularly when they're
16 not being managed. Their behavior is -- can be
17 unpredictable, and it can be sudden. I've seen patients
18 when I was at Dorn Veterans Administration who would go
19 from sitting calmly in a chair reading a newspaper, to
20 suddenly just agitated and out of control. And so,
21 literally, patients with Post Traumatic Stress Syndrome
22 can be unpredictable, but particularly when they're not
23 under active treatment.

24 Q In a period of time of less than two hours, could
25 those kind of changes happen in someone who's been

1 diagnosed with PTSD?

2 A Yes. And in fact, I think we do see them happen
3 over the course of the day. What we know about the
4 course of the day, I think we do see it happen from the
5 10:00 a.m. meeting with Mr. Ray to determine if there
6 was any benefit or eligibility for Veterans benefits,
7 which there's not, because he's still active-duty, as
8 you know, to the emergency room, where he's upstairs
9 with Nurse Smith. And at first, Ms. Nurse Smith thinks
10 he's calm. But then, he starts making noises, and he
11 starts rocking, and he starts acting in a way that is
12 very disturbing, concerning to Nurse Smith. She asks
13 additional screening questions, and finds out about
14 wanting to hurt himself or hurt somebody else.

15 Then, they come down to the emergency room, and at
16 first, we're sad, we're depressed, we're calm. But by
17 the time Mr. Mann sees him, Mr. Mann says he's
18 aggressive, agitated. There's another A word that Mr.
19 Mann used, aggressive, agitated, unsettled. He's
20 unsettled. He's not thinking clearly. You're seeing a
21 progression here. You're seeing a progression of
22 behavior, and then, you suddenly see this -- this
23 elopement, where Mr. Hunt goes out for, quote, a *breath*
24 *of fresh air*, runs away, strips naked, goes to the front
25 gate, steals a fire truck, and runs over a patient

1 [sic].

2 Q Now, you were telling us about a progression of
3 that day. What's the significance of the word used by
4 Mr. McDonald that Calvin Hunt was angry?

5 A Angry is -- is a very large red flag in a patient
6 who comes in, who is having thoughts of harming himself
7 or harming someone else. Because angry patients
8 frequently are preparing -- will -- will take action in
9 some way. They're either going to act out against
10 themselves; they're going to act out against the staff;
11 and they're going to -- or they're going to act out
12 against the community, if they elope. And so, when you
13 have an angry person who is having those types of
14 feelings, it is even more important, the duty to secure
15 the patient, make Mr. Hunt safe, safe room, disrobed,
16 clothes off, gown on, shoes and socks off, okay, make
17 him safe against himself, safe for the staff, and safe
18 for the community, becomes even more important, because
19 angry patients who are having these type of thoughts,
20 this type of thinking that's not clear, will often act
21 out quickly and suddenly and irrationally, with little
22 or no warning. And yes, you've prepared. And that's
23 where the duty becomes so important to prepare. Prepare
24 the room, prepare Mr. Hunt by having removed things he
25 can use to harm himself or your staff. And -- and the

1 answer is, no, you may not go out. And the warning, the
2 reason being is, we're concerned about you, Mr. Hunt,
3 and we need to keep you safe; we need to keep the staff
4 safe; we need to keep the community safe.

5 Q Now, first off, let me ask you this. I can wheel
6 it over there.

7 A I got it.

8 Q There was some concern yesterday -- is this a
9 picture of Dr. Jansen?

10 A Yes.

11 Q Okay. That's what he looks like. Dr. Jansen.
12 Were there any red flags in information that he had
13 about Kalvin Hunt?

14 A Yes.

15 Q Okay. What red flags do you see on our
16 demonstrative?

17 A Well, first off is that Dr. Jansen had all the
18 information that preceded his visit. That is, he knew
19 what had happened upstairs with Nurse Smith. He knew,
20 or should have known, what happened in triage. He knew,
21 or should have known, what Joe McDonald, the treating
22 nurse, thought. What Joe McDonald's observations were.
23 So, when Dr. Jansen goes into the examination room, he
24 already has a lot of information. And then, he collects
25 his own information, which -- which agrees with, or

1 actually amplifies the information he already has from
2 -- from his staff.

3 Q Okay. So, with respect to the emergency room
4 record that Dr. Jansen filled out, are there any red
5 flags that you see on this record, Doctor?

6 A Yes.

7 Q Okay. I'll stand over here to the side. Tell us
8 what red flags you see on the record that Dr. Jansen
9 filled out himself.

10 A Well, first off, we have that there's severe --
11 that the symptoms which Mr. Hunt is presenting with are
12 severe.

13 Q And why is that a red flag here, Doctor?

14 A The choices are mild, moderate, and severe. Severe
15 being the most severe of symptoms. Severe also is a --
16 is a modifier that tells us that this is a patient who
17 is getting ready to explode. This is a patient who is
18 going to do something. He's tachycardic. He's
19 depressed. He's angry. He's sad. He's under a lot of
20 pressure. He's being discharged dishonorably from the
21 Marines. He's under a lot of pressure. And that also
22 is -- is being mentioned here next, he is being
23 dishonorably discharged from the Marines, losing his
24 rank of corporal. He's depressed, he's angry, under
25 current complaints. Again, all of this is severe. He's

1 having suicidal thoughts, and he's having thoughts of
2 hurting others.

3 If we go over to past medical history, there's a
4 history of drug and alcohol abuse, depression, and prior
5 suicide gestures or attempts. He's tried to hurt
6 himself before. And then, also ran out of his
7 medications. And we talked about the fact that Mr. Hunt
8 has been out of his medications for an unknown period of
9 time, which means that he is -- he has gone untreated
10 for some period of time.

11 Q But again, nobody working for CasePro that day knew
12 how long it had been?

13 A Correct.

14 Q Dr. Baker, in your opinion, based upon your
15 training, education, and experience, was there
16 sufficient information, with all three of these persons,
17 Nurse Janice McDonald, Nurse Joe McDonald, and Chris
18 Jansen, for all three of them to do what they should
19 have done that day?

20 A Yes. Individually and collectively, yes.

21 Q And talk to us a little bit about this collective
22 responsibility for these three persons.

23 A Yes. The collective responsibility, in the
24 emergency room, we are a team. The triage nurse, the
25 treating nurse, the treating physician, we are a team of

1 professionals who have the responsibility to evaluate
2 and treat patients who come in to see us. In this
3 particular case, you have each individual knew enough,
4 starting with Janice McDonald in triage; Joe McDonald,
5 when the patient came back to Room 4; and Dr. Jansen, by
6 the time he goes in to see the patient; there is more
7 than enough information individually for each of them to
8 understand their duty and their responsibility to keep
9 the patient safe. Safe room, take off the clothing,
10 gown him up, take off the shoes and socks. Give him a
11 pair of booties, if you have to, to keep the feet warm,
12 but keep the patient safe, and an escort. That is, to
13 not go anywhere without being escorted.

14 They each individually knew that, but collectively,
15 collectively, this team knew, or should have known, that
16 this was a patient who was at high risk, the highest of
17 risk, for doing something. And I use the word *exploded*.
18 Usually, I'm not a person, physician, I'm not a
19 physician who typically uses those type of words, but
20 what we have here is, we have a patient who's on the
21 edge who's going to do something. You have all the
22 signs and symptoms of a patient who is going to act.

23 Q And there's been some questioning by various
24 lawyers in this case about the difference between
25 thoughts and a plan. I'm going to walk over here

1 towards you, Doctor, and show you the note that Dr.
2 Jansen typed up that day. And Dr. Jansen notes that,
3 even though Calvin Hunt was well-dressed and
4 cooperative, he was poorly communicative.

5 A Correct.

6 Q What's the significance of a patient with all these
7 red flags you've been telling us about, all the past
8 history of PTSD, depression, prior suicide attempts, an
9 altercation with his superior, and the fact that he or
10 she is poorly communicative, what's the connection,
11 Doctor?

12 A The connection is that this is a patient who is
13 having thoughts, as they sit there, and failed to
14 communicate with you about those thoughts. It's not
15 that there's a lack of thinking going on with this
16 patient. This patient's having lots of thoughts; you
17 just don't know what they are. And again, that's part
18 of a dangerous situation. When patients come in with
19 these signs and symptoms to my emergency room, this is a
20 potentially dangerous patient, until I treat this
21 patient, and de-escalate, that is, calm down, de-
22 escalate the situation. And I do that by keeping the
23 patient safe in the ways that I've described, and by
24 warning the patient, that is, communicating with the
25 patient about the plan and what we're going to be doing;

1 and letting the patient know that, at any time they have
2 a need, they'll just tell the sitter or the person
3 that's with them and we will provide it, you know; we'll
4 provide all reasonable requests.

5 Q Now, that's the second or third time I've heard you
6 use the word *sitter*. In your hospital, who, typically,
7 if not exclusively, are the sitters for patients with
8 these kind of red flags?

9 A The sitters are one of the emergency department
10 staff, either one of my certified nursing assistants or
11 one of my R.N.s.

12 Q On this particular day, February 24, 2012, was
13 Edward Ray employed by CasePro, Incorporated, to your
14 understanding?

15 A To my understanding, he was not.

16 Q To your understanding, on February 24, 2012, did
17 Edward Ray earn his paycheck for anything whatsoever
18 having to do with the operations inside the four walls
19 of the hospital?

20 A No, not at all.

21 Q Was he a medical provider of any type, to your
22 knowledge?

23 A No, he was not.

24 Q Okay. And I think I can ask you this. What do you
25 know about Mr. Ray?

1 A I know that Mr. Ray was an agent, an employee of
2 the Veterans Administration Affairs Office here in
3 Beaufort. I think it was a one-man department, as I
4 understand it. His responsibility was to work with
5 veterans, that is, men and women who had been active
6 duty for at least 180 days, to insure that they receive
7 the benefits that they're entitled to, after completing
8 their active duty. And that was actually the initial
9 reason that Mr. Hunt went to see him, was to find out if
10 he would be eligible for benefits as a veteran.

11 Q You may have told us this, and I just didn't write
12 it, because I was so busy listening to you, but poorly
13 communicative, is that also a red flag, or is that just
14 something that helps us put the other red flags in
15 context?

16 A It's a very important, separate red flag.

17 Q Doctor, based on your review of these medical
18 records and the information that was available to Nurse
19 Janice McDonald, Nurse Joe McDonald, and Dr. Chris
20 Jansen, all three of whom were employed by CasePro,
21 Incorporated, on that fateful Friday, do you have an
22 opinion as to whether or not it was foreseeable that
23 Calvin Hunt would actually harm others?

24 A Yes, it was foreseeable.

25 Q All the information was there.

1 A All the information was there. If you did not
2 protect Mr. Hunt from himself, and protect the staff,
3 and protect the community, Mr. Hunt was going to take
4 action. All the information that you needed is -- is
5 right there on the medical record. It was known. And
6 Mr. Mann, in his deposition, even confirms that.

7 Q And with respect to the opinion that you just gave
8 us, is that opinion one that you are offering to a
9 reasonable degree of certainty within the field of your
10 expertise?

11 A Yes.

12 Q Doctor, I believe you told us one of the
13 transcripts you reviewed was a transcript of a gentleman
14 who is here in the courtroom, by the name of Dr. Erik
15 Oberg. Did I hear that correctly?

16 A Yes.

17 Q And remind us who Dr. Oberg is.

18 A Dr. Oberg is a physician who has been retained by
19 the Defense for CasePro to defend the actions of the
20 staff that day in the emergency room.

21 Q And do you have any criticisms or comments with
22 respect to Dr. Oberg's opinions?

23 A I do.

24 MR. LOVELL: Objection, your Honor. Calls for this
25 witness to comment upon the testimony of another.

1 THE COURT: Pitting witness?

2 MR. LOVELL: Pitting witnesses, yes.

3 THE COURT: Yes. Sustained.

4 BY MR. HOYLE:

5 Q I'll simply asked this question: do you agree with
6 Dr. Oberg's opinions, as you understand them?

7 MR. LOVELL: Same objection, your Honor.

8 THE COURT: Sustained.

9 BY MR. HOYLE:

10 Q Last question, Doctor, until I pass you to my
11 friend, Mr. Lovell. Do you believe that, if these three
12 persons, Nurse Janice, Nurse Joe, and Dr. Jansen, had
13 done what they should have done on that fateful Friday,
14 that this tragedy could have been avoided?

15 MR. LOVELL: Objection. Calls for speculation.

16 THE COURT: Sustained.

17 MR. HOYLE: Thank you, Doctor.

18 A You're welcome.

19 THE COURT: Cross-examination?

20 DR. TERRENCE L. BAKER

21 CROSS-EXAMINATION, BY MR. LOVELL:

22 Q Good afternoon, Dr. Baker.

23 A Good afternoon, sir. How are you?

24 Q We've talked twice in one day.

25 A That's good.

1 Q It won't take too long. Get my housekeeping done.
2 You mentioned a couple things in your qualifications
3 that you are board certified, correct?

4 A Yes, I am.

5 Q And you understand, Dr. Jansen also is board
6 certified, right?

7 A Yes, he is.

8 Q You mentioned board certification is given to
9 people who have shown that they have qualified
10 knowledge, education, and experience, in the field of
11 emergency medicine, right?

12 A Yes.

13 Q So, we can assume, from the fact that Dr. Jansen
14 passed the same boards that you did, that he was
15 qualified by knowledge, education, and experience in
16 internal -- external -- emergency medicine to do that,
17 right?

18 A Yes.

19 Q Couple other questions. You said you went to go
20 visit the Pope. Did you actually meet him?

21 A No.

22 Q Okay. Just wanted to check. I was going to be
23 nicer to you if you said yes.

24 A Oh, thank you.

25 Q You mentioned your clinical rotations included

1 psychiatry. That's common in medical school, that you
2 rotate through psychiatry and internal medicine and
3 different areas, right?

4 A Yes. It's an important part of training as a
5 medical student, as well as internship and residency,
6 particularly in family medicine.

7 Q So, we could assume that Dr. Jansen did the same
8 thing, rotated right through like you did?

9 A I haven't looked at his particulars, but in
10 general, I would expect him to have done that, yes.

11 Q You said, I thought, that you worked 70 to a 100
12 hours per week in the areas of your board
13 certifications. Did I get that right?

14 A Yes, you did.

15 Q Let's see. That's geriatrics board certification,
16 family medicine or family practice board certification,
17 forensic medicine board certification, and emergency
18 medicine, right?

19 A Yes.

20 Q So, and you also mentioned, in your family
21 practice, you see thousands of patients per year. Did I
22 hear that correctly?

23 A Several thousand patients per year, correct.

24 Q And that includes weight loss, this laser whatever
25 it is you said you do, pain management with pills and

1 the laser? So, I assume that takes up a whole lot of
2 that 70 to 100 hours a week, right?

3 A All areas of medicine, emergency medicine, family
4 medicine. I have patients in the nursing home, patients
5 in rehab. And yes, as part of the family practice, in
6 the office, we do help people lose weight, and help
7 people to make their pain better using medical
8 therapeutic lasers, correct.

9 Q I'm not saying there's anything wrong with that.
10 I'm just saying that, that family practice, which
11 includes all those things you just said, probably takes
12 up the bulk of your time, doesn't it?

13 A Well, I am a family doctor who also does emergency
14 room. I'm a full-time E.R. physician, and I'm one of
15 the directors in the emergency room, in terms of being
16 base station director, that is, supervising
17 communication with paramedics and fire fighters, and
18 also, director of education.

19 Q Never worked in a Naval hospital like Beaufort
20 Naval Hospital where you're treating active duty vets
21 and their families in an emergency department.

22 A That -- that is correct. I've never worked in a
23 Naval hospital. I did work at Dorn Veterans
24 Administration for quite a while.

25 Q And as a physician, you mentioned you were asked,

1 and the question was, you said you earn money doing all
2 these doctor things you do. But you also earn some
3 money doing what you're doing here today, being a paid
4 expert, correct?

5 A I do.

6 Q And it sounds like you've been doing that paid
7 expert work since the eighties?

8 A Yes, sir.

9 Q Would you agree with me that an expert who comes in
10 and submits himself in front of a jury to tell his
11 opinions should give those in an unbiased and truthful
12 way?

13 A Yes.

14 Q And that they should make sure that the evidence
15 upon which they base those opinions is true and
16 accurate, right?

17 A Yes. In general, that's true.

18 Q Because, if you come in and formulate an opinion
19 that you give to the lawyers that hire you or write
20 reports about, and that opinion is based on faulty facts
21 or assumptions that are wrong, then, the opinion might
22 not be so good, right?

23 A Yes, that's true. And that's what I think happened
24 with Dr. Oberg.

25 Q Okay. Well, let's see what happened with you in

1 just a minute on some of those, Doctor, as we go through
2 some of the information that you were --

3 A Okay.

4 Q But you'd agree, incorrect information in your
5 opinion means what's coming out when you express them is
6 also incorrect.

7 A Well, that's true. Discovery's ongoing, however.
8 And so, you have to look at when an expert gives their
9 opinion, at that point in time, what's been discovered.
10 There's times that depositions haven't been taken, or
11 information hasn't been provided to the expert yet. And
12 so, the expert's giving opinions based upon what they
13 know at that moment in time.

14 MR. LOVELL: Your Honor, may I approach?

15 THE COURT: You may.

16 BY MR. LOVELL:

17 Q I'm going to hand you Exhibit 27.

18 A Um-hmm.

19 Q I'm going to lay the foundation for this. In your
20 expert witness activities, did you use various services
21 to help connect you with some of the attorneys that may
22 hire you. Is that right?

23 A Yes. I'm listed in two expert witness directories
24 as a physician who is available to review charts for
25 either plaintiffs or defendants, to answer questions

1 that might be arising.

2 Q And one of those is entitled SEAK Expert Service.

3 A Yes. It's a service out of Falmouth,
4 Massachusetts, that's owned by an attorney, Steven
5 Babitsky.

6 Q And you advertise through that service using their
7 web page or Internet resources, all of the various
8 places -- or, I'm sorry, all of the various areas of
9 medicine that you're willing to hold yourself out as an
10 expert, correct?

11 A Well, I -- I disagree. What the directory has, the
12 directory chooses areas that are listed in the
13 directory, and they simply go through and identify the
14 areas where my credentials would allow me to give
15 opinions based upon my board certifications.

16 Q Well, I put in front of you Exhibit 27. Have you
17 seen that before today?

18 A I have not seen this recently, no.

19 Q But you've seen it? What they advertised for you,
20 or you allow them to advertise for you, at SEAK Expert
21 Witness, right?

22 A I have seen it at various times. I'm not sure I've
23 seen this exact copy.

24 Q Well, it has you listed, and you tell me if any of
25 these are wrong, and you don't want them holding you out

1 as an expert through the Internet to other people. Let
2 me back up one thing, Doc. Would you allow them to hold
3 you out as an expert in an area where you didn't feel
4 like you were?

5 A No. But -- but scanning these specialty focuses,
6 they're all within my boards.

7 Q So, it has you, emergency medicine, family
8 medicine, correct?

9 A Yes.

10 Q Nursing home care, home health, assisted living,
11 decubitus, falls, dementia?

12 A Yes.

13 Q Medicare. Have I misread any yet?

14 A No. I have patients in all those areas.

15 Q HMO, life care planning, pressure ulcers, pressure
16 sores, hospice, Alzheimer's Disease, hypertension, wound
17 care, pneumonia, weight loss, depression, osteoporosis,
18 diabetes, bed sores, laser medicine, laser safety. All
19 areas you hold yourself out as an expert?

20 A Yes. All areas that I practice in virtually every
21 day, yes.

22 Q What I didn't see on that list is E.R. medicine at
23 a Naval hospital facility, treating active-duty Naval
24 officers at a facility like Beaufort Naval. Did I miss
25 it?

1 A No. That's correct. I've already testified that
2 I've not practiced in a Naval Hospital.

3 Q Well, another way to make money -- oh, how much of
4 your income comes from just what SEAK or the other
5 service paid you in terms of expert witness testimony?
6 Just percentage. I don't need to know dollars.

7 A Yeah. I get one or two cases a year from this
8 directory.

9 Q All of them. I'm talking about all of your expert
10 work.

11 A Altogether? Altogether, this is somewhere between
12 15 to 20 percent of my total income.

13 Q And that's coming into court and testifying either
14 against doctors, nurses, or hospitals, 60 to 70 percent
15 of the time; or on behalf of them, 20 to 30 percent?

16 A It's from reviewing medical records and documents
17 and answering questions, sometimes in the courtroom.
18 Although, I'm not in court very often.

19 Q Do you hold yourself out as an expert in trying to
20 help doctors learn how to double their clinical income
21 by devoting one day a week to medical legal matters
22 serving as experts?

23 A I think that was an advertisement that was put out
24 by SEAK, the owner of SEAK, Steven Babitsky, at one
25 point, yes.

1 Q All right. Let's look at this one. I'm handing
2 you Exhibit 28. Now, let me ask, Doctor, you, in
3 addition to working with lawyers, apparently, you help
4 to train doctors on how to start, run -- start, build,
5 and run successful expert witness practices, right?

6 A Yes. I have done that from time to time. I work
7 either -- either alone. I teach a course alone, or
8 Judge David Lawson, who's a federal judge from Detroit.

9 Q I've given you Exhibit 28. Do you recognize that
10 document?

11 A Yes. I've -- I have seen this or something similar
12 in the past.

13 Q And in fact, this is from February of calendar year
14 2015, right?

15 A Yes, it is.

16 Q And you participated in a seminar that we talked
17 about, *How to Start, Build, and Run an Expert Witness*
18 *Practice*. Did you not?

19 A Yes, I did.

20 Q And you've done it every year for the last four,
21 five, six, seven, eight years, right?

22 A I don't know if it's been seven or eight years, but
23 it's been several years. That's true.

24 Q This year, last year, I know, for sure, because
25 those are there.

1 A Yes, last two years I know, for sure.

2 Q And you tell doctors that they can make -- they can
3 double their clinical income by doing what you're doing
4 here today and charging four hundred to a thousand bucks
5 an hour and working only a day a week?

6 A I don't tell them that. I don't write the
7 literature, that is, the -- the brochure that Counsel's
8 referring to. I don't write that. It's written by
9 Steven Babitsky, who is the owner of SEAK, who sends out
10 flyers to physicians who might be interested in serving
11 as expert witnesses, because there's a severe shortage
12 of experts around the country, and particularly in some
13 specialties. And so, there's a need to train physicians
14 who are interested in doing this type of work.

15 Q Did you ever call Mr. Babitsky and tell him, hey, I
16 don't want you writing that about what my seminar's
17 about; I don't think that's something --

18 A I have -- I have actually sat down with Mr.
19 Babitsky and -- and told him that he should, you know,
20 -- I know why he sends out those advertisements to get
21 physicians interested, but I have instructed Mr.
22 Babitsky that he should not send out things that are so
23 -- could be so inflammatory.

24 Q But year after year he uses the same language, and
25 you don't quit talking into things, do you, Doctor?

1 A Well, Judge David Lawson and I, we've had conver --
2 the Judge and I have had conversations about this. In
3 fact, just two weeks ago I spent two days with the
4 Judge. We've talked about the fact that Mr. Babitsky
5 does this, but we still believe that teaching physicians
6 the principles of being an expert is important.

7 Q Including how to write a good expert witness
8 report, correct?

9 A Certainly, because it's not something you learn in
10 medical school, how to write a report that meets legal
11 standards. You learn how to write a medical report, but
12 you don't write -- know how to write a report that means
13 something that can be used in this court.

14 Q How much of the \$1,295.00 per-participant tuition
15 goes to Dr. Baker from these seminars?

16 A Nothing. Judge Lawson and I neither one receive
17 any funds, other than we do get an airline ticket. We
18 do get a meal or two at the conference. They serve
19 lunch. We eat lunch. And we get a motel room for the
20 night of the conference.

21 Q Now, Doctor, let's talk a little bit about expert
22 reports and stuff. You'd agree that it's not fair for
23 you to judge what any of these healthcare providers did
24 by looking back in hindsight, knowing the outcome, and
25 second-guessing what they did on the days they were

1 involved, right?

2 A Alone, that's correct.

3 Q Because you, as an expert, come in and have a ton
4 of information that didn't exist at the time Nurse
5 Janice McDonald, Nurse Joe McDonald, or Dr. Jansen were
6 involved in the care and evaluation of Mr. Hunt,
7 correct?

8 A That's true. But the science of doing chart review
9 requires the expert to look at what the physician knew
10 or should have known at that point in time, not what was
11 known a week from now, or what was known from later in
12 the day, after the fire truck got stolen. But an
13 expert, like myself, is required to look at what was
14 known at that moment in time.

15 Q And then, I'll hand one of those -- and backing up
16 to that, though, you've given opinions here today where
17 you've talked about foreseeability and what you think
18 should have been foreseeable, but you have the benefit
19 of knowing what occurred from the time that Mr. Ray and
20 Mr. Hunt left the emergency room to go get a breath of
21 fresh air, up until the time of the pictures we saw
22 where the fire truck's crashed up into the woods, right?
23 You had all of that information --

24 A That's --

25 Q -- before you ever formed any of these opinions.

1 A That's correct. At the end of my review, I did
2 have all that information. Although, discovery's been
3 ongoing. And as I'm sure you're going to point out here
4 shortly is that I've been learning right up until today.
5 For example, I hadn't seen the video until today. I've
6 been learning right up until today the facts that are
7 important to the opinions that I've formed.

8 Q But when you authored your opinion, when you first
9 put something in writing or talked to somebody on a
10 deposition, we touched on it a little earlier today, I
11 mean, you had already made up your mind about a lot of
12 these issues from what you had reviewed; had you not?

13 A Based upon the facts that were in evidence, yes.

14 Q And once facts are told to you or represented to
15 you, or you reach a conclusion using those facts, those
16 faulty facts, if they're wrong, continue to stay in your
17 mind as you look at all of the rest of the facts and
18 information that's provided to you by whoever's giving
19 it to you, right?

20 A Well, that's true, but that's the science of chart
21 review, medical chart review. There's a science to
22 reviewing the chart. As additional facts come into
23 evidence, your opinions change. There's been times when
24 I've been right up here on this stand, and in a case in
25 Arkansas several years ago, where, right on the stand,

1 it became obvious that the facts that I had reviewed
2 were faulty, and that the opinions I was rendering were
3 wrong. And as soon as I recognized that, I said that.

4 Q Have you still got Defendant's 29, your report, up
5 there, Doctor?

6 A Yes.

7 Q I'm going to try to do this so you and I can look
8 at it together and the jury can look at it.

9 A Actually, it may have moved away from me.

10 Q I'm sorry. There it is.

11 A Thanks. Thanks.

12 Q I'll put these aside for now. September 24, 2015,
13 you authored Defendant's 29, as we talked about earlier,
14 a report you wrote, prior to your deposition, right?

15 MR. HOYLE: Your Honor, I'm going to object to this
16 document being published. I don't think it's been
17 moved into evidence.

18 MR. LOVELL: We'll move it into evidence, your
19 Honor, 29.

20 THE COURT: Very well. Any objection?

21 MR. HOYLE: Without objection.

22 THE COURT: Very well.

23 ITEM IDENTIFIED AS LETTER/REPORT

24 TO MR. HOYLE FROM DR. TERRENCE L.

25 BAKER, DATED SEPTEMBER 24, 2015,

1 MARKED DEFENDANT'S EXHIBIT NUMBER 29,
2 ADMITTED AS EVIDENCE.

3 BY MR. LOVELL:

4 Q I'm going to stick it over here, Doctor. And I
5 apologize. It's hard for you to see or anybody else.

6 A No problem.

7 Q But you've got it in front of you.

8 A I do.

9 Q You mentioned when you authored this, this was
10 written some time -- was it the same morning you gave
11 your deposition in discovery in this case to Doug over
12 there?

13 A Yes. Per my routine, I'll often write some notes
14 to help keep my thinking clear and accurate during the
15 course of my discovery. Discovery is often a stressful
16 time, with many questions, and it's good to have some
17 notes. And so, this is written in the form of a letter
18 report, but it's essentially notes to myself to remind
19 me of what I've reviewed, and the thoughts I have at
20 this time, and some of the facts that I believed to be
21 true at this time in discovery.

22 Q And you, as an expert, have the duty to yourself
23 and the people who are paying you for your opinions to
24 make sure your facts are accurate before you start
25 relying on them, correct?