THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable John C. Hayes, III

RECEIVED
Oct 26 2020
SC Court of Appeals

Case No. 2017-CP-26-1571
Appellate Case No. 2019-001665

David L. Scheer, as Personal Representative of the
Estate of Matthew J. Scheer,.....Respondent,

v.

Southern Myrtle Inpatient Services, LLC, Nirlep A.
Patel, M.D. and Rachel Ash-Bernal M.D. ..... Defendants,

Of which
Southern Myrtle Inpatients Services, LLC is.....Appellant.

RECORD ON APPEAL
VOLUME II
Pages 0415-0910

Robert L. Widener
BURR FORMAN McNAIR
Post Office Box 11390
Columbia, South Carolina 29211
(803) 799-9800

ATTORNEYS FOR APPELLANT

Francis M. Hinson, IV
William R. Padget
FINKEL LAW FIRM, LLC
1201 Main Street, Suite 1800
Columbia, South Carolina 29201
(803) 765-2935

Nicholas D. Mermiges
1720 Main Street, Suite 202
Columbia, South Carolina 29201
(803) 587-0472

ATTORNEYS FOR RESPONDENT

INDEX

VOLUME I

Order and Pleadings

Order Denying Post-Trial Motions and Entering Judgment Against Defendant Southern Myrtle Inpatient Services LLC 0001
Verdict Form, May 29, 2019 0034
Supplemental Verdict Form, May 29, 2019 0036
Complaint, April 13, 2017 0037
Amended Complaint, August 10, 2017 0042
SMIS Answer to Amended Complaint, September 1, 2017 0052
SMIS Motion for Judgment Notwithstanding the Verdict or, in the Alternative Motion to Alter or Amend Judgment or, in the Alternative, Motion for a New Trial, June 3, 2019 0058
Plaintiff's Memorandum in Opposition to Defendant's Post-Trial Motions, with exhibits, June 14, 2019 0077
Defendant SMIS's Reply to Plaintiff's Memorandum in Opposition To Defendant's Post-Trial Motions, June 21, 2019 0150
Plaintiff's Surreply in Opposition to Defendant's Post-Trial Motions, June 26, 2019 0159

May 20-24 Trial Transcript 0166
Motions 0173
Opening by Mr. Hinson 0240
Opening by Ms. Spears 0263
Direct Examination of Robert Robinson by Mr. Hinson 0287
Cross-Examination by Mr. Gresh 0345
Redirect Examination by Mr. Hinson 0381
Video Deposition of Rachel Ash-Bernal (see R. 1008) 0393
Video Deposition of Gregory Pheabus (see R. 1114) 0396
Direct Examination of Duane Doherty by Mr. Hinson 0403
Cross Examination by Mr. Gresh 0410
Redirect Examination by Mr. Hinson 0413

VOLUME II

Direct Examination of Timothy Malone by Mr. Hinson 0415
Cross Examination by Mr. Gresh 0452
Redirect by Mr. Hinson 0484
Direct Examination of David Scheer by Mr. Hinson 0495
Cross Examination by Mr. Gresh 0530
Redirect Examination by Mr. Hinson 0537
Direct Examination of Erik Scheer by Mr. Padget 0538
Excerpts of Southern Myrtle Inpatient Services 30(b)(6) Deposition published 0547
Direct Examination of Debra Scheer by Mr. Hinson 0557
Motions 0571

Direct Examination of Nirlep Patel by Ms. Spears 0614
Cross Examination by Mr. Padget 0637
Redirect Examination by Ms. Spears 0674
Direct Examination of Rachel Ash-Bernal by Mr. Gresh 0676
Cross Examination by Mr. Hinson 0719
Redirect Examination by Mr. Gresh 0758
Direct Examination of Oscar F. Lovelace, Jr. by Mr. Gresh 0761
Qualification Exam by Mr. Hinson 0765
Direct Examination continued by Mr. Gresh 0768
Cross Examination by Mr. Hinson 0794
Redirect Examination by Mr. Gresh 0800
Motions 0802
Direct Examination of James Ballenger by Mr. Gresh 0810
Cross Examination by Mr. Padget 0838
Redirect Examination by Mr. Gresh 0861
Motions 0864
Closing Argument by Mr. Hinson 0868

VOLUME III

Closing Argument by Mr. Gresh 0911
Reply by Mr. Hinson 0931
Charge 0942
Questions from Jury 0967
Allen Charge 0983
Questions from Jury 0985
Verdict 0989
Closing - Punitives 0992
Charge - Punitives 0998
Verdict – Punitives 1004

Transcripts of Video Depositions Played at Trial

Dr. Rachel Ash-Bernal deposition transcript 1008
Examination of Ash-Bernal by Mr. Hinson 1010
Gregory Pheabus deposition transcript 1114
Examination of Pheabus by Ms. Peavy 1119
Examination by Mr. Hinson 1159
Examination by Ms. Peavy 1192
Examination by Mr. Hinson 1197

Plaintiff's Trial Exhibits

Ex. 1 – Medical Records-Grand Strand 1201
Ex. 2 – Lighthouse Records 1333
Ex. 3 – Transfer Records 1337
Ex. 5 –Notice of Privacy 1340
Ex. 6 – Informed Consent 1350
Ex. 7 – DHHS Letter 1361

Ex. 8 – Application for Voluntary Emergency 1363

Plaintiff's Rule 32 Deposition Designations 1367

VOLUME IV

Deposition Transcripts

Southern Myrtle Inpatient Services LLC 30(b)(6) deposition transcript 1370
Examination of Shane Caldwell by Mr. Hinson 1375
Examination by Mr. McKay 1453
Examination by Mr. Hinson 1454
Grand Strand Medical Center 30(b)(6) deposition transcript:
Gina Trahey 1464
Examination of Gina Trahey by Mr. Hinson 1466
Tushara Rhodes 1533
Examination of Tushara Denise Rhodes by Mr. Hinson 1535
Dr. Nirlep Patel deposition transcript 1563
Examination of Dr. Patel by Mr. Hinson 1565

Certificate of Counsel 1675

1 Q No further questions, Mr. Doherty.
2 THE COURT: All right. You can step down and be excused.
3 Mr., Mr. Doherty, you can step down and be excused. We
4 appreciate your time.
5 A Beg your pardon?
6 THE COURT: You can step down and be excused. We
7 appreciate your time.
8 A I'm, I'm a little hard of hearing, sir.
9 THE COURT: All right. You, you're through testifying.
10 So you can step down.
11 A Okay.
12 THE COURT: And you're excused. Thank you. All right.
13 Call your next witness.
14 MR. HINSON: Plaintiff calls Dr. Tim Malone.
15 Whereupon, Timothy Malone is called to the stand, duly
16 sworn by the clerk and testified as follows:
17 THE CLERK: If you'll please state and spell your first
18 and last name.
19 MR. MALONE: Dr. Timothy Malone, T-I-M-O-T-H-Y, M-A-L-O-
20 N-E.
21 DIRECT EXAMINATION
22 BY MR. HINSON:
23 Q Good morning, Dr. Malone.
24 A Good morning.
25 Q Would you please tell the jury what you do for a living?

1 What kind of physician are you?
2 A Well, I'm a psychiatrist, and I am also a clinical
3 professor for the University of South Carolina, been in that
4 position for approximately the last 20 years or so. I have a
5 very active outpatient practice where I actually see
6 inpatients in a psychiatric facility. I teach child and
7 adolescent and general psychiatry residents and fellows.
8 These are MDs that are pursuing further education in, in the
9 field of psychiatry, also work for the athletic department for
10 the University of South Carolina.
11 Q What do you do for the athletic department for the
12 University of South Carolina?
13 A Well, I'm the wellness director for the athletic
14 department, been in that role for about 15 years. So my role
15 there is to oversee and supervise the mental health issues as
16 they relate to our student athletes. There are some 625 or so
17 student athletes that we take care of. We have a
18 multidisciplinary treatment team. I'm not the only one, but
19 I'm certainly one in charge of taking care of those student
20 athletes.
21 Q Do you sometimes travel with the Gamecocks?
22 A I do. Gamecock fan.
23 Q And Dr. Malone, tell us a little bit about your, your
24 education starting with medical school.
25 A Well, I graduated from the College of Charleston with a

1 degree in physics. I then traveled to Columbia where I went
2 to medical school at the University of South Carolina. After
3 finishing there, I did my postgraduate training in psychiatry
4 at the William S. Hall Psychiatric Institute, which is
5 actually no more. It's actually a ballpark now, but in any
6 event, that program is now the University of South Carolina.
7 So I did my general psychiatry training and child and
8 adolescent psychiatry training at the William S. Hall
9 Institute in Columbia.
10 Q And did, after you finished that, what was your next step
11 in your education and work history?
12 A Well, I proceeded to get myself board-certified in both
13 general and child and adolescent psychiatry. I also did
14 additional training in addiction medicine and became board-
15 certified in the area of addiction medicine and also did
16 additional training and sat for my forensic psychiatry board
17 certification which I, too, completed.
18 Q And for those of us who aren't physicians or
19 psychiatrists, what generally is forensic psychiatry?
20 A Forensic psychiatry is psychiatry as it pertains to the
21 law, so something like what I'm doing now, but also doing
22 evaluations on criminal responsibility for criminal procedures
23 or evaluations of individuals who have competency issues, any
24 issue of psychiatry that pertains to the law.
25 Q In your career, have you had the occasion to testify in

1 court in criminal matters?
2 A I have, as a resident. I did. Uh-huh.
3 Q And are you -- well, tell us what hats you currently
4 wear. Just kind of describe the different -- you talked about
5 the, the Gamecocks and what you do there, but do you work at
6 any particular hospitals or inpatient psychiatric facilities?
7 A Certainly. I -- my professorship is based at the, at now
8 Prisma Health. It was Baptist Hospital in Columbia. That is
9 the location that I see primarily child and adolescent cases,
10 and I teach child and adolescent psychiatry fellows and
11 interns. So they learn from me. I teach them how to manage
12 and take care of child and adolescent cases, psychiatry cases.
13 I also do some inpatient psychiatric treatment at Three Rivers
14 Medical, which is also in Columbia. There I primarily wear my
15 addictions hat. I'm the director of the addictions program
16 there. I do their outpatient program, their inpatient detox,
17 and I also see a number of adult patients at that facility. I
18 see some adults at the, the Baptist as well, but it's much
19 fewer and far between.
20 Q The patient population that you treat, does it include
21 patients with -- who are suffering from some form of
22 psychosis?
23 A Absolutely.
24 Q And Dr. Malone, I'm going to ask you to, to toot your own
25 horn and praise your own pond just for a second, do you, do

1 you -- have you won any awards, any particular awards,
2 fellowship awards?
3 A I'm not very good at that, but yes, as a resident I was a
4 Ginsberg fellow. I had the opportunity to work hand-in-hand
5 with one of our leaders in forensic psychiatry, Dr. Phil
6 Resnick, and learned a great deal with -- from him about the
7 field of forensic psychiatry. So it was quite an honor.
8 MR. HINSON: At this time Plaintiff would move to qualify
9 Dr. Tim Malone as an expert in psychiatry and the forensic
10 psychiatry.
11 THE COURT: Voir dire?
12 MR. GRESH: None, Your Honor.
13 THE COURT: I find he's qualified in both those areas.
14 BY MR. HINSON:
15 Q Okay. Dr. Malone, what have you reviewed in this case?
16 A Well, I have -- make sure they can hear me. I reviewed a
17 number of records, depositions from too numerous physicians,
18 nurses. I've reviewed the hospital records for Matthew
19 Scheer, his parents' depositions. That would be the lion's
20 share of what I've reviewed.
21 Q And, and Dr. Malone, I want to certainly give you the
22 opportunity to drill down to your basis for your opinions, but
23 do you hold any opinions as to whether Defendants Patel and
24 Ash-Bernal met the standard of care?
25 A I do have an opinion.

1 Q And what is that opinion?
2 A I do not feel that they met the standard of care, no. I
3 do not.
4 Q Okay. Dr. Malone, what does it mean to put a temporary
5 hold on a patient?
6 A Well, temporary truly is, is a little bit misleading, but
7 in this state, the, the state statute allows us to place what
8 is called a 72-hour hold on a patient who is displaying
9 concerning behavior, that is either at an imminent risk of
10 harm to themself or others or at a -- at -- because of a
11 mental state are incapable of making appropriate decisions and
12 being responsible essentially for themselves in a manner that
13 likely would represent a risk of harm to themselves or, or
14 others. So that 72-hour hold is allowed. This is probably
15 the most liberal state in the world in terms of commitment.
16 It's one of the reasons why I believe what happened in
17 Virginia Tech a few years ago would not have happened here
18 because truly it only takes one certified physician to
19 initiate a temporary hold in order to further evaluate and
20 make sure that the person is being appropriately treated, so.
21 Q If a physician believes that it takes two physicians'
22 signatures to put a temporary hold on a patient is that
23 physician properly and adequately trained on how to do a
24 temporary hold in South Carolina?
25 A Absolutely, they, they -- that is incorrect. It does not

1 take two, only one.
2 Q And is that something that a physician should be aware
3 of?
4 A It is absolutely something the physician should be aware.
5 Q Are there times and situations when a physician is
6 required, that the standard of care requires the physician to
7 put a temporary hold on a patient?
8 A Yes. Yes.
9 Q And tell us what would be a situation where that would be
10 required?
11 A Well, if you have a patient who is presenting themselves
12 with suicidal ideations, for example, that are not able to
13 contract for safety but at that, at that same time not willing
14 to remain in a safe treatment environment, i.e., the hospital,
15 in that case the statute does allow us to place a temporary
16 hold on that individual. It also includes other examples.
17 For example, someone who has homicidal ideations may also be
18 placed on a, a temporary hold, and, and then the final
19 example, I would say suicide holds are probably about 60
20 percent of what we do. Homicide, just a few, most of those
21 tend to be characterological at their base, but the lion's
22 share of the rest, at least 30 percent or more, are
23 individuals that because of their mental infirmity from a
24 mental illness have the -- have -- don't have the capacity to
25 make appropriate judgments for themselves either vis-à-vis

1 paranoia, psychosis or other delusional ideas that, that make
2 them unsafe.
3 Q So there are three, three reasons for which a patient may
4 be put on a psychiatric hold or on a temporary hold?
5 A Yes.
6 Q Okay. And if you could summarize what are the -- just
7 quickly those three reasons are what?
8 A Suicide, which is the lion's share, homicidal ideation
9 and grave disability from a mental illness that they are not
10 able to make appropriate judgment due to their mental illness,
11 i.e., paranoia, psychosis and delusional thinking.
12 Q What does it mean for a person -- well, generally
13 speaking, what is psychosis?
14 A Well, psychosis is a broad term, and it can be
15 interpreted a number of ways. Psychosis can be responding to
16 internal stimuli. Voices in one's head is a form of
17 psychosis, visions, seeing things that obviously aren't in
18 front of you is a number -- another form of psychosis.
19 Paranoia is also a form of psychosis. So we're talking about
20 things that aren't true. You would -- you're, you're fearful
21 for no reason that people are either out to get you or people
22 are -- in, in the case of Matthew, fearful that people are
23 poisoning your food, that others are plotting against you, and
24 if that has no basis in reality that is, in fact, an example
25 of psychosis and paranoia.

1 Q What are the dangers of a patient with psychosis and
2 paranoia not being in an inpatient or some sort of facility
3 where they're receiving treatment?
4 A Well, as you can imagine, if you, in, in the case and
5 I'll use Matthew, the last of his life he discussed or, or
6 proclaimed that the individuals in the hospital at Grand
7 Strand were all devil worshipers. Now, to the best of, I
8 think, all of our, our knowledge they -- that is not true, and
9 I think most of us would agree that wasn't true, but he
10 believed it. In a hospital he can be managed. That can be
11 treated and is a very treatable illness with medication,
12 counseling and therapy, but in an outpatient setting, without
13 the guidance and the supervision of either his family or some
14 other entity to make sure that he is safe, you can imagine
15 where that can go, the foreseeability of him having an
16 altercation with a police officer, let's say, you know, whom
17 he now thinks is a devil worshiper or some other individual
18 could place him in, in dire harm so.
19 Q Are there occasions where people with psychosis have
20 unintentionally killed someone else?
21 A Oh, absolutely. I mean, for example, if you are under
22 the belief that, you know, that you can fly, you might very
23 well jump off a cliff or you may feel that you're invincible
24 and drive erratically and, and cause harm to others as a
25 result of your disorganized and, and paranoid ideas,

1 delusional ideas, so yes.
2 Q Dr. Malone, from your review of the record, do you
3 believe Matthew was suffering from psychosis?
4 A Absolutely, he was.
5 Q And, and tell us just a little about what you understand
6 Matthew's mental state to be? What types of things was -- how
7 was his psychosis exhibiting itself?
8 A Well, I think the PA put it best and it, it did not
9 change throughout his stay, that he presented with
10 hallucinations, which as I've described may be visual, which
11 was described later, auditory hallucinations, which he did
12 describe, paranoia, that he thought that his food was being
13 poisoned, and as fact, as a fact -- as a matter of a fact, he
14 hadn't eaten in several days because that he thought his food
15 was poisoned. He -- on, on Monday, I believe, I recall
16 believed that he was healed from his epilepsy. He had what we
17 would call a religious grandiose delusion that, that he was
18 suddenly healed and he no longer needed to take medication.
19 So under, again, the delusional thought process, a medication
20 that he had taken safely for quite some time, he discontinued,
21 which, likewise, put him at risk.
22 Q Is there any cure for epilepsy?
23 A There's no cure but there's an adequate treatment.
24 Q And what treatment is that?
25 A Treatment is complying with your medication, in his case

1 the Keppra that he was supposed to take.
2 Q Was his failure, refusal to take Keppra, was that putting
3 him at risk of anything?
4 A It absolutely was putting him at risk.
5 Q Was that putting him at imminent risk of something?
6 A It was putting him at imminent risk of a seizure for one,
7 and also putting him at imminent risk for what can happen in
8 the, the mindset that one's seizure disorder is not being
9 treated, which can present in a number of different ways,
10 including psychosis and delusional thinking.
11 Q Doctor, are involuntary holds or temporary holds, are
12 they typically put on patients who are willing to receive
13 treatment?
14 A No. They are not.
15 Q And why not?
16 A Well, if someone is delusional and yet agrees to stay
17 because, and this happens all the time, "I'm here because my
18 mom says I need to be here. So I'm going to stay. I don't
19 think I have anything wrong but I'm going to stay," or one may
20 decide, "I understand that my thoughts are not clear, but I'm
21 going to acquiesce to the, the request of the doctors and
22 receive treatment," and provided that that is, is taking place
23 in a cordial manner, they do not need to be placed on a hold,
24 certainly.
25 Q At the time Matthew was in the ER on the morning of

1 October 2nd, was there any reason to put him on an involuntary
2 hold?
3 A No. I don't believe so. No.
4 Q And why not?
5 A Well, he was -- despite the fact that he was clearly
6 delusional and he was clearly psychotic at that point, he was
7 compliant in part, I believe, because his dad was there and
8 was a comforting influence on him, but he was not asking to
9 leave. He was compliant with, with the request of the
10 hospital with the exception of taking his Keppra, of course,
11 but there was no need or urgency towards commitment at that
12 point.
13 Q Matthew presents to Lighthouse, and what was your
14 understanding of what occurred there? Was, was he treated
15 there?
16 A He was not treated there. No.
17 Q And why, why was Matthew not able to be treated at
18 Lighthouse?
19 A Well, there, there was this notion of a medical clearance
20 that was given, and mind you, as I instructed you, I do work
21 in a facility very similar to where Dr. Oduwole was working
22 that night.
23 Q And that's -- is that -- Dr. Oduwole works where?
24 A At the Lighthouse. I'm sorry. At the Lighthouse, and
25 so, much like that facility, there isn't a lab, there isn't,

1 you know, EKG, the ability to do IV fluids for someone who is
2 dehydrated as Matt was, inability to care for someone with a
3 medical illness. Dr. Oduwole's notion was that, clearly,
4 Matthew was suffering from some sort of psychosis, but because
5 of his concern for Matthew, I think that he did the right
6 thing. He was concerned and did the right thing for Matthew,
7 making sure that his medical issues were addressed, which
8 included his elevated white count and his elevated bilirubin.
9 Q Did anyone at Lighthouse make any kind of finding that
10 Matthew was competent?
11 A No. I did not see that, sir. No.
12 Q And what did the records from Lighthouse reflect was
13 going on with Matthew mentally, psychologically?
14 A My recollection is the description was that he was
15 responding to internal stimuli, that he was, essentially,
16 psychotic at that time when he presented with his dad.
17 Q And when you, when you say responding to internal
18 stimuli, what is -- what do you mean by that?
19 A Well, when one is responding to internal stimuli,
20 auditory hallucinations, you may notice that they're
21 whispering, talking to themselves, much like I think the
22 earlier Mr. Doherty was talking, he was, you know, talking to
23 himself, raising his hands, you know, speaking to the air, if
24 you will, responding to internal stimuli, that kind of
25 behavior.

1 Q Is a person doing that and behaving that way safe to be
2 among the public?
3 A Absolutely not.
4 Q And but would -- should Lighthouse have involuntarily
5 committed him at that time?
6 A The safe thing for Matthew at that point was to address
7 the medical issues. Mind you, at this point we don't know why
8 Matthew is psychotic. There are medical issues that can cause
9 psychosis as well as psychiatric ones, and so the medical
10 issues needed to be addressed first and foremost. I have no
11 problem with an individual who has an elevated white count and
12 a bilirubin that is up having a medical evaluation because the
13 risk for sepsis and dissemination of his infection vis-à-vis a
14 hot gallbladder is very concerning, and that is borne out when
15 he returns to Grand Strand because, what did they do? They
16 order a CT scan. They order an ultrasound of his, of his
17 gallbladder and repeat labs and a GGT to further evaluate his
18 medical condition.
19 Q Should the folks at Lighthouse have put Matthew on a
20 temporary hold?
21 A Absolutely not.
22 Q And why not?
23 A Well, in order, if you place the temporary hold at the
24 Lighthouse, then you have to then house and treat him there,
25 and they did not have the capacity to house and treat Matthew

1 there.
2 Q Was Matthew calm and cooperative as the record -- do the
3 records reflect that Matthew was calm and cooperative at
4 Lighthouse?
5 A Sitting beside his father he was calm and cooperative.
6 That's correct.
7 Q Is the fact that Matthew was with his father and calm and
8 cooperative is that relevant to your opinion?
9 A Actually, no. I mean, I think his father was certainly a
10 calming influence on him, but as we know, this illness can,
11 can wax and wane, and so this was a period of time that he
12 was, as I think it was reported, appearing to respond to
13 internal stimuli. He did appear to be psychotic, but he was
14 sitting calmly. He was not agitated, threatening, etcetera.
15 Q Does calm and cooperative equate to no psychosis?
16 A Absolutely not.
17 Q And Matthew -- had Matthew at the time he was at
18 Lighthouse not been with his father and not been calm and
19 cooperative, would he have been somebody that a -- that
20 different action should have been taken?
21 A It was possible, but at the same time the, the issue is,
22 first and foremost, his medical stability, which was not
23 addressed prior to his transfer to that facility and that
24 needed to be done.
25 Q Did you see in the record who signed -- jump back in time

1 just, just a second. At the -- when Matthew left, Matthew and
2 David left the ER for Lighthouse, did you see who signed
3 Matthew out?
4 A I think it was his, his father. Correct.
5 Q Does that have any significance to you?
6 A Well, I think it -- it's relevant as it suggests even
7 though he was calm and cooperative he was not, he was not
8 focused, alert and, and competent to sign his own signature at
9 that time. So it is certainly relevant.
10 Q All right. Dr. Malone, I want to move now back to
11 Matthew and his dad represent at Grand Strand in the
12 afternoon.
13 A Right.
14 Q And he's again seen in the ER.
15 A Right.
16 Q What was Matthew's demeanor at that time?
17 A According to Dr. Patel I believe it was -- well, first,
18 Dr. Battisti who saw him in the emergency room, and she's,
19 she, she's interesting and important because she saw him prior
20 to his, his departure for Lighthouse and she saw him when he
21 returned. She notes that he is not changed, that he is still
22 displaying evidence of psychosis and paranoia and, and, and
23 obviously in need of treatment.
24 Q What was his -- was he calm and cooperative, was he
25 agitated, how was he demeanor-wise though?

1 A Well, he was cooperative in that he was not attempting to
2 leave. He was not removing his shirt or becoming aggressive.
3 You know, if they placed him in the room he stayed there, but
4 that's as much as I can say about my impression.
5 Q Was there any reason to put him on a temporary hold
6 then?
7 A Absolutely not.
8 Q You've read Dr. Patel's deposition. You've read Dr.
9 Patel's notes from the medical record. Did Dr. Patel's
10 treatment of Matthew meet the standard of care?
11 MR. GRESH: Objection, Your Honor. May we approach?
12 (Whereupon, a bench conference is held in the presence,
13 but out of the hearing of the jury.)
14 MR. GRESH: Thank you, Your Honor.
15 Q Dr. Malone, what's your understanding of what Dr. Patel,
16 what type of doctor Patel is?
17 A It's my understanding that Dr. Patel is a hospitalist,
18 which means, I presume then he has his degree in internal
19 medicine.
20 Q Right.
21 A Right.
22 Q And you, like Dr. Patel, went -- both went through med
23 school?
24 A That is correct.
25 Q And you did, when you went through med school, rotations

1 in all sort of different fields?
2 A Yeah. Remember it fondly. We, we all -- medical school
3 is the same for everyone. We all have the same basic training
4 in, in medical school.
5 Q And at the time Dr. Patel is, is Matthew's attending
6 physician, he's attending to a patient who's been admitted
7 for, among other things, treatment of acute psychosis?
8 MR. GRESH: He's leading.
9 A That's correct.
10 Q And, Dr. Malone, are you familiar with the standard of
11 care as applicable to a physician in Dr. Patel's position
12 looking at treating a patient with acute psychosis in the
13 hospital? Are you familiar with the standard of care
14 applicable in this situation?
15 A I am. Yes.
16 Q Dr. Malone, did Dr. Patel meet the standard of care?
17 A I do not believe so. No, sir.
18 Q And tell us how he, how he failed to meet the standard of
19 care.
20 A Well, from his records he, he certainly indicates that he
21 sees evidence of psychosis, hallucinations that are present.
22 He does admit him to the hospital, and he does the appropriate
23 medical evaluations that have been requested by the Lighthouse
24 and Dr. Oduwole. However, my concern for his, his conduct is
25 that he does not leave medication that could begin to treat

1 his psychosis. Mind you, it does not matter what the etiology
2 of his psychosis is, but the fact that it remains untreated,
3 and there was no medication placed in the record to begin to
4 address the psychosis that ultimately Matthew suffered with
5 that night. The other issue that I have is the handoff. I
6 did it as I drove down here yesterday to, to appear in front
7 of you, discussing the cases that I have in the hospital with
8 my medical backup and, you know, this is what's going on with
9 this person and this is what's going on with that one, and
10 this is what you need to look out for, etcetera, and that was
11 not done, and there, there, there is a standard of care in
12 both psychiatry and medicine in general that the handoff must
13 happen, and it could be, it could be a checkout list.
14 Preferably it's a face-to-face or at least a phone call to let
15 someone know who's covering for you or who's coming on the
16 shift what's going on with the patients that you've been
17 managing and that's my concern.
18 Q Dr. Malone, you mentioned Dr. Patel's failure to order
19 any drugs for Matthew. What type of drugs could have been
20 ordered, should have been ordered?
21 A Sure. Haloperidol, Geodon, which is one of the -- it
22 shouldn't -- not newer now. It's been out for some time, but
23 both are antipsychotic medications. These are medicines that
24 regardless, again, of the etiology of your psychosis, if it
25 were due to a urinary tract infection or if it were due to,

1 you know, the onset of a mental illness, these medicines can
2 render an individual within really a matter of a few minutes
3 either calm and cooperative and able to have a rational
4 discussion, the delusions, again, maybe not completely
5 eliminated, but the paranoia lessened to the point that one
6 might eat, one might, you know, engage in conversation. One
7 might, you know, take the medication that's being offered so.
8 Q How are these medications administered? Are they oral,
9 are they through an injection?
10 A So they can be given, they can be given orally and we do
11 that if, if people are -- patients are cooperative even though
12 they may be psychotic or delusional. I have some patients who
13 will say, "Yeah, Doc, I'll take it," and you know, so we can
14 avoid the other method, which would be intramuscular. We can
15 give the -- both of those medicines intramuscularly and --
16 Q When you say intramuscular what do you mean?
17 A Oh, I'm sorry, as a shot, as a shot.
18 Q Is one option quicker than the other as far as how fast
19 it'll react?
20 A Yeah. The shot, obviously, is, is definitely has a
21 quicker onset, but it is invasive, and if you have someone who
22 is cooperative you certainly would, you know, opt towards
23 using the oral version. If someone is not, the injection is
24 certainly available to you. It can also be given IV as well.
25 Q Did you see in Dr. Patel's note that he mentions giving

1 some sort of drug for, for agitation?
2 A He does mention that.
3 Q Does he ever enter that order?
4 A I don't see that he ordered it. No, sir.
5 Q If an order isn't entered, regardless it just appears in
6 the physician's note, does that give a nurse the authority to
7 give the medication if it's never entered?
8 A The nurse reading his note, you know, acknowledging that
9 he thought about ordering it but didn't order it, no, does not
10 allow the nurse then to administer the medication. It has to
11 be entered.
12 Q And this handoff, your second criticism, this handoff,
13 could you give us kind of an example of how that would, how
14 that would go in this -- with the case of Matt what type of
15 thing would --
16 A Certainly. Well, I mean, I, I think that, first and
17 foremost, in the, the era of electronic medical records, it's
18 impossible to miss information. So we have the PA's note. We
19 have the notes from Dr. Battisti, the first note. We have the
20 second note, and now Dr. Patel comes on. The references to
21 how he appeared, Matthew that is, appeared, is not conveyed at
22 least in my mind to Dr. Patel or at least from his, in terms
23 of him reading those records, and then conveying the
24 importance of that to the individual who's going to be
25 managing him, you know, through the night. I think we would

1 all agree as physicians things happen at night, and so to not
2 convey this is an individual that is just here for us to do a
3 medical evaluation on some abnormal labs from the Lighthouse,
4 but make no bones about it, he's, he is here primarily his
5 presenting problem is psychosis, and that was the issue that
6 is not conveyed to the, to the on-call doctor coming in later,
7 and the reason that is important is because even though
8 Matthew is cooperative at that time, with some things, again,
9 he's refusing his Keppra, and he's refusing to eat for the
10 most part, you know, the issue about his continued delusion
11 and paranoia and psychosis is not addressed to the point that,
12 listen, the handout might go something like this. I'm sorry
13 for rambling, but for me, the handoff might be something like
14 this. This gentleman is here for us to do some labs to
15 evaluate his elevated white count and his elevated bilirubin,
16 but he has presented and we know this from the PA's note after
17 having thrown all his clothes away. He is, you know, been --
18 he's hallucinating and feels paranoid, that people are out to
19 get him. He's not eating and hasn't eaten in several days
20 because of his psychosis. If this individual, you know, at
21 any point during the night gets to the point where he's not
22 cooperative, these are some steps that we need to do to
23 address that, A, medication, which was not written, B, we need
24 to spend some time talking with either him or with his family
25 and making sure that he is remaining compliant, and then

1 ultimately I would have let them know if he became disruptive
2 to the point that he was refusing to stay, this is someone
3 that I would actually, and I have done this many times in the
4 chart, please initiate commitment should he attempt to leave
5 against medical advice.
6 Q Dr. Malone, when -- at the time that Dr. Patel was seeing
7 Matthew, was Matthew trying to leave the hospital?
8 A He was not.
9 Q At the time Dr. Patel was treating Matthew was Matthew
10 calm and cooperative?
11 A He was cooperative. Right.
12 Q Was there any reason to put a temporary hold at that
13 point?
14 A There was not.
15 Q Who was with Matthew at that point in time besides Dr.
16 Patel?
17 A His dad.
18 Q And Dr. Patel or, excuse me, Dr. Malone, approximately
19 what time did the one physician or did Dr. Patel leave?
20 A I'd have to go back and review. I thought it was around
21 five-ish or five or six somewhere in the afternoon, evening.
22 Q And at the time he -- well, when, when should this, this
23 sign-out or handoff take place?
24 A You know, it happens simultaneously. I mean, I've
25 actually I've done it in the hospital, I've done it on the way

1 home, but it needs to happen before you then turn off your
2 pager and go about the rest of your, your day. So it has to
3 happen succinctly.
4 Q You mentioned a minute ago that Matthew was, was throwing
5 his clothes away. Tell us what you're speaking of there.
6 A It was reported that he had, he had thrown some -- many
7 of his belongings away prior to his dad driving down from Ohio
8 to check on him. Yes.
9 Q And Dr. Malone, was there a change in Matthew and his
10 demeanor in the early morning hours of October 3rd?
11 A Yes. There were.
12 Q And at the time -- you've seen the nurse's notes from
13 that. Does that have significance, this, this change around
14 1:30, 1:15 in the morning?
15 A Yes. It does. Yes. It does.
16 Q At what -- you mentioned a minute ago that Dr. Ash-Bernal
17 fell below the standard of care. Tell us how, how she failed
18 to meet her obligations as a physician.
19 A Well, at this point I think Dr. Ash-Bernal is called.
20 It's 1:15, 1:20 or so in the morning, I believe. The record
21 reads that she does come, and she spends, I think, Nurse Bell
22 says between four or five minutes evaluating Matthew because
23 he has ripped his shirt off, ripped off his armband and is
24 demanding to leave and proclaiming that everyone in the
25 hospital are devil worshipers, that Obama is the devil and,

1 and was presenting himself quite agitated at that time. Yeah.
2 Q What should have been her first step to, to have met her
3 obligation and duty to her patient?
4 A Well, see, I think the first step was missed. It, it
5 really should have been the handoff to understand the context
6 of what was going on throughout the day. So she's the, I
7 hate, you know, she's the one that comes on last, but you
8 know, this is why we have to have handoffs so that we
9 understand the context of what occurred in Matt's --
10 throughout Matt's day. So she comes on and, and what she sees
11 at that point is obviously an agitated patient or reportedly
12 at that point, and, and she was told that, you know, he had
13 proclaimed that everyone was devil worshipers and that Obama
14 was the devil, etcetera, and so she went in to do, presumably,
15 her evaluation of Mr. Scheer.
16 Q All right. And what should she have done?
17 A Well, you know, this, this is an area that you, you, you
18 turn the clock off because at this point it takes however much
19 time it takes because we have an individual who obviously is
20 delusional and in his delusional paranoid state, despite his
21 request to go, cannot go, and so, at that point, one must, you
22 know, first do, in my opinion, build some rapport. Let's,
23 "Hey, let's, you hungry? Let's get a cup of coffee. Let's,
24 you know, let's talk. Let's -- can we call your father or
25 call someone else that, that, that perhaps you'd like to speak

1 with." In other words, do your best to get him talking, lower
2 his defenses and try to get him to, to express more about
3 what's going on with, with him at that time. At that time she
4 should also be exploring these delusions. "So what does it
5 mean, Matt? Tell me what does it mean that you feel like
6 everyone is a devil worshiper?" I mean, might his next
7 statement be, "I need to go out and kill all the devil
8 worshipers?" I don't know? We don't know that unless we ask.
9 MR. GRESH: Speculation.
10 THE COURT: Yeah, I, I sustain the objection as to what
11 he may have done.
12 Q What other types of questions should, should a proper
13 evaluation of a patient who's come in with a diagnosis of
14 acute psychosis who wants to leave at 1:30 in the morning,
15 what other types questions should have been asked of Matthew?
16 A Well, obviously, she should be asking him about his
17 safety and thoughts that he may have towards harming himself
18 or others. She should be getting more information regarding,
19 you know, his delusions about food. This is someone who's
20 designed -- desiring to leave at 1:30 in the morning with a
21 hurricane overhead, and he hasn't eaten, and so my concern,
22 even though it's an A -- potentially an AMA discharge in her
23 mind, the disposition needs to be considered. So questions
24 about his, his judgment as it pertains to his ongoing
25 delusions should have been further vetted.

1 Q Can one accomplish that in two to four or five minutes?
2 A I have no -- I cannot imagine that that could be done in
3 two to five minutes. We're talking about an evaluation that
4 at a minimum was, you know, 30 to 40 minutes or an hour at
5 least in my opinion.
6 Q Have you had time in your, in your career to have to sit
7 down and talk with a patient in that, in that manner?
8 A Absolutely.
9 Q And typically, when a physician takes the time to sit
10 down and talk with the patient, as you've described, what,
11 what typically in your experience has been the outcome?
12 A It typically is, is very good. It, it -- almost
13 unanimously I would say, yes.
14 Q When you say it's very good, what do you mean?
15 A In that, you know, the patient will calm down. The show
16 of force was there. I mean, there was no imminent risk. I
17 mean, there were two police officers or security officers
18 there. So, there, there wasn't, there wasn't a hurried
19 atmosphere that we needed to make a disposition with this
20 gentleman at this moment. So you had the luxury of time to
21 sit with him, bring the nurse in, whomever else he may have
22 had, you know, some, you know, rapport with and sit down and,
23 and talk with him to try to get him to comply, A, hopefully
24 with taking some medication to treat what we all know was
25 going on with Matt, which was his psychosis and paranoia.

1 Q In your experience as a physician treating patients with
2 psychosis, do you believe to a reasonable degree of medical
3 certainty that that would -- that a proper evaluation and
4 conversation in your experience would that have been
5 successful in calming Matthew down?
6 MR. GRESH: Objection, Your Honor, speculation.
7 THE COURT: Yeah. I sustain the objection.
8 Q Dr. Malone, in your experience, the vast -- do most
9 patients -- are most patients able to be calmed and convinced
10 to stay with the proper evaluation and conversation?
11 A Yes. Most patients are.
12 Q You mentioned a minute ago he wasn't in imminent risk.
13 Explain what you meant by that comment.
14 A Well, you know, at this point there is an officer there.
15 He, you know, according to her note had, had calmed down
16 enough to have some words with her. So he wasn't physically
17 aggressive. He wasn't, you know, combative to the point that
18 individual staff members were being harmed. So there was the
19 luxury of time to be able to sit and build rapport with this
20 gentleman in the middle of the night to try to determine, you
21 know, what is going on with his thoughts.
22 Q From your review of the medical record and the
23 depositions in the case, did Dr. Ash-Bernal utilize her luxury
24 of time that she had available to her?
25 A It does not appear that way, sir, no.

1 Q What other options were available to Dr. Ash-Bernal to
2 try to keep Matthew in the hospital and comply with the
3 standard of care?
4 A I think she could have called his father. One misnomer
5 about HIPAA is that it is there to protect the flow of
6 information, and to some degree that's true, but it's not to
7 handicap the physician from doing what is common sense and
8 right. The sharing of information is obviously prohibited,
9 but to make a phone call to Matt's dad and say, "Please come
10 down," would have been an appropriate thing to do.
11 Q Is there anything in your understanding of how the law
12 applies to physicians, is there anything that would have
13 prevented such a phone call to take place?
14 A Nothing.
15 Q Did she have Matthew's, Matthew's dad's contact
16 information available to her?
17 A It was my understanding that she did.
18 Q Who would have been made the emergency contact for
19 Matthew?
20 A His father.
21 Q Does the physician have a duty and an obligation to
22 understand when disclosures of patient information can be made
23 for patient safety?
24 A Yes. They do. Yes. They do.
25 Q Did you see anything in the medical record that would

1 reflect that Matthew had revoked his dad as being the person
2 to notify or the emergency contact?
3 A I did not see that. No.
4 Q Have you had occasions in your practice, Dr. Malone, when
5 you've had to call family members?
6 A I have.
7 Q Have you had occasions where you had to call family
8 members despite the patient not wanting the family member
9 called?
10 A Yes, and, and that is predicated in, in the HIPAA
11 document as well. The doctor using judgment, their judgment
12 can in a situation where they feel the patient is, is not
13 presenting themselves with appropriate judgment due to a
14 mental infirmity can decide to contact family without the
15 approval of the, of the patient. That certainly is there.
16 Q In your experience are family members oftentimes able to
17 help the situation?
18 A Almost unanimously. It's amazing what mom and dad or
19 wife or husband can do.
20 Q Can, can family members oftentimes prevent or lessen a
21 threat to the patient and others?
22 A Absolutely.
23 MR. GRESH: Speculation, Your Honor.
24 MR. HINSON: In his experience.
25 THE COURT: Yeah. I, I overrule the objection.

1 A In my experience we do. In fact, we oftentimes will
2 allow on some difficult cases more liberal visitation of
3 family members if we have someone who's an agitated state to,
4 to come and stay with the patient.
5 Q If adequate and proper conversation with Matthew, if a
6 proper evaluation and discussion had taken place, and had
7 Matthew's dad come and Matthew still not wanted to stay, still
8 been unwilling to stay voluntarily, what other option was
9 available to Dr. Ash-Bernal?
10 A Well, that's where we get to the, the 72-hour hold. So
11 he could have been placed with the, the solo signature of Dr.
12 Ash-Bernal at that time to place him under a hold, commitment
13 to the hospital.
14 Q Did his signs and symptoms and presentations of psychosis
15 justify a hold if Matthew was unwilling to stay?
16 A Absolutely. I mean, at, at 1:30 in the morning
17 absolutely. Not earlier in the day, even though he was
18 psychotic. He was talking to himself. He was displaying
19 paranoia and not eating. At 1:30 in the morning he is now
20 aggressive. He is now demanding to leave, which he wasn't
21 doing earlier. He is proclaiming delusional rants, religious
22 rants. So he's clearly not -- he's clearly affirmed in his
23 mind at that point.
24 Q Was it foreseeable that if released by himself alone at
25 1:30 in the morning that Matthew might do some sort of harm to

1 himself or others?
2 MR. GRESH: Objection, Your Honor.
3 THE COURT: I sustain the objection. You asked if it was
4 conceivable. I sustain it. You asked if it was conceivable.
5 I sustain the objection.
6 Q Is it --
7 THE COURT: I sustain the objection.
8 Q Dr. Malone, should the physician be -- have concern about
9 what the patient may do, what Matthew may do if, if released?
10 A Absolutely. In, in fact, this is the reason why the
11 third provision with the, the state law says about civil --
12 about these types of commitments is allowed because under the
13 influence of a delusional mindset, an individual, the
14 foreseeability of an individual becoming either self harmful
15 or harmful toward others is highly imminent, and so that is
16 the reason why that provision is there to allow him to be held
17 on a 72-hour hold, the minimum.
18 Q Had Dr. Ash-Bernal complied with the standard of care and
19 ensured that Matthew didn't leave the hospital at 1:30 in the
20 morning, do you believe he could have been successfully
21 treated?
22 A Well, I don't think there's a question at all that he
23 could have been successfully treated. His psychosis, you
24 know, his medical issues clearly could have -- would have been
25 adequately addressed, and, and with short time, yes.

1 Q Dr. Malone, in your experience patients in their mid-20s
2 having their first ever mental illness with no history of
3 mental illness in their family, what percentage or degree of
4 those patients are able to successfully receive treatment?
5 A I would say that, you know, the lion's share, the
6 majority of these cases do very, very well with treatment.
7 Q Do they go on to live productive, normal lives?
8 A Not only productive but professional, you know, lives
9 and, and own businesses, you know, professors, etcetera, yeah.
10 MR. GRESH: Speculating.
11 THE COURT: I overrule your objection.
12 MR. GRESH: Thanks. Thank you.
13 Q Dr. Malone, do you know, and I'm certainly not asking for
14 any names, but do you know people in the University of South
15 Carolina with, with -- that -- in professorships that have --
16 that hold -- have mental illness that, that have been treated?
17 A Several, yes, successfully, and some of them are the most
18 esteemed colleagues I have.
19 Q Dr. Malone, have you read some of the depositions in this
20 case from the physicians that the Defense has hired to come
21 testify?
22 A I have.
23 Q All right. Is there -- did you read the deposition of
24 Dr. Oscar Lovelace?
25 A I did.

1 Q And are there any opinions that he offered in his
2 testimony under oath that you would like to address with this
3 jury because this is my opportunity to --
4 THE COURT: Yeah.
5 MR. GRESH: Objection.
6 THE COURT: I -- do you object?
7 MR. GRESH: Yes, I do.
8 THE COURT: I sustain the objection.
9 MR. HINSON: Okay.
10 BY MR. HINSON:
11 Q Dr. Malone, Defendant Ash-Bernal came when called. She
12 spent a few minutes speaking with Matthew. She had Matthew
13 sign this AMA form, and she had Matthew released. Does that
14 meet the standard of care?
15 A It does not.
16 Q Just generally speaking, why not? She, she, she came,
17 she came, she talked to him and she filled out the form. Why
18 does that not meet?
19 A As I've said before, Matthew was in an incredibly
20 infirmed state at that point. He was delusional. He was
21 paranoid, and he deserved and required a more thorough
22 evaluation. To come in and spend four to five minutes doing
23 what essentially was an AMA checklist is not in my
24 professional opinion an adequate evaluation of him at that
25 time.

1 Q Would it take more time and effort to do an adequate
2 evaluation or more time and effort to fill out an AMA
3 form?
4 A Obviously the AMA form.
5 Q But which would, which, which would take more time?
6 A Is -- it's -- the -- oh, I'm sorry, more time. Yeah.
7 Obviously, the -- you know, this was a situation, as I've said
8 before, this is, pull up a chair, we're going to be here for a
9 while. You know, everyone's secured. The, the officers are
10 there. We're going to chat. We're going to talk. We may
11 talk about your childhood. We'll talk about, you know, who
12 your interests are, but I'm going to build rapport with you so
13 that I can reach you and which is, is entirely common, even
14 with the most psychotic of patients that you can reach them at
15 some level whether it's about sports or whether it's about,
16 you know, someone -- something else in their life, to calm
17 them down and then, and then be able to treat them and rescue
18 them. So yes, that's going to take a little longer period of
19 time.
20 Q And you as a psychiatrist, do you have the same
21 expectations of a hospitalist in this situation?
22 A Yes. I mean, there's, you know, the mental status exam
23 as I've said, we do four years of medical school, and so the
24 mental status exam is an, an evaluation of mental state is
25 something we all learn. So it is, it is part of what we do as

1 physicians. So no, this was not out of the privy or the
2 understanding of a hospitalist.
3 Q Dr. Malone, you've seen this AMA form in the medical
4 record; is that correct?
5 A Not quite that big, but yes.
6 Q Not quite this big. Dr. Malone, did Matthew have the
7 mental capacity to sign this form?
8 A It appears he did not, no.
9 Q And I could hand you or have the court reporter or hand
10 you Exhibit One. If you could turn to page 68.
11 A 68.
12 Q 68 of the Bates numbers, and I'm looking at Dr. Ash-
13 Bernal's cross cover note.
14 A You may have to help me with it.
15 Q I got a really big one of that, too, Dr. Malone.
16 MR. HINSON: May I approach the witness, Your
17 Honor?
18 THE COURT: Yes, sir.
19 A Bates numbers on the bottom?
20 Q These right here.
21 A Got you. Okay.
22 Q Dr. Malone, it says on page 68 of Plaintiff's Exhibit
23 One, [as read], "Patient indicated he understood that it was
24 recommended that he remain in the hospital for further
25 evaluation of his psychiatric issues but he refused to stay.

1 Patient seems able to weigh the information" -- then in
2 parentheses -- "(he interrupted his religious rant to think
3 about the question)." Do you see that?
4 A Yes. I do.
5 Q Is that an adequate assessment of a patient admitted for
6 psychosis to determine whether they understand the risks of
7 leaving?
8 A It is not.
9 Q Thank you, Dr. Malone. No further questions at this
10 time.
11 THE COURT: All right. We'll take a break before we do
12 cross examination. If you'd go to the jury room we'll take
13 about a 15-minute refresher break.
14 (Whereupon, the following takes place outside the
15 presence of the jury.)
16 THE COURT: Dr. Malone, during the break you can step
17 down.
18 A Okay.
19 THE COURT: Have some water or use the restroom but don't
20 discuss -- just don't have any conversations with anybody
21 about anything is probably the best way to look at it. We'll
22 be at ease till about five after 11.
23 MR. GRESH: Thank you, Your Honor.
24 OFF THE RECORD
25 (On the record. The following takes place outside the

1 presence of the jury.)
2 THE COURT: Thank you. You may take your seats. Dr.
3 Malone will come back up on the stand. We can bring in the
4 jury.
5 (The following takes place in the presence of the jury.)
6 THE COURT: Mr. Gresh.
7 MR. GRESH: Thank you, Your Honor.
8 CROSS EXAMINATION
9 BY MR. GRESH:
10 Q Good morning, Dr. Malone.
11 A Good morning.
12 Q I'm Jack Gresh. You and I didn't meet. We met earlier
13 today.
14 A Oh, yeah, uh-huh.
15 Q Yeah. I wasn't at your deposition, but I, I did read it
16 and I appreciate that. I have a copy here. If at any time
17 you need it to refresh your recollection just let me know.
18 A Thank you.
19 Q But I wanted to kind of start where the Plaintiff started
20 with you on the direct examination, this idea of a temporary
21 hold, and I thought you said that's kind of a misnomer or a
22 little bit misleading. Right?
23 A It is very misleading.
24 Q Because what happens is when a physician puts you under a
25 temporary hold, an involuntary temporary hold, you may be held

1 for 72 hours, then you're taken to Columbia?
2 A I stand corrected. I'm sorry. I thought you were going in
3 a different direction. I spoke too soon.
4 Q Oh, okay. I was trying to explain a little bit about the
5 process. We haven't heard from a psychiatrist yet. So I was
6 going to talk about the involuntary hold. Once you're under
7 one of those things, and it may be 72 hours, that's just
8 before the hearing has to occur; right?
9 A That is not true.
10 Q There's a hearing to decide how long you get to stay there?
11 A That is not true.
12 Q Okay. How -- what's your --
13 A At any point the 72-hour hold can be, can be dropped, can
14 be released.
15 Q If the physician certifies that you're --
16 A Absolutely.
17 Q All right. But in this case without a psychiatrist at
18 Grand Strand over the weekend one would have to wait until
19 Monday before that patient could be --
20 A It would not need a psychiatrist.
21 Q All right.
22 A The state statute states that any physician can.
23 Q Well, we know one physician who was, was there with him and
24 had talked to him, but let's keep going on about this
25 temporary hold. When a patient does -- when they want to

1 leave, and you as the physician decide they can't leave, we
2 actually would hold the patient down if necessary and give
3 them medications to calm them down; correct?
4 A It would be the, the, the last resort. That's -- that is
5 correct.
6 Q And they don't get any longer to decide what is in their
7 best interest? You as the physician would make that decision
8 for them?
9 A At the point that is determined that they are
10 disorganized and paranoid to the point that they are a risk of
11 harm to themselves out of the facility, yes.
12 Q The -- you had mentioned on the direct examination that
13 you've done this other times where you leave a note or you
14 talk to folks and say, "He's here voluntarily at this point,
15 but if the patient tries to leave don't let them,
16 involuntarily commit him." You've done that; right?
17 A I've left those. Uh-huh.
18 Q When you look through the medical records from Dr.
19 Battisti and the physician's assistant who saw him in the
20 emergency department that morning, did you see any indication
21 from them that they gave that type of direction to anyone?
22 A I don't see that. No.
23 Q When he goes to Lighthouse and is seen by a masters level
24 social worker, and you've seen her notes; right?
25 A Yes.

1 Q Did you see any indication from her along the lines of,
2 "He's going back voluntarily, but if he decides to leave don't
3 let him"?
4 A Right. No.
5 Q Instead what the social worker says is, "When he gets to
6 Conway pay special attention to the medical issues, the white
7 blood cell count and the bilirubin level"; correct?
8 A That's what I recall.
9 Q Earlier there was discussion about whether Lighthouse
10 could have involuntarily committed him, Matthew Scheer, to
11 Lighthouse, and I understood you to say, no, no, no because he
12 has the medical issues going on; right?
13 A That's correct.
14 Q And that's within their purview. Lighthouse is a
15 psychiatric facility and they don't have full spectrum medical
16 capabilities. Is that your understanding?
17 A That is my understanding.
18 Q But in that same parking lot is Conway Medical Center.
19 If Lighthouse thought this person needs to be involuntarily
20 committed, they wouldn't commit him to Lighthouse because of
21 his medical conditions, instead they would have involuntarily
22 committed him right next door to Conway; correct?
23 A That is possible I would imagine. Sure.
24 Q When -- I understood you on direct to say that it was
25 really important to you that when Matthew Scheer left Grand

1 Strand that morning that it was his dad that had to sign him
2 out and that somehow that was evidence of an, an
3 acknowledgment that Matthew didn't have capacity. Did I
4 understand that correctly?
5 A It is.
6 Q Who signed in when they came back to Grand Strand?
7 A You'd have to refresh my memory.
8 MR. GRESH: If I could approach, Your Honor.
9 THE COURT: You may.
10 BY MR. GRESH:
11 Q Represent to you I can't read that but that says self.
12 Does that say Matthew J. Scheer?
13 A It appears to.
14 Q Okay. Signed himself back in to Grand Strand?
15 A Uh-huh.
16 Q Right? And also Dr. Battisti we know, we know she's the
17 ER doc that sees him not only in the morning but also in the
18 afternoon. She has something called additional notes and I'll
19 just read it with you.
20 A Uh-huh.
21 Q [As read], "Discussed with patient ED findings," and
22 that's a good thing; right?
23 A Certainly.
24 Q [As read], "And the plan for admission. Patient
25 understands and agrees with that plan, all questions

1 addressed." Did I read that correctly?
2 A You did.
3 Q So what we have is other evidence that say, hey, whether
4 Mr. Scheer signed him out or his son signed him out I don't
5 know, but when they come back the plan is discussed with the
6 patient. He understands where he is. He understands the plan
7 for admission and the medical clearance, and that's what Dr.
8 Battisti acknowledges in her note; correct?
9 A That is correct.
10 Q Now, you mention also on direct examination that you saw
11 somewhere that Matthew Scheer had thrown away all of his
12 clothing?
13 A Thrown away some items.
14 Q Some items. The -- I'll represent to you, but no, you
15 tell me, you've read Plaintiff's Exhibit One or Defendant's
16 Exhibit One. They're both copies of the Grand Strand records.
17 A Uh-huh.
18 Q Did you see any PA, nurse or medical doctor that wrote in
19 their note that Matthew Scheer had thrown away all of his
20 personal effects?
21 A No. They did not.
22 Q Instead, the only evidence that we have about what
23 Matthew Scheer was wearing at the time that he left Grand
24 Strand would have come from the deposition of Gregory Phaebus.
25 You know, you know Gregory Phaebus?

1 A I know who he is.
2 Q The security guard; right?
3 A Security guard, right.
4 Q We watched his deposition yesterday, and do you remember
5 what he said Matthew Scheer was wearing at the time of
6 discharge?
7 A I do not.
8 Q I'm going to hand you page 53. Read that to yourself.
9 A Uh-huh.
10 Q I tried to make it big and blue, and does that refresh
11 your recollection of what Mr. Phaebus says Matthew Scheer was
12 wearing at the time that he walked him out to the door?
13 A Yes. It is.
14 Q And what did, what did Mr. Phaebus testify Matthew Scheer
15 was wearing at the time he walked out the door?
16 A Tennis shoes and had jeans and T-shirt on, uh-huh.
17 Q Thank you. So he hadn't, clearly hadn't thrown away all
18 of the clothes. He was still in tennis shoes?
19 A He wasn't naked.
20 Q Yeah. He was in tennis shoes, jeans and a gray shirt?
21 A Right.
22 Q All right. When the patient comes to Grand Strand from
23 Lighthouse, and I apologize. I'm, I'm jumping around a
24 little bit.
25 A Yeah.

1 Q When the patient comes back to Grand Strand the second
2 time, he's seen in the emergency department by Dr. Battisti.
3 We read a little bit of her note. Dr. Patel is the next
4 physician who actually lays eyes on Matthew Scheer; correct?
5 A That's correct.
6 Q But in the intervening time, Dr. Battisti, the ER doctor,
7 talks to Dr. Oduwole, the psychiatrist. Did you see that in
8 the note?
9 A Yes.
10 Q Did you see any note from Dr. Oduwole to Dr. Battisti or
11 Dr. Battisti to Oduwole or to anybody that said, "Hey, I know
12 Matthew Scheer is here voluntarily, but if he tries to leave
13 don't let him"? Do you see that kind of note anywhere?
14 A I did not. No.
15 Q So even from the psychiatrist that warning wasn't passed
16 on to any of the other care providers?
17 A May, may I clarify my earlier comment?
18 Q Yes, sir.
19 A Okay. I, I think what I was referring to is the fact
20 that on some occasions when I have someone who I am concerned
21 about the possibility of an AMA that I might leave that type
22 of order in the chart, in the record. Mind you, and we've
23 discussed already the earlier presentations of Matthew did not
24 display the need for commitment at all.
25 Q Right. If you had concerns that he couldn't care for

1 himself, even if he's here voluntarily, you would give the
2 person who comes on behind you the benefit of your insight and
3 let them know, "He's here voluntarily. He's not on papers,
4 but man, I've evaluated this guy, he's a danger to himself or
5 others. Don't let him go if he wants to leave"; right?
6 A I would certainly allow that doctor to make their
7 discernment on this, but the important thing is that they
8 understand the context in which he presented, and I wouldn't
9 want that to be lost in the translation. So that's the
10 purpose for that.
11 Q Right. And that's -- I think you and I are
12 communicating, but I just want to make sure. The situation we
13 have with Dr. Battisti, Matthew Scheer is feeling things crawl
14 on his arm, he is seeing things that are not there, he is
15 hearing voices that aren't being spoken; correct?
16 A That's correct.
17 Q When he presents to Lighthouse, you saw those records,
18 it's essentially the same, and none of these people who
19 actually evaluated Matthew Scheer at the time were so
20 concerned that they thought, "You know what, I better give
21 some of my insight to those folks coming on later"; correct?
22 They didn't give the kind of warning or cautionary statement
23 that you sometimes give to folks; correct?
24 A I, I do believe that Dr. Oduwole felt that he was very
25 disorganized. That was the report that he received, and that

1 he felt he needed psychiatric care.
2 Q And the plan was, right, Battisti and Oduwole talked, the
3 plan is --
4 A Uh-huh.
5 Q -- let's admit him to Conway or Grand Strand.
6 A Sure.
7 Q Admit him to Grand Strand, get medical clearance from
8 folks like Dr. Patel and Dr. Rachel Ash-Bernal and then Dr.
9 Oduwole would come by as the psychiatric consult; correct?
10 A That was what was discussed in the record. Yes.
11 Q That the, that's the plan. Okay. I understood on direct
12 examination that you are critical of Dr. Patel. He's seated
13 over here. Have you ever met Dr. Patel?
14 A I have not.
15 Q This is Dr. Patel.
16 A Hi.
17 Q That you're critical of Dr. Patel for not ordering PRN
18 Ativan; correct, that's one of the criticisms you had?
19 A Ativan and an antipsychotic either Haldol or Geodon.
20 Q When Dr. Patel saw Matthew Scheer he made a specific note
21 that said no hallucinations; right?
22 A That is not to my recollection accurate.
23 Q Did you see that in the medical record where Dr. Patel
24 said no hallucinations?
25 A You want to refresh my memory?

1 Q I don't want to -- it's in there. I'll find it later.
2 A Paranoia, not eating, that the food was poisoned, those
3 were items entered, entered at that time.
4 Q Was calm?
5 A Psychosis.
6 Q Calm and cooperative; correct? At the time he saw Dr.
7 Patel Matthew Scheer was calm and cooperative; correct?
8 A He mentioned that he was calm, but he also mentioned that
9 and I would have to re-read the, the entry.
10 Q Okay. Okay. The patient denies hallucinations, do you
11 see it there in blue brackets?
12 A I do.
13 Q And that's Dr. Patel's note?
14 A It was -- can --
15 Q So at the time --
16 MR. HINSON: Your Honor, object.
17 A Can I read the rest?
18 MR. HINSON: He's -- the witness needs to be able to see
19 the -- see the full exhibit, I mean, not just flash it in
20 front of him.
21 THE COURT: All right. Let him take a look at it.
22 MR. GRESH: Of course.
23 BY MR. GRESH:
24 Q This is the -- you can just use mine.
25 A Okay.

1 Q If that's okay.
2 A Certainly.
3 Q I think the question was did Dr. Patel specifically note
4 in his record that the patient denied hallucinations?
5 A Certainly. He did.
6 Q Okay. Because what we know is he didn't -- Battisti, he
7 had hallucinations. We talked about that.
8 A Uh-huh.
9 Q Talked about what happened at Lighthouse. We talked
10 about when he comes back he's having hallucinations with
11 Battisti, but now when he gets to Dr. Patel he's calm, he's
12 cooperative and there are no hallucinations; correct?
13 A He describes tangential thinking, which shows his
14 disorganized thought process to which Haldol and Ativan can
15 certainly be helpful to address. This is a waxing and waning
16 illness, and so, the fact that the moment he sees him at five
17 in the afternoon and denies hallucinations doesn't mean that,
18 that this isn't an ongoing illness that needs to be addressed.
19 So that's what PRN means that in the need, in the event that
20 it is necessary that it is available there.
21 Q Because he -- Matthew may not need it right now if there
22 are no hallucinations and he's calm and cooperative but he
23 might need it in the future.
24 A Absolutely. Based on his day, absolutely.
25 Q And that's why Dr. Patel in your opinion would have

1 ordered it PRN; right?
2 A Absolutely. Right.
3 Q But three hours before that he's feeling things crawl all
4 over him. He's seeing things that aren't there. He's hearing
5 things that aren't there, and Dr. Battisti, the PA, Dr.
6 Oduwole, the social worker, even in the throes of all of this,
7 actively seeing those things they don't order Ativan; correct?
8 A Well, Dr. Oduwole, I don't believe was in a treating
9 role. Dr. Battisti certainly could have ordered PRN or direct
10 medication at that time. She sure could have.
11 Q And nursing staff at the hospital taking care of patients
12 who are admitted, and you're familiar with that; right?
13 A Absolutely.
14 Q And you've read -- I know you've read all the nurses'
15 depositions in this case --
16 A Yes.
17 Q -- Brittany Bell and Jacqueline Freeman?
18 A Ms., Ms. Freeman.
19 Q Yep -- that they testified they saw the patient at least
20 every hour, went in and checked on him; right? You remember
21 that's what they said?
22 A I'll, I'll -- I'd have to defer to what you say on that
23 one.
24 Q That's fine, and but what we know from clinical
25 experience and from reading those depositions is that if at

1 any time a nurse thought, "Wow, I need to have something to
2 calm this patient down," what's typical is they'll pick up the
3 phone and say, "I have a patient who's a little bit agitated.
4 Can I get some, some Ativan," or something like that; right?
5 A Certainly.
6 Q That's what they're trained to do. They're trained to
7 pick up the phone and say, "Wait a minute. This guy was just
8 cool, calm and collected, no hallucinations, and now something
9 is different." They're trained to pick up the phone and call;
10 correct?
11 A Correct.
12 Q But sometimes nurses if they see something say, "Wait a
13 minute, I don't want to just call and get some Ativan. I want
14 the physician to come to the bedside"; right?
15 A That's certainly one, one venue of doing it. Yeah.
16 Q And that's exactly what happened in this case; right?
17 Dr. Ash-Bernal, that's her over here.
18 A Uh-huh.
19 Q Dr. Ash-Bernal is just kind of walking down the hallway
20 at about 1:15 or so when Matthew has this outburst and the
21 nursing staff comes and gets her to come evaluate Matthew
22 Scheer; right?
23 A Correct. If we had a PRN --
24 Q Right. They, they didn't --
25 A -- ordered it.

1 Q -- they didn't say, "Dr. Ash-Bernal, can I get some
2 Ativan?" They said, "Dr. Ash-Bernal you need to come evaluate
3 this patient. They're trying to leave the hospital against
4 medical advice"; right?
5 A That's what they asked Dr. Ash-Bernal to do.
6 That's correct.
7 Q All right. You also talked about the handoff between
8 physicians?
9 A Uh-huh.
10 Q And that it would be important in this setting for Dr.
11 Patel, as the hospitalist who leaves on a shift and then Dr.
12 Ash-Bernal who comes in as the nocturnist for another shift,
13 it'd be important that those two communicate so that Dr. Ash-
14 Bernal would know that Matthew was here being treated for
15 psychosis; correct?
16 A Correct.
17 Q If anybody looks at that chart, the one in front of you,
18 the chief complaint is psychosis; right?
19 A It's interesting that Nurse Bell didn't know that.
20 Q Yeah. Yeah. But Dr. Ash-Bernal did, and any of the
21 medical doctors and PA's, anybody that looked at the chart and
22 saw the chief complaint would know he's there for psychosis;
23 correct?
24 A One would presume so.
25 Q Well, now, when the attorney took your deposition I

1 thought it was pretty clear that you don't know how
2 hospitalists actually do handoffs in a hospital?
3 A I've never been a hospitalist. I'm a physician, however,
4 and physicians, regardless of your discipline, do handoffs.
5 It's, it's, it's appropriate care. Oh, I'm sorry.
6 Q But you've never, you've never walked a mile in their
7 shoes and understood as a hospitalist, who takes in people
8 from the emergency department at nighttime, who don't round on
9 patients during the nighttime unless they're needed, you don't
10 know how hospitalists do handoffs; do you?
11 A I can say this, if a handoff doesn't happen you've not
12 met the standard of care.
13 Q Do you know how it's done at this hospital?
14 A I've said I do not.
15 Q At a lot of hospitals the oncoming physicians just get a
16 list of patients that they're hospitalized for; isn't that
17 correct?
18 A That's correct.
19 Q And you don't know how night hospitalists do it; do you?
20 A No. I've said I do not. I have only asserted that it
21 must be done or you have not met the standard of care.
22 Q Did you know a hospitalist testified yesterday?
23 A I wasn't aware.
24 Q You know if that hospitalist who sat in exactly the same
25 seat that you're sitting in today said that there had to have

1 been a handoff between those two doctors?
2 A I'd say, no, I don't.
3 Q The plan for Matthew when he got to Grand Strand was for
4 the hospitalist service to perform medical clearance and Dr.
5 Oduwole would come on as the psychiatric consult; correct?
6 A That was my understanding.
7 Q But you know from reading the depositions or otherwise
8 that at Grand Strand Regional Medical Center, right down the
9 street, they don't have access to stat psychiatric consults;
10 correct?
11 A That's what I'm told.
12 Q And that instead an ER physician or a hospitalist can
13 make a consult for a psychiatrist like Dr. Oduwole, but they
14 can't control the speed at which Dr. Oduwole is able to
15 accomplish that consult; true?
16 A Which justifies the reason for a PRN medication to make
17 sure that the patient stays stable pending whatever timeframe
18 that that occurs, and mind you, we're under the hurricane and
19 that I'm sure had some precipitating issues with the consult
20 as well.
21 Q You're not saying Dr. Oduwole didn't come because it was
22 --
23 A I don't know. I'm just --
24 Q Because what you testified to in your deposition and I
25 think you would still say is that the Defendants cannot

1 control the speed at which Dr. Oduwole comes in and performs
2 his psychiatric consult; correct?
3 A No. But they can control a delusional and psychotic
4 patient with appropriate care, which involves an adequate
5 mental status exam and medication to help stabilize him.
6 Q And you know from reading the deposition testimony I
7 think that the father left at about seven p.m.
8 A I believe that's correct.
9 Q And that while the father was there with Dr. Patel he's
10 cool and calmer; we know that?
11 A Right.
12 Q But that even after Mr. Scheer left at 8:00 o'clock, 9:00
13 o'clock, ten, 11, 12, 1:00 o'clock in the morning even without
14 his dad there Matthew Scheer was calm and collected; right?
15 A Until sometime after one in the morning is my
16 understanding.
17 Q Sometime after one in the morning, 1:13 I think Nurse
18 Freeman says in her note, sometime around 1:13 Matthew
19 presents to the nursing station, we've heard this, ripped his
20 armbands off?
21 A Sure.
22 Q And he says he wants to leave, he knows his rights and he
23 wants to leave voluntarily. "You can't keep me"; correct?
24 A That's what he said.
25 Q Nurse Freeman does the correct thing and runs to go get

1 Dr. Ash-Bernal to evaluate Matthew; correct?
2 A That's correct.
3 Q What the standard of care would require from Dr. Ash-
4 Bernal is to talk to the nurses that came to get her; right?
5 A Correct.
6 Q Take time, look at the electronic medical record?
7 A Absolutely.
8 Q Understand for yourself, "What did Battisti think, what
9 did the PA think, what did my partner, Dr. Patel think?"
10 That's all part of the standard of care; right?
11 A It is.
12 Q Armed with the information that you learn from the
13 nursing staff and from the medical record, the standard of
14 care would then say you as the physician must go talk with the
15 patient; right?
16 A Certainly.
17 Q And it might be helpful to bring with you one of the
18 nurses with whom maybe he had formed a rapport, maybe like
19 Bethany Bell; right?
20 A Possibly.
21 Q Because we know Nurse Bell had seen him at eight, nine,
22 10, 11, 12, they probably had talked during that seven-hour
23 period; right?
24 A I don't know that she documented that, but --
25 Q But it might be helpful?

1 A Certainly.
2 Q Not only would you want the physician to go in there,
3 let's also bring in Bethany. That's a good thing; right?
4 A Correct.
5 Q And you know from reading the deposition testimony when
6 those two women went in there they wanted Matthew Scheer to
7 stay. You saw that from their deposition testimony; right?
8 A I know that they testified to that. Yes.
9 Q Let's talk a little bit more, if we can, about Bethany
10 Bell. Is it your understanding from reading her deposition
11 testimony that Nurse Bell was the primary nurse for Matthew
12 Scheer from approximately seven p.m. that evening right up
13 until he left against medical advice?
14 A I do believe so.
15 Q And that when a nurse on the medical floor like Matthew
16 was admitted to comes on shift, the first thing they would do
17 is an initial assessment. You saw that?
18 A Uh-huh.
19 Q And that a part of this initial assessment they
20 essentially do a physical assessment of you from the head to
21 the toe; right?
22 A Correct.
23 Q And part of the initial assessment would have included
24 asking Matthew Scheer about hallucinations and performing a
25 suicide risk assessment; correct?

1 A Correct.
2 Q And that Bethany Bell asked Matthew Scheer if he's having
3 any thoughts of harming himself, he's ever tried to harm
4 himself, if he was here because he didn't feel safe. You saw
5 all that documented?
6 A I did.
7 Q She asked him, "Are you having any thoughts that are not
8 your own? Are you hearing any voices or seeing things that
9 may not be real?" You saw that documented, too?
10 A Yes.
11 Q She marked in the chart that all of those answers were
12 no; correct?
13 A Yes, but may I qualify?
14 Q Sure.
15 A So in the throes of a delusional or psychotic episode it
16 is not uncommon for the patient to not disclose the content of
17 what their thoughts are. Either the theory would be that, you
18 know, they're, they're too dark or they're too disturbing or
19 that it might get them committed, etcetera, etcetera. So
20 there are reasons why one would not necessarily share that
21 they're having hallucinations.
22 Q And that's exactly why a nurse wouldn't walk into your
23 room and say, "You think you're going to kill yourself?"
24 Right? That would be an inappropriate way to do that --
25 A Right.

1 Q -- because the patient is probably going to say no. Right?
2 A Right. But it's also inappropriate just to ask one time
3 and get an answer and walk out.
4 Q True, which is why a nurse like Bethany Bell would say, "Do
5 you have any thoughts of harming yourself? Have you ever
6 tried to harm yourself? Are you here because you don't feel
7 safe? Are you having thoughts that are not your own? Are you
8 hearing voices that aren't there? Are you seeing things that
9 aren't real?" You would have -- this isn't a singular
10 question. This is a broad scope of questions from a nurse --
11 we're just talking about Bethany here -- from a nurse trying
12 to identify for herself does she think this patient is a
13 suicide risk; correct?
14 A You're -- she's reading from a nurse checklist. That's
15 what she's, she's going through the checklist.
16 Q A nurse checklist --
17 A That's right.
18 Q -- is designed to identify those patients who might be at
19 risk for harming themselves or others; correct?
20 A Which is useless if one is not willing or unable to discuss
21 their suicidality or homicidality.
22 Q If the patient doesn't want to tell medical providers that
23 they have a plan, all the conversations and the checklists are
24 useless?
25 A That is true.

1 Q Whether the checklist is useful or not in a situation
2 like this, Bethany Bell marks that all of the questions were
3 no, and then writes in the affirmative that patient is not at
4 risk for suicide; correct?
5 A She does.
6 Q Nurse Bell also talked a little bit about what happens
7 when a patient tries to leave the hospital against medical
8 advice. You saw that; right?
9 A Yes.
10 Q And that physicians and nurses play a role in talking to
11 patients about leaving against medical advice; true?
12 A True.
13 Q And that Nurse Bell would try and reinforce and did try
14 to reinforce that Matthew Scheer was admitted to the hospital
15 for some reason and that it was in his best interest to stay
16 there; correct?
17 A Correct.
18 Q And that Bethany Bell is in the room with Dr. Ash-Bernal
19 for at least some of her -- in the room with Dr. Ash-Bernal
20 for at least some of Dr. Ash-Bernal's interaction with Matthew
21 Scheer; correct?
22 A I believe that was documented.
23 Q And that Bethany Bill recalled that Dr. Ash-Bernal asked
24 the orientation questions, do you know who you are, alert and
25 oriented times four; correct?

1 A That's correct.
2 Q Tell us what alert and oriented times four is?
3 A So person, place, time and situation. So it's not enough
4 to say as we see written on many records O times four. You
5 have to give the example to which you use to measure their
6 understanding of their situation. So, "Yes, I've been having
7 auditory and visual hallucinations for the last several days.
8 I've not been sleeping. I've not been eating, you know,
9 because I believe the food is, is poisoned." Those are the
10 things that help you understand whether they recognize their
11 situation or not, so, and --
12 Q And those are the types of questions that Bethany Bell
13 asked when she came on and that Dr. Ash-Bernal now is asking
14 at the bedside; correct?
15 A We don't know. It's not documented.
16 Q I'm going to hand you a copy of the deposition of Bethany
17 Bell, which I know you've read?
18 A Sure.
19 Q And I want you to read to yourself, please don't read it
20 to anybody else.
21 A Okay.
22 Q There's a question that's asked, "You know, what's your
23 recollection that Ash -- what did Ash-Bernal say to Matthew?"
24 Read Bethany's answer and see if that refreshes your
25 recollection about whether they asked --

1 A What you have underlined?
2 Q Yes, sir. Just -- it's really -- did Bethany Bell and Dr.
3 Ash-Bernal ask orientation type questions, "Who are you, what
4 day is it, do you know why you're here," to Matthew Scheer?
5 A Well, it is documented that they asked questions,
6 questions about alert, him being in an alert or oriented
7 state.
8 Q Okay. They also -- Bethany Bell asked, "Do you have any
9 thoughts of hurting yourself, any thoughts of killing
10 yourself?" You see that; right?
11 A That's correct. That's not part of orientation or
12 situation.
13 Q Right. This is -- it's, it's orientation, but we can't
14 just stop at orientation; right?
15 A Absolutely not.
16 Q If somebody is A and O times four, that doesn't end the
17 discussion; right?
18 A You will miss a lot of --
19 Q Right.
20 A -- ill people if you do it that way.
21 Q Yeah. And, and, and they didn't do it that way; right?
22 Instead they said, "I know you're alert and oriented times
23 four, but I'm going to ask some more questions"; right?
24 A Again, my criticism here is there is -- there needs to be
25 documented the method in which they determined his orientation

1 and understanding of his situation and that is not here.
2 Q Did they ask him if he had thoughts of hurting himself?
3 A That his -- part of his risk assessment for suicide, but
4 not his orientation.
5 Q Did they ask him when they're there at the beside?
6 A They did. They did ask him if he was suicidal.
7 Q Or homicidal?
8 A Or homicidal.
9 Q Did Bethany Bell tell him that he might die from
10 infections or seizures? You remember that; right?
11 A That was part of the documentation at the AMA. That's
12 correct.
13 Q And that --
14 A Against medical advice discharge.
15 Q And that Bethany Bell said that Matthew Scheer stopped
16 his religious talk, listened to the questions that Dr. Ash-
17 Bernal posed and answered those questions; correct?
18 A Correct. And I'm trying to imagine this because they're
19 documenting that they're asking questions about orientation
20 and his mindset in the midst of him ranting about religious
21 material and he pauses to answer the questions. Obviously,
22 that is not someone who is in a rational state at that point.
23 Q We don't, we don't lock up people who talk about
24 religion; right? You have to be a danger to yourself or to
25 others; right?

1 A Paranoia and psychosis is, as I've mentioned earlier, one
2 of the mandated reasons for involuntary holds, constitutes
3 about 30 percent of the, of the commitments throughout this
4 state.
5 Q Which is why you have to talk to the patient?
6 A Correct.
7 Q And that's why Bethany Bell is there and she's saying,
8 "'If you leave, Matthew, you could die from infections,
9 seizures, that Matthew listened to the questions, that he
10 answered,' this is important, "answered Dr. Ash-Bernal's
11 questions appropriately." You saw that; right, in her
12 deposition testimony?
13 A Again, appropriately how? Does he simply say yes or does
14 he give context to what he is speaking to. There is no
15 context to his -- the statement of him being alert and
16 oriented in all spheres. That is my problem.
17 Q And that Bethany Bell who's there with Dr. Ash-Bernal for
18 a part and then she leaves to go get paperwork and comes back,
19 she testified that the encounter with Ash-Bernal and Matthew
20 Scheer was roughly 10 minutes; correct?
21 A No. She testified that it was about four to five minutes
22 is -- and I could be incorrect, but that's what I recall.
23 Q And there was a lot of paperwork.
24 A Oh, my gosh.
25 Q I'm not trying to say you need to memorize everything.

1 Would you refresh your collection as to what she says?
2 A "Took less than 10 minutes. Ten minutes would be a rough
3 estimate," is what she said.
4 Q So roughly estimated that Dr. Ash-Bernal spent about 10
5 minutes with Matthew Scheer; correct?
6 A That's what she documented or that's what she said in her
7 deposition.
8 Q And, and that Bethany Bell, and we, we heard a little bit
9 yesterday from a hospitalist, knew what the chain of command
10 was. You know what the chain of command is; right?
11 A Yes.
12 Q And the chain of command would empower a nurse who's
13 there listening to all of this go on for 10 minutes, if that
14 nurse believed that the patient shouldn't be discharged the
15 nurse would have the opportunity to go up the chain of
16 command; right?
17 A Yes. My criticism doesn't just rest with the physicians
18 in this case. It also involved the staff. My criticisms
19 don't just rest with the physicians in this case. There were
20 others that could have intervened on this medical staff.
21 Q There -- you also talked a little bit about in your
22 direct examination that HIPAA might have allowed the patient,
23 excuse me, the physician in her judgment to call the family
24 members?
25 A No. HIPAA does allow. It's not that it might. It does

1 allow in the event that the physician feels that the
2 individual is not able to make appropriate --
3 Q If the physician feels that the patient is incapacitated
4 --
5 A Right.
6 Q -- the physician can in her judgment or his judgment call
7 the family member?
8 A That's correct.
9 Q But there are times that you are trained that you don't
10 want to do that; right? You wouldn't just do that all the
11 time; would you?
12 A Well, you're not able to do that all the time.
13 Q And in a situation where the patient just said -- a
14 patient's now calm, put his shirt back on, you've just talked
15 to the patient, the nurse has just talked to the patient,
16 everybody's calm, the patient just told you, "Don't call my
17 dad," that might be one of those times that you don't go
18 running out and calling the dad and having the dad show up
19 when the patient just said, "Don't to do that"?
20 A Are we forgetting that he just iterated that everyone in
21 the hospital is a devil worshiper and Obama is the devil. I
22 mean, how do we contextually place one discussion next to the
23 other and reasonably feel this is an individual who is in his
24 right mind? I don't understand that.
25 Q You'd have to talk to the patient to be able to answer

1 that question?
2 A You'd have to spend more than 10 minutes talking to the
3 patient. You're right.
4 Q And in your, in your view of the records, Dr. Ash-Bernal
5 spent about 10 to maybe 15 minutes with the patient; right?
6 A I'm going to have to defer to you on that. I mean, it
7 does seem like Ms. -- Nurse Bell says 10 minutes. I'm --
8 don't recall.
9 Q Do you remember what your opinion was as to how long Dr.
10 Ash-Bernal spent with the patient? I've got a copy here. If
11 you said 10 to 15 minutes would --
12 A Ten to 15 minutes was, in my professional opinion still
13 would not be adequate to assess the situation in this patient.
14 Q Okay. And when you have a patient who is having
15 delusional thoughts or paranoid thoughts, we do not
16 involuntarily commit or lock up all of those patients; do we?
17 A No. We do not.
18 Q One can have as a high school kid growing up in Atlanta
19 that I am delusional and think I'm better than Jordan and I
20 don't get locked up; right?
21 A Sure. Certainly.
22 Q Because not all delusions are created equal; correct?
23 A That is correct.
24 Q There's no evidence in that chart that says the delusion
25 that Matthew Scheer was having was that he was invincible or

1 that he could fly or that he could jump off buildings;
2 correct?
3 A Not the ones you mentioned, but it doesn't make the ones
4 he did mention less concerning.
5 Q A physician would have to talk to the patient and
6 understand in 10, 15, however long it takes to talk to the
7 patient and say, "You got delusions," but then they have to
8 make a judgment decision for themself to say are these
9 delusions dangerous imminently to yourself or to others;
10 correct? That's what you'd want to do?
11 A That's correct.
12 Q Okay.
13 A Matthew said, "I believe all fish could fly," you know,
14 that would probably be a delusion that would not require his
15 involuntary stay. The concern here is that his delusion was
16 of a demonic force affecting everyone around him, that others
17 were plotting against him, that his food was being poisoned,
18 and that individual, as a result of those thoughts, is a
19 danger to himself and potentially to others.
20 Q Was there anything in the medical records that you've
21 seen where Dr. Patel or Dr. Ash-Bernal would have been on
22 notice that Mr. Scheer would allegedly run out into the ocean
23 in the middle of the night?
24 A Nor jump off of a building, no.
25 Q No?

1 A There was not, but that doesn't exclude the
2 foreseeability of someone who has these delusions being an
3 imminent risk of harm to himself. He was paranoid. He needed
4 to be committed to the hospital if he wasn't willing to stay
5 voluntarily.
6 Q And if you as the physician believe that the patient is
7 not in imminent danger to themselves or others it's their
8 legal right to leave the hospital?
9 A Could you repeat the question? I'm sorry.
10 Q If you as the physician believe the patient is not in
11 imminent harm to themselves or others, it is their legal right
12 to leave the hospital.
13 A Again, if the physician is -- does not feel after they've
14 done an adequate evaluation feel that they are in need of a
15 72-hour hold, absolutely, it's a free country. They're --
16 they would be allowed to leave.
17 Q And if you wrongfully commit someone against their will
18 they can bring a lawsuit against you for false imprisonment;
19 can't they?
20 A If my judgment leads me to believe that they're -- this
21 individual is an imminent risk of harm to themselves I'll take
22 that lawsuit any day.
23 Q But it is a right that not only are you free in this
24 country to leave the hospital, you're also free in this
25 country to sue somebody that keeps you and you think that's

1 wrong; right?
2 A Certainly. It's a free country.
3 Q Do you agree that Dr. Ash-Bernal felt that Matthew Scheer
4 had sufficient insight and capability to make a decision to
5 leave the hospital even though she didn't want him to?
6 A That's what she writes. Again, I don't see the context
7 of that discussion in that evaluation, which is what's
8 troubling to me.
9 Q But we know she spent, whatever it was, 10 or 15 minutes
10 with the patient and at the conclusion of that she would have
11 completed this statement that, "I certify that the patient or
12 the individual acting on the patient's behalf has the mental
13 capacity to understand the risks and benefits of leaving AMA";
14 right?
15 A It is on the AMA checklist.
16 Q She certifies that she spent the time and that she made
17 the judgment call; correct?
18 A She does.
19 Q I'm sorry. That's all I have. Thank you very much.
20 A Thank you.
21 THE COURT: Redirect?
22 MR. HINSON: Thank you, Your Honor.
23 REDIRECT EXAMINATION
24 BY MR. HINSON:
25 Q Dr. Malone, I want to give you the opportunity to not

1 just show you select portions of, of Ms. Bell's testimony, and
2 don't read this out loud.
3 A Okay.
4 Q But looking at the portions of Ms. Bell's testimony, how
5 long did she testify at her deposition that Dr. Ash-Bernal's
6 interaction lasted with Matthew Scheer?
7 A You're just talking about the highlighted portion, I
8 presume?
9 Q Well, just how long did, did she remember the, the
10 interaction between Matthew and Ash-Bernal lasting?
11 A She says 10 minutes would be a rough estimate.
12 Q And what did she say? She says in the section --
13 A I'm sorry.
14 Q -- also in the deposition --
15 A Got you.
16 Q -- what does she say?
17 A She says, [as read], "I honestly don't remember, and
18 maybe four to five minutes." That's where I got my figure
19 from, four to five minutes.
20 Q So at one point she says it may have been as little as
21 four to five minutes?
22 A She says maybe four to five minutes. That's what I
23 recalled earlier.
24 Q And during this time that Dr. Ash-Bernal would have to
25 come and that this AMA form would have to be retrieved,

1 security would have to -- they'd be instructed to escort
2 Matthew out, Dr. Ash-Bernal also has to look at the record.
3 MR. GRESH: Leading, Your Honor.
4 THE COURT: I sustain the objection.
5 Q What other things in this time period -- well, let's back
6 up a second. Could we have Defendant's Exhibit One, please,
7 and, Dr. Malone, I'm going to turn your attention to the, to
8 the nursing note and the occurred time.
9 A Okay.
10 Q And what time does the record indicate that Matthew's
11 outburst began, his psychotic rants?
12 A Sure wish we had larger print. So 1:13.
13 Q So 1:13?
14 A Uh-huh.
15 Q And then at what time is Matthew's AMA form already
16 signed?
17 A It's one -- it's 1:29 I thought.
18 Q So one -- what time we got right here, Dr. Malone?
19 A Yeah. I can't see it.
20 Q I'm sorry. Let's see. I'm sorry, right here.
21 A Too many books. 1:27.
22 Q 1:27?
23 A A.M., sorry about that.
24 Q So the time period between the earliest she could have
25 gotten there till the time she's already discharging him how

1 much time passed?
2 A Not much. I'm a physics major, but yeah, not, not much
3 time at all, yeah.
4 Q At, at max 14 minutes?
5 A Right.
6 Q Maximum amount of time and that would assume she was
7 there the minute the nurses called her, and during this time
8 period what all would have to take place?
9 A Well, you know, discharge is, is not easily accomplished,
10 you know, in, in several hours. So the fact that, that he's
11 out of the door in literally less than 14 minutes is pretty
12 impressive. So that's a coordinated effort by security, by
13 the nursing staff, you know, etcetera, to, to make that happen
14 that fast.
15 Q The paperwork would have to be done?
16 A Absolutely.
17 Q With a patient who's come to the hospital for treatment
18 for psychosis can a physician make an adequate and proper
19 determination in 14 minutes that the patient is safe to leave
20 at 1:30 in the morning by himself?
21 A There is, in my professional opinion, there's no way that
22 that could be accomplished in 14 minutes, no, sir.
23 Q And how long did the security guard recall the
24 interaction taking place between Dr. Ash-Bernal and Matthew?
25 A I think he, too, said maybe four to five minutes.

1 Q And so the rest of the time would be filled with
2 paperwork and such?
3 A Right. Correct.
4 Q Four to five minutes talking, paperwork, out the door,
5 is that the standard of care?
6 A It is not, sir.
7 Q Earlier Mr. Gresh asked you about Bethany Bell and, and
8 whether or not she had an opinion of Matthew's competency.
9 Does a nurse have the same training in treating and as talking
10 with patients with psychosis as a physician?
11 A No. They do not.
12 Q Does a nurse have the same training and responsibility as
13 a physician to evaluate the patient's mental competency before
14 letting him leave the hospital at 1:30 in the morning in a
15 hurricane?
16 A It is my impression and my opinion, no, that is -- they,
17 they do not.
18 Q Do nurses go to medical school?
19 A They do not.
20 Q Do nurses do a residency in, in psychiatry?
21 A No. They do not.
22 Q Is it simply -- to you have a patient -- if I come to the
23 hospital, any patient comes to the hospital with a kidney
24 stone, severe kidney stone, for whatever the reason the
25 patient does not want treatment. Does that patient have a

1 right to leave?
2 A Yes. They do, as a matter of a fact, they do.
3 Q No matter how bad that patient's decision is, the patient
4 with the kidney stone, they have a right to leave?
5 A Yes. They do.
6 Q Well, what's different about this? Matthew clearly wants
7 to leave.
8 A Right.
9 Q Tell us how this is different.
10 A Well, the, the, the patient with the kidney stone does
11 not have -- is not incapacitated by a mental illness, and so,
12 in such, one is allowed to lose their kidney or lose their
13 life if it is their choice as long as they understand clearly
14 their illness and the risk that, that they are under by
15 refusing the treatment. So consent, they need to be competent
16 to give consent to refuse such treatment.
17 Q So did Matthew have the competency to consent to refusing
18 this treatment?
19 A Matthew did not have the competence to consent.
20 Q And allowing Matthew to leave, what are the dangers of
21 that to Matthew and others?
22 A Well, I mean, to, to himself, you know, that, again, we
23 need to understand, no one knows what was going on in
24 Matthew's mind at, at those moments. Perhaps he was
25 responding --

1 MR. GRESH: It's speculation then, Your Honor.
2 THE COURT: Yeah. I sustain the objection.
3 A Okay.
4 Q Dr. Malone, what are the dangers of letting him leave?
5 A Okay. The dangers of letting him leave, obviously, are
6 the risk for harm to himself and others as a result of his
7 delusions, which we knew had been present, the paranoia and
8 the psychosis that had been present all day.
9 Q In your career have you heard and learned in your study
10 and education of occasions when psychotic patients who are
11 allowed to leave harmed others?
12 A Absolutely.
13 Q Do you have any examples of that?
14 A Virginia Tech.
15 MR. GRESH: Your Honor, relevance, Your Honor.
16 THE COURT: I sustain the objection.
17 Q Dr. Malone, Mr. Gresh asked you about the time that
18 Bethany Bell was doing her assessment of Matthew?
19 A Yes.
20 Q Do you remember what time that was by chance? If you
21 could turn to what -- I know we've got a lot of --
22 MR. HINSON: May I approach, Your Honor?
23 THE COURT: Yes.
24 BY MR. HINSON:
25 Q If you could turn to 114.

1 MR. GRESH: Your Honor, mine's up here. Can I go grab
2 it?
3 THE COURT: Yes.
4 Q Dr. Malone, I'm looking at the timestamp at the top left-
5 hand corner of that -- excuse me, top right-hand corner of
6 that page. What time did Nurse Bell do her assessment of
7 Matthew?
8 A So this is military time, 19:15, so.
9 Q So that's what time in a.m., p.m.
10 A That's 7:15. Thank you.
11 Q And what time did David -- approximately what time did
12 David Scheer leave the hospital?
13 A Around 7:15.
14 Q So his father had --
15 A Seven, there, thereabouts.
16 Q -- had been there around this same time?
17 A Right.
18 Q And so when his father was there and Nurse Bell was
19 assessing him he was calm and cooperative?
20 MR. GRESH: Leading, Your Honor.
21 A That is correct.
22 Q How was his state at the time that his father was there
23 and Nurse Bell was, was evaluating him?
24 A His, his evaluation at that time was, was unremarkable.
25 She reported that he was calm and, and cooperative at that

1 time.
2 Q At the time when who was with him?
3 A With his father was there, when his father was present.
4 Q And that was about how long before he left?
5 A Before Matthew left?
6 Q Before Matthew left, before the outburst at 1:15,
7 approximately how long before the outburst?
8 A Six hours, yeah, thereabouts.
9 Q Doctor, you've heard Mr. Gresh use the word liberty a
10 lot. Do you value your liberties?
11 A I do.
12 Q Do you -- when you have the occasion, when you -- your
13 duty and your responsibility as a physician requires you to
14 put a temporary hold on somebody is that something you enjoy
15 doing?
16 A No. It is not. No.
17 Q Why do you do it?
18 A It is of necessity. I'd much rather spend the time to --
19 talking with the patient, talking with the family and getting,
20 you know, a cooperative treatment plan with the individual,
21 but sometimes that does break down, and in those cases then
22 you have to move towards commitment.
23 Q And the decision to, to do that, put that temporary hold
24 whose -- for whose safety is that?
25 A That is for the safety of the individual, but let's not

1 forget, it's also for the safety of others. You know,
2 paranoia is -- has been responsible for a number of violent
3 outbursts in the community as a result of people working and
4 operating under paranoid delusions.
5 Q Can you simply ask a patient with psychosis, "Are you
6 suicidal or homicidal"?
7 A You cannot.
8 Q Are people who are suicidal and homicidal always honest
9 and answer that question truthfully?
10 A The ones in my 30-year experience that are truly suicidal
11 are no longer on your team. They will deny. They will lie.
12 They will not be honest with you. So the question alone is
13 not enough to vet it out.
14 Q And, Dr. Malone, Mr. Gresh asked you about Matthew sign
15 out of the ER that was signed by his dad.
16 A Right.
17 Q And then his sign in to the ER where Matthew actually
18 initialed.
19 A Right.
20 Q Should the nurses at the ER have said, "No, you can't
21 sign yourself into the ER," and just refused him treatment?
22 A No. Absolutely not.
23 Q If a, if a psychotic patient showed up at your facility
24 would you say to them, "I'm sorry. You're too psychotic to
25 sign yourself in"?

1 A No. I would not.
2 Q Would that be proper?
3 A That, that would be totally appropriate for them to --
4 again, psychosis does not necessarily in some instances take
5 away the ability to ask for help. So if you are asking for
6 help I'm, I'm going to allow that until such time as you
7 become uncooperative and I'm not able to, to convince you that
8 you need further treatment in which case commitment may, may
9 come into play.
10 Q So just because the nurses allowed Matthew to sign
11 himself in doesn't mean he didn't need help?
12 A That's right. That's correct.
13 Q Nothing more. Thank you, Dr. Malone.
14 A Thank you.
15 MR. GRESH: Nothing further.
16 THE COURT: You can step down and be excused. We
17 appreciate your time.
18 A Thank you.
19 THE COURT: Thank you, Dr. Malone. Take care of those
20 Gamecocks for me.
21 A We'll do our best.
22 THE COURT: All right. We, we -- the jurors' lunch is
23 coming around one. So see if we can get started on a witness
24 from now to 1:00 o'clock.
25 MR. HINSON: Yes, Your Honor. Would you mind if I just

1 kind of clean up the --

2 THE COURT: Sure.

3 MR. HINSON: -- the exhibits up there before we have

4 things all over the place.

5 Plaintiff calls David Scheer.

6 THE COURT: All right. Please come up and be sworn.

7 Whereupon, David Scheer is called to the stand, duly

8 sworn by the clerk and testified as follows:

9 THE CLERK: Please say your name and spell your first and

10 last name.

11 MR. SCHEER: Very good. Great. Okay. I'm sorry. What

12 did I have to do?

13 THE CLERK: Spell your first and last name for the court

14 reporter.

15 MR. SCHEER: David Scheer, D-A-V-I-D, S-C-H-E-E-R.

16 DIRECT EXAMINATION

17 BY MR. HINSON:

18 Q Good afternoon, Mr. Scheer.

19 A Good afternoon.

20 Q Now moved into afternoon. Could you please introduce

21 yourself to the jury? Tell us just a little bit about

22 yourself, your -- where you grew up and what you do?

23 A I grew up in South Jersey. I'm a bartender for the last

24 40 years. I've worked the last 35 years in the casinos in

25 Atlantic City, first at the Trump Plaza, then Trump Taj Mahal

1 and now at the Hard Rock Casino. I've been married for 31 and
2 a half years.
3 Q Is your spouse in this room with us?
4 A My lovely spouse is in the room, Debbie, and --
5 Q Well, let me -- Mr. Scheer -- go ahead, if you had more
6 to say. How, how did you get into the food and beverage
7 industry?
8 A I was in college, and I got my degree, but I started
9 bartending in college, and I just liked it. I like people and
10 I just kept going and much to the sorrow of my parents who had
11 helped put me through college, and -- but as, as -- when I got
12 a steady job and all that they were very pleased.
13 Q How'd you, how'd you meet your, your bride here?
14 A She moved me in below me in an apartment in Ocean City,
15 New Jersey.
16 Q How old were you?
17 A When we met I'm going to say 28.
18 Q Sorry. I didn't mean to put you on the spot with your
19 wife here.
20 A Well, that's when -- when I met her I'm not sure I'll
21 say. When we married I would say.
22 Q Did you all have children?
23 A Yes. We had two sons. Matthew was the oldest and Erik.
24 Q And when were they born?
25 A Matt was January 19th, 1989, and Erik is May 20th, 1991.

1 Q All right. And Dave, tell, tell us a little bit about
2 Matthew and, and Erik growing up. Were they --
3 A They were brothers. They fight with each other all the
4 time, drive us crazy, but they always had each other's back
5 when push came to shove, and they're brothers. They, you
6 know, play together, we go to the beach, we go on vacations
7 together, and the next moment I'd be like yelling at them
8 because, "Just stop it you two. You're driving us crazy," and
9 just they were just typical brothers. I had one, so I --
10 Q And Dave, what kinds of things did Matt like to do? Was
11 he into sports, was he into art, was he into band, theater?
12 Tell us a little bit about Matt.
13 A Well, he loved sports. He's -- all four of us are
14 Phillies fan or Philadelphia fans, the Phillies and the Eagles
15 and everything, and we'd spend a lot of time at that. We like
16 to golf. Matt was my golfing buddy down here whenever I came
17 down. He loved the beach, the beach atmosphere. He just
18 liked being around it and everything. He worked, worked
19 around it. He just had a variety of interests, you know,
20 nothing that serious, but the golf was, was pretty serious,
21 but it was a pain in the butt how far he could hit the ball.
22 It just didn't seem right, didn't seem fair to me.
23 Q Who could hit it further?
24 A Oh, him.
25 Q Dave, we're here in Horry County, South Carolina, and

1 you're from New Jersey. How did, how did you come to be in
2 Horry County at, at times?
3 A Debbie's sister and husband got a place down here years
4 ago, and we would come down with them a lot, you know, as a
5 family and everything, spent time. We all really liked it, and
6 eventually, we were able to buy our own place down here and
7 spend time down here. We love the Myrtle Beach area. We're
8 -- Debbie and I bought it with the intention of retiring.
9 Q And did, did the kid comes, too?
10 A Oh, yeah. Yes. Definitely.
11 Q Earlier in this case we've heard mention of, of Matt
12 having epilepsy. When in his life was he diagnosed with
13 epilepsy?
14 A Immediately after being born.
15 Q And through his childhood and young adulthood, was it
16 able to be treated with medication or other, other treatments?
17 A Yes.
18 Q And what would happen if Matt wouldn't take his
19 medication on occasions when for whatever reason it was
20 forgotten?
21 A His type of epilepsy he didn't immediately necessarily
22 have an epileptic episode, but the better medications
23 prevented him from having them.
24 Q The purpose of the medication was what?
25 A To control the seizures.

1 Q Is there any history in your family, Dave, of, of mental
2 illness?
3 A Absolutely not.
4 Q Do you know of any history in your spouse's family of
5 mental illness?
6 A Absolutely none.
7 Q Did Matthew anytime through childhood exhibit any type
8 of, of mental illness or problems with suicide or depression?
9 A Absolutely not.
10 Q Did Matthew come to live in South Carolina at some point?
11 A Yes. He did.
12 Q And what brought him down here?
13 A Well, our time spent here he, he had loved it and
14 everything and there was better job opportunities down here.
15 Our area got hit very, very hard by that 2009 recession, and
16 --
17 Q What did Matt want to do with his career?
18 A He wanted to be a bartender.
19 Q Why did he want to do that?
20 A I think I had some influence there. I wasn't encouraging
21 him. I just think he wanted to be -- he liked, he like what
22 he saw I did. He liked people.
23 Q How was your relationship with your son?
24 A Very good. We loved each other. We spent time together.
25 We -- a lot of times he, he had problems with something --

1 when it came to -- went to mom if he had questions about life
2 stuff, and he came to me when he had problems with a or
3 questions about, you know, working on the car. We did -- we
4 worked on cars together and, and stuff like that.
5 Q And David, approximately when did Matthew move to South
6 Carolina? We don't need the exact day.
7 A I came down with him. It was over the Christmas holidays
8 of 2013.
9 Q And did he find employment down here?
10 A Yes.
11 Q In early October 2015, did you and Debbie come to observe
12 some dramatic change in your son?
13 A Debbie saw a disturbing posting on Facebook and, yes, I'm
14 sorry, yes, we did become concerned about our son.
15 Q Why, why were you all concerned about this post?
16 A I did not see it. My wife had contacted Matt immediately
17 and, and talked him into deleting the post, but apparently it
18 was very dark in nature.
19 Q Was that typical of Matt to have dark posts?
20 A Not at all.
21 Q And did you all talk to Matt after this posting on
22 Facebook in -- on -- on or about October 1st?
23 A Yes. Yes. We did. We called him.
24 Q And what did you glean from this conversation with Matt?
25 A We were very concerned. It didn't seem like Matt. I

1 mean, parents just know when there's something, you know,
2 their -- with their child and just something wasn't right.
3 Q What types of things was he talking about?
4 A He was responding to our questions basically, and he --
5 it was evasive in nature, which was not the way he -- we
6 reacted with each other, you know, Debbie, me, Matt, Erik, you
7 know. Pretty much didn't get a straight answer, and we were
8 not getting that. We were, we were just concerned. You know,
9 we were talking to him about the post. We were talking about
10 him, is, is everything all right, and you know, yes, yes, and
11 -- but you knew -- we're a parent. We just knew something
12 wasn't right there.
13 Q Do you have any training in psychiatry?
14 A None.
15 Q But it was your observation something wasn't right?
16 A Yes.
17 Q And Mr. Scheer, what did you and Debbie decide to do for
18 your son?
19 A We decided, you know, we had recently moved. So we
20 decided on a two-part plan. Debbie would stay home and
21 prepare a room for him because we had moved and the spare room
22 was just full of junk, and she was going, going to set up --
23 we wanted to get him evaluated if he needed to. So she was
24 trying to set up things, and we decided I would drive down and
25 get him because that was the soonest way I could get there.

1 Q Did, did you look into flights?
2 A Yes, but we kind of knew the flights from our area
3 because we had been hit down here so many times, and there was
4 -- I could get there quicker by driving.
5 Q What -- did you drive down?
6 A Sooner, sooner by driving, let's put it that way, sooner
7 by driving.
8 Q And approximately, well, obviously, did you drive down to
9 South Carolina?
10 A Yes. I did.
11 Q And what was the weather like in that drive?
12 A I went through rain showers all the way down. There'd
13 be potential torrential rain. It would stop. Torrential
14 rain, it would stop. It was -- there was, there was really
15 never steady rain but it was just whenever it rained it
16 rained.
17 Q Were there any -- was there any particular discussion at
18 that time in early October 2015 about the weather pattern on
19 the East Coast?
20 A Yeah. There was Hurricane Joaquin was, was off the
21 coast, and all the states were on alert, and it had, it had
22 brought in another big weather pattern down here along, along
23 the East Coast and it was -- all the weather people were very
24 concerned.
25 Q And --

1 A Then the governments were concerned. I think some of
2 them had emergency alerts on and --
3 Q Approximately what time did you arrive in, in Myrtle
4 Beach to find your son?
5 A 3:30 in the morning.
6 Q Did you work the day before?
7 A No. But I had been up since 5:00 o'clock in the morning.
8 I'd worked the night -- I'd worked Wednesday night, and I got
9 up at Thursday -- I had been up since 5:00 o'clock just I kind
10 of get up early.
11 Q So when you arrived at 3:30 in the morning you had almost
12 at that point been up how long?
13 A What's that? I'm going to go with the last guy about
14 math, but I'm going to say approximately 11 hours?
15 Q Okay. And tell us, Dave, how did you find your son?
16 A Oh, is that right? No. I'm sorry. That's not 11 hours.
17 That's 23 hours, 23 hours. I'm not the math guy. I'm --
18 Q You had been almost up a full day?
19 A 23 hours I had been up almost.
20 Q Almost a full day?
21 A Yeah.
22 Q And so 3:30 in the morning where do you come to find your
23 son, like where, where do you go?
24 A I, I, I got there. I went up to the condo. All the
25 lights were on, and Matthew was sitting on the couch with a

1 blanket wrapped around him.
2 Q And what did you find?
3 A He had no clothes on under the blanket.
4 Q What about his belongings?
5 A I came to find out that he had thrown out all his
6 belongings.
7 MR. GRESH: Your Honor, can we approach real quick?
8 (Whereupon, a bench conference is held in the presence,
9 but out of the hearing of the jury.)
10 BY MR. HINSON:
11 Q Mr. Scheer, I'm going to pick back up. So what did you
12 find about his belongings?
13 A That he had thrown out nearly all his belongings.
14 Q Tell us, Dave, the next few hours of interaction with
15 your son, kind of describe what happened for us.
16 A Prior to me finding out he had thrown out all his
17 belongings, I got there and we started talking and I, you
18 know, we talked about why he was naked because he said he just
19 got out of the shower, and but the conversation kind of
20 started out normal, and on the way down Debbie had talked to
21 him and thought that things had calmed down, and, and I'm
22 thinking, okay, this is, this is going to be fine. I'm still
23 planning on taking him home, but okay, and then all of a
24 sudden he started talking about -- he, he told me he wanted to
25 -- he, he thought he should tell me something, and he told me

1 he thought he was a new prophet, and then he told me why he
2 was naked because prior to me arriving he had been out, and I
3 don't know where it was, I don't know how long it lasted, but
4 he had been out fighting demons, and he had come home and
5 gotten in the shower to clean off and apparently had been
6 rolling around, I, I don't know exact, I can't say exactly.
7 This was -- that's what he told me.
8 Q What was your understanding? What was your understanding
9 though from your discussion with your son, that -- well --
10 A That something was seriously wrong here.
11 Q And so did you -- what did you observe about his eating
12 habits?
13 A I'd, I'd asked, you know, during the parts of the
14 conversation I'd asked if he'd been eating, because in the
15 back of my head was, you know, you know, what's going on, and
16 he said no, and then I checked the -- there, there was like no
17 food in the house, everything was gone.
18 Q Did he tell you why he hadn't been eating?
19 A He said he needed to cleanse himself. He needed to lead
20 a, a pure life, and, and that he -- the reason he got rid of
21 everything is he wanted to live off the land.
22 Q And did he seem to be, in your observation of your son,
23 was he in the same reality that you were?
24 A Not at all.
25 Q And so did you continue with your plan to take him back

1 home to New Jersey?
2 A That was still going to be the plan. I, I was -- I'm --
3 at this point I'm confused and, and I'm like really taken
4 aback. I've never dealt with anything like this before, but
5 he was still calm and, and he was, he was calm, and he told me
6 he got -- he was tired, and I said, "Well, let's" -- by now
7 it's probably 5:00 o'clock in the morning, and I said, "Well
8 if you want to lay down you lay down," and I'm exhausted, but
9 I'm still -- say, "Oh, well, I'll, I'll lay down." I laid
10 down first in the bed. Then I immediately went out to the
11 couch because I wanted to -- if something -- if he, if he
12 moved around or something, but I never fell asleep anyhow. I
13 couldn't. You know, my head's churning and I'm -- I never did
14 sleep.
15 Q And then what happened next, Mr. -- Dave?
16 A Started to realize I was in over my head, but meanwhile,
17 by this time, I, I called my wife and we determined that we
18 had to get him to a medical facility. We needed to get -- he
19 needed medical care.
20 Q Why did you not just put him in the car and take him back
21 to New Jersey?
22 A Well, this time -- by this point I'm realizing that this
23 could be dangerous, I mean, he could jump out of the car. I
24 don't know what I'm dealing with. He's -- the, the, the way
25 he's talking he could have jumped out of the car, he could

1 have grabbed the wheel. He could have, you know, there could
2 have been a number of bad things happening that could have
3 hurt him or me.
4 Q Did you think it would have been safe to put him in the
5 car and put him on a road trip of several hundred miles?
6 A Oh, no. Not at all. Absolutely not.
7 Q So where did you take Matt?
8 A I did take him first to -- he hadn't been eating, and I,
9 I, I figured it's going to be a long day. He's calm. I, I
10 took him over to Dino's, which is our favorite breakfast spot.
11 Q Did he eat a meal there?
12 A And, and he, and he just pushed his food around with his
13 fork and everything, and then we, from there we went to the --
14 I took him to the hospital. I was hoping I could get some
15 food in him just because I knew from when he had seizures
16 younger you get, you get in a hospital it's -- becomes a long
17 day, and, and but --
18 Q Dave, where'd you take him?
19 THE COURT: All right. Before we get into the events of
20 the day, I think our lunch is here, the jury's lunch. So
21 while it's still warm we'll break for an hour till about one,
22 a little after 1:30. So we'll take a break at this time.
23 (The following takes place outside the presence of the jury.)
24 THE COURT: All right. We'll take a break for an hour.
25 Mr. Scheer, of course you can step down and have lunch. Now,

1 he's not just a witness. He's a client. So I think he can
2 talk to counsel.
3 MR. GRESH: I -- yeah. I think that's the rule, and just
4 real quickly, we had approached to Your Honor during the
5 direct examination of Mr. Scheer, and we had previously made a
6 motion to keep out the Dead Man's Statute stuff, and I
7 respected the Court's ruling on that issue. The first time I
8 thought that the testimony might be in contravention,
9 different than the Dead Man's Statute I think allows objected
10 but really just wanted to have a running objection with the
11 consent of Plaintiff's counsel that I think a lot of the
12 testimony about the conversations between the father and his
13 son that led up to the death would be disallowed by that
14 statute, and I respected the ruling, and we have agreed, I
15 believe, that I don't have to stand up every time and make
16 contemporaneous objections to that.
17 MR. HINSON: So stipulated. So agreed.
18 THE COURT: All right.
19 MR. GRESH: I appreciate the indulgence of the Court and
20 Plaintiff's counsel on that.
21 THE COURT: Well, I, I ruled that you have a running
22 objection to the extent I can based on my earlier ruling this
23 morning.
24 MR. GRESH: Thank you, Your Honor.
25 THE COURT: All right.

1 MR. GRESH: And thank you.
2 MR. HINSON: And just for clarity, the running objection
3 is solely to the Dead Man's Statute.
4 THE COURT: Dead Man's, that's, I mean, I, I ruled on
5 something else this morning, but right now we're dealing with
6 the Dead Man's Statute. That's, that's all.
7 MR. HINSON: Thank you, Your Honor.
8 THE COURT: Okay. We'll be at ease.
9 MR. GRESH: Thank you. I'm sorry, Your Honor, until
10 which time? I apologize.
11 THE COURT: Let's, let's say around 1:30, give you a few
12 minutes after that because I know it's -- you all got to get
13 something to eat, but --
14 MR. GRESH: Thank you very much.
15 OFF THE RECORD
16 (On the record. The following takes place outside the
17 presence of the jury.)
18 THE COURT: Thank you. You may take your seats. Mr.
19 Scheer, you can come back up on the stand. You can bring in
20 the jury.
21 (Whereupon, the following takes place in the presence of
22 the jury.)
23 THE COURT: You may proceed.
24 MR. HINSON: Thank you, Your Honor.
25 BY MR. HINSON:

1 Q Dave, before we broke for lunch I think the last thing we
2 were talking about, apparently this is a microphone right
3 here, Dave, and I tend to keep covering it, so. I believe we
4 were going through your day with Matthew on October 2nd, 2015.
5 Tell us what happened when you brought him to Grand Strand.
6 A When I brought him to Grand Strand we went into the
7 emergency -- I took him to the emergency room, and I went up.
8 The first person there was a guard, and I went up and told him
9 I have -- my son needs help, and he, he got a doctor. I'm
10 sorry, I'm assuming it's a doctor. It's just my assumption,
11 but they came out, talked to us briefly out there, and then
12 took us both back, both into the emergency room area, at which
13 time they took Matthew into a cubicle area by himself. The,
14 the gentleman who -- the doctor took Matt into the cubicle
15 area by himself, and I went off to the side. Someone came --
16 I don't know if he came over to officially talk to me, but
17 someone came then -- came over, had to wait a few minutes
18 because, you know, all throughout the day while I was with
19 Matthew I was -- tried to stay calm and -- around him and, you
20 know, not get emotional, all that, and talking to him normal
21 and everything, but the strain had almost every time like he
22 -- when he immediately left my presence for a while like to go
23 for a test or something I'd start crying, and --
24 Q Take your time.
25 A -- and then I'd get, you know, I wouldn't cry a lot but

1 I'd get back together and then I could function, but I always
2 had to release. So then I talked to, was talking with this
3 guy. I don't even if it was an official at all, but I was
4 just talking with this guy, and then eventually they came and
5 told me that they were admitting him to the ER, and from that
6 time on I was with him whenever he was in his room. They did
7 take him out for like some, some tests and that was the, the
8 times that I was separated from him.
9 Q Mr. Scheer, I'm going to -- Dave, I'm going to show you
10 something from Plaintiff's Exhibit One, see if you can shed a
11 little more light on it. Can you see that from where you are?
12 Can you all see that, too? Give a little --
13 A Yeah.
14 Q Okay. And this, this is my question for you. I'm
15 looking at Plaintiff's Exhibit One, page 12, but it says,
16 this is from the ER record. Says, [as read], "Father reported
17 he had an extended complex vision last night lasting a couple
18 of hours," and could you tell us a little bit more about what,
19 about what, what that's about as you understood it?
20 A Well, that, that was the night before when I -- he
21 started explaining to me so or explaining to me what, what was
22 going on with him. He, you know, he told me about the voices
23 he was hearing. He, he thought, thought God had told him to
24 go, that he was going to go to Jerusalem on a -- I can't
25 remember the term he used, but you know, he's on a mission.

1 I'll call it a mission, and he also told me about fighting
2 demons. He had been -- that's why, you know, why, why he had
3 no clothes on he had been out fighting demons, and, and I --
4 and I assumed it had gone on for a long time, and while I'm
5 talking to him he's obviously he's still having -- I can tell
6 this stuff's still or I think this stuff's still going on in
7 the background the whole time.
8 Q And while you were in the ER, Dave, did, did they run
9 tests and labs and things like that?
10 A Yes.
11 Q And what ultimately was the, was the disposition? What
12 did the emergency room staff tell you to do with your son?
13 A They told me to take him to Lighthouse.
14 Q Okay. Did they tell you to take him sometime next week,
15 sometime whenever there was an availability? When did they
16 tell you to take him to Lighthouse?
17 A Immediately.
18 Q And what did you do at that point? Well, let me ask you,
19 did you leave Grand Strand?
20 A Yes.
21 Q Okay. Dave, let me show you from Plaintiff's One, this
22 is the sign-in sheet. This is the sign-in sheet for Grand
23 Strand. Whose signature is that right there?
24 A That's Matt's.
25 Q And right there?

1 A Matt.
2 Q So they let him sign himself in. Dave, whose signature
3 is that right there?
4 A That poor signature would be mine.
5 Q Who did they have sign him out?
6 A Me.
7 Q And did you all -- where did you go next with your son
8 after you signed, after you signed your son out of the ER?
9 A To the Lighthouse.
10 Q And did you all go immediately as instructed?
11 A Yes.
12 Q And tell us what happened. You get him to the
13 Lighthouse. Were they able to admit him?
14 A What we did is we went in, we explained that, that, you
15 know, I explained what the problem was, and I gave them the
16 paperwork that they had given me to, to go to the Lighthouse.
17 They had given me that, that release thing with the order of
18 treatment, and a young lady came out. I remember her first
19 name. I don't remember her last, Amanda, and she took Matt in
20 the back. She asked him if she wanted -- me along and he said
21 no, and she took him in the back and I spent the rest of the
22 time until he was done in the waiting room.
23 Q And then what happened once he came back from the -- when
24 you were in the waiting room?
25 A When he came back from the waiting room we actually stood

1 around for 10 or 15 minutes and then she came out and informed
2 me that the physician, she didn't use a name, but she said the
3 -- or, or I'm saying physician, I -- the doctor had said there
4 was still medical issues that needed to be addressed and that
5 they, they had to send me back and told me to go back to the
6 hospital.
7 Q Did they tell you Matt didn't need mental health care?
8 A No. They didn't -- did not tell me that.
9 Q And you were told to take him to the hospital. Where did
10 you go then?
11 A Took him to the hospital. I took him to Grand Strand.
12 Q Okay. Did you take him directly back to Grand Strand?
13 A Yes. I did.
14 Q Tell us what'd you do once you pulled into Grand Strand?
15 Do you -- where, where do you take him?
16 A Took him back to the emergency room.
17 Q And what was his condition there at the emergency room?
18 A The same as it had been all night and all day, nothing
19 had changed.
20 Q And was Matt admitted to the hospital?
21 A He was admitted to the emergency room. Yes.
22 Q All right. And then did -- was he further admitted to
23 the hospital?
24 A Yes. He was.
25 Q And at some point you with Matt when Dr. Patel comes in?

1 A Yes. I was.
2 Q And was Matt at that time similar in his thinking?
3 A Nothing, nothing had changed. Everything was still the
4 same. He was calm, he was cooperative but there was stuff
5 going on in the background the whole time.
6 Q Did you understand that -- well, did you feel that Matt
7 was at that point in a safe place?
8 A Yes. I did.
9 Q And Dave, at some point I understand you left the
10 hospital?
11 A Oh, seven, 7:30 that night.
12 Q Okay. So around seven, 7:30 at night you leave the
13 hospital. Tell us what was, what was the purpose, purposes
14 for you -- why'd you depart?
15 A Well, Matt was in a -- I felt Matt was in a safe place.
16 He was under professional medical supervision. I had been up
17 since 5:00 o'clock the morning before. It's now 7:00 o'clock
18 Saturday, 7:30. So I had been up, what's that 35, 36 hours.
19 I hadn't really eaten myself. I'm exhausted, but and Matt,
20 but Matt said he was tired. He was still calm and
21 cooperative. So I wanted to go -- the plan was still I wanted
22 to get him back home as soon as possible, New Jersey, but I --
23 and I didn't know whether that would happen the next morning,
24 you know, I didn't know what it was going to take to stabilize
25 him. So I went back to the, to the -- our condo to try to

1 rest and --
2 Q Were you going to gather anything for Matt?
3 A Well, I -- he had thrown all his clothes in a donation
4 bin and he had told me where it was, and I went over and a
5 flashlight and a broomstick and I got a -- I found a couple of
6 bags of our stuff, and I was able to get it out, and then I
7 -- I didn't try to get it all. I just wanted to get something
8 because I knew he needed some clothes because all he had was
9 the shorts and T-shirt and flip-flops he had, and so I took
10 that back to the condo and I threw some in the wash.
11 Q You were going to bring that back for him?
12 A Yeah.
13 Q So at the time you left Matt, what did he have on his
14 person? What did, what did he have with him at the hospital?
15 A The only thing he had was T-shirt, I assume the
16 underwear, shorts and flip-flops and his glasses. He had
17 nothing. He had no car keys or wallet or money or anything,
18 and I had his cell phone because his cell phone had run out of
19 juice. So I took it back to charge it at the, at the
20 condominium.
21 Q Without you, did he have any means to get a cab, get an
22 Uber?
23 A None whatsoever.
24 Q So Dave, you go back to the family condo. What's the,
25 what's the next thing that happened from your perspective?

1 A I did some straightening up. I did the laundry and then
2 I went, went to bed, and then I got up in the morning.
3 Q At the time you left Matt did you think he was in a safe
4 place?
5 A Absolutely.
6 Q Did you ever before you leave make sure to do anything to
7 ensure that your contact information was available?
8 A Just prior to leaving I went out to the nurse's station
9 and introduced myself. You know, from, from the past when he
10 had had seizures real young and he had hospital care you just
11 get in the habit of knowing the nurses or, you know, that,
12 that's who you -- that's who you go to. So I went out and I
13 introduced myself. I made sure they had my phone number, and
14 then I went back in and, and said good night to Matt, hugged
15 him and kissed him and --
16 Q Take your time, Dave.
17 A And -- sorry.
18 Q Take your time.
19 A And then I left and went to the condo. Yeah. I'll take
20 that. Okay. Go ahead.
21 Q Yeah. And Dave, when you were speaking for making sure
22 that your cell phone was available to the healthcare
23 providers, did you -- was it your understanding that if there
24 was a change in Matt that, that the physicians would notify
25 you?

1 MR. GRESH: Your Honor, speculation or hearsay.
2 MR. HINSON: Asked him what his understanding was.
3 THE COURT: I overrule your objection.
4 MR. GRESH: Thank you.
5 BY MR. HINSON:
6 Q Was it your --
7 A My understanding that I'd be called. If something
8 serious was going on that I'd be called.
9 Q So you go home, do some laundry for Matt, get a little
10 rest. What's the next thing that happens from your
11 perspective?
12 A Well, I get up in the morning. I, I call Deb and we talk
13 and I say I'm going to, I'm going to head over there soon,
14 and, and we just went over again what was going on and
15 possible plans and stuff like that, and, and, you know, then
16 we hung up.
17 Q What happened next?
18 A Well, I'm sorry, just before we hung up she goes, "I'm
19 going to," you know, I said, "I'm going to go there as soon
20 as" -- she says, "Well, I'm going to give him a call, you
21 know, say good morning, see how he's doing," and the, and the
22 next thing I know she called back hysterical saying they had
23 let Matt out of the hospital at a quarter till two in the
24 morning. Okay.
25 Q Where'd you go?

1 A I hop in the car and started driving to Grand Strand
2 Medical Center, and I got on the phone to the Myrtle Beach
3 Police and told them I needed to -- an officer to meet me
4 there because I had no -- that my son was missing.
5 Q Did a police officer come meet you?
6 A Yes. He did.
7 Q Dave, were you surprised to learn that the --
8 A I'm sorry. Okay.
9 Q -- physician at 1:30 in the morning had allowed Matt to
10 leave without contacting you?
11 A I was completely startled.
12 Q And did the police fill out a, a missing person for Matt
13 and launch a search or put him on the missing person?
14 A He, he took my information. I can't speak to whether he
15 started a search.
16 Q Yeah.
17 A He, he took my information.
18 Q And then, Dave, what -- you heard today, obviously, Mr.
19 Doherty testify. What was the next thing you learned with
20 regard to Matt?
21 A The next thing I learned, myself and Debbie's sister and
22 my brother-in-law had been searching for him all day, and
23 around 6:30 on Saturday evening the police called me and said
24 -- asked me if I could stop by. They, they said they had some
25 more information on my son, could I stop by, and I said,

1 "Well, my wife is" -- Debbie had, as soon he -- found out
2 missing, had caught the quickest flight she could, but it
3 didn't come in till 7:00 o'clock that night. So I said I'd be
4 over as soon as I pick up my wife from the airport. I picked
5 her up and we went over to the Myrtle Beach Police station.
6 Q And what did the police tell you?
7 MR. GRESH: Hearsay.
8 Q What was your understanding of why they were calling you?
9 A Well, they didn't -- what they did first is, is they had
10 us identify or not identify. They asked if we recognized some
11 clothes.
12 Q Was it the same?
13 A And, and immediately recognized the clothes Matt had had
14 on the day before.
15 Q It was the clothes Matt had when you had left him in the
16 hospital?
17 A Yes, and I identified it as such.
18 Q And what was your understanding of where the clothes had
19 been found?
20 A They explained to me that the clothes had been found on
21 the beach.
22 Q What was your perception of the way the police were
23 conveying this information to you?
24 A Well, they then told me that a young man matching my
25 son's description --

1 MR. GRESH: Hearsay.
2 THE COURT: Yeah. I sustain the objection.
3 Q Mr. Scheer, did you, following your time there, so that
4 would be October 3rd you're in the police department?
5 A Yes.
6 Q When you left the police department that day what was
7 your understanding of what had happened to your son?
8 A That he had drowned in the ocean.
9 Q Mr. Scheer, did you ever receive a statement from the
10 Myrtle -- excuse me. Did you ever receive a statement from
11 the Myrtle Beach Police Department setting forth their
12 activities, the agency's activities with regard to their
13 search for your son?
14 A Yes. I did.
15 MR. HINSON: May I approach the witness, Your Honor?
16 MR. GRESH: Yeah. May I approach?
17 (Whereupon, a bench conference is held in the presence
18 but out of the hearing of the jury.)
19 THE COURT: Well, it's kind of border-line. I'm going to
20 allow it in over 83 -- 803(8).
21 MR. HINSON: Thank you, Your Honor.
22 THE COURT: Huh?
23 MR. GRESH: Everything in it?
24 THE COURT: Yeah.
25 MR. GRESH: Thank you.

1 BY MR. HINSON:
2 Q Mr. Scheer, I'm going to show you what we'll mark as
3 Plaintiff's Exhibit Ten. Mr. Scheer, can you identify that
4 document?
5 A It's -- I'm sorry, it's a document from the Myrtle Beach
6 Police Department. It's a letter addressed to whom it may
7 concern.
8 Q Did they provide this to you?
9 A Yes. They did.
10 MR. HINSON: Your Honor, we'd move this into evidence.
11 THE COURT: Over objection. It's in under 803(8).
12 (Plaintiff's Exhibit Number Ten [MBPD - Activities]
13 admitted into evidence and appropriately marked.)
14 BY MR. HINSON:
15 Q And Mr. Scheer, I'm not going to ask you to read the
16 whole, the whole letter, but what was your understanding of
17 the police department's efforts over the next few weeks,
18 months to look for Matt or his body, just generally, Mr.
19 Scheer?
20 A Well, they had done a number of things. When -- to start
21 with when we were at the police department they swabbed my
22 wife and I with DNA, took DNA samples for which to put it in
23 the national whatever they call it, the database that they put
24 all that stuff in, and then they, they had a -- did extensive
25 land search. They notified the, the Myrtle Beach lifeguards

1 to be on the lookout. They conducted a -- they conducted
2 helicopter searches.
3 Q Were they keeping you up-to-date on their efforts?
4 A Yes. They were.
5 Q Did you have a, did you have a, a contact person, an
6 officer who was -- that was Matt's --
7 A Corporal Shelton, this is her -- she's the author of this
8 letter apparently.
9 Q Were you satisfied with her efforts to look for Matt's
10 body?
11 A Yes. I was.
12 Q And Mr. Scheer, I'm going to show you Plaintiff's Exhibit
13 Four.
14 A Oh, I'm sorry. Thank you.
15 Q Mr. Scheer, what is Plaintiff's Exhibit Four?
16 A It's a, a death certificate.
17 Q For whom?
18 A Matthew Scheer.
19 Q And Mr. Scheer, did you all have a memorial service for
20 Matthew?
21 A Yes. We did.
22 Q Approximately how many -- was it, was it in Horry County
23 or was it back in New Jersey?
24 A It was back in New Jersey.
25 Q Approximately how many people came?

1 A Over 200, you know, but maybe less stayed for the final
2 service, but over 200 to maybe even closer to 300 came through
3 to pay their respects, maybe a hundred, 125 stayed for the
4 service.
5 Q Dave, I want to show you some pictures.
6 A It was probably more than that that stayed.
7 Q Dave, I'm going to show you Plaintiff's Nine(A). Can you
8 see that, Dave, or we need to turn it a little bit more?
9 A No. I can see it fine.
10 Q And this was -- this Nine(A) is what we were showing to
11 Mr. Doherty. Who is, who is this right here?
12 A Matthew.
13 Q Okay. Who?
14 A That, that's our family.
15 Q Tell me, when was this picture taken?
16 A It's our last family photo. Erik was going off to
17 Oklahoma City. He'd been accepted as an air traffic
18 controller, and we had a sendoff party for him. There was a
19 lot more people there, and, and -- but that was our last time
20 we were together as a family.
21 Q About how -- when was this, how far? That's okay, Mr.
22 Scheer.
23 A I --
24 Q That's okay. If, if you would --
25 A No. I think it was June or July.

1 Q You had come -- you and -- you all came down here? Where
2 was this?
3 A That was up in New Jersey.
4 Q Just --
5 A Yeah. That's got to be the boys at Ocean City Beach. I
6 was burying them like a, you know, in the sand.
7 Q Was Matt, was Matt a beach guy, mountain guy, what was his?
8 A He liked the beach. I mean, he, he was not a, a, a
9 sunbather, but he liked to go to the beach. I mean, he wasn't
10 -- once he got tired of, you know, throwing footballs around
11 or Frisbees or something or softball he had no real interest
12 in sitting there getting a tan.
13 Q How about Nine(C), Dave?
14 A That was their street hockey phase.
15 Q Who is in that picture?
16 A Erik and Matt.
17 Q What we got here?
18 A That's Matt with a fish, flounder.
19 Q Where, where are you in the picture?
20 A I'm actually taking the picture. That's -- he's with a
21 -- the guy behind him is an old friend of mine who he had the
22 boat.
23 Q Who are these?
24 A Vacation picture.
25 Q Did you all turn that into a --

1 A Christmas card. Hoover Dam in Nevada.
2 Q What, what brought you all out to Nevada?
3 A Vacation.
4 Q How about this is -- who's --
5 A That's Matt's graduation with Erik and Debbie and my mom.
6 Q Dave, how has, how has Matt's death impacted you and your
7 family? Starting with you, how has this impacted you?
8 A Matt was like a -- he was a really good guy. He was one
9 of the good guys and he, he was a good guy even when he was
10 little. I, I -- you know, I worked nights and when he was a
11 baby I, I'd be tired in the morning. I could guarantee if I,
12 if I laid down on the couch, put him on my, my chest we'd both
13 be out in about a minute, you know. Erik I had to beg to take
14 a nap.
15 Q How has your life changed since Matt's death? How, how
16 are you different?
17 A I, I miss him every day, every day. You know, both my
18 sons they, they were my buddies. Down here I'd play golf with
19 Matt, and during -- we're all big Philadelphia sports fans,
20 and you know, during big games or, or stuff I -- or the games
21 they couldn't watch, I'd, I'd -- we'd text back and forth.
22 I'd let them know what was going on or we'd discuss it in
23 texts, and you know, both my sons are my joy, and I'm often --
24 got some frustration and anger now because I don't understand
25 why he's gone. I sleep a lot worse. As a family we --

1 there's a, there's a big hole there now.
2 Q How, how have you observed changes in your wife?
3 A Well, I don't know what everybody else thinks but if you
4 have kids -- if you have multiple kids you always figure at
5 some point you figure out one's like one parent and one's like
6 the other, and Matt was kind of like a Debbie clone. So they,
7 they -- Matt had a, a great laugh, and he -- and those two
8 would get started and Erik would be like, "You guys just stop
9 it, you know." They're like peas in a pod, and she feels his,
10 his loss immensely. You know, he was just a -- one of the
11 things I loved, loved most about Matt is he, he was one of
12 those guys that things happen to, you know what I mean, just
13 -- and he always just laughed -- could laugh it off and
14 everything. He, he could laugh at himself. One time he calls
15 me and he -- and he's yelling, "Dad, Dad," and I'm like, you
16 know, "Matt, I can't understand you. Are you all right?"
17 "Dad, Dad." "Matt, what are you, what are you doing, you know,
18 please go." So he calms down, he goes, goes, "Dad, my -- I'm
19 driving down 31 here, and it goes -- my tire came off the
20 car." I'm like, "What?" He goes, "Yeah, I got, I got it to
21 the side of the road." I go, "Well, can you get the tire back
22 on?" He goes, "Well, it's still rolling down the highway,"
23 and we both just started laughing our asses off, and then he,
24 he, he got a, a beach chair out of the car, sat down, and, and
25 started reading his book. Things are happening to him, he, he

1 like wasn't fazed.
2 Q Had a good attitude.
3 A He just kind of took stuff in stride, and, you know, it's
4 kind of like what his, his mom's like, and me, I'd get all
5 nervous about something, but he, you know, he's just -- and,
6 and --
7 Q Have you seen changes in Debbie though?
8 A Oh, yes. Definitely she's -- it's like she's missing a
9 piece. It was her firstborn and, and, like I said, it was her
10 clone and her -- you know, we will be watching something and
11 she'll, she'll start crying because it's reminding of, of
12 Matt. Well, we, we both can get that way, you know, songs,
13 places.
14 Q Any particular places or songs that are hurtful?
15 A Well, for me, I, I can't hear U2's Song for Someone
16 without crying and Steve Earle's Galway Girl -- Galway Girl
17 that has nothing to do in particular except that we enjoyed it
18 and it was a, you know, upbeat song, and, and --
19 Q Did you -- do you still have the condo where Matt was
20 living?
21 A No. We don't. We tried going down there a few times
22 afterwards, and it was, it was -- everything in the Myrtle
23 Beach, particularly I guess the condo, was very emotional for
24 us. So we rented it out for a couple of years just to -- or a
25 year and a half just to see if it -- time would change that,

1 and in August of this year the rental ended and we used it a
2 couple of times and realized it really hadn't changed
3 anything. So we just recently sold it.
4 Q As a result of Matt's death are there things you worry
5 about for your and Debbie's future?
6 A Well, to start with our retirement plan was Myrtle Beach.
7 So that, that's gone, and we don't know what to do. The
8 concern about how it's going to impact Erik down the, down the
9 road is, going to be faced with a, you know, Debbie and I,
10 god-willing live, you know, healthy lives and everything, but
11 Debbie and I both went through -- three of our four parents
12 went through extended medical care at the end, and for anyone
13 that's been through that that's a difficult thing,
14 emotionally, financially, time-wise. Debbie, we were
15 fortunate in Debbie's case she has three siblings with, with
16 spouses. I have two, and you know, everybody gets along and
17 everybody, you know, there's times to work to make sure
18 everybody was -- our, our, our parents, whenever it happened
19 to them, were comfortable and taken care of, and that meant
20 splitting the burden and, and, and taking care of these
21 things. Well, Erik's got to -- it's all on him now, and
22 that's -- can be a difficult things to handle. He's also he's
23 stationed in -- on the West Coast and we're on the East Coast.
24 Q Dave, do you, grown man, but do you, do you still cry for
25 your son?

1 A Yes.
2 Q Do you watch -- does your wife still cry for Matthew?
3 A Yes. Often.
4 Q Nothing further, Dave, at this point. Thank you.
5 CROSS EXAMINATION
6 BY MR. GRESH:
7 Q Good afternoon Mr. Scheer. You need any water or
8 anything?
9 A I have some. Thank you.
10 Q Talking about Matthew, yet it sounds like from your
11 testimony earlier that Matthew had moved down in maybe I think
12 you said December of '13; is that right?
13 A Yes.
14 Q This is the date we've been talking about is October of
15 '15?
16 A Yes.
17 Q Matt had been here about almost going on two years?
18 A Yes.
19 Q He had, thanks to you and Debbie, had a nice condo to
20 live in?
21 A Yes. He did.
22 Q He was working at Dune's, Dune's Village?
23 A Yes.
24 Q And he had a couple of good friends there in Matt and
25 Courtney and some others?

1 A Yes.
2 Q And from reading the deposition testimony, Mr. Scheer, it
3 also appeared that is it Debbie's brother or brother-in-law?
4 A Debbie's sister and, and husband.
5 Q Debbie's sister and husband, they also lived pretty close
6 to that condo area?
7 A Yes. They do.
8 Q So he had a -- while, while Matthew is here he'd had a
9 pretty good support system around him? Fair enough?
10 A Yes, if, if, if he had some problems, yes.
11 Q And I'm just looking back through, when you all -- when
12 you took him to Lighthouse that morning or afternoon it looks
13 like you all were there for about an hour, hour and a half or
14 so, maybe two hours?
15 A That sounds about right.
16 Q And then came back to Grand Strand. I guess this is for
17 the second time that afternoon?
18 A Yes.
19 Q You left about seven or 7:30 that evening and --
20 A Yes. I did.
21 Q -- your son was still calm and not agitated at that
22 point; correct?
23 A Yes. Yes.
24 Q And up to that point you had never heard your son
25 threaten to harm anyone; correct?

1 A No. I had not.
2 Q Or threatened to harm himself; correct?
3 A No. I had not.
4 Q And you then you left, went home and got some rest from
5 there. I wanted to talk to you a little bit about one of the
6 exhibits.
7 MR. GRESH: If I could approach, Your Honor, one of the
8 exhibits.
9 BY MR. GRESH:
10 Q I'm sorry, Mr. Scheer, I don't know the number of it.
11 Just give me two seconds. Number 10.
12 A Yes.
13 Q Number 10 is the and just to remind folks, that's the
14 letter that the Myrtle Beach Police Department, I guess, gave
15 to you and to Debbie as part of opening Matthew's estate; is
16 that right?
17 A Yes. It was.
18 Q And it talks about the efforts that the Myrtle Beach
19 Police Department had put in to try and locate Matt; correct?
20 A Yes.
21 Q And up until this point nobody has been able to find
22 Matthew; correct?
23 A That is correct.
24 Q And the -- but there were some clothes that were found
25 on, on the beach, some sandals and gray --

1 A They didn't find -- they did not find the sandals. I
2 just knew he had had sandals.
3 Q And there was like gray underwear and --
4 A Khaki shorts.
5 Q -- khaki shorts. When you left the hospital that evening
6 you had testified that Matthew's cell phone was out of juice?
7 A But it, it might've had --
8 Q But I know what you mean.
9 A -- it might have had like two percent or something.
10 Q Got you. And you took it home to the condominium to
11 recharge it?
12 A Yes.
13 Q And then we know that Matthew leaves the hospital. I
14 assume the phone gets recharged?
15 A Yes.
16 Q You're not able to open the telephone?
17 A He had it password protected.
18 Q Did you try and open the phone, look for texts and calls
19 and all those things?
20 A Yes. Yes. I did.
21 Q And I assume you can't crack the code?
22 A I tried a number of passwords I, I thought might work. I
23 knew a couple of his old ones and nothing worked.
24 Q I assume you asked friends and family for their help to
25 see if they could help cracking it?

1 A Yes.
2 Q It was a Samsung type telephone?
3 A Yes. It was.
4 Q At some point did you take that cell phone to Verizon?
5 A Yes. I did.
6 Q And when you took it to Verizon it was to do a full
7 factory reset on the telephone?
8 A Yes. Well, I, I took it to them to find out if they
9 could somehow get into it, but they explained to me that the
10 -- these -- they don't -- Verizon doesn't give those
11 passwords. It's, it's device specific.
12 Q The Samsung might have the code that Verizon --
13 A Yeah. No, Samsung -- nobody would have it except the
14 owner of the phone.
15 Q And so the only choice that Verizon had is to?
16 A Do a factory reset.
17 Q Which essentially wipes out all of the -- or supposed to
18 wipe out all the data on the phone? That was your
19 understanding going into it?
20 A No. They, they had explained to me -- you know, I'm
21 sorry. I don't recall.
22 Q Okay.
23 A I know the result of it, but I don't recall what --
24 Q The result of it was essentially all of the data had been
25 wiped off the phone; fair?

1 A I don't want to jump ahead of you, so -- were, were -- I,
2 I -- can I explain how -- my --
3 Q Yes, please.
4 A They explained to me that the -- if you do a factory
5 reset --
6 Q Actually, you can -- one of the rules is you can't say
7 what somebody else said, and that's not --
8 A Oh, okay. I'm disobeying with --
9 Q -- and I don't mean to cut you off, but just tell me what
10 the, the end result was or what did you find when you looked
11 at the phone?
12 A That, that if you do a factory reset you're, you're going
13 to lose -- well, you're going to lose all your personal data
14 and that some might come back because they had -- this was
15 when the cloud thing was kind of new, and what happens is
16 when, when I, when I did the factory reset it was just a blank
17 phone, and then the next day, I guess, it, it cycles or
18 whatever and some data came back.
19 Q And were you -- at this point because it had gone through
20 a factory reset you are now able to have access to that data;
21 correct?
22 A Yes. I was, the data that came back.
23 Q The data that came back and there were some pictures that
24 came back?
25 A There were some pictures that came back.

1 Q And some text messages that came back?
2 A Text messages don't come back. It was explained to me
3 that what happens with text messages, and this is why certain
4 data comes back and certain doesn't. They only keep your text
5 messages in the cloud for 10 days, and I asked him why. He
6 said, "Well, if we kept everybody's text messages forever we'd
7 have to have a zillion servers." So what it brings back is
8 like I had been hoping to get his, his songs and be able to
9 listen to them. I got his playlist, but the songs themselves
10 didn't come back, playlist, the data for the playlist is, you
11 know, some words. It's letters. It doesn't take much up, but
12 they couldn't keep the songs because it would hold -- it's too
13 much data for the cloud to hold.
14 Q And --
15 A And so the text messages, this was long after 10 days
16 when I did this, and, and the -- that did not come back.
17 Q Did any of the, the telephone calls?
18 A No telephone calls came back.
19 Q How about any of the emails that Matt had made? Do you
20 know if any of those came back?
21 A I don't think so. I don't, I don't recall that one way
22 or the other.
23 Q So other than some pictures resurfacing on the phone
24 you're not aware of any other data that would have been
25 available after the factory reset?

1 A To the best of my memory.
2 Q And it's now unlocked. You're going through the phone
3 and you see some pictures. Do you delete some of those
4 pictures and save some of those pictures?
5 A Well, not save I did -- just pictures I didn't -- there,
6 there was a, a -- some pictures of -- that Matt had on there
7 that were obviously private, meant only for him. I felt like
8 I was invading his privacy even seeing them. So I deleted
9 them.
10 Q And in the, the process of, of this case when everybody's
11 exchanging documents I guess because they were deleted they
12 weren't able to be exchanged; is that fair?
13 A Yeah.
14 Q Okay. Mr. Scheer, thank you so much for your time.
15 MR. HINSON: Very briefly.
16 REDIRECT EXAMINATION
17 BY MR. HINSON:
18 Q Mr. Scheer, the questions about you and this phone, when
19 did you take the phone and allow Verizon to do this factory
20 reset or approximately?
21 A January of 2016.
22 Q Nothing further, Mr. Scheer.
23 THE COURT: All right. You can step down. Have a seat
24 with counsel. Thank you.
25 All right. You can call your next witness.

1 MR. PADGET: Your Honor, at this time the Plaintiffs
2 would call Erik Scheer.
3 Whereupon, Erik Scheer is called to the stand, duly sworn
4 by the clerk and testified as follows:
5 THE CLERK: State and spell your first and last name.
6 MR. SCHEER: Name's Erik Scheer, first Erik, E-R-I-K, and
7 Scheer, S-C-H-E-E-R.
8 DIRECT EXAMINATION
9 BY MR. PADGET:
10 Q Erik, good afternoon.
11 A How you doing?
12 Q Could you tell us where you live?
13 A In the Bay Area of California.
14 Q Okay. How long have you lived there?
15 A Almost four years now.
16 Q And to be clear, Erik, you're Matthew's brother?
17 A Yes. Younger brother.
18 Q And you and Matthew are the natural sons of your parents,
19 Dave and Debbie Scheer?
20 A Yes.
21 Q Is that right? Are you now married?
22 A Yes. Got married last month.
23 Q Congratulations.
24 A Thank you.
25 Q Could you tell us a little bit about what you do for a

1 living now?
2 A Air traffic control out in the Bay Area at a radar
3 center. We work all the flights across the Pacific Ocean and
4 to and from the Bay Area to L.A. Basin Area.
5 Q The civilian flights?
6 A Yes.
7 Q That kind of flights? Let's go back in time a little
8 bit. Growing up in the Scheer household, growing up with your
9 family, could you tell us a little bit about that?
10 A Yeah. Growing up, my brother and I we lived in a
11 neighborhood in a cul-de-sac, and you grow up, you know,
12 playing outside with all your friends, ride bikes. We'd eat
13 dinner at the table almost each night, celebrate holidays.
14 Q Erik, can you see what I've put up, Plaintiff's Exhibit
15 Nine(B)? Is this a photograph of you and your brother when
16 you were younger?
17 THE COURT: All right. You've got to answer with a word.
18 A Yes.
19 Q How would you describe your relationship with Matthew?
20 A One second.
21 Q Please take your time.
22 A Me being younger, we played a bunch of sports and stuff.
23 We were close, competitive though. I'm a -- like to win a lot
24 of things. So we'd, you know, race, do sports, played games,
25 argued. I mean, we were only two years apart, but I mean, got

1 along, kept up with each other, things of that nature.
2 Q He was your older brother. If you would for us, Erik,
3 could you describe your brother's relationship with your
4 mother and your father?
5 A He was a lot better. I'm a terrible communicator. I
6 don't keep up too well. He can ramble. He'd keep up with my
7 parents often. I know him and my mom would talk every day.
8 Q Did he also speak with your father?
9 A All the time. Yeah, they'd, like he said, talk about
10 sports. I mean, he'd always want to be like my dad, and in
11 growing up we'd take turns mowing the lawn, and I always
12 thought they were dorky looking, but my dad would wear these
13 stupid goggles mowing the lawn. He bought us both a pair. Me
14 being myself wouldn't want to wear them. My brother would put
15 the goggles on, just always try to emulate him. I mean, he
16 went into, I think, the restaurant industry to, you know, my
17 dad was a bartender his whole life. I think he got into that
18 field to be, be like him.
19 Q I've, I've put Exhibit Nine(C) up here. Is this a
20 photograph of you and your brother playing looks like some
21 street hockey?
22 A Yes.
23 Q You guys play together like that a lot growing up?
24 A Yeah. And I probably won if we were playing one-on-one.
25 Q Okay. Now, as you grew up together from these younger

1 ages and became teenagers and, and started going out or out in
2 the world on your own a little bit, did you guys stay close as
3 a family?
4 A Oh, yes. We'd always, like I said, you'd have holidays
5 together, we'd eat dinners together as much as we can with all
6 our working schedules. Yeah. Still kept up. Still did
7 everything as a family.
8 Q Did you travel together?
9 A Yes.
10 Q Did you come down to the beach together?
11 A Oh, yeah. Definitely.
12 Q Did your family, would you have fun together?
13 A Yeah. I mean, growing up, you'd get in your arguments,
14 but I mean, we were a happy household. We'd eat dinner almost
15 every night, went on lots of vacations.
16 Q At some point, Erik, you moved out of the house to pursue
17 your career in air traffic control?
18 A Yes.
19 Q And he came down, at some point came down to the beach
20 and started working in the food and beverage industry?
21 A Yes.
22 Q Even though you guys were apart geographically, did you
23 still try to keep up with one another?
24 A Yes.
25 Q Well, tell us about the types of things you would do with

1 your brother to stay in touch with him?
2 A I mean, we'd try to do a phone call each week just to, to
3 touch base. I mean, at one point I moved -- originally to get
4 the job you -- I went from New Jersey to Oklahoma for about
5 four months, and he'd call, ask how that's going, and then
6 the, the one photo you guys showed of our last time, I came
7 home to move out to California, but we'd, we'd keep in, in
8 touch through texts, phone calls, that nature.
9 Q Okay. And did, to your knowledge, did, did your brother,
10 did Matthew, did he keep up with your parents the same way?
11 A Yes.
12 Q Did you have conversations with your parents where they
13 communicated what was going on in his life and you
14 communicated what's going on in yours?
15 A Yes, definitely.
16 Q And you said you guys did that, you said that about every
17 single week or --
18 A Tried to, maybe like every couple of weeks, but as much
19 as I could that -- I was going through training and it took up
20 a lot of my time, so like whenever I had some spare time.
21 Q You and your brother have any nicknames?
22 A Yeah. I had for some reason one day coined the term for
23 him McGirt.
24 Q McGirt?
25 A I don't know where it came from, but yeah, it just suited

1 him.
2 Q So you called him that thereafter?
3 A Yeah. That was his name in my phone.
4 Q Did he have any nicknames for you?
5 A Probably can't say them.
6 Q Turning to October of 2015, how did you learn about the
7 events of early October 2015 regarding your brother?
8 A The day of the 3rd, later that evening I got a call from
9 my parents about what happened.
10 Q What did your parents tell you?
11 MS. SPEARS: Objection, Your Honor, hearsay.
12 THE COURT: I, I sustain the objection.
13 MR. PADGET: Your Honor, I'll rephrase the question.
14 BY MR. PADGET:
15 Q What is it that your father, Mr. Scheer, what did he tell
16 you?
17 MS. SPEARS: Objection, Your Honor, hearsay.
18 THE COURT: Well, he's a party opponent.
19 MR. PADGET: He's a party, Your Honor, which by
20 definition is not hearsay.
21 A He just let me know that, that something happened to
22 Matt, that he drowned in the ocean and that he like walked
23 out and did it himself, and that, you know, I had to come
24 home.
25 Q Did you and your family have a memorial service for your

1 brother?
2 A We did.
3 Q When did you guys do that?
4 A As I recall, the week after about.
5 Q About a week later?
6 A Yeah.
7 Q And you attended?
8 A I did.
9 Q Along with it sounds like --
10 A Christie, my wife, yeah.
11 Q Christie your wife did as well. If you would, please,
12 Erik, describe what it's been like for you and your family for
13 the last couple of years living without your brother.
14 A I mean, I'll start with my parents. One, I mean, the
15 crying. Growing up, I mean, I was always super intimidated of
16 my pops. He was kind of a man's man in my eyes, worked long
17 hours to like help us pay bills, go on vacations and stuff,
18 and there was work needed around the house to be done he'd do
19 it, didn't really show too much emotion. Seeing him cry now
20 it hurts. I mean, growing up we had a -- they had a nice home
21 with a basement. You know, you'd -- everybody would always
22 come to our house. They'd host -- they like hosting a lot of
23 events, parties of that nature, and always wanted to entertain
24 people. I mean, now they just have a two-bedroom condo, don't
25 really host anything or, you know, have people over, and then

1 for myself, I mean, just last month I got married, and growing
2 up I always pictured, you know, him being my best man standing
3 next to me and not having him there is tough. If we decide to
4 have kids, they won't have an uncle, and I don't have a choice
5 to be an uncle now. Also, this past Monday was my birthday.
6 I turned 28. I'm now two years older than my brother was when
7 he left us, and being the older brother really sucks.
8 MR. PADGET: No further questions, Your Honor.
9 THE COURT: All right. Cross.
10 MS. SPEARS: No questions, Your Honor.
11 THE COURT: All right. You can step down. Appreciate
12 your time. Thank you.
13 A Thank you, sir.
14 THE COURT: I think this is the time we'll take an
15 afternoon break.
16 (Jury exits courtroom.)
17 OFF THE RECORD
18 (On the record. The following takes place outside the
19 presence of the jury.)
20 THE COURT: Keep your seats. Take your seats. Have a
21 seat. All right. You ready?
22 MR. PADGET: Yes, we are, Your Honor.
23 THE COURT: All right.
24 MR. GRESH: You know, just for, for housekeeping purposes
25 it looks like we're going to have a quick 30(B)(6) read in of

1 the corporate Defendant, and then Mrs. Scheer is going to
2 testify. I believe she to be maybe the last witness for the
3 Plaintiffs.
4 MR. HINSON: That's correct, Your Honor.
5 MR. GRESH: Then we'd have some, some motions, obviously,
6 and I'd prefer if the Court would indulge to start the Defense
7 case tomorrow morning at 9:30 rather than having to call
8 somebody at 4:30 today.
9 THE COURT: All right. If we get to around 4:30 then we
10 won't start into because we got motions and that sounds good.
11 Still look like we going to have to be here Tuesday?
12 MR. GRESH: No, sir. If, if we get -- if, if the Court
13 would indulge me to start tomorrow morning, I may have one
14 witness first thing out the box on Friday.
15 THE COURT: Okay.
16 MR. GRESH: And I would, I would anticipate resting
17 before lunchtime.
18 THE COURT: All right. Well, good. Well, I can go
19 cancel my reservation I just made at Comfort Suites. Don't
20 forget about the charges. If you could have them for me in
21 the morning I can start looking at them.
22 MR. GRESH: Yes, Your Honor.
23 MR. HINSON: Yes, Your Honor.
24 THE COURT: Thank you. All right. Bring in the jury.
25 (Whereupon, the following takes place in the presence of

1 the jury.)
2 THE COURT: Call your next witness.
3 MR. PADGET: Thank you, Your Honor. At this time the
4 Plaintiffs, actually along with the Defendants would mutually
5 are publishing excerpts of the deposition, the Rule 30(B)(6)
6 deposition of the corporate Defendant, Southern Myrtle
7 Inpatient Services.
8 THE COURT: All right. How are you going to do it?
9 MR. PADGET: Ms. Spears has been kind enough to offer to
10 read on behalf of the corporate Defendant.
11 THE COURT: All right. This is a deposition, not, not a
12 video one, but Ms. Spears will take the stand and read the
13 verbatim answer, that is the lawyers will read the questions
14 that were asked at this deposition when the witness I -- whose
15 name I don't know at this point -- was under oath and asked
16 certain questions, and for the purposes of trial they can be
17 read into the record, and again, just like with the video,
18 even though Ms. Spears is not the person and you're not seeing
19 the right -- the person on a TV screen, you take her testimony
20 or her reading the testimony just as though that witness was
21 here testifying. Ms. Spears, you can come take the stand.
22 MS. SPEARS: Yes, Your Honor.
23 Whereupon, Lauren Spears is called to the stand, duly
24 sworn by the clerk:
25 THE CLERK: Please state and spell your first and last

1 name.
2 MS. SPEARS: My name is Lauren Spears, S-P-E-A-R-S, and
3 this --
4 MR. PADGET: And for the record, Your Honor, the, the
5 30(B)(6) designee was a gentleman named Matthew Shane Caldwell
6 on behalf of the corporate Defendant, Southern Myrtle
7 Inpatient Services, LLC.
8 THE COURT: All right.
9 DEPOSITION PUBLISHED
10 BY MR. PADGET:
11 Q If you would turn to page 14, please?
12 A Yes, sir.
13 Q And beginning on line 17. [As read], "Okay, Mr.
14 Caldwell, paragraph 47 just asks if the physician has the
15 ability to temporarily detain the patient against his will.
16 Has Southern Myrtle Inpatient Services done any research into
17 the legal rights of a physician to detain a patient if the
18 patient may cause injury to himself or others?"
19 A [As read], "The training is done by the hospital and by
20 the physicians themselves in the course of their education."
21 Q [As read], "Mr. Caldwell, has Southern Myrtle Inpatient
22 Services done any research into a physician's ability to
23 temporarily detain a patient against his or her will if the
24 patient may cause injury to himself or others?"
25 A [As read], "No."

1 Q Going down to page 16 beginning on line seven. [As
2 read], "What efforts did Southern Myrtle Inpatient Services
3 take to research the topic of the physician's ability to
4 temporarily detain a patient against his will?"
5 A [As read], "We do not take that stance. Southern Myrtle
6 does not take that stance."
7 Q [As read], "Would you agree, would Southern Myrtle
8 Inpatient Services agree that regardless of the circumstances
9 through which a patient comes to the hospital, if a physician
10 believes that the patient because of mental illness or
11 instability has the likelihood of causing injury to himself or
12 others the physician has the ability to temporarily detain the
13 patient against his will?"
14 A [As read], "The physician has, has the right. We don't
15 get involved in the practice of medicine. The physicians
16 have, have the right practice, right to practice medicine."
17 Q [As read], "And part of that right to practice medicine
18 includes the ability to temporarily detain a patient if the
19 patient because of mental illness has the likelihood of
20 causing injury to himself; does it not?"
21 A [As read], "I'm not a clinician. I cannot specifically
22 answer that question."
23 Q I'm turning now to page 47, beginning on line 24. [As
24 read], "Topic number four of the deposition notice states
25 details relating to the policies and procedures applicable to

1 Drs. Patel and Ash-Bernal, whether promulgated by Southern
2 Myrtle Inpatient Services, Grand Strand Regional Medical
3 Center or some other entity, organization or individual. Do
4 you see that?"
5 A [As read], "Yes."
6 Q [As read], "Did Southern Myrtle Inpatient Services
7 have any policies or procedures in 2015 that it promulgated
8 that would be applicable to Drs. Rachel Ash-Bernal and
9 Patel?"
10 A [As read], "No."
11 Q [As read], "What efforts, if any, did SMIS take to ensure
12 that its physicians, particularly Patel and Ash-Bernal, were
13 knowledgeable of the policies and procedures applicable to
14 Grand Strand Regional Medical Center?"
15 A [As read], "These are highly trained and educated
16 clinicians, rely on their education and their actions as a
17 professional, and again, they're credentialed to be approved
18 to act in that way."
19 Q [As read], "Southern Myrtle Inpatient Services took no
20 specific action to determine whether or not Dr. Patel and Ash-
21 Bernal were adequately knowledgeable on the policies and
22 procedures of Grand Strand; is that fair?"
23 A I'm sorry. I have to interrupt. That is not part of my
24 -- I apologize.
25 Q I'll reread the question. [As read], "Southern Myrtle

1 Inpatient Services took no specific action to determine
2 whether or not Dr. Patel and Ash-Bernal were adequately
3 knowledgeable on the policies and procedures of Grand Strand;
4 is that fair?"
5 A [As read], "Yes."
6 Q Turning now to page 50, beginning on line 14. [As read],
7 "Mr. Caldwell, we just provided you what's been marked as
8 Exhibit Six, and this is the notice of privacy practice,
9 practices, issued by Grand Strand Regional Medical Center. Do
10 you see that?"
11 A [As read], "I do."
12 Q [As read], "And what do you -- what you have right there
13 is a printout from the website, which is also a little
14 bulleted or brochure that was produced in discovery from the
15 hospital that has the same information on it, and I represent
16 to you this is the privacy practices, the notice of privacy
17 practices that patients are given at the hospital. Are you
18 generally familiar with those documents?"
19 A [As read], "Please clarify."
20 Q [As read], "Well, you're aware as Southern Myrtle
21 Inpatient Services is aware that there are notices of privacy
22 practices that are provided to patients in hospitals;
23 correct?"
24 A [As read], "I would think so."
25 Q [As read], "If you would look at page four, about a third

1 down the page, there's a paragraph that begins, 'As permitted
2 by law we may also use and disclose health information for the
3 following types of entities, included, but not limited to,' do
4 you see that section?"
5 A [As read], "Yes."
6 Q [As read], "And then there's a number of bulleted points,
7 and the last one listed where a person's health information
8 may be disclosed, you will read that last bullet point?"
9 A [As read], "A person or persons able to prevent or lessen
10 a serious threat to health or safety."
11 Q [As read], "So you would agree with me that according to
12 Grand Strand's own notice of privacy practices of the
13 disclosure of a patient's personal health information could
14 serve to prevent or lessen a serious threat to health or
15 safety, health information can, in those circumstances, be
16 disclosed?"
17 A [As read], "According to this document, yes."
18 Q [As read], "And you would and Southern Myrtle Inpatient
19 Services would expect its physicians working at Grand Strand
20 to generally be familiar with the notice of privacy practices
21 document?"
22 A [As read], "To my knowledge, yes. They follow the
23 policies and procedures of the hospital."
24 Q [As read], "Is there an exception in HIPAA that would
25 allow for a limited disclosure of a patient's personal health

1 information when the patient is suffering from mental
2 incapacity and disclosing the health information would be in
3 the patient's best interest?"
4 A [As read], "I'm not 100 percent certain."
5 Q Page 58, beginning on line seven. [As read], "Did
6 Southern Myrtle Inpatient Services undertake to educate their
7 physicians on what HIPAA does and does not allow?"
8 A [As read], "No. We, we rely on each individual
9 physician's education as well as the hospital's policies and
10 procedures."
11 Q Turning now to page 64. [As read], "Does Southern Myrtle
12 Inpatient Services have any specific knowledge of the training
13 provided, and by that I mean would they have received notice
14 such as on December 2nd, 2015, did Dr. Patel attend -- attended
15 such and such a seminar provided by an X, Y, Z entity?"
16 A [As read], "I'm not certain."
17 Q [As read], "Do doctors -- do the doctors report, does Dr.
18 Patel and Dr. Rachel Ash-Bernal when they worked for Southern
19 Myrtle Inpatient Services did they report any ongoing
20 continuing medical education that they received, did they
21 report that to SMIS?"
22 A [As read], "I'm not certain."
23 Q Turning now to page 66. [As read], "Looking back at
24 Exhibit 12, the third bullet point states, 'Training modules
25 conducted online over the years by employers'. Do you see

1 that?"
2 A [As read], "Yes."
3 Q [As read], "SMIS didn't provide any training to Drs.
4 Ash-Bernal or Dr. Patel; did it?"
5 A [As read], "I'm not, I'm not certain. We -- there are
6 online overview compliance training."
7 Q [As read], "So SMIS did on occasion provide training to
8 its employees?"
9 A [As read], "There is a general training, annual training,
10 yes.
11 Q [As read], "Who conducted that training to Drs. Patel and
12 Ash-Bernal?"
13 A [As read], "It's an online course."
14 Q [As read], "It was an online course created by SMIS?"
15 A [As read], "I'm not certain who it was created by."
16 Q [As read], "So my question was did SMIS as an entity
17 providing trainings to Dr., Drs. Patel and Ash-Bernal?"
18 A [As read], "I'm not certain exactly what you're asking."
19 Q [As read], "Well, doctors have to get continuing medical
20 education; correct?"
21 A [As read], "Yes."
22 Q [As read], "Did SMIS, as an entity, provide any training
23 to Drs. Ash-Bernal or Patel?"
24 A [As read], "Not, not to my knowledge."
25 Q [As read], "Okay. Who -- what entity created or

1 promulgated this online training you just spoke of?"
2 A [As read], "I'm not certain."
3 Q [As read], "When did Drs. Ash-Bernal and Patel receive
4 this training you spoke of that was online?"
5 A [As read], "I'm not certain."
6 Q [As read], "How would -- who would know the answer to
7 that question?"
8 A [As read], "I would."
9 Q [As read], "Okay. How would you gain that information?"
10 A [As read], "Within our systems."
11 Q [As read], "So you could provide a more detailed answer
12 to number one stating when Drs. Ash-Bernal and Patel received
13 HIPAA training?"
14 A [As read], "If, if they attended the HIPAA training, the
15 corporate HIPAA training, then yes. If not, then no."
16 Q [As read], "Have you ever been asked to look in your
17 system and make a determination if the corporate HIPAA
18 training was attended by Dr. Ash-Bernal and Patel?"
19 A [As read], "I have not until just now."
20 Q [As read], "Is that corporate HIPAA training, is that
21 something the corporation still has?"
22 A [As read], "Yes. And to be more specific it is more
23 compliance driven and overarching. It doesn't get into
24 detail. It is more from a corporate level and not in the day-
25 to-day practice of medicine aspect of HIPAA."

1 Q [As read], "So what types of things then would it cover?"
2 A [As read], "It's covering things such as not sharing
3 patient information, again, at a corporate level and more
4 compliance driven. It is not HIPAA specific. It is related
5 to things such as the Stark Act and Anti-Kickback and those
6 type of things."
7 Q [As read], "So SMIS undertook to research certain aspects
8 of HIPAA and provide training to some of its employees on
9 those particular aspects of HIPAA; correct?"
10 A [As read], "Again, as I stated, it is more from an
11 overarching corporate standpoint, not in the practice of
12 medicine. We rely on the individual clinicians and their
13 education, along with the hospital, to provide such
14 trainings."
15 Q Turning over to page 72, line 24. [As read], "So SMIS
16 would have no specific knowledge one way or another whether
17 Rachel Ash-Bernal had received any specific training of the
18 do's and don'ts of HIPAA; is that fair?"
19 A Bill, that's not what's marked on mine.
20 MR. PADGET: Begging the Court's indulgence, Your
21 Honor.
22 THE COURT: Okay.
23 BY MR. PADGET:
24 Q I'll begin again. Page 72. [As read], "So SMIS would
25 have no specific knowledge one way or another whether Rachel

1 Ash-Bernal had received any specific training of the do's and
2 don'ts of HIPAA; is that fair?"
3 A [As read], "Through our -- depending on what, again, we
4 have credentialing systems with, within SMIS and what is
5 contained there. I cannot speak to the specifics of what is
6 contained there."
7 MR. PADGET: That's all, Your Honor.
8 THE COURT: All right. You can step down.
9 A Thank you.
10 THE COURT: All right. Plaintiff.
11 MR. HINSON: Plaintiff calls Debra Scheer.
12 Whereupon, Debra Scheer is called to the stand, duly
13 sworn by the clerk and testified as follows:
14 THE CLERK: Just say and spell your first and last name.
15 MS. SCHEER: First name is Debra, D-E-B-R-A, last is
16 Scheer, S-C-H-E-E-R.
17 DIRECT EXAMINATION
18 BY MR. HINSON:
19 Q Debbie, good afternoon.
20 A Hello.
21 Q Debbie, would you tell the jury just a little bit about
22 yourself?
23 A I am retired now, but I worked as -- I work in the school
24 system as a physical therapy assistant working with children
25 with a variety of physical disabilities.

1 Q And Debbie, where did you grow up?
2 A I grew up in a town called Haddon Township, New Jersey,
3 which is in southern New Jersey.
4 Q And when did you and your husband start coming to Horry
5 County approximately?
6 A I believe it -- gosh, the kids were young because my
7 sister and friends of ours had places down here. So we would
8 come down, you know, for little family vacations, and that was
9 probably, gosh, I don't know, 19 -- late 1990s.
10 Q Debbie, you heard me ask Dave a little bit ago about Matt
11 growing up. I want to hear mom's perspective. Tell us about
12 Matt growing up.
13 A You know, Matt growing up, you know, your first child
14 there's always all those, you know, all those firsts. He was
15 a very generous, gregarious kid, who was just involved in
16 everything. You know, he, goodhearted kid just involved in a
17 lot of things.
18 Q What, what's one memory you have of things Erik and Matt
19 liked to do?
20 A Make a fort.
21 Q Where would they make a fort?
22 A We had, any neighborhood that we lived in, there were
23 always lots of kids around. We sort of had the entertainment
24 house wherever we lived. Kids would gather in the house or in
25 the, in the cul-de-sac, you know. Riding bikes everywhere was

1 a big thing, whatever the current sport of the season was.
2 Q With the exception of epilepsy, was there any serious
3 illness or, or condition in Matt's medical history up until
4 October of '15?
5 A No. There was not, absolutely not.
6 Q When was Matt diagnosed with epilepsy?
7 A When he was born.
8 Q And how was it treated?
9 A He was on medication from day one. There were a couple
10 of times where they took him off, but then he went back on the
11 seizure medication.
12 Q Did he require the anti-seizure medication?
13 A Absolutely.
14 Q And what generally was the purpose of the medication?
15 A So there would not be a seizure.
16 Q Debbie, what happened first, October 1, 2015, that led
17 you to believe that Matt might be suffering from some sort of
18 mental illness?
19 MR. GRESH: Objection, Your Honor. May we approach?
20 THE COURT: Yes.
21 (Whereupon, a bench conference is held in the presence,
22 but out of the hearing of the jury.)
23 MR. GRESH: Thank you, Your Honor.
24 Q Ms. Scheer, was there some event or thing that prompted
25 you to become concerned about Matt's mental health on October

1st, 2015?

A I was going through -- I'm not a big Facebook person, and I wasn't one to comment on my kids' posts, but in looking something that Matthew had posted, it was really concerning because it was very dark, it was very odd. It was --

THE COURT: Don't go, don't go -- he's not asking to go into what it was.

A Oh, sorry.

THE COURT: Just was there, was there something that alerted you or caused you concern?

A I apologize. Yes. It caused me great concern.

Q Was it typical of Matt?

A Absolutely not.

Q Would it be typical of anybody in their right mind?

A Absolutely not.

Q And as a result of viewing this posting, what did you do?

A I contacted Matthew --

Q And how was --

A -- and asked -- go ahead.

Q Okay. And how was he acting?

A He -- we, we had a good conversation. He was fairly calm. We talked about the post and would he take that down.

Q And did he seem like himself to you?

A Then he did. Yes.

Q And then what happened later?

1 A So then the post came down and came back up again, and I
2 had phoned him and he was not talking quite rationally.
3 Q And did you consult with your husband about this?
4 A Yes. I did. I called Dave and said there's something up
5 with Matt and I asked Dave then to call him.
6 Q And from your interactions with Matt what did you and
7 Dave decide that was best for Matt?
8 A So that was when Dave decided, "I'm going to drive down,"
9 and I'm going to stay back. We had recently moved into a
10 smaller home. The place was not arranged. I said, "I will
11 see if we can get the room ready for Matt here," and in
12 addition, if he needs additional help, I was checking out
13 different facilities where he might be able to be treated if
14 that was needed.
15 Q And what happened next?
16 A Dave left. I'm sorry. Dave left that night to drive
17 down here to Myrtle Beach, and I stayed back starting to fix
18 things up and arrange things.
19 Q Approximately how, how far is that drive from you all's
20 home in New Jersey to, to Myrtle Beach, South Carolina?
21 A I only know by hours not by miles. So I know it's at
22 least like a -- it's generally like a ten mile [sic] drive
23 without traffic, without other conditions.
24 Q It's a ten, you said ten mile drive.
25 A I said ten miles. I meant 10 hours.

1 Q And without you said conditions?
2 A Without conditions.
3 Q What were the conditions at that time?
4 A So there was a storm down here in Myrtle, a storm coming
5 in. There were these rains. This Joaquin hurricane was
6 coming in and it was raining lots, you know. I know certain
7 areas were flooded.
8 Q Were you and Dave keeping in contact as, as he made the
9 journey on occasion?
10 A Yes. Yeah. We would, we would, you know, phone back and
11 forth. I knew as it got later because he left later and I,
12 you know, we were having conversations on and off.
13 Q And did Dave contact you when he got to South Carolina?
14 A Yes. He did.
15 Q And what was your understanding of your son's condition
16 when, when your husband got here?
17 A He told me, he said, "I have Matt here. I -- he's on the
18 couch, you know, he has a blanket on him, no clothes, but I'm
19 here and we're okay."
20 Q Did that alleviate you all's concern about his mental
21 condition?
22 A We still knew something was wrong, but felt a little
23 better because Dave was there, his father was there.
24 Q Why did Dave not -- why did you all decide not to bring
25 Matt back at that point?

1 A At that point in time we didn't feel Matt, from Dave's
2 assessment and hearing him, he was capable of taking that long
3 drive back knowing that something could happen, maybe Matt
4 would jump out of the car, maybe he would take the wheel,
5 maybe -- it didn't seem in Matt's best safety for him to drive
6 back that, at that time.
7 Q Earlier today, Ms. Scheer, we heard Dave tell about
8 taking Matt to Grand Strand and Lighthouse and back to, to
9 Grand Strand. Were you being kept informed as, as all of this
10 took place?
11 A Yes. He was calling me saying, "We're on our way to
12 there. We're in the ER. This is what they found out.
13 They're sending us to a facility in Conway and then they're
14 sending us back to Grand Strand." So yes, we were back-and-
15 forth.
16 Q And when Matt's finally admitted to the hospital as an
17 admitted patient, we heard Dave talk about going back to the
18 condo?
19 A Uh-huh.
20 Q And what was your understanding why Dave was going back
21 to the condo?
22 A Because he needed some sleep. He needed himself to be
23 safe to take care of his son, and he had to go back and get --
24 he was going back to also get like toiletry stuff for Matt,
25 you know, like deodorant, toothbrush, mouthwash, things like

1 that that he would need if he were to be in the hospital.
2 Q And did you and Dave at that time think that Matt was in
3 a safe place?
4 A Absolutely. We took our son. He was under the care. We
5 trusted the hospital and the doctors in the hospital.
6 Q And did you trust that if something happened with Matt
7 and some change in Matt, behavior that your husband would be
8 contacted?
9 A Absolutely, because he said -- we talked about signing
10 the form. He said, "Yes, I've signed the form." So that was
11 our -- that was the communication we had, absolutely.
12 Q Your understanding was that Dave had been made the
13 contact, the emergency contact?
14 A Yes.
15 Q At that point when Dave's come back to the condo, getting
16 the toiletries and getting clothes for Matthew, did you feel
17 that things were on the right path?
18 A Yes, knowing that Dave in the morning was going to go
19 back to the hospital and see what the plan was, see what, you
20 know, was he going to come back home and what were the
21 doctors.
22 Q And what was the next thing that happened, Debbie?
23 A So when Dave called me in the morning and he said, "I'm,
24 I'm going over to get Matt," I said, "I'm going to call him on
25 the phone," and I called and they answered and they said,

1 "Well, Matthew Scheer left at 1:30 in the morning," and I
2 freaked out and called Dave back and said, "He's gone, that he
3 -- they let him go."
4 Q And what was the next thing that you, that you -- your
5 next involvement in this?
6 A So at that point in time I had to get down to South -- I
7 had to get down to Myrtle. So I had to catch the first flight
8 out of there. We'll usually fly out of Atlantic City because
9 it's a really short flight, but I had to fly out of
10 Philadelphia. So I flew down. I, I absolutely forget what
11 time my flight was, but it was out of Philadelphia.
12 Q And when you arrived what was the state that you observed
13 of your husband, his --
14 A So I saw Dave. We met. You know, we cried, we cried and
15 he said, "We have to go to the police department. They have
16 something -- they have some information for us."
17 Q And what did, what did you observe in the police
18 department?
19 A So in the police department they told us they had found a
20 young man's -- a man's clothing that was matching the
21 descriptions of Matt's clothes, and they showed us the picture
22 of the clothes, I think I have that correct.
23 Q Did you recognize the clothes?
24 A I absolutely did because I bought them for him.
25 Q Where, where, where were the clothes from? You remember

1 --
2 A Excuse me.
3 Q You remember buying those particular clothes?
4 A Absolutely. I remember the underwear and the shorts.
5 Q Debbie, did you and Dave fly or drive back to New Jersey
6 eventually? How, how did you eventually get back to New
7 Jersey?
8 A Eventually, after, I forget how long we stayed down here,
9 five or six days. We -- then we drove back to New Jersey.
10 Q How was that drive? Can you tell us about that drive?
11 A It was a, a long drive, a long quiet drive just quiet
12 because we were both I just think contemplating what in the
13 world just happened.
14 Q Debbie, I want to just very briefly show you a few
15 pictures and just ask you to identify them so we can know
16 what, what we're looking at. This is Plaintiff's Nine(J).
17 Can you see that?
18 A I had come down to visit Matt before I went back to
19 school. It was in like mid-August, maybe the end of August,
20 and we went to Charleston, you know, and did the carriage ride
21 and whatnot. So that was him with the horse that was on our
22 carriage.
23 Q Kind of jump around in time. What about that one?
24 A And that would be your typical Matt picture with his arm
25 around his dad because Matt was the kind of guy was the first

1 one in the family to give you a big hug. Like you'd see him
2 and he'd just give you a big hug. He was a big hugger, kisser
3 guy.
4 Q How about that?
5 A That's from his high school graduation with a good friend
6 of his and that was, again, that's Charleston. I forget what
7 area that was but that was that same trip we had just about
8 the end of August when we went down to Charleston for the day.
9 Q This one?
10 A And that probably the last drink I had with him. We had
11 played golf and went to the Anchor Café. So that was the mom
12 and McGirt shot.
13 Q What's the McGirt shot?
14 A No. The picture I mean.
15 Q Oh, oh, McGirt meaning he's --
16 A That's what I meant McGirt, yeah.
17 Q Did you call him McGirt sometime?
18 A Yes.
19 Q Debbie, how has Matt's death impacted you? Can you tell
20 us some about that? I know you probably can't put it into
21 words, but to, to the best of your ability.
22 A It's changed our life totally. It will never be the same
23 again. You, you lose your firstborn child, you know, they
24 have just a different part in your heart because they're your
25 firstborn. You know, you remember all those firsts, the first

1 times they rolled over, the first time they talked, the first
2 time they rode a bike. So any of those firsts we'll never see
3 again. I am a person who dreams a lot. I have many, many,
4 many dreams about Matt, and in every dream I'm in the dream
5 and I go, "Oh, my gosh, you're back, you're back," and I wake
6 up in the dream and I go, "No. You're not here. You're
7 really not here." That pretty much happens once or twice a
8 week.
9 Dave and ours relationship has changed incredibly. We're
10 pretty active people. We entertain a lot. So we've found
11 that we have -- our friends have diminished somewhat. You
12 know, friends you have when your kids are younger I really
13 have a hard time, you know, talking to them. It's really
14 hard. It's hard to enjoy other people's joy because you have
15 so much sorrow. I -- we've had a hard time going to family
16 functions because my one niece has two, you know, young boys,
17 and it's just, it's hard. You know, our, our holidays have
18 become like, "It's Christmas, I don't really care." You know,
19 "Don't give me a card for Mother's Day." I don't want a card
20 on my birthday.
21 Q What changes have you observed in your husband?
22 A You know, by nature Dave's a Norwegian. They're pretty
23 stoic as it is, but, you know, I'm one if I'm upset I'll meet
24 with my friends and I'll talk about it. I know Dave keeps a
25 lot of things inside. You know, it's hard when you come home

1 and you hear your husband crying from the next room, but I
2 know that's his own personal, personal way of, of dealing with
3 that.
4 Q Have you -- are there things that you and Dave used to
5 specifically do that you don't do anymore?
6 A There are specifically things in the area. We have a
7 really hard time going to the movies because that -- Matt was
8 the movie guy. We'd go, "Okay, Matt, what movie did you see,"
9 you know. So we really haven't gone to the movies, and as we
10 were saying, we enjoyed a lot of things down in Myrtle, and
11 that place we just found that we were really unable to keep
12 without it being too emotional.
13 Q Debbie, are there things you worry about in the future as
14 a result of Matt's death?
15 A I do. I, you know, we're not getting any younger, and I
16 kind of -- I, I fear for -- not fear for Erik. I worry about
17 Erik because of, of the stress of aging parents, you know,
18 emotional stress, and you know how challenging it is to take
19 care of a parent if you're living in a different state. "What
20 am I going to do with my parents?" So I worry that can he
21 carry that burden without his brother.
22 Q When was the last time you saw Matt in person?
23 A The last time I saw Matt in person was when I left the
24 condo when I was down that time in August. I mean, we had
25 gone to the Anchor Café, came back and then I probably left

1 like the next morning. I guess I flew down. So I probably
2 left sometime in the nighttime, and he was like, you know,
3 "See you mom. See you next time later. Love you," because he
4 was also the big I love you guy.
5 Q How often would you and Matt talk on the phone?
6 A Matt and I would talk at least like once a week because
7 I would get all the gossip from him. He was the chatty
8 one.
9 Q What do you miss most about Matt?
10 A I miss his hugs. I miss his like he would call and say,
11 "Hey, mom, I, you know, I found this great new band. You have
12 to like listen to this playlist," or, you know, "Hey, mom, I
13 finally learned how to make a new drink. I think you're
14 really going to like it," or, "Mom, I found this recipe. I
15 think you should try it." I just miss him.
16 Q Thank you, Debbie. Please answer any questions Mr. Gresh
17 has.
18 MR. GRESH: No questions, Your Honor.
19 THE COURT: All right. You can step down.
20 MR. HINSON: The Plaintiff rests, Your Honor.
21 THE COURT: All right. Members of the jury panel, the
22 Plaintiff is telling us they have presented their evidence.
23 We've reached a point in the trial where I have to take up
24 some legal matters before we move to the next stage, which
25 would be the Defense having the right to present its evidence.

1 I'm told at the last break that we most likely will not go
2 into next week, that we -- looks like we're on track to finish
3 Friday. I say that with some caveat in case it changes, but
4 that's what I was told the last. So we'll see you back at
5 9:30 in the morning, and again, we've got some matters to take
6 up. We're going to, we're going to stop -- we're not going to
7 stop working now, but it will probably take us a good hour to
8 do what we've got to do and that will take us almost to five,
9 probably take us more than an hour, but anyway, we'll see you
10 back at 9:30.
11 Now, even though the Plaintiff is rested, you're not in a
12 position to discuss the case. We hadn't reached that point.
13 You're not to even try to make up your own mind. We haven't
14 reached that point. So we'll see you in the morning at 9:30.
15 (Whereupon, the following takes place outside the
16 presence of the jury.)
17 THE COURT: Anything from Plaintiff?
18 MR. HINSON: Nothing, Your Honor.
19 THE COURT: All right. Mr. Gresh.
20 MR. GRESH: Thank you, Your Honor. We are at the point
21 of the trial that the Plaintiff has rested their case, and I
22 come before Your Honor making motions for directed verdict.
23 Oftentimes I'll take this podium and say some things, I know
24 they're going to get denied, and I just have to do it
25 perfunctory.

1 Today I rise before you not saying something that's
2 perfunctory. I think there is some real issues here that
3 merit dismissal of Plaintiff's case entirely, and I would
4 start with the idea that this jury has been told that Matthew
5 Scheer died by suicide. Now, that is in over Defense
6 objection on the death certificate. I didn't want it in, but
7 I knew if it came in cases like Scott versus Greenville
8 Pharmacy or Crolley versus Habersham [sic - spelled
9 phonetically] have stood long time for the proposition that
10 suicide is an intervening cause, that even in a wrongful death
11 case will preclude recovery by the estate. The cases, there
12 was a recent case of Wickersham versus Ford Motor Company that
13 kind of went through this same argument and what the
14 Wickersham case and the Crolley case and the Scott case all
15 talk about is that suicide as a mechanism of death is so
16 multifactorial, the different things that go into it, that it
17 cannot be foreseen. What we have in this case is a lot of
18 testimony from different folks, experts and laypeople that
19 have talked about you should have maybe involuntarily
20 committed Matthew or otherwise, but when anybody asks the
21 question as I did to the Plaintiff's experts, "Is there
22 anything in this chart that would have told Dr. Patel or Dr.
23 Ash-Bernal that Matthew might run into the ocean and might
24 kill himself, going to exactly this suicide question, and the
25 Plaintiff's experts said no. That's the foreseeability link

1 that these cases talk about when you have a suicide case,
2 which is what this is, that's the problem with these types of
3 cases is a matter of law on these cases it cuts the causal
4 connection between the tort and the outcome.
5 You know, for instance, in the Scott versus Greenville
6 Pharmacy case 48 S.E.2d 324, Greenville Pharmacy wrongfully,
7 absolutely wrongfully prescribed and administered and gave
8 barbiturates to a kid, and the Plaintiff said the kid under
9 the influence of these barbiturates killed himself and that
10 that would've been foreseeable, a natural and probable
11 consequence of the drug overdose from the barbiturates, and
12 what our Court held is, no, that unfortunately suicide an
13 entity is so multifactorial that it can't be foreseen. Then
14 we had a similar discussion in the, in the Crolley case and in
15 the Wickersham case. Your Honor, I stand before you saying as
16 a matter of law generally when one takes all of the evidence
17 that has been presented from the witness stand and from the
18 documents, the conclusion is suicide, and suicide would
19 preclude any recovery in a wrongful death case, and so I think
20 as a matter of law, under those, under those cases, that ends
21 the discussion.
22 THE COURT: All right. Let me hear from Plaintiff on
23 that.
24 MR. GRESH: And Your Honor, just for the, just for the
25 sake of argument, there's obviously more motions, but I think

1 it's easier to take them one at a time if the Court would
2 indulge.
3 THE COURT: Yeah. And I, and if you have copies of those
4 cases I'd appreciate it. It might take me overnight to look
5 at them, but --
6 MR. GRESH: Yes. Your Honor, I will certainly -- I'll
7 print them out or email them. We'll get them, we'll get them
8 to the Court.
9 THE COURT: Don't email them. I don't have any -- I'm
10 not going to have any way to get emails down at the office, so
11 if you --
12 MR. GRESH: I'll, I'll bring them to, to Brink and Your
13 Honor today at the hotel. That's easy enough.
14 THE COURT: Okay. That's fine.
15 MR. HINSON: Your honor, I think there's a case that's
16 exactly on point and comparable, in fact, in many ways to the
17 case before you, and that is Bramlette versus Charter Medical-
18 Columbia, which is 302 S.C. 68. It's a Supreme Court case
19 from 1990, and there's two things that it talks about in
20 Bramlette. Bramlette is a patient with mental illness, the
21 same as this, and Bramlette is a patient with mental illness
22 who is admitted to an institution, and during the course of
23 the patient's time in the, the institution, I don't think this
24 patient's involuntarily committed either. He's -- comes
25 willingly to the, to the facility seeking treatment, and the

1 opportunity is created for this person to take their own life,
2 and he does, and a lawsuit ensues, and as far as the
3 foreseeable aspect, the case says, [As read], "Although
4 foreseeability of some injury from act or omission is a
5 prerequisite of establishing proximate cause, the Plaintiff
6 need not prove that the actor should have contemplated the
7 particular event which occurred. The Defendant may be held
8 liable for anything which appears to have been a natural and
9 probable consequence of his negligence," which is what we have
10 before you, Your Honor. It is a natural and probable
11 consequence of the negligence of allowing an actively
12 psychotic patient to leave at 1:30 in the morning. While you
13 may not know if he's going to jump out in front of a car,
14 while you may not know if he's going to jump off of a
15 building, while you may not know if he's going to go take a
16 gun and take it to a school and then put it on himself, it is
17 foreseeable that an actively psychotic patient with delusions
18 and who is hearing voices may cause some harm and may even
19 take his own life, and in the Bramlette case talking about
20 suicide it says, [As read], "This Court has recognized a cause
21 of action in negligence for breach of duty to prevent a known
22 suicidal patient from committing suicide." Now, Matthew
23 wasn't, quote, suicidal, but he was psychotic, and there's
24 been plenty of testimony that a psychotic patient who is
25 outside of his right mind may take his own life, not doing it

1 in a sense that he was -- he had depression and wanted to, but
2 would take his own life in -- as a result of his psychosis and
3 delusions, and it's, it's comparable, our Supreme Court has
4 said this -- when you, when you fail to protect the person
5 from injury to himself and you had a duty to do so, which a
6 physician who is the, the attending physician who discharges a
7 patient at 1:30 in the morning had a duty to prevent him from
8 harming himself, Your Honor, our Supreme Court has said that
9 it recognizes a cause of action in negligence just as this,
10 and that's the Bramlette case, and I don't think we need any
11 other cases beside that. I'll be happy to do some more
12 research, but I think Bramlette speaks for itself.
13 THE COURT: Well, do you, do you have a copy for me?
14 MR. HINSON: I did not expect to rest today, but I will
15 get you one promptly, Your Honor.
16 THE COURT: Okay. Just leave it at the desk.
17 MR. HINSON: Thank you. Yes, sir.
18 MR. GRESH: Your Honor, as a, as a second motion, I would
19 move for a directed verdict on the issue of entitlement to
20 punitive damages. The Plaintiff has pled in the complaint
21 that the actions of Dr. Patel and Dr. Ash-Bernal and, I guess,
22 Southern Myrtle were so willful and wanton such as the
23 imposition of punitive damages is warranted. As Your Honor
24 knows, they must prove entitlement to that by clear and
25 convincing evidence. What we have, taken in the light most

1 favorable to the non-movant, what we have in this case is
2 testimony that Dr. Ash-Bernal didn't do the right judgment.
3 This is a judgment call. There is no question that she
4 receives information from nursing staff that is concerning.
5 There's no disagreement that she looked at the chart. There's
6 no disagreement that she came to the bedside. There's no
7 disagreement that she talked to Matthew Scheer. There's no
8 disagreement that she wrote a note and that she certified that
9 he was ready to go. The Plaintiffs have said she did that
10 wrong. I understand that, but there's been no testimony that
11 said not only did she do that wrong but that was gross or
12 willful or she wanted this thing done or she was under the
13 influence or any of those types of things which would warrant
14 the imposition of punitive damages. As to Dr. Patel, I'm
15 still not sure what the allegations are against Dr. Patel. At
16 best -- I heard of none yesterday. What I heard today were
17 two things, one, that he didn't give a PRN order for Ativan,
18 thought about it, but didn't give it, and that there may not
19 have been a good handoff is what I heard today from Dr. Patel
20 to Dr. Ash-Bernal. Your Honor, again, taking that as even
21 truth, the question for this Court becomes has the Plaintiff
22 as a matter of law submitted enough testimony to those 12
23 folks that would allow them to even consider the idea that
24 those two folks deviated from the standard of care, maybe, but
25 warrant punitive damages against them the answer is no. There

1 just was no testimony about willful or wanton or gross conduct
2 or anything of the sort. Southern Myrtle is the other third
3 Defendant in this case who is respondeat superior, liable,
4 allegedly, for the conduct of Patel and Ash-Bernal. The thing
5 we heard yesterday is that they didn't do enough maybe in
6 their PowerPoints on HIPAA, but again, there's been no
7 testimony that, that they -- they did do training. Everybody
8 admits they did do training. Was the training such that it's
9 willful and wanton, they turned a blind eye towards HIPAA when
10 I've got 70 pages worth of a HIPAA PowerPoints that were
11 produced? Your Honor, I think that the Plaintiffs may have
12 submitted evidence of negligence, but have they submitted
13 sufficient evidence of willful and wanton conduct to get the
14 issue of punitive damages to the jury, I think it's
15 overwhelmingly they hadn't. This is a tough, tough judgment
16 call, and where they're going to have experts on one side,
17 Your Honor, tomorrow and the day after we're going to have
18 experts on the other side talking about how close this
19 judgment call is, but close judgment calls are not punitive
20 damages calls.
21 MR. HINSON: Your Honor, in response, and, and I'll be
22 happy to provide you the case law that says this, that
23 recklessness is a conscious failure to do something that is
24 incumbent upon one to do under the circumstances, and that's
25 what this case is about. It was incumbent upon Dr. Patel

1 under the circumstances, this is Plaintiff's allegation,
2 obviously, it was incumbent upon him to have a signout to the
3 next, the next physician. It was a -- and that was a
4 conscious failure. This was not an accident. He chose not to
5 pick up the phone or to have a face-to-face conversation, and
6 that, Your Honor, under our case law in South Carolina is
7 recklessness. Dr. Ash-Bernal chose, she made a conscious
8 failure to spend more time with Matthew to do, to do a proper
9 evaluation. It's not that she spent 50 minutes with him and
10 then ultimately made the wrong choice. She made a conscious
11 decision to spend a very short amount of time with him, and
12 that, Your Honor, could be -- the jury should have the
13 opportunity to consider that to be reckless, and I'll be happy
14 to get you the case law that says that a conscious failure to
15 do or not do what's incumbent under the circumstances is
16 recklessness.
17 THE COURT: I appreciate it. Thank you.
18 MR. GRESH: Now, no -- there was no -- I know Plaintiff
19 can allege that, and that's what their Plaintiff may very well
20 say, but somebody has got to take that stand and say, "You
21 know what, as I as an expert look at the conduct of Dr. Patel
22 that's a conscious failure on his part," and there simply
23 wasn't any of that. There wasn't somebody that took the stand
24 and said Dr. Ash-Bernal and going through and only spending
25 four minutes, five minutes, 15 minutes, whatever the time was,

1 there has to be evidence that says that is clear and
2 convincing, which is the standard, and that it rises to a
3 level of recklessness, willfulness and wantonness, and I think
4 in the absence -- my argument is in the absence of that
5 evidence from this witness stand, now that the Plaintiff has
6 rested their case, they no longer may rely upon what was pled
7 in a complaint. They've got to prove it here, and they
8 haven't done it, and so I think that's, that's the, that's the
9 motion that I was trying to make in front of Your Honor.
10 MR. HINSON: Your Honor, Mr. Gresh wants to have his cake
11 and eat it, too. We took the deposition of Dr. Kenneth
12 Scissors and we decided not to play it for time and, and for,
13 for everybody's sake I think we, we've proved our case,
14 nonetheless, but in Dr. Scissors' deposition, I asked him, "Do
15 you believe it," and we're speaking of the Defendants'
16 deviations, "do you believe it rose to the level of being
17 reckless?" Mr. Gresh objected and said calls for a legal
18 opinion and then when he -- we had our deposition
19 designations, his objection was that the question of
20 recklessness, Your Honor, was the province of the jury, and so
21 that's the position he took with me just a few days ago and
22 now he's coming before Your Honor saying the exact opposite.
23 I don't how to keep him happy when he's telling me that I
24 don't need to -- when he's telling me I don't need to have my
25 experts talk about recklessness, that's essentially what he

1 said when he objected to it, and now when I don't come in here
2 and talk about that because he objects to it, he's now
3 complaining that I didn't do it. He can't have it both ways,
4 Your Honor. He himself has said it falls into -- under the --
5 the, the question of recklessness falls under the province of
6 the jury and now he should not be allowed to come in here and
7 argue the other way around.
8 MR. GRESH: And I would have lost that objection. Right?
9 If they had called Dr. Scissors to the stand and they -- and
10 we would have had a discussion with Your Honor and he would
11 have tried to play that and I say you can't do that and I
12 would have lost that objection. The jury needs something to
13 hang their hat on. This is beyond the ken of the average
14 layperson. The average layperson all they've heard right now
15 is judgment, judgment, judgment, judgment call. Okay.
16 There's been no testimony that said not only is this a
17 judgment call that was not done appropriately, this one's not
18 close. This is something that we ought to punish Dr. Ash-
19 Bernal for to prevent conduct like this in the future. That
20 wasn't asked. No -- there's been no testimony. To allow a
21 jury to simply say, "You know, what, from what I've heard that
22 sounds like something we should punish," it just allows them
23 to speculate, and so, this deposition of Dr. Scissors wasn't
24 played. There is no testimony from anybody on the witness
25 stand that would allow them to link up this punitive damages

1 claim, and I, in fact, that's the reason I'm moving to have
2 that part of the allegations against the Defendants stricken.
3 THE COURT: All right.
4 MR. HINSON: Your Honor, I stand on my prior comment you
5 can't have it both ways. You can't be objecting to it as, as
6 something that falls under the province of the jury and then
7 when I leave it to the province of the jury say that I -- we
8 needed expert testimony. The question of recklessness is a
9 question for the jury to determine. There's, there's adequate
10 evidence in this, this, in, in this case that there was a
11 conscious failure to do the right thing, and, and that should
12 go to the jury whether or not they determine recklessness.
13 This is not an issue or, or gross negligence. These -- to the
14 -- the question of gross negligence is a jury question. It's
15 not something that falls under the and, and what's typically
16 brought from an expert. The jury decides if there's gross
17 negligence in this case, and we'd submit it should go to the
18 jury.
19 THE COURT: All right. Anything further?
20 MR. GRESH: Yes, Your Honor. As to Dr. Patel, today we
21 heard from a psychiatrist that there were two allegations on
22 the standard of care: one, failure to order Ativan PRN, and
23 the handoff issue between Dr. Patel and Dr. Ash-Bernal. Those
24 claims against Dr. Patel fail as a matter of law due to a lack
25 of proximate cause testimony. Nobody, you know, they have two

1 experts, Dr. Robinson and Dr. Malone, both testified that the
2 nurses could have asked for Ativan if they wanted. They
3 didn't. The nurses could have asked Dr. Ash-Bernal for Ativan
4 if they wanted it and didn't, and they both said it is
5 entirely appropriate for the nurses to go get Dr. Ash-Bernal
6 to come evaluate this patient. Nobody said Matthew Scheer
7 would be here but for Dr. Patel's decision not to order PRN
8 Ativan. Okay. There's a legal cause, and but for cause and
9 neither one of them are met as to Dr. Patel. There's too many
10 people that are intervening in between those times who didn't
11 ask for it, didn't desire it or give it or try and give it and
12 somehow been precluded from giving it. All this is is a
13 criticism to which no proximate cause testimony is attached.
14 In order for the issue of Dr. Patel's negligence to get to the
15 jury, one must have both pieces, and I can't, you know, I, I
16 took copious notes, and I know Your Honor did and I know
17 Plaintiff's counsel did looking for somebody to link up a PRN
18 or as needed order of Ativan to causing the death, and nobody
19 said it, and as to the issue of the handoff, this one's even
20 more odd. What we heard from the stand was you had to tell
21 Dr. Ash-Bernal of patient is here with a psychosis. All
22 right. Well, because I guess the theory goes if you had told
23 Dr. Ash-Bernal that the patient had psychosis then what?
24 Plaintiffs have to establish that something different would
25 have happened. Okay. There's been no testimony that had Dr.

1 Ash-Bernal only known the patient's chief complaint the
2 outcome would have been different. Instead, the opposite
3 happens. Of course, Dr. Ash-Bernal knows the patient's here
4 with psychosis. The testimony elicited during the Plaintiff's
5 case is that she looked at the chart before going in to talk
6 to the patient. She talked to the nursing staff before going
7 in and talking to the patient. We have two very tenuous
8 allegations against Dr. Patel, but neither one of them are
9 linked up by way of expert testimony to causing the outcome.
10 This is a case where the Plaintiff alleges that Dr. Ash-Bernal
11 shouldn't have let the patient go at 1:30. This is not a case
12 that back at 5:30 p.m. something Dr. Patel did or didn't do
13 could have changed that outcome. That testimony, whatever the
14 standard of care allegations, that testimony that the outcome
15 would have been different is wholly missing at this point in
16 the case as to Dr. Patel, and so for that reason we would move
17 for a directed verdict as to Dr. Patel for a lack of proximate
18 cause testimony.
19 MR. PADGET: Your Honor, I suppose I'll address this one.
20 We start with the proposition, we start with the proposition
21 that proximate cause is typically a question from the jury.
22 There's hundreds of cases that, that say that in our case law.
23 There is testimony today from Dr. Malone elicited by Mr.
24 Hinson where after he described the breaches of the standard
25 of care by Dr. Patel, which were twofold, as, as Mr. Gresh has

1 indicated, the failure to enter that order to give the anti-
2 agitation medication, even though he noted that it was proper
3 but failed to enter the order to empower the nurses to do so,
4 and also the failure to do a proper handoff communication with
5 Dr. Ash-Bernal when she came on shift later that day. Dr.
6 Malone also testified, most importantly, that just like the
7 vast majority of patients that he has treated with this type
8 of psychosis and with this type of mental illness, that had
9 Matthew Scheer received proper care and treatment he would
10 have remained safely in the hospital. He also testified that
11 the vast majority of patients like Matthew Scheer who have
12 this type of psychosis who receive proper treatment under the
13 standard of care can go on to live long, happy, productive
14 lives, and that's all that our laws require, Your Honor, in
15 order to get -- submit this issue to the jury. Again,
16 starting from the, the proposition that it is a jury question,
17 and the last point I would make is that there are many cases,
18 too, that indicate where you have joint tortfeasors, where
19 you've got more than one alleged actor has committed a
20 wrongful act, that those acts can combine to cause injury and
21 result in, result in an injury, and that's exactly what we
22 have here. Your Honor, we've got testimony there's two
23 physicians that were negligent in this particular case and
24 that that particular action, their failures in communication
25 and also their failures to do certain things and Drs. -- I

1 don't believe there's any motion pending with regard to Dr.
2 Ash-Bernal, but those two actions, the actions by each
3 physician combined as joint tortfeasors to result in a
4 singular injury, and that is Matthew Scheer's death. So for
5 those reasons, Your Honor, we'd ask that the motion for
6 directed verdict be denied.
7 MR. GRESH: Just real briefly on that, the last point.
8 When Dr. Malone tried to testify just generalities that was
9 all speculative and we stopped him from doing that because
10 what he had to say, doesn't have to use these magic words, but
11 what he has to say, essentially to a reasonable degree of
12 medical certainty that whatever Dr. Patel did caused the
13 injury and he didn't. He said, "Sometimes when I talk to
14 folks the majority of them will, will walk out of here just
15 fine." What that means is that some of them don't. Okay.
16 The jury can't be left to speculate, "Well, is this one of
17 those where, where if they had done everything Matthew Scheer
18 would have walked out or is this one of those things where
19 they do everything they can and the patient doesn't." It
20 can't be left to speculate as to that. Somebody's got to take
21 that stand and say, "I know the answer based upon 30 years of
22 education, training and experience and as a board-certified
23 psychiatrist I can tell you to a reasonable degree of medical
24 certainty that had Dr. X done Y the outcome would have been
25 different," and that's what we don't have as to Dr. Patel.

1 This has got nothing to do with Ativan. This has got nothing
2 to do with the handoff, and nobody tried to link up. They
3 didn't even try to link up the handoff or the Ativan with the
4 later disappearance of his checking themself out AMA.
5 THE COURT: All right. Next.
6 MR. GRESH: Thank you, Your Honor. The -- at this time I
7 would also move for a directed verdict on the issue of
8 corporate negligence for Southern Myrtle Inpatient Services.
9 At the time the testimony was elicited from, I believe it was
10 Dr. Robinson, the first witness for the Plaintiff, he says
11 that the Southern Myrtle did not do enough in its
12 PowerPointing to educate the physicians on HIPAA as a matter
13 of law. At the time -- before that information was adduced at
14 trial, I objected, and I said this is not pled in the
15 complaint, training on discharge is pled, but there is no
16 pleading about training on HIPAA law. It's just not pled.
17 They didn't plead it. I thought maybe it could have been kept
18 out. It wasn't, but even once it got into the case, what he
19 said and what everybody said is that it's not the employer's
20 job to be the all, end-all, be-all and tell everybody that
21 this is what they need to know, that it comes from the
22 hospital, that it comes from general education. Okay?
23 Somebody had to say Southern Myrtle, but for their failure to
24 have more slides in their PowerPoint, Matthew Scheer would be
25 alive. Who came in and said, "To a reasonable degree of

1 medical certainty that based on the testimony that I reviewed
2 and the evidence before me that not only was it a breach of
3 standard of care to not include more slides in the PowerPoint,
4 but also had they been there Matthew would be alive," and
5 that's testimony that we just don't have. We have testimony
6 about, you know, did they comply with HIPAA or not comply with
7 HIPAA, but you got to go back to Southern Myrtle because this
8 is not against Dr. Ash-Bernal. This is against Dr. or, excuse
9 me, Southern Myrtle Inpatient Services as a corporate
10 Defendant that somehow they, and laying aside their potential
11 respondeat superior liability, that they also had a duty and
12 that they also breached that duty and the breach of that duty
13 caused this, this, this outcome, and there was, again, a lack
14 of proximate cause testimony on that point as well.
15 THE COURT: All right. Plaintiff.
16 MR. PADGET: Judge, with regard to the corporate
17 liability, first of all, Dr. Robinson did plainly testify that
18 not only does -- this was actually in cross, too, by the way,
19 a medical entity like the many he's worked for over the years
20 has a duty and obligation to train its physicians regarding
21 HIPAA do's and don'ts, and he also testified in direct that
22 based upon the information provided by Southern Myrtle
23 Inpatient Services in discovery, that they failed to properly
24 train their physicians on the do's and don'ts because they
25 only trade them -- train them on the don'ts and not any of the

1 do's, particularly with regard to the scope of permitted
2 disclosures of medical information in these types of
3 circumstances. That was his testimony.
4 Today, we read, as well, from the 30(B)(6) deposition of
5 Southern Myrtle, and we read that Southern Myrtle -- we asked,
6 "Did Southern Myrtle Inpatient Services undertake to educate
7 their physicians on what HIPAA does and does not allow?" And
8 the answer was, "No, we rely on each individual's physician's
9 education as well as the hospital's policies and procedures."
10 So the answer was, "No, they do not undertake to educate their
11 physicians on HIPAA." Dr. Robinson says the entities have a
12 duty and obligation to do so and they failed to do so, and in
13 this case they admittedly failed to do so according to their
14 own 30(B)(6) witness's testimony. Now, with regard to the
15 proximate cause element as to the corporate Defendant, had Dr.
16 -- the issue before the jury is had Dr. Ash-Bernal and Dr.
17 Patel, particularly Ash-Bernal in this case, in this factual
18 circumstance, had she been properly trained on HIPAA and been
19 informed about those laws and her ability to contact Matthew's
20 father in that situation, had she been properly trained it is
21 certainly more likely than not that she could have contacted
22 and known that she had the ability to contact Matthew's
23 father. She testified via video that she did not believe she
24 could do so because he -- because Matthew told her or told the
25 nurses specifically that he did not want to speak to his

1 father, which is a complete misunderstanding of the HIPAA
2 provisions, and so, Your Honor, there is a -- and certainly
3 it's a -- within the jury's province. This is not medical
4 expert testimony that's needed had Matthew [sic] Scheer been
5 contacted as the emergency contact for Matthew he'd come to
6 the hospital, and just as he had in the days prior could've
7 made sure his son was safe until he received proper treatment.
8 That is not speculation. That is just common sense that had
9 he gotten a phone call in that situation that he would've come
10 to help his son and that this tragedy could have been avoided.
11 So for those reasons, Your Honor, we'd ask this directed
12 verdict motion be denied.
13 MR. GRESH: Real quick on that point, it is not enough to
14 have a hospitalist say a corporation needs to train on do's
15 and don'ts, not just don'ts. Okay. Because let's think about
16 that, somebody has to say that Southern Myrtle had an
17 obligation to tell Dr. Ash-Bernal do this particular thing,
18 not just anything, this particular thing, to call a dad if you
19 have somebody that has -- you think may be incapacitated.
20 THE COURT: Well, not that particular thing, but that
21 specie of thing.
22 MR. GRESH: Yeah. But it -- but this is a training
23 issue, right, and so the issue is I can't just generally train
24 on HIPAA, is the allegation is I had to have trained on a
25 particular point in HIPAA, that if I had trained on that point

1 that Dr. Ash-Bernal would have known that point and would have
2 been allowed to do it. All we have is general do's and
3 don'ts. Somebody has to say what the do is. You have to
4 identify the duty, what was the duty on Southern Myrtle. You
5 know, generalized duty testimony you have to include not just
6 don'ts under HIPAA but also do's. Dr. Robinson did not say in
7 an -- "I, in my expert capacity Southern Myrtle Inpatient
8 Services must include in its HIPAA training the situation
9 where you have a patient who maybe by reason of mental illness
10 has already given you an emergency contact but now they've
11 revoked it, what do you do." Right. There was none of that
12 do testimony elicited from the witness. It was just a
13 generalized you have to -- you can't -- it's not enough just
14 to do don'ts. You have to also do do's. He didn't identify
15 the do, and then didn't identify how that would have changed
16 the outcome, and I think you need both sides of this. You need
17 both the standard of care, identification of the duty, and
18 then expert testimony that the breach of that duty proximately
19 caused injury, and that's, that's what we're missing.
20 THE COURT: All right. Yes, sir.
21 MR. PADGET: Your Honor, I'm happy to respond if
22 necessary, but I stand by what we previously said which is the
23 fact it was in cross where it came across most clearly where
24 Dr. Robinson testified that, that medical corporate entities
25 have an obligation to inform their physicians about the

1 permissible disclosures. That was his testimony, and I know
2 Mr. Gresh has some concerns about a doctor's competency to
3 testify to that, but I'm not sure who else in the world other
4 than a, than a physician who practices with those entities and
5 who trains other employees within those entities on these
6 permissible disclosures would be any better to testify about
7 those things. The do's, the do's and don'ts, the do's were on
8 the permissible disclosures, that you can contact a family
9 member in the event you have what is exactly written in the
10 hospital's policies, which is an exhibit to this, in a
11 situation where, and that is a permitted disclosure, where it
12 is a person or persons are able to prevent or lessen a serious
13 threat to health or safety, and that is exactly what this case
14 is about. The, the entity also recognized in the 30(B)(6)
15 deposition that we read that they expect their physicians to
16 follow these policies, and so Dr. Ash-Bernal there's
17 sufficient evidence before that, that she did not follow these
18 policies, and for that reason that establishes the duty
19 element, the breach element, and then with regard to proximate
20 cause, again, we're just talking about whether or not the
21 father was contacted if this tragedy could have been avoided
22 and, and all the evidence would indicate certainly that it
23 would have, that he could have come to the hospital and, and
24 taken care of Matt the same way he did in the days prior.
25 Again, we'd ask it be denied, Your Honor.

1 THE COURT: All right. That it?
2 MR. GRESH: Yeah. Your Honor, just to make sure that the
3 one I did initially, the foreseeability, I think would also
4 apply to Dr. Ash-Bernal. Right. I just want to make sure the
5 record's real clear here, when you look at the, the chart at
6 every step of the way it is no homicidal ideation, no suicidal
7 ideations. There are like 10 or 15 instances of that in the
8 chart, and he left, and the testimony is that he don't think
9 he really committed suicide, that he went out and just like in
10 some purification event and just washed all the way into the
11 ocean. It has to be foreseeable, and it's -- there's just
12 really and I just wanted to kind of reiterate just for the
13 record make sure I started out generally but especially as to
14 her as well there has to be some testimony that he would walk
15 out based on the, the things that he had told her in the
16 hospital, was recorded in the chart that somehow his death
17 could have been foreseeable, and there just really isn't any
18 testimony to that, to that effect. So I just want to make
19 sure the record was clear on that.
20 THE COURT: Okay.
21 MR. HINSON: Your Honor, I just briefly want to say I
22 think there has been so much testimony in this case that if
23 you allow a psychotic patient who's an actually psychotic
24 patient to leave the hospital that the danger is that they
25 will harm themselves or others and that has been repeated

1 borderline ad nauseam in this, in the Plaintiff's
2 presentation. So I, I disagree with Mr. Gresh's --
3 MR. GRESH: And I think that, that illuminates my exact
4 point. This isn't enough to say there's a generalized danger
5 of letting folks go. We have a statute directly on point, A, B
6 and C -- will you pull that up for me -- that talks about you
7 have to, for physical harm to yourself, you have to manifest a
8 plan to kill yourself. There's none of that. Under harm to
9 others, you have to manifest a plan by evidence of intending
10 to harm others, and there's just none of that. There is no
11 evidence manifested anywhere from the testimony of anybody
12 that said Matthew had those kind of things. What they're
13 trying to hang their hat on is this just generalized third
14 one, which if I put my goggles on real quick, Your Honor, two
15 seconds, Your Honor, because this is as a matter of law we
16 define likelihood of serious harm means that because of mental
17 illness there is, A, a substantial risk of physical harm to
18 the person themself as manifested by evidence of threats or
19 attempts at suicide or bodily harm. Not a single witness took
20 the stand and said, "I find that there are evidence or
21 attempts at suicide." It's not there. B, a substantial risk
22 of physical harm to other persons as manifested by evidence of
23 homicidal or violent behavior and a serious harm to them.
24 Nobody took the stand and said here's the evidence of
25 homicide, a homicidal plan. C says a very substantial risk of

1 physical impairment or injury to the person themself
2 manifested by evidence that the person is gravely disabled and
3 that reasonable provision for the person's protection is not
4 available in the community. That's the standard. These folks
5 can take the stand and try and make up whatever standard they
6 want, but Your Honor is going to charge this jury as a matter
7 of law that they are not able, you cannot hold Dr. Ash-Bernal
8 or Patel liable for not involuntarily committing somebody
9 unless it falls under one of these three things. Everybody's
10 talked about we are a free society and very rarely you go with
11 either A, B or C, "I can imprison you." They had to have done
12 that. One of them didn't even know the law. The other one
13 just says if you're psychotic we can lock you up. That's not
14 the law. You have to have evidence that the person is going
15 to do this, and they got to cite to something. What's the
16 evidence that they can cite to? It's not just grandiose
17 delusions or anything like that. There's got to be some
18 evidence that would put folks on notice that they can't let
19 them go, and nobody connected up using the law as it pertains
20 in this state to the conduct from Dr. Ash-Bernal. They tried
21 to come up with their own standard and they just didn't
22 follow, didn't follow along in that regard.
23 THE COURT: All right. Would you provide me with a copy
24 of the statute, too?
25 MR. GRESH: I shall, Your Honor.

1 MR. HINSON: We got one.
2 THE COURT: Oh, okay.
3 MR. PADGET: I'd be happy to hand it up, Your Honor.
4 THE COURT: Yeah. That's fine. I, I don't -- can I keep
5 it?
6 MR. PADGET: Yes, Your Honor. We'll print out another one.
7 MR. GRESH: Both parts?
8 MR. PADGET: It's the definition section.
9 MR. GRESH: Where, oh, where it defines substantial harm.
10 MR. PADGET: It's all there.
11 MR. GRESH: Yeah. That's what I was arguing.
12 THE COURT: Section 13, likelihood of serious harm.
13 MR. PADGET: Yes, sir.
14 MR. GRESH: That's right.
15 MR. HINSON: Your Honor, if I could also hand up one more
16 statute which is 44-66-20 which is -- defines unable to
17 consent because what Mr. Gresh conveniently leaves out is that
18 in addition other parts of Plaintiff's case is that Matthew
19 Scheer didn't have the ability to consent to this AMA form,
20 and I'd just like to hand up the statute on what his, what
21 mental status he had to have per our law to consent to the AMA
22 form.
23 THE COURT: All right. Well, I'll take a look at this
24 tonight, and you'll have requests to charge in the morning for
25 me and verdict forms.

1 MR. HINSON: Yes, Your Honor.
2 THE COURT: I think, I think that's all I need other than
3 having some stuff to look at tonight.
4 MR. HINSON: Yes, Your Honor.
5 MR. GRESH: Your Honor, I think that would conclude the
6 directed verdict motions. Before the Defense begins its case
7 there is one other housekeeping matter. The Plaintiff had
8 moved to exclude the picture of Matthew, then and the father
9 testified today that he deleted a picture or pictures after he
10 got the cell phone. I just want to know the Court's ruling on
11 that. Can I call a cell phone forensics person who will
12 testify that in January after the disappearance of Matthew
13 somebody went in and deleted this picture?
14 THE COURT: What's the relevance? I still haven't quite
15 seen the relevance.
16 MR. GRESH: The --
17 THE COURT: I know you -- we've talked about maybe as
18 impeachment of, of Mr. Scheer.
19 MR. GRESH: Your Honor, I, I --
20 THE COURT: But I -- he didn't -- he testified that
21 there, there was some wiping of the telephone.
22 MR. HINSON: And I thought Mr. Gresh had said that if Mr.
23 Scheer takes the stand and admits that he deleted a picture
24 of, of -- that that was the end of the issue.
25 THE COURT: That --

1 MR. GRESH: And I thought it was going to have to be that
2 picture.
3 THE COURT: That was sort of what I heard, but --
4 MR. GRESH: Okay. Well, then I'll withdraw it, I mean,
5 if that's, if that's what I said.
6 THE COURT: No. I don't want you to withdraw it. If you
7 feel like, I mean, that's just what I heard -- remember
8 hearing, but --
9 MR. GRESH: I thought it was if he had said, "This is the
10 picture that I deleted," and I would just kind of take it
11 down, but what I heard was he didn't -- deleted a picture or
12 pictures.
13 MR. HINSON: That he said that, that he realized Matthew
14 did not want to see, that they were private pictures. I think
15 it got out the idea that the pictures at issue here were never
16 intended to be seen by Matthew's father and -- or any member
17 of his family.
18 THE COURT: Well, in any event, I, I -- you're
19 withdrawing it, but on the -- well, I, I won't -- I don't need
20 to make an alternative ruling then. All right. Well, if you
21 all will get those to me I'll start looking at them tonight,
22 and --
23 MR. GRESH: Your Honor, I promised to bring you copies of
24 case law, but I don't know where you're staying.
25 THE COURT: Staying at the Comfort Suites downstairs from

1 them.
2 MR. GRESH: Is that -- okay.
3 THE COURT: Where are you all staying?
4 MR. GRESH: We're over in Myrtle Beach.
5 THE COURT: Oh, okay.
6 MR. GRESH: You all are here in Conway?
7 THE COURT: Yeah.
8 MR. GRESH: I'll work it out with Brink, and we'll, we'll
9 get everything we need to you.
10 THE COURT: Yeah. Maybe you could fax it to him and
11 then, I mean, fax, nobody faxes anymore, email it to him and
12 he can print them out because he's right upstairs.
13 MR. GRESH: That'll be fantastic.
14 MR. HINSON: Jack, yeah, I have a printer at my hotel
15 room. If you can let me know but please don't send them at 2
16 a.m. but I'll be happy to.
17 THE COURT: No. I, I won't be up at 2 a.m.
18 MR. HINSON: We'll be happy to -- we'll -- I'll
19 coordinate with Defense counsel, Your Honor. We'll --
20 MR. GRESH: Thank you, Your Honor.
21 MS. SPEARS: Thank you.
22 MR. GRESH: 9:30 in the morning?
23 THE COURT: 9:30 in the morning.
24 MS. SPEARS: Thank you.
25 (Adjourned for day.)

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF HORRY) 2017-CP-26-1571

David L. Scheer, as Personal Representative of the Estate of Matthew J. Scheer,	)	
Plaintiff,	)	
versus	)	May 20-24, 2019
Southern Myrtle Inpatient Services, LLC, Nirlep A. Patel, M.D., and Rachel Ash-Bernal, M.D.,	)	VOLUME II
Defendants.	)	

B E F O R E:

Honorable John C. Hayes, III
Horry County Courthouse
Conway, South Carolina

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

Francis M. Hinson, IV, Esquire
William R. Padget, Esquire
Attorneys for Plaintiff

Jack G. Gresh, Esquire
Lauren V. Spears, Esquire
Attorneys for Defendants

Grace L. Hurley, CVR-CM-M
Circuit Court Reporter

1 I N D E X

2 **(May 20, 2019.)**
3 Motions. 5
4 Voir Dire. 47
5 Jury Selection 62
6 Opening Instructions by the Court. 64
7 Opening by Mr. Hinson. 69
8 Opening by Ms. Spears. 92
9 **(May 21, 2019.)**
10 Robert Robinson
11 Direct by Mr. Hinson 116
12 Cross by Mr. Gresh 174
13 Redirect by Mr. Hinson 210
14 Video Deposition of Rachel Ash-Bernal. 221
15 Video Deposition of Gregory Pheabus. 224
16 **(May 22, 2019.)**
17 Duane Doherty
18 Direct by Mr. Hinson 232
19 Cross by Mr. Gresh 239
20 Redirect by Mr. Hinson 242
21 Timothy Malone
22 Direct by Mr. Hinson 244
23 Cross by Mr. Gresh 281
24 Redirect by Mr. Hinson 313
25 David Scheer

1 Direct by Mr. Hinson 324
2 Cross by Mr. Gresh 359
3 Redirect by Mr. Hinson 366
4 Erik Scheer
5 Direct by Padget 367
6 30(B)(6) Deposition Published. 377
7 Debra Scheer
8 Direct by Mr. Hinson 386
9 Motions. 400
10 **(May 23, 2019.)**
11 Motions. 429
12 Nirlep Patel
13 Direct by Ms. Spears 437
14 Cross by Mr. Padget. 460
15 Redirect by Ms. Spears 497
16 Rachel Ash-Bernal
17 Direct by Mr. Gresh 499
18 Cross by Mr. Hinson. 542
19 Redirect by Mr. Gresh. 581
20 Oscar F. Lovelace, Jr.
21 Direct by Mr. Gresh 584
22 Exam Re: Qualifications by Mr. Hinson. 588
23 Direct Continued by Mr. Gresh. 591
24 Cross by Mr. Hinson. 617
25 Redirect by Mr. Gresh. 623

1 Motions. 625
2 **(May 24, 2019.)**
3 James Ballenger
4 Direct by Mr. Gresh 633
5 Cross by Mr. Padget. 661
6 Redirect by Mr. Gresh. 684
7 Motions. 687
8 Closing Argument by Mr. Hinson 691
9 Closing Argument by Mr. Gresh. 734
10 Reply by Mr. Hinson. 761
11 Charge 765
12 Questions from Jury. 790
13 Allen Charge 806
14 Questions from Jury. 808
15 Verdict. 812
16 Closing - Punitives. 815
17 Charge - Punitives 821
18 Verdict - Punitives. 827
19 Certificate. 830
20
21
22
23
24
25

1 Plaintiff's Exhibits

2 P-1 Medical Records -- Grand Strand

3 P-2 Lighthouse Records

4 P-3 Transfer Records

5 P-4 Death Certificate

6 P-5 Notice of Privacy

7 P-6 Informed Consent

8 P-7 DHHS Letter

9 P-8 Application for Involuntary Emergency

10 P-9 A through L -- Photographs

11 P-10 MBPD Activities

12 Defendants' Exhibits

13 D-1 Medical Records

14 Court's Exhibits

15 C-1 Photograph of Matthew Scheer

16 C-2 Plaintiff and Defendant Voir Dire

17 C-3 Deposition of Dr. Ash-Bernal

18 C-4 Deposition of Gregory Phaebus

19 C-5 Deposition of Robert Robinson, III, M.D.

20 C-6 Deposition of James Ballenger, M.D.

21 C-7 Habit Charge

22 C-8 Question from Jury Re: Negligence

23 C-9 Question from Jury Re: Right to Hold

24 C-10 Question from Jury Re: Charges

25 C-11 Note from Jury Re: We want to stay

1 C-12 Question from Jury Re: Not unanimous

2 C-13 Question from Jury Re: Zero percent

3 C-14 Charge

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 (On the record, May 23, 2019. The following takes place
2 outside the presence of the jury.)
3 THE COURT: Good morning. I had asked for requests to
4 charge and verdict forms.
5 MR. HINSON: Yes, Your Honor.
6 THE COURT: All right.
7 MR. HINSON: We both, both have them. We, we have
8 exchanged them. We have some -- well, I haven't yet seen
9 Defense requests to charge, but I have seen the proposed
10 verdict form from the Defense.
11 THE COURT: All right. Now, I asked that you all give me
12 a complete charge since I don't have a law clerk. Remember
13 that.
14 MR. GRESH: Yeah.
15 MR. HINSON: Yeah. Yes, sir. May I approach?
16 THE COURT: Okay. Yeah, and we'll, we'll -- I'll look at
17 it today and tomorrow and then we'll fine tune it in the
18 morning as far as --
19 MR. HINSON: All right. And Your Honor, Plaintiffs had
20 two proposed verdict forms. They are identical. Other than
21 for your discretion the first question is worded a little bit
22 differently.
23 THE COURT: Okay.
24 MR. GRESH: Your Honor, if I could approach. Here's the
25 Defense verdict form that I already objected. I know it's my

1 own, but --

2 THE COURT: Okay.

3 MR. GRESH: We'll -- I'm sure we're going to talk about

4 it today, whether there's one beneficiary for purposes of a

5 cap for an estate or because it's a husband and a wife is

6 there two. I've seen an order from Your Honor, and I believe

7 I know how that's going to turn out.

8 THE COURT: I can't remember it, but I --

9 MR. GRESH: Good. Good. Then I won't, then I won't

10 prejudice myself.

11 THE COURT: Well, it --

12 MR. GRESH: But I would just say that it -- this makes an

13 assumption that I believe is the wrong one but if it -- we can

14 certainly talk about it.

15 THE COURT: Okay.

16 MR. GRESH: I just don't want it to look like I stipulate

17 to that, and Your Honor, here's a request to charge that I

18 gave to the Plaintiff's counsel. I'm waiting on one more

19 charge.

20 THE COURT: Okay.

21 MR. GRESH: So this -- I believe this is 95 percent

22 complete, and as I get that one I will supplement that. I

23 believe, you know, our law clerk clerked for Judge Hughston

24 and he says that's the -- what he's always done. So I hope it

25 has everything in there.

1 THE COURT: Okay.
2 MR. GRESH: At least a good starting point.
3 THE COURT: All right. Anything else before I rule on
4 the directed verdict motions?
5 MR. HINSON: From the Plaintiff, Your Honor, yesterday
6 and this is, this is on me without a doubt, I did not ask
7 David and Debbie Scheer while they were on the stand for their
8 birthdays, and I think that their statutory life expectancy is
9 relevant for the consideration by the jury of the amount of
10 pain, suffering and grief that they will have. The number of
11 years they are expected to live is pertinent to the degree of
12 pain, suffering and grief, and Your Honor, I would either ask,
13 one, to just briefly be able to reopen the evidence to ask
14 them one question, which is what is your birthday or, Your
15 Honor, I'd ask that the Court take judicial notice of their
16 birthdays.
17 THE COURT: Well, I can't take judicial notice of it, but
18 would Defense stipulate to it?
19 MR. GRESH: Your Honor, I can't, and, and only for this
20 reason what I think is going to happen with that evidence is
21 that there will be a birthday that is produced, there will be
22 probably a jury charge from Your Honor about statutory life
23 expectancy, there will be a mathematical calculation about
24 here's how long and then in their closing argument the
25 Plaintiff will, will get up there and say, you know, for the

1 next 24.7 years here and 25.4 years here, you know, let's get
2 a, you know, a thousand dollars a day or something along those
3 lines. I would not be zealously advocating for my client if I
4 said this -- Plaintiffs can open up --
5 THE COURT: All right. Well, I'll, I'll allow them to
6 reopen the case just for the one question.
7 MR. GRESH: If the -- if it, if it pleases the Court, if
8 we're going to do that, I think the easier way may be just to
9 stipulate as to the, the numbers rather than the oddity of
10 reopening the Plaintiff's case for one question.
11 THE COURT: All right.
12 MR. HINSON: That's perfectly fine with me, Your Honor,
13 as long as we could stipulate to whatever the -- we'll
14 calculate whatever the statute, the statute would say.
15 THE COURT: Life expectancy.
16 MR. GRESH: The, the statute is what it is and the
17 birthdays are what they are.
18 MR. HINSON: Okay. Thank you.
19 THE COURT: Okay.
20 MR. HINSON: That would work.
21 THE COURT: All right. Thank you.
22 All right. As to the motion for directed verdict, as to
23 Defendants' motion for directed verdict on the basis that none
24 of the Defendants can be held liable for Matt Scheer's suicide
25 based on the argument that suicide negates any causal link

1 between any negligence and the suicide, that is that suicide
2 is an intervening cause, I find Scott and Crolley cases not to
3 be controlling based on their fact pattern in, in this case,
4 and the fact pattern in those cases. In the Wickersham case,
5 Judge Norton denied a motion for summary judgment based on the
6 suicide being an intervening cause. I'm told that that case
7 is still in the pipeline. That was a motion for summary
8 judgment, and it seems to go contra to the -- well, he
9 discusses the, the Scott case, I -- and, and the Crolley case,
10 but he denied a motion for summary judgment based on the same
11 theory that Defendants have postulated here. I find Bramlette
12 to be the controlling law in this case. Bramlette involved a
13 suicide patient. Here we have a psychotic patient. I find
14 this case fits within the Bramlette holding. As to Matt
15 Scheer I find his suicide is not an intervening cause between
16 any wrongful negligence by the Defendant, a Defendant and his
17 death.
18 As to the motion for directed verdict on the issue of
19 punitive damages, looking at, looking at all these -- I look
20 at all these motions in the light most favorable to Plaintiff
21 incidentally. I forgot to say that. As to motion for
22 directed verdict on the issue of punitive damages, looking at
23 the motion in the light most favorable to Plaintiff, I find
24 the issue of punitive damages to be a question for the jury.
25 I find that a jury -- it is a jury issue as to whether or not

1 one or more of the Defendants acted recklessly, that is with a
2 conscious disregard for the rights of others, particularly
3 Matt Scheer.
4 As to the motion for directed verdict on behalf of Dr.
5 Patel, I find there is testimony in the record from which a
6 jury could find that Dr. Patel should have prescribed Ativan
7 and should have told the staff and doctor or doctors to whom
8 Matt Scheer was handed off that he was psychotic and that, and
9 again, I'm not finding this, but there is evidence in the
10 record from which a jury could conclude that Dr. Patel
11 breached that duty and that such breach was a proximate cause
12 of Matt Scheer's suicide.
13 As to Southern Myrtle, I find the testimony of Dr.
14 Robinson, coupled with the testimony of Southern Myrtle's
15 30(B)(6) witness creates a jury issue as to whether or not
16 Southern Myrtle had a duty to train its physicians as to the
17 law on permissible disclosure, whether -- and -- to, to -- let
18 me go back, it created -- this, this testimony creates a jury
19 issue as to whether or not Southern Myrtle had a duty to train
20 a physician as to the law of permissible discovery, as to
21 whether or not Southern Myrtle breached any such duty and as
22 to whether any such breach was a proximate cause of Matt
23 Scheer's suicide. I believe that's the four -- was that -- is
24 that -- were there just four?
25 MR. PADGET: I believe that's correct, Your Honor.

1 MR. GRESH: I think that's correct, Your Honor.
2 THE COURT: All right. Now, ready for the jury?
3 MR. GRESH: Your Honor, just a matter of, of
4 housekeeping, I think the Plaintiff rested a little bit
5 earlier than I thought, which is why we trimmed it back from
6 Tuesday till, till Friday. If it pleases the Court, I've got
7 Dr. Patel who I believe we'll call, I believe I'm going to
8 call Dr. Rachel Ash-Bernal immediately following Dr. Patel and
9 then we'll call Dr. Oscar Lovelace, with a lunch in there
10 somewhere. At the conclusion of Dr. Lovelace's testimony, I'm
11 out of witnesses until tomorrow morning at 9:30 when Dr.
12 Ballenger will be here to testify. If it pleases the Court,
13 I'd like to spend the remainder of the afternoon going through
14 the jury charges and jury verdict form and having all those
15 lined up such that when Friday rolls around we can roll right
16 into it.
17 THE COURT: All right. The only caveat or the only
18 concern I have with that is I'm going to be listening to the
19 testimony and kind of looking at the charges and the verdict
20 form. So I don't know if I'll be ready to do much this
21 afternoon, but hopefully I will and then I won't have to work
22 on it tonight.
23 MR. GRESH: And I -- and what, what I was really trying
24 to come up with is I don't have anybody else to call. Through
25 no fault of anybody's the case I think came in faster than we

1 anticipated and the next expert's not available till Friday.
2 THE COURT: All right. Dr. Lovelace will take about an
3 hour, two hours.
4 MR. GRESH: Yes, sir. And I think everybody is going to
5 be about that range. It may not be that early but I just
6 wanted to call to the Court's attention it may be 3:30, it may
7 be 3:00. I don't know exactly.
8 THE COURT: We can work with that. Along those same
9 lines, looking at tomorrow, I know this case has a lot of meat
10 in it, but I'm going to ask that closing arguments try to be
11 tailored to around an hour at the outside. I think you lose a
12 jury after, after that. You certainly lose the Judge, but --
13 MR. HINSON: An hour limit will not be a problem, Your
14 Honor.
15 THE COURT: Okay.
16 MR. GRESH: That's fine.
17 THE COURT: All right. Bring in the jury.
18 (Whereupon, the following takes place in the presence of
19 the jury.)
20 THE COURT: Good morning. I believe they've, they've got
21 -- here, here in Horry County they got me eating better than I
22 eat at home so.
23 All right. Call your -- now, the case is up to -- is in
24 the Defendants' side of the case, and so, they will call such
25 witnesses as they believe, as they desire. So I'll turn it

1 over to counsel for the Defense.

2 MS. SPEARS: Thank you, Your Honor. The Defense calls

3 Dr. Nirlep Patel.

4 Whereupon, Nirlep Patel is called to the stand, duly

5 sworn by the clerk and testified as follows:

6 THE CLERK: If you'll just state and spell your first and

7 last name.

8 MR. PATEL: Okay. Nirlep Patel, N-I-R-L-E-P, Patel, P-A-

9 T-E-L.

10 DIRECT EXAMINATION

11 BY MS. SPEARS:

12 Q Good morning, Dr. Patel.

13 A Morning.

14 Q Would you please introduce yourself to the jury?

15 A So I was born in Chicago in August of '78, lived there

16 for a few years. Then we moved to a small town in northern

17 Massachusetts, Chelmsford, Massachusetts, lived there for

18 pretty much through high school, graduated high school there,

19 and then went to school, went to college at Duke University.

20 Came down here to go to school here and finished that. Then

21 returned home for a couple of years, worked at a lab at MIT

22 for a few years, then attended medical school after that.

23 Actually first got a masters degree at Boston University and

24 then attended medical school after that and between '03 and

25 '07, graduated in '07 and then did residency in, in downtown

1 Philly at Hahnemann University Hospital at which point about
2 2010 accepted a job here at Grand Strand.
3 Q You said you went to Duke University; is that correct?
4 A That's correct.
5 Q What year did you graduate from Duke?
6 A 2000.
7 Q And did you get any degrees after you graduated from Duke
8 University?
9 A Yes. I got a masters at Boston University when I went
10 back home to -- when I was working for the lab for a few
11 years.
12 Q And following your degree --
13 A Uh-huh.
14 Q -- masters degree at Boston did you then go to medical
15 school?
16 A I did.
17 Q And what year did you graduate from medical school?
18 A '07.
19 Q What year did you complete your residency?
20 A 2010.
21 Q And in medical school did you receive any awards or
22 honors?
23 A It was an academic honor society for first, first year
24 and then tuition scholarship assistance first year as well.
25 Q And in your career as a physician, have you had a chance

1 to be published in any journals or articles?
2 A It was primarily when I was working at the optics lab at
3 MIT. It was mostly imaging, engineering type work, and we
4 attended some conferences and published some papers when we
5 were working there.
6 Q Are you board-certified?
7 A Board-certified in internal medicine.
8 Q And what led you to be an internal medicine physician?
9 A I would say something, you know, it's -- well, most
10 medical students kind of go through their -- when they're
11 going through their classes and their rotations and everything
12 it's something you figure out, you know, kind of what you
13 like, what you're good at, what you don't like, that sort of
14 thing. I kind of liked surgery initially, you know. Then,
15 you know, we did medicine and OB and, you know, pediatrics and
16 all that stuff, and I just, you know, after all, doing all
17 that you kind of figure out what you're good at, what you like
18 and kind of the variety of internal medicine and, and what you
19 do, the day-to-day stuff, was kind of most intriguing. So
20 then in the fourth year you tend to kind of focus on some
21 electives and what you like, and that kind of further
22 solidifies, you know, those, those things and, and then that's
23 kind of how I pretty much knew.
24 Q And Dr. Patel, we've heard the term hospitalist a lot
25 this week. Are you a hospitalist?

1 A Correct.
2 Q And where do you currently work as a hospitalist?
3 A Since 2010 I've worked as a hospitalist at Grand Strand
4 on 82nd Parkway.
5 Q And as a hospitalist at Grand Strand what are some of
6 your duties and responsibilities?
7 A So a hospitalist is typically at, at our facility
8 responsible for, we admit patients that come in through the ED
9 or other, other places, other hospitals that transfer patients
10 to Grand Strand, smaller hospitals that may or may not have
11 certain services, that sort of thing. They may come from a
12 nursing home, but then they typically go through the ED
13 anyway, direct admissions from the office, sometimes that
14 happens as well, and then we're also responsible for
15 discharging patients after they've been treated from the
16 hospital, whether they go home or to a nursing home that sort
17 of thing, and of course, caring for the patients while they're
18 physically in the hospital, and we typically do this because,
19 you know, there's many physicians in the community, but not
20 all of them come to the hospital and have privileges there and
21 able to admit and discharge their own patients. So, you know,
22 we take care of their patients when they're hospitalized and
23 then we discharge them back to them to follow up and that sort
24 of thing.
25 Q And as a hospitalist are you managing medical care for

1 patients admitted to the hospital?
2 A That's correct.
3 Q In October 2015 were you working as a hospitalist at Grand
4 Strand Regional Medical Center?
5 A Correct. I was working day shift on, on that day as a
6 hospitalist.
7 Q Do you have an independent recollection of Matthew Scheer?
8 A I don't have an independent recollection, mostly just sort
9 of thought processes and general impressions. Of course,
10 reviewing the medical records kind of jogs a little bit of
11 those memories somewhat, but still just general impressions
12 and, and thoughts.
13 Q And in your review of the medical records have you come to
14 refresh your recollection as to how you got involved in the
15 care of Matthew Scheer?
16 A I, I have, just been, been able to review that.
17 Q I'm going to --
18 A Uh-huh.
19 MS. SPEARS: May I approach the witness, Your Honor?
20 THE COURT: Yes.
21 BY MS. SPEARS:
22 Q Dr. Patel, I'll represent to you this is Defendant's
23 Exhibit One, which are the medical records of Matthew Scheer,
24 and if I could have you turn to page 49, please?
25 A Is that the Bates number?

1 Q Yes. In the bottom right-hand corner.
2 A Yes. The one with the first line at the top is patient:
3 Matthew Scheer, that one?
4 Q Yes.
5 A Okay.
6 Q Doctor, at the bottom of this note and I'll -- well,
7 first of all, tell me, is this an emergency department note?
8 A It is.
9 Q Okay. And is this your name on the bottom where it says
10 consultation to?
11 A Yes. It is.
12 Q What does this note reflect?
13 A So this note reflects the discussion that I would have
14 had with the ED physician to admit Matthew to the hospital.
15 So when he returned back to the hospital the second time and
16 we'll probably discuss some of the details and some of those
17 were discussed earlier, you know, we were asked to admit
18 Matthew back to the hospital. So this is when the ER
19 physician, and that's typically what happens, they discussed
20 with the hospitalist, you know, what's, you know, what's going
21 on with the patient, the events of the day leading up to, you
22 know, they're talking to me, you know, test results, lab
23 findings, who they talked to and, and why they feel that the
24 patient needs to come into the hospital and stay in the
25 hospital as opposed to going home. So that's what that

1 generally reflects.
2 Q And where it says consultant agrees with plan, would that
3 be a plan you discussed with Dr. Battisti?
4 A That's correct.
5 Q And in your discussion with Dr. Battisti, was -- at any
6 time were you or either Dr. Battisti felt that the patient
7 needed to be involuntarily committed?
8 A Not at that time. No.
9 Q After you discussed your plan with Dr. Battisti, did you
10 go to evaluate Matthew Scheer?
11 A Correct. So after we talked about what, what needed to
12 happen and everything, all the information she conveyed over
13 to me, you know, I would ask, okay, so where the patient is
14 and what room number, that sort of thing, and then I would go
15 and evaluate the patient.
16 Q Is part of your evaluation to have a discussion with the
17 patient?
18 A Yes. I would, you know, of course get a history, ask,
19 you know, him or her what's going on, what brought you to the
20 hospital, you know, that -- those types of things, and then
21 going into more, more specific things, of course, and then, of
22 course, do a physical exam, go over any test results or
23 imaging findings, that sort of thing, you know, that would
24 basically, you know, constitute what we would do in that, in
25 that situation.

1 Q To your recollection when you were evaluating or
2 discussing with Matthew Scheer what was his demeanor?
3 A It was based on the, the medical records, yeah, and just
4 general impressions what I have is that he was otherwise calm
5 and, you know, agreeable with questioning, had a general
6 normal conversation. From my recollection, father was in the
7 room. So it was just kind of a general discussion over some
8 things, you know, look at Matt, look at father, you know, just
9 like you would talk to someone and, you know, family members
10 being in the room so to speak, but that was the general
11 impression or the gist of it.
12 Q Dr. Patel, can you please turn to page 82 of Defendant's
13 Exhibit One?
14 A Okay.
15 Q Does this appear to be your note from your evaluation of
16 Matthew Scheer?
17 A It is.
18 Q And what is noted as the chief complaint in this note?
19 A So it says sent over for a psychiatric evaluation and
20 abnormal white count and bilirubin.
21 Q Okay. Were you aware at this time that there were
22 concerns for -- psychiatric concern for Matthew Scheer?
23 A Correct, as twofold. Obviously, the main reason for him
24 coming back was in the event of the abnormal blood test, but
25 the ongoing issue was still the abnormal behavior and the

1 psychiatric findings and the need for that evaluation. So
2 those are the two things.
3 Q Okay. And is it fair to say that you were involved in
4 Matthew Scheer's care for his underlying medical issues,
5 including the white blood cell count and elevated bilirubin?
6 A That's correct.
7 Q And your evaluation of Matthew Scheer you were addressing
8 the white blood cell count in what way?
9 A So in that sense, as a patient comes back with, with
10 these lab values, you know, some of the things that we're
11 going to go over and discuss is, you know, why is his -- why
12 is his white cell count elevated and what could be causing
13 that. You know, we've already reviewed and kind of gone over
14 what was done in the ED. They'd done some preliminary things
15 as they would normally do and we review those, but when he
16 comes back from Lighthouse, their thought was, you know, and,
17 and their concerns were, "We're still not entirely comfortable
18 with this, this white cell count, and what's going on. Can we
19 dig a little bit deeper," which is certainly reasonable. So
20 in, in that sense, you know, we're going to look at his
21 elevated white count and look for signs of infection or what
22 else could be causing it, whether it be dehydration or some
23 sort of substance or anything of that sort or some other
24 process in the body, and same with the bilirubin, what could
25 be causing his elevated bilirubin, going over the history and

1 everything that he's told me up till this point. We're going
2 to probably run some tests to try and find out, you know, why
3 his bilirubin is elevated or not. Also to -- basically also
4 check and see if any of these labs are erroneous or if there's
5 something we need to double check, you know, that sort of
6 thing, if things weren't adding up.
7 Q As part of your workup of Matthew Scheer's medical
8 concerns did you order fluids for him?
9 A We ordered fluids for him, ordered his medication, also
10 ordered additional blood tests, repeat blood tests for the
11 morning, additional tests that could be added on to the blood
12 already drawn in the ED for that day to kind of further look
13 at, you know, what else could be causing his bilirubin. They
14 did kind of a preliminary thing, and then other, you know,
15 imaging finding -- tests that, you know, could further look at
16 what else could be causing his bilirubin to be up or his white
17 cell count or both together. So that -- those are some of the
18 things that we tried to look at.
19 Q Did you also order some IV nutrition to help address some
20 of these abnormal lab values?
21 A We ordered some IV fluids, correct.
22 Q Okay. And you said some imaging. Did you order an
23 ultrasound of the abdomen?
24 A So and, I mean, certainly on exam he had a pretty benign
25 abdominal exam. There was no pain or, or anything or

1 tenderness elicited. You know, my suspicion was low for some
2 sort of occult abdominal process going on, but an ultrasound
3 is generally a, a fairly simple and readily available test
4 and, you know, in some cases the patient may not present with
5 obvious, you know, pain and tenderness in that situation. So
6 starting with ultrasound to look at the liver and the
7 gallbladder which seems to be kind of where the focus is
8 seemed reasonable. So that's, that's what we started with.
9 Q And did you order a repeat blood test for the following
10 day?
11 A Yes. As I said earlier we ordered a repeat, you know,
12 general labs, you know, morning labs, typical morning labs for
13 the following morning to see if, you know, some of the things
14 that we looked at if they have changed, if they've improved,
15 if things that we've tried had helped and if, you know, we're
16 on the right track or if we're not on the right track at all
17 and they're still abnormal or going up, well, do we need to go
18 in a completely different direction, that sort of thing.
19 Q You mentioned you order some medications. Was one of
20 those Keppra?
21 A Keppra is one of his home medications, and yes, I believe
22 we ordered that.
23 Q And what was the reason for ordering Keppra?
24 A Well, as I understood from the history and other
25 information Keppra was one of his normal medications that he's

1 been taking for a number of years, and per the history again,
2 apparently he had not been taking it for some time. So it
3 seemed reasonable that if he's supposed to be on this
4 medication that he takes to help reduce the risk of seizures
5 that, you know, we would put it back on. We typically -- I
6 believe that currently we give Keppra and those medications at
7 2100 hours or thereabouts. So I think what I did was I
8 ordered it to be given at the next scheduled time or next
9 routinely scheduled time.
10 Q Doctor, as part of your plan did you also make a note for
11 PRN Ativan?
12 A Yes. You know, certainly based on what was going on
13 earlier in the day and after talking with him, I certainly
14 thought about, you know, giving him, you know, potentially as
15 needed medications. He certainly didn't need it at the time
16 that I saw him. That's clear, but you know, in the event that
17 it arose, you know, it was something that I thought about,
18 thought about giving. However, at the same time, you know, I
19 -- beyond evaluating patients, you know, like that in other
20 admissions that I've done at this time you also want to see
21 the patient sort of as he is or as, as she is at the time that
22 they come in. At the time that I saw him he certainly seemed
23 pretty reasonable, and I've been in situations where both from
24 the ED and on the floor patients receive sedative medications
25 and they're just pretty much out of it. They're asleep, and

1 you're not going to get much of a good evaluation at that
2 time. So, sort of weighing both of those things at, at that
3 time and also knowing that if the medication was necessary at
4 a later date, seeing as how we and multiple other physicians
5 are available 24-7, within a matter of minutes we could get a
6 medication like Ativan. At that time I did not order it.
7 Just like if someone came in with, with and had nausea
8 sometime at 10:00 o'clock or had diarrhea or a headache or any
9 number of things that could happen, these are medicines that a
10 nurse would just let us know, said, you know, "Hey, Doctor,
11 someone's, you know, having some nausea. You know, can we get
12 Phenergan," or someone having this or that and we go, that
13 sort of thing.
14 Q And if a nurse felt that Matthew Scheer or any patient
15 needed medication for agitation what could she do or he?
16 A A couple of things. I mean, she could certainly page --
17 at that time we still had pagers. Now we have discarded our
18 pagers for the wonderful text messaging apps that, that we now
19 have. So now we do that, but they could text us now, but back
20 then, you know, they could page us or the nighttime doctor or
21 the nurse practitioner who is either on the floor or in the ED
22 admitting patients at the hospital or if they're just kind of
23 walking on the floor as a number of doctors typically are or
24 in this case may be sitting right next to you while they're
25 admitting another patient or seeing someone.

1 Q So a nurse could call a doctor to come evaluate the
2 patient?
3 A Correct. She could, you know, definitely always call a
4 doctor, say, you know, "Something's, you know, changed or
5 something's amiss. Can, you know, can you come and see this
6 patient and let me know what you think," or you know, "This is
7 going on, you know. I think we need something like this. Can
8 we get something, a medication for this or that and can you
9 swing by and, and take a look," something of that sort.
10 Q And at Grand Strand Hospital is there a physician
11 available 24-7 to order medication if it's needed?
12 A Multiple physicians.
13 Q Doctor, I'm going to direct your attention to where it
14 says history of present illness and on page 82 of the records.
15 Where would you obtain the information that's contained in the
16 history of present illness?
17 A So this would be your history of present illness
18 basically kind of your interview and evaluation of the patient
19 in the, in the ER. So all this information would have been,
20 you know, I would have gotten it from talking with the patient
21 or family members present in the room, you know, and also kind
22 of looking through the documentation that I would have, maybe
23 some ER notes and that sort of thing.
24 Q Does this history of present illness also reflect your
25 findings from your evaluation of Matthew Scheer?

1 A It does.
2 Q And what does this H and P note say with regards to
3 hallucinations?
4 A Well, it says the patient denies hallucinations.
5 Q And what does this H and P note state with regards to
6 your findings of suicidal ideations in Matthew Scheer?
7 A It says denies any suicidal ideation.
8 Q And what does this reflect with regards to homicidal
9 ideations in Matthew Scheer?
10 A And denies any homicidal ideation.
11 Q I'm sorry. Say that again.
12 A I'm sorry. And denies any homicidal ideation.
13 Q And at the time that you evaluated Matthew Scheer and
14 wrote your findings in this H and P, was there anything that
15 indicated that Matthew Scheer needed antipsychotic
16 medications?
17 A There was not.
18 Q In your review of the medical records did it appear at
19 any time on October 2nd that a provider ordered Matthew Scheer
20 antipsychotic medications?
21 A From -- not that I could see from, you know, either
22 ordered or executed medications leading up until that time,
23 no.
24 Q Doctor, if you'll speak in the microphone.
25 A I'm sorry.

1 Q It's a little hard to hear you.
2 A No problem. I'm sorry.
3 Q If you'll turn over to the next page in your notes, 83.
4 Here where it says assessment and plan, what does your
5 assessment and plan state with regards to a psych consult
6 order?
7 A So it says, number one, possible psychosis. We will place
8 a psychiatric consultation for Dr. Oduwole for this evening as
9 requested.
10 Q There was a psychiatric consult ordered for Matthew Scheer?
11 A There was.
12 Q And is there a psychiatrist on call 24-7 at Grand Strand
13 Regional Hospital?
14 A At that time we did not have one.
15 Q And did you have any expectation as to when the
16 psychiatrist was going to come evaluate Matthew Scheer?
17 A Well, based on previous experience I had a, you know, a
18 thought that and also with, you know, the discussion earlier
19 with the ED physician in terms of what they had discussed, my
20 understanding was that he would probably come by later on that
21 evening as he typically does, you know, make his rounds, you
22 know, sometimes after his office hours. I've seen him in the
23 hospital between 6:30 and 9:30 typically at times. It's my
24 understanding is given that he's already aware of the patient
25 that he would probably swing by sometime later that night to

1 be able to evaluate Matthew.
2 Q At the time you evaluated Matthew Scheer, did you feel a
3 psychiatric consult was required stat?
4 A Not at that time. No.
5 Q Dr. Patel, the remainder of your assessment and the plan
6 number two and number three are those to address Matthew
7 Scheer's underlying medical concerns?
8 A Right. So number two is the leukocytosis. Do you want
9 me to read it or just --
10 Q No. My question is more is this your outline of what you
11 would intend to do for Matthew Scheer with regards to his
12 underlying medical, medical concerns?
13 A Right. So the, the other two points, the elevated white
14 cell count or leukocytosis and the hyperbilirubinemia, you
15 know, just generally stating, you know, what we've reviewed so
16 far with his urinalysis, any overt physical exam findings of
17 which there weren't, weren't any. You know, the first thought
18 was to, of course, as I said earlier, to repeat the blood
19 tests to see if there's, you know, anything amiss, anything's
20 changing in that short period of time and also anything that
21 we may have done is did that help or did that, you know,
22 change anything. As for the hyperbilirubinemia the other part
23 of the thought process is, well, what else could be causing it
24 aside from the liver and gallbladder issues, you know,
25 hemolysis or other abdominal process, again, that's sort of

1 what we were thinking about, and so we did the ultrasound or
2 ordered the ultrasound to look at the gallbladder
3 specifically, but again, as I said before, generally low
4 suspicion given his otherwise normal physical exam, and then
5 other, again, repeat tests, other liver function tests to see
6 if that was causing his elevated bilirubin possibly.
7 Q And during, throughout or throughout your evaluation
8 Matthew Scheer was not exhibiting any signs of agitation; is
9 that right?
10 A No. He was not.
11 Q Is this note what we looked at from page one and page two
12 a comprehensive overview of the medical care you provided to
13 Matthew Scheer?
14 A I would say it is.
15 Q Is this note available to any provider in the hospital
16 who would need to reference it?
17 A So typically, and this was round about, you know, so we
18 go to the, the next page, if we -- you know, I saw, saw
19 Matthew around about 5:00 o'clock or so and I still dictate my
20 notes. When I first started here in 2010 we just had a few
21 typewritten templates and most of us, all the physicians
22 dictated their notes and it was transcribed. It goes out to a
23 company and they transcribe it and then it gets uploaded in
24 the system, and over the years they've changed that. I'm one
25 of the few people that probably still dictates. Most of the

1 newer guys they type it up or and that, and that sort of thing
2 now, but yes, it was dictated around about 5:30 or so or
3 that's, that's when I finished, and then it gets sent off to a
4 transcription company and then they, they transcribe, you
5 know, what they hear, and then it's uploaded in the system
6 looks like around about 8:00 o'clock or so that night or
7 19:54.
8 Q On October 2, 2015, were you working day shift?
9 A Yes. I was working day shift that day.
10 Q And hospitalists in the hospital work in shifts, right,
11 some work days and some work nights?
12 A Correct. I do about half-and-half. Just the
13 Saturday/Sunday before this trial I worked the evening shift
14 into the night shift. So yeah, we, you know, we typically
15 work day shifts. We don't work the same shift on the same
16 calendar day typically, but yeah.
17 Q So you wouldn't work 24 hours a day; right?
18 A Generally no, although there are some, some that do do
19 that. All the power to them, but --
20 Q As a day shift hospitalist what are your typical hours?
21 A Typically for day shift day starts around about seven,
22 finishes around about 7 p.m., sometimes a little before,
23 sometimes a little bit after, just kind of really depends on
24 the day-to-day happenings and what you need to do. You know,
25 some, some, something may, you know, happen towards the end of

1 the day or it might be a, a quieter admission night, that sort
2 of thing, so generally about seven to seven day shift.
3 Q And when your shift ends at seven do you get to leave the
4 hospital right then?
5 A I mean, again, it just depends on the workflow. If
6 there's something going on, you know, we might need to stay a
7 little bit longer to address it. If everything seems to be
8 taken care of then, you know, around 7:00 o'clock or so we, we
9 head home.
10 Q And when the day shift hospitalist is going off shift and
11 a nighttime hospitalist is coming on shift, can you describe
12 the typical procedure of how that works?
13 A So typically, you know, we, as a day shift physician, we
14 round on anywhere from, you know, 16 to 20 patients or so. It
15 just really depends on the day to day. So we go through and
16 have reviewed everything for the day. We've spoken to the
17 patient, evaluated them, ordered any tests, you know,
18 typically anything under the sun that could have happened we
19 address those issues, and if there's anything critical or
20 urgent or anything like that say at 6:30, you know, someone
21 was having shortness of breath and, you know, you're the one
22 that saw them and you wanted to make sure they didn't have a
23 blood clot or something. So maybe you ordered a scan of their
24 chest to, to rule that out. Well, know that's going to happen
25 immediately. So, you know, you would put in the order and you

1 may pass along to the nurse practitioner who's handling cross
2 cover or one of the night docs, "Hey, you know, we have this
3 test. You know, if this comes back abnormal, you know, do
4 this," or -- and I mean, in some cases we don't really have to
5 say, I would just say, "Hey, just follow up with this test,"
6 or, "I ordered this test," because generally speaking they,
7 they kind of know what to do. I've been in those same shoes.
8 So, you know, that's normally what we would do. Just the, the
9 really pressing, urgent matters is what we would focus on and
10 highlight to pass along.
11 Q In your capacity when you work as a nighttime hospitalist
12 and you come on, do you have access to all of the medical
13 records for a patient?
14 A Yeah. We do. Most, I mean, these records are typically
15 electronic. Back in 2010 we still had paper notes. Of
16 course, you'd have to go to the chart in many cases, and you
17 know, leaf through everything and try and decipher some
18 things, but right now pretty much everything is generally
19 available, you know, pretty quickly if, if we need it. It's
20 pretty comprehensive in terms of what the goings-on of that
21 day.
22 Q At Grand Strand Regional Medical Center how common is it
23 to do a face-to-face handoff where you would talk to the
24 oncoming physician when you leave?
25 A Well, in, in my 10 years probably that's a very rare

1 occurrence to, to go through the whole census and say, you
2 know, you know, everything about every patient that's there.
3 Like I said earlier, we typically focus on the highlights
4 because those are the most important things, the most urgent
5 things that we need to have our, our night guys or night folks
6 focus on and, and follow up. So those are the things that we
7 would highlight, and typically these days it's just a simple
8 text message or pass them in the hallway and generally know
9 kind of where they're going to be sitting so I can swing by
10 and say, "Hey, you know, follow up on this," or, "Hey, do me a
11 favor and check on this, you know," or I could text them if a
12 nurse contacts me, you know, after I'm already home and say,
13 "Hey, something happened," and then I would relay that
14 information along, but generally speaking, that's a pretty
15 fluid process like that.
16 Q When you were leaving the hospital on October 2nd, 2015,
17 were there any concerns, findings or pending critical results
18 for Matthew Scheer?
19 A No. As I said earlier, the, the labs that we order for
20 -- that we want to check on were for the next morning and
21 those were routine labs. There was a couple of add-on labs
22 that we did. Again, I wasn't highly suspicious of something
23 going on based on the history and physical to, to see anything
24 there, but those are routine, and the ultrasound I ordered,
25 again, was also routine, not an acute surgical abdomen, not

1 any acute physical exam findings. So my expectation is that,
2 and again, at the time I don't remember if we had ultrasound
3 24-7, but you know, my thought was if it got done that
4 evening, great, if not early in the morning I would be able to
5 check on that and see if anything came of it.
6 Q At the time you left the hospital on October 2nd had you
7 addressed Matthew Scheer's medical concerns to your
8 satisfaction?
9 A I had.
10 Q And was a psychiatrist coming to address Matthew's
11 psychiatric concerns?
12 A As I had put the consult in my understanding is that, you
13 know, he would be evaluated in due course by a psychiatrist.
14 Q And when you went off shift or left the hospital on
15 October 2nd, 2015, did you have any concern that Matthew Scheer
16 may need to be involuntarily committed?
17 A At the time that I evaluated Matthew, no.
18 Q And looking back, at any point in your discussion or
19 evaluation of Matthew Scheer did he express to you a desire to
20 harm himself?
21 A He did not.
22 Q Did he express a desire to harm anyone else?
23 A He did not.
24 Q At any point in time when you were evaluating Matthew
25 Scheer did you feel him to be a serious threat of harm to

1 himself?
2 A I did not feel that way, no.
3 Q Did you feel he was a serious threat of harm to anyone
4 else?
5 A I did not feel that.
6 Q Is this the type of patient that you would think that
7 antipsychotic medications are indicated?
8 A At the time that I evaluated, no.
9 MS. SPEARS: One second, Your Honor. Nothing further.
10 THE COURT: All right.
11 MS. SPEARS: Answer any questions, any questions that
12 Plaintiff's counsel may have.
13 MR. PADGET: Your Honor, may I approach and just go ahead
14 and grab --
15 THE COURT: You may.
16 MR. PADGET: -- Plaintiff's Exhibit One, the medical
17 record to have that handy.
18 THE COURT: Certainly.
19 CROSS EXAMINATION
20 BY MR. PADGET:
21 Q I'm going to give this to you, Dr. Patel.
22 A Okay.
23 Q Good morning, Dr. Patel.
24 A Good morning.
25 Q We can all agree that a physician should never needlessly

1 endanger their patient; isn't that right?
2 A And certainly, we, we would not want to needlessly
3 endanger a patient, you know, after, after evaluating the
4 patient that's certainly the case.
5 Q You were Matthew Scheer's admitting physician on October
6 the 2nd, 2015?
7 A Correct.
8 Q You're his doctor?
9 A Correct.
10 Q Okay. Now, you, that weekend was a big weekend for South
11 Carolina. Do you remember the weather pattern that weekend?
12 A Again, I had to go back and kind of review what was noted
13 in the chart, but there was a storm approaching, as I
14 understand it.
15 Q Do you remember the thousand year flood here in South
16 Carolina?
17 A I do remember that term being used by the, at that time,
18 governor.
19 Q Two feet of rain fell in some parts of Horry County
20 within 24 hours? Do you remember that?
21 A I don't know the exact amounts, but.
22 Q Severe flooding, I'm just trying to spur your
23 recollection. Do you have any memories of that?
24 A I do remember there was a lot of rain and that there was
25 some areas of South Carolina that had some flooding.

1 Q And it was that weekend?
2 A As I understand it to be, yes.
3 Q Now, you're an internal medicine physician by background
4 and training; correct?
5 A That's correct.
6 Q And you work exclusively in a hospital?
7 A Correct.
8 Q Okay. You don't work in a clinic and then in a hospital
9 or in a doctor's office and then a hospital. You're a
10 hospitalist, you work in a hospital?
11 A Correct. We, we don't have an office. We work
12 exclusively in the hospital to admit and discharge patients as
13 I described earlier.
14 Q Now, as an internal medicine physician, you went through
15 training and are trained to handle psychiatric patients;
16 correct?
17 A Correct. Part of our training does include, you know,
18 the, the basics of, of psychiatric care and handling
19 psychiatric issues.
20 Q And in, in this circumstance, in this case, the events
21 giving rise to this, you have testified that you have
22 absolutely no independent recollection of the care that you
23 gave to Matthew Scheer; isn't that right?
24 A As I said earlier, general impressions, kind of what I
25 remember going through the chart, thought processes and

1 impressions is pretty much the only recollection that I, that
2 I have at this time.
3 Q All you have is the chart essentially and then your
4 practices and your usual protocol to try to piece back
5 together what you did that day?
6 A That's generally the case.
7 Q But you don't have any memories?
8 A I don't have any independent recollection, no, of
9 Matthew, no.
10 Q Now, when you treated Matthew on Friday, this is the 2nd
11 when he came to be in your care, you were aware that he had
12 been at Grand Strand earlier that day?
13 A Correct, based on the ER documentation, correct.
14 Q He had gone to the emergency department and was seen by
15 Dr. Battisti, had been sent to an outpatient psychiatric
16 facility?
17 A He had been evaluated in the emergency room, correct, by
18 Dr. Battisti and then he was sent over to Lighthouse, which is
19 both inpatient and outpatient. Patients that we send over to
20 Lighthouse are oftentimes there to be committed and they, they
21 need inpatient psychiatric care. That's one of the main
22 reasons that patients go over to Lighthouse, but among other
23 things that are -- they do outpatient care, too, I believe, at
24 the time.
25 Q The only time you actually interacted with Matthew Scheer

1 on the 2nd was during this time when you sat down with Matthew
2 and his father, David, he was there according to the note;
3 correct?
4 A Correct. When, when I saw Matthew in the ED with his
5 father, that was the time that -- that was the only time that
6 I interacted with Matthew when I evaluated him.
7 Q And that was according, I believe your testimony, about
8 5:30 or so on the 2nd?
9 A A little bit before that, yes, leading up to that. I
10 think 5:30 or around abouts is when I dictated or finished my
11 dictation, but give or take around there, five, 5:30,
12 something like that.
13 Q And you did your evaluation and it's your testimony that
14 you never saw Matthew Scheer ever again after that; correct?
15 A Correct.
16 Q And we are in agreement that you at no point in time ever
17 spoke to your partner, Dr. Rachel Ash-Bernal, about Matthew's
18 care; did you?
19 A That's correct, did not speak to her.
20 Q Never once had a conversation with her about Matthew's
21 case?
22 A No. That's correct.
23 Q Never once had any sort of discussion with regard to the
24 highlights, as you testified to a moment ago, of his
25 particular situation that would be important for her to know,

1 his doctor later that evening?
2 A I did not have a discussion with Dr. Ash-Bernal about the
3 admission or, or those types of things at that time because at
4 the time I felt, you know, most of those issues had been
5 addressed, you know, the plan of care that had been agreed
6 upon between the ER doctor and myself and, of course, what she
7 had discussed with Lighthouse, the providers and Dr. Oduwole
8 there. Those, those plans were in motion. The orders were
9 placed, and there was nothing further or urgent at that time
10 that I needed to -- any actionable things that needed to go on
11 that night for that.
12 Q So at no point in time did you ever tell Dr. Ash-Bernal
13 that Matthew had been accompanied by his father during this
14 entire visit previously when he was in the emergency
15 department, when he'd gone to Lighthouse and now back in the
16 hospital under your care, never told her that?
17 A No. I -- that's correct. I did not pass that
18 information along. Most of the information, I believe, was in
19 my history and physical and readily available, that, the
20 summary of that care, and of course, also the ER documentation
21 is also readily available in regards to, as you said, the
22 father being present in the room. I think in my history and
23 physical I also stated, you know, the father had helped with
24 the history. So one could glean from that that, you know,
25 some of the history was obtained from both the patient and

1 family members.
2 Q But a fact like for somebody who comes in with a
3 potential diagnosis of psychosis, as you described it in that
4 day, isn't it an important fact that he had a family member
5 with him at every step, at the initial ED visit, at
6 Lighthouse, back from Lighthouse, back to Grand Strand and
7 with you? Isn't that an important fact that, that another
8 physician would want to know?
9 A It's certainly an important fact. Again, that's
10 information that's also available in the chart, which is
11 something that, you know, a normal physician would review at
12 the time if they ever had any question, so.
13 Q And that's in this, you know, roughly 130-page document
14 that's Exhibit One? You know, that's the medical record with
15 that information that's contained therein from this one day
16 period.
17 A Well, much of that is also, again, electronically
18 generated forms. The things that as physicians we look at are
19 going to be the ED note, which is a couple of pages long, a
20 history and physical, which is a couple of pages long, and
21 possibly a nurse's note or two because, again, most of
22 everything happened was that calendar day. So aside from all
23 the electronically generated pages, the 130-some odd pages
24 that, that is being referred to, a vast majority of that is
25 not something that we're going to be looking at. We're going

1 to be looking at mostly those three things that I specified.
2 Q Now, going back to how Matthew became your patient --
3 A Uh-huh.
4 Q -- you had a conversation, a telephone conversation with
5 Dr. Battisti when she admitted him from the ER into your care?
6 A Correct.
7 Q Is that right?
8 A So whenever we admit patients to, to the hospital, and on
9 the thousand of times that I've probably done that we always
10 talk to the ER physician or the nurse practitioner, PA,
11 resident. Now we have a residency program. We discuss the
12 patient with them, you know, we talk about what led up, the
13 events of that day, why the patient needs to stay as opposed
14 to why they can go, labs, any imaging, any ancillary
15 conversation they had, any of their thought process, why they
16 feel a patient needs to stay, and then, you know, we ask where
17 the patient is and we go evaluate them and generally admit
18 them to the hospital.
19 Q So that's the discussion you had with Battisti?
20 A Correct.
21 Q No discussions with Dr. Ash-Bernal ever; correct?
22 A Correct. Did not discuss this with Dr. Ash-Bernal.
23 Q Now, let's talk about the time you spent with Matthew and
24 with David doing your evaluation. You sit down with them
25 someplace in the hospital. You get a history. David tells

1 you that he had some concerns about their son, comes down from
2 New Jersey. He, he finds him in a condition. He decides he
3 needs to go to the hospital. He goes to the emergency
4 department. He tells you they've been to Lighthouse and tells
5 you they've come back from the psychiatric care facility.
6 They wouldn't admit him there. Back into the hospital; is
7 that true?
8 A I mean, that generally kind of sums up the, the
9 chronology of it. You know, and that's also would have --
10 what would be available from the ER documentation and also
11 what the ER doctor would have summarized to me in the
12 conversation with her just probably minutes earlier. So but
13 that's the general chronology of it, yes.
14 Q In your note -- I'm on page 65 now of Exhibit One.
15 A Your exhibit or the original exhibit?
16 Q It's the one I handed you, Exhibit One.
17 A Okay.
18 Q I think it's your HPI, Doctor.
19 A At what -- I'm sorry, what page did you say?
20 Q I'm on 65 there at the bottom. It's the, the Bates
21 number, not the page number. In addition, they told you that
22 Matthew had been having visions; is that right?
23 A That's correct. It says he has been having visions.
24 Q And he also had what the father described as a psychotic
25 episode where he ran out into the woods?

1 A That's correct.
2 Q So they shared this, this personal information with you
3 about the troubles that Matthew had been having over the last
4 few days?
5 A That's correct.
6 Q And you had a discussion -- you had time to speak with
7 Matthew and ask him some questions; correct?
8 A Yes. You know, as I would go and evaluate him, we'd kind
9 of have a conversation about what's been going on that day and
10 kind of what brought, brought you to the hospital, those types
11 of things, correct.
12 Q And this is not a hurried process for a, for a -- an, an
13 inpatient admission like this; is it?
14 A No. It's not a hurried process. It, it can take some
15 time.
16 Q It's a thorough process?
17 A I'm sorry?
18 Q It's a thorough process doing this initial HPI and exam?
19 A That's correct.
20 Q You estimate that when you sat down with them and did
21 this that it took you at least 30 minutes to do this; is that
22 a fair estimate?
23 A I don't know exactly how long it took. Again, every
24 patient, every situation, encounter is different, you know,
25 anywhere from 15 to 30 minutes or thereabouts, somewhere in

1 between, between evaluating, examining the patient is, is
2 about, about how long it would take. Again, it depends on
3 many factors, you know, you know, if they have a long history,
4 if they have a lot of medications, you know, if it's an 82-
5 year-old patient with a lot of things going on, then certainly
6 that might take a little bit longer, you know, those types of
7 things, but it does vary from patient to patient.
8 Q And it certainly can vary, Doctor, but your estimate for
9 Matthew's case was 30 minutes?
10 A Again, I don't know exactly the number but sounds about
11 right give or take a few minutes.
12 Q And that's what you testified to at your deposition;
13 correct?
14 A I believe so. Yeah.
15 Q And you were under oath when you gave that deposition
16 just like you are today?
17 A Correct.
18 Q Now, at the time you spent this estimate of 30 minutes
19 with Matthew and his father going over all this information,
20 Matthew was calm, there wasn't any sort of emergency or he
21 wasn't agitated. There was nothing particularly concerning at
22 that point in time according to you; correct?
23 A To my recollection, no.
24 Q So in this time where there's nothing particularly
25 concerning, he's not agitated, he's not acting out, he's not

1 accusing people of being things they're not, he's not throwing
2 hospital equipment around or taking off his clothes, you
3 decided that it was necessary to spend 30 minutes with him in
4 that initial evaluation; is that right?
5 A Again, about that, correct, between talking to Matthew,
6 father, getting a history, also reviewing some of the
7 laboratory values, you know, because we typically go through
8 those before we go in and evaluate the patient. Oftentimes,
9 the workflow is, you know, we sit down at the computer. We're
10 on the phone, and as we're talking about the patient we're
11 kind of both going through the same things at the same time,
12 at least we try to, then we scan through that and then we
13 typically go and evaluate the patient, and a patient may be on
14 the floor, too. Again, that doesn't always happen, but it
15 just depends on where, where we were at the time and, and that
16 sort of thing.
17 Q Now you had -- a, a psych -- an order had been placed for
18 a psych consult; correct?
19 A That's correct.
20 Q And you, it was your expectation that Dr. Oduwole was
21 going to come that evening and do an evaluation of Matthew?
22 A Right. As I had said earlier, that conversation had
23 occurred between Dr. Battisti and Lighthouse and the providers
24 at Lighthouse, and shortly after -- concluding that
25 conversation, she called me, and as I said earlier, we

1 discussed all of these things, including all the other
2 objective values and, and, and findings and conveyed that
3 information over to me. Ergo, I place the consultation based
4 on my expectation that that's the next -- that's part of the
5 process that we're doing here, so.
6 Q So Dr. Battisti not only called you, she had previously
7 contacted somebody at Lighthouse?
8 A Right. As --
9 Q That's your understanding?
10 A That, that's my understanding, and again, I have no
11 independent recollection of my conversation with Dr. Battisti.
12 I've spoken to her for dozens of admissions before, and again,
13 the, the many times that I've admitted patients that's our
14 usual practice, to go over these types of things and, and
15 that's how she'd relay that to me.
16 Q Well, she not only did that, she also documented that she
17 did that in her notes; didn't she?
18 A I believe she did.
19 Q Now, you never contacted Lighthouse or Dr. Oduwole or any
20 of those folks to determine when he may be expected on this
21 Friday night at the hospital sometime around 7 p.m. or after
22 with a hurricane outside, you never contacted him to determine
23 if a psych consult was going to happen that Friday night?
24 A Again, no, like I said earlier, Dr. Oduwole's usual habit
25 is to pretty much round, you know, after six, somewhere

1 between six and nine. He typically makes his rounds for the
2 patients that are on his list, and the way they get on his
3 list is we put the order in and that shows up. The other
4 method that we use is we have a social worker case manager and
5 they're already aware of the patient, if he needs to be seen
6 by Dr. Oduwole at the time. So they already have a running
7 list as well, and she typically hands them that list or they
8 -- they're in contact, and, you know, they let him know,
9 "Okay. So we have a patient in 1295, 94, 91 and then this
10 patient down still in the ED is a, is a hold patient," and
11 everything of that sort. So she would let him know, and then
12 that's still how we do it as to who needs to be seen that day.
13 Q So we're all in agreement you never spoke with Dr.
14 Oduwole or Dr. Ash-Bernal who were the two physicians who were
15 expected to be involved with his care that evening; is that
16 correct?
17 A That's correct.
18 Q You knew Matthew had been prescribed and taking Keppra
19 for a seizure disorder; correct?
20 A That's correct. Keppra was one of his home medications
21 that, that -- per the history. He had not been taking for
22 some days. So it was ordered to be resumed.
23 Q And you agree that his failure to take that seizure
24 medication was putting Matthew, I believe that I quote, at
25 risk, excuse me, significant risk for serious harm. That's

1 your testimony; isn't it?
2 A Seizure medications, of course, reduce the risk of
3 seizures. So not taking a seizure medication can put you at
4 significant risk for having a seizure. Goes the, you know,
5 the same with a blood pressure medication. If you stop taking
6 your blood pressure medication for a number of days or a
7 number of weeks it can spike up and cause problems or if
8 you're supposed to take Plavix for a heart stent and you don't
9 take it for a few days it could close off your stent. Any
10 number of medications for any number of conditions if you
11 don't take them as, as prescribed, as directed, there's always
12 a risk that something bad can happen.
13 Q But with Keppra and a seizure disorder the nature of the
14 risk is a serious, excuse me, significant risk for serious
15 harm; correct?
16 A There's a significant risk for that medication along with
17 any medication that you take or don't take.
18 Q Now, at no point in time did you have any discussion with
19 Dr. Ash-Bernal that it would be important to make sure that
20 Matthew actually gets administered or takes this Keppra later
21 that evening for this condition that is a significant risk for
22 serious harm, you never had that discussion; did you, Doctor?
23 A Did not and part of the reason is a medication that I've
24 ordered my anticipation and expectation is that medication is
25 going to be given to the patient and they're going to take

1 that medication. Now, if that medication is not given or not
2 given at the right time or refused or that sort of thing then
3 my expectation would be that we would be notified of a
4 medication that is ordered as important as it may be that the
5 patient is saying no or we can't give it because suppose the
6 medication is IV only and the patient doesn't have an IV or,
7 you know, if they're not able to swallow pills anymore, and
8 they're not able to give an oral medication we need to find
9 another route. In any case, if a medication is not, not
10 administered when it's ordered we would expect that, you know,
11 the physician, whether it be me or whoever is on call or
12 available would be notified that the patient is not taking it
13 or not able to take it or, you know, whatever the reason may
14 be.
15 Q And you have no recollection of any conversations with
16 the nurses to remind them of the importance of making sure
17 that he got this medication; do you?
18 A Again, as I said, since the medication was in the
19 computer and it was ordered at its appropriate time as with
20 the hundreds of thousands of other medications that I've
21 ordered my expectation is a medicine that I've ordered would
22 be given at its appropriate time.
23 Q Let's talk about the orders for a second, Doctor. You've
24 ordered the psychiatric consult with Dr. Oduwole; correct?
25 A Correct.

1 Q Never happened; correct?
2 A No. Dr. Oduwole did not come and see the patient that
3 evening.
4 Q And but we, we agree the psych consult never happened;
5 right?
6 A Correct.
7 Q And you ordered Keppra; right?
8 A That's correct.
9 Q And Keppra never given; correct?
10 A Keppra was not given based on the, the medical record
11 later on in the day.
12 Q Now, let's talk about the other thing. You also ordered,
13 or excuse me, noted that Ativan, an anti-agitation drug, could
14 be given as needed to Matthew in the event he became agitated;
15 correct?
16 A Correct.
17 Q You thought that was a good idea, you wrote it in your
18 note?
19 A Correct. In my history or assessment plan, sorry, I
20 believe, I noted that Ativan is an as-needed -- as-needed
21 medication, you know, it would be something that we may want
22 to consider giving if it became necessary.
23 Q But you never entered the PRN order for Ativan. We all
24 agree on that, too; correct?
25 A No. The order was not -- it was not ordered. I'm sorry,

1 not entered, and you know, part of the reason for that, again,
2 as I may have alluded to earlier is, you know, certainly
3 thinking about giving that medication or placing an order for
4 that medication, but again, in my experience, you know,
5 there's been a number of cases where, you know, situations
6 where a patient receives a sedative medication. This has
7 happened in the emergency room when a patient receives Haldol
8 or Geodon, and then I go in and try and talk to the patient
9 and they're pretty much out of it or asleep, not really
10 interacting with me. So I mean, that was kind of going
11 through my head as well. If I order Ativan, even on a PRN
12 basis, and the patient receives the medication, and it may be
13 appropriate for the patient to get, and if necessary, that's
14 fine, but my expectation was that Dr. Oduwole, per my
15 discussion with Dr. Battisti earlier, was probably going to
16 swing by and see Matthew later on, probably may be shortly
17 after I leave or after I'm completed, you know, my admission.
18 If that were the case then, you know, if he needed Ativan and
19 he got Ativan, you know, he might not be able to, you know,
20 give a good evaluation to Dr. Oduwole when he saw him. That's
21 happened a number of times, and also know furthermore that,
22 you know, because Ativan is, is a medication that could
23 readily be given, you know, if a nurse needed it if anything
24 were to happen, again, we're available, I'm available, really
25 in a matter of minutes, you know, a nurse all she has to say

1 or he has to say is, "You know, this patient is a little bit
2 agitated, a little bit anxious," or anything, "could we have
3 this medication," or Ativan or Geodon or what have you. You
4 know, it could also be the case for any number of things as I
5 said earlier. If the patient exhibits these symptoms or these
6 signs and something is indicated we're a phone call away. So
7 knowing those things, you know, kind of my thought process at
8 the time that I was thinking about giving the Ativan and why I
9 didn't order the Ativan, those are some of my considerations.
10 Q Doctor, can we agree that the time that it would have
11 taken you to order the Ativan, actually put it -- enter the
12 order into the computer --
13 A Correct.
14 Q -- would have been less than the time it took to give
15 that answer?
16 A I would say, I don't know, maybe about 30 seconds to type
17 in Ativan and put it in.
18 Q You never ordered any psychotic or, excuse me,
19 antipsychotic medication for Matthew; is that correct?
20 A At the time I evaluated him I did not feel that he needed
21 any antipsychotic medications.
22 Q All right. So let's go over your plan for Matt, psych
23 consult, we agree it never happened; right?
24 A Correct.
25 Q All right. There was Keppra, he needed to take it, we

1 agree he never got it; right?
2 A Correct.
3 Q And Ativan may be needed, we agree you didn't enter the
4 order and he never got any that night; correct?
5 A I'm sorry. Say that again.
6 Q We agree that you entered the -- excuse me, you wrote the
7 note that Ativan may be necessary?
8 A Uh-huh.
9 Q You also agree that we never -- you never actually
10 entered the order for the Ativan?
11 A I did not order -- enter the order for Ativan. Correct.
12 Q So Matthew received none of the treatment that you
13 ordered for him?
14 A Based on the Keppra, he did not receive the Keppra. We
15 ordered some blood tests and, and that sort of thing in terms
16 of diagnostics, so that -- some of that did happen. The
17 ultrasound that we ordered that did occur that night. So we
18 were able to evaluate, you know, some of the medical issues
19 that, you know, we were investigating that night. So that did
20 occur.
21 Q Ativan's for agitation. I think we already established
22 that. Right?
23 A Correct.
24 Q Now, later that night around 1:13 a.m. we've all seen the
25 record that indicates what happens then, Matthew's shirtless.

1 He's removed his shirt. He's pacing the halls. He's removed
2 his wristband from the hospital. He's becoming aggressive
3 with the staff. He's yelling that the staff are devil
4 worshipers, they cannot control him nor could the president at
5 the time, Obama. Would you agree with me that that would be
6 an agitated state?
7 A I would agree that certainly that's odd behavior and
8 certainly not the condition that he was when I saw him, and he
9 certainly appears to be, you know, in an agitated state at
10 that point.
11 Q And no one at that point in time according to the
12 records, with no order entered, gave any Ativan to Matthew;
13 correct?
14 A The records don't reflect any Ativan given at that point.
15 Q Now, and instead the nurses at that time they, they,
16 without an order to give any Ativan or other anti-agitation
17 medication, they contacted Dr. Ash-Bernal; correct?
18 A I believe at the time one of the nurses contacted Dr.
19 Ash-Bernal as she was -- I think she was walking onto the
20 floor at the time to see another patient, I believe.
21 Q Let's talk a little bit about some of the permissible, I
22 can't say the words, permissible disclosures healthcare
23 information. Do you believe, is it your belief that HIPAA or
24 the other privacy laws would permit a healthcare facility or
25 provider from stating whether or not a person was present in a

1 facility?
2 A I'm not sure. It would depend on the circumstance I
3 suppose.
4 Q And people can designate under our laws, they can
5 designate other people to have access and be provided their
6 healthcare information; correct?
7 A That's correct. That's something they can provide.
8 Q That happens all the time, every day in every hospital in
9 America; correct?
10 A That's correct.
11 Q They've got emergency contacts, they can hear it;
12 correct? Hospital's got forms that everybody fills out so
13 they can get their medical records; correct?
14 A Correct.
15 Q You were aware that David Scheer, after sitting down with
16 him and talking with him and all of that earlier in the
17 evening, you knew that he was Matthew's emergency contact;
18 right?
19 A I don't know if I specifically knew that he was his
20 emergency contact. He was obviously the person that, you
21 know, presented with Matthew. One could infer from that that,
22 you know, that's his contact person, that's, you know, whoever
23 came with him that day.
24 Q There was no problem with all of Matt's personal
25 discussions and what happened the day before, hallucinations

1 and visions and so forth that were discussed and other things,
2 there wasn't any problem with David knowing any of that
3 information when you sat down with him; correct? That was
4 entirely appropriate?
5 A That was entirely appropriate. Yes.
6 Q And if there was a change in Matthew's condition after he
7 -- you left the hospital, that paperwork that was completed we
8 all agree that would allow David Scheer to be provided that
9 information?
10 A In terms of? Say that -- say -- I'm sorry. Say that
11 again.
12 Q Certainly. You guys went through all that paperwork, he
13 was listed as the emergency contact and all that. If there
14 was a substantial change in Matthew's condition and David
15 wasn't in the hospital, we all agree that he could have been
16 contacted to learn of that substantial change?
17 A As long as the patient consents to that, yes, he can be
18 contacted.
19 Q And that role of consent and you're trained to do mental
20 status exams and so forth, and you've had plenty of times in
21 your practice where a patient who is not suffering from mental
22 illness cannot consent or not consent to certain things; isn't
23 that true?
24 A Typically, yeah, we, we encounter those situations, you
25 know, throughout our, our day.

1 Q Now, you have estimated, too, that at the hospital there
2 are involuntary commitments that occur a couple of times a
3 month; is that accurate?
4 A Yeah. I'm not, I'm not referring to just the patients
5 that I see.
6 Q Not just you.
7 A But I'm, you know, among the 15 or so physicians working
8 on a, on a day-to-day basis, I don't know the coming and
9 goings of every patient in the ED, but yeah, I would presume
10 there's a number of them per day, you know, and as we've grown
11 over the last 10 years probably more so.
12 Q So this is not some infrequent event that occurs so
13 rarely where the, the big guys come in the dark uniforms and
14 haul somebody off to a room. This is something that happens
15 frequently, the hospital staff are trained to address; isn't
16 it?
17 A In which part of the hospital are you referring to?
18 Q I'm talking about the hospital in general.
19 A Well, in -- I would probably try and differentiate
20 between the floor and what happens in the emergency room. In
21 the emergency room a lot of things occur that obviously we're
22 not privy to. Patients come and go for a variety of reasons,
23 and we're not involved in every patient in that situation,
24 traumas, you know, other, you know, forms of abuse, any kind
25 -- any number of things. So we, we don't know, but as far as

1 I'm -- as far I know the, the number the patients that are
2 probably, you know, committed that can sometimes we have none
3 per day. Sometimes we may have, you know, a handful per day.
4 It, it really varies on a day-to-day basis.
5 Q So on this floor you're on it has psych rooms; right?
6 A Doesn't have psych rooms per se. There's a couple of
7 rooms segregated on the floor, you know, that are made a
8 little bit safer in the sense that, you know, we try and
9 remove any potentially, you know, dangerous obstacles that,
10 that may be in a room. There's a bed. There's a sink. At
11 that time there were -- some had TVs, some did not have TVs.
12 They try and remove cords and cables and there's probably a
13 number of other things. The doors are typically left open,
14 you know, and they're, they're just these four rooms or four
15 or five rooms there that, you know, can have easy access to,
16 but they're not -- it's not a locked unit. It's, it's not a,
17 a segregated unit or anything of that sort. We don't have
18 that, per se, in this hospital.
19 Q Now, so you're on the floor and there are psych rooms
20 there, and you're on the floor, you said that these
21 involuntary commitments may happen a lot more frequently down
22 in the emergency department; is that right?
23 A Yeah. Current -- at, at that time in, in 2015, yeah,
24 they may happen, but currently we have, you know, facilities
25 that the patient can go. So, you know, currently we don't

1 necessarily have as many because, you know, more recently
2 we've had, you know, facilities in the area that have allowed
3 us to send patients directly to those facilities as we're not
4 a psychiatric facility. Back then if a patient, you know,
5 needed involuntary commitment, they would, you know, have to
6 be committed in the ED and then they would come up to the
7 floor, and, and then we would progress.
8 Q Let's focus on 20 -- October 2015 when all this happened,
9 Doctor. Times change. Hospitals change. So let's focus back
10 on October 2015.
11 A Sure.
12 Q If, if involuntary commitments are happening down in the
13 ER on a daily basis, potentially, I think is what you just
14 said, if somebody had questions about what to do in those
15 situations up on your floor, you simply could summon somebody
16 from the emergency department, and say, "Hey, whoa, we're not
17 familiar with involuntary commitments. Get somebody up here
18 who has some more information about how these can be done"?
19 A Well, not --
20 Q That could be done; couldn't it?
21 A Not, not quite as easily as you're describing it.
22 Emergency physicians are downstairs. I mean, we can have a
23 phone call and just ask.
24 Q Come up here; right?
25 A Actually, no. They typically don't leave the emergency

1 room because they have patients in the ER that they can't just
2 leave, but --
3 Q Can you ask them?
4 A Huh? As I just said, you know, you can ask them on the
5 phone.
6 Q Ask them, "Hey, this is what's going on. I'm not familiar
7 a with involuntary commitments. I need this information."
8 MS. SPEARS: Your Honor, can the witness finish his
9 answer?
10 THE COURT: Yeah. Let him finish his answer.
11 MR. PADGET: Sure.
12 A Not, I believe like I said, you know, we could talk to
13 them on the phone and ask them a question and that sort of
14 thing or paperwork if it's present on the floor we can, we can
15 do that on the floor as well.
16 Q But the information's a phone call away?
17 A It can be.
18 Q Now, you said -- now, those -- these involuntary
19 commitments happen on a daily basis down there. It's not your
20 testimony that these patients that are being involuntary
21 committed that no one has any concern for their liberties.
22 You're not here saying that; are you?
23 A Well, I mean, there's always a concern for that.
24 Remember, you're -- when you're committing a patient that's
25 not a decision that you take lightly. You know, you're,

1 you're basically saying that, you know, you can no longer, you
2 know, have the things that we take for granted, you know,
3 phone calls, TV, you know, those, you know, many other things.
4 You're saying that they can't have visitors. You're saying
5 that, you know, no one can, you know, they can't contact
6 anybody unless they have explicit permission from the
7 physician, among other things. You're saying that, you know,
8 these are your four medications and you must take these four
9 medications right now or, you know, we're going to force them
10 upon you. So I mean, it's not a decision that you take
11 lightly because those are some of the things that, you know,
12 you're going to be subjecting your patient to.
13 Q And nobody is saying anybody should take those decisions
14 lightly, Doctor. I'm just saying that there are situations
15 that occur where the physicians determine it's in the best
16 interest of the patient, for a variety of reasons, that they
17 need to be involuntarily commitment -- committed and that
18 happens on a fairly regular basis at Grand Strand Regional
19 Medical Center?
20 A If they feel that it's appropriate, correct.
21 Q You've actually completed some of these -- the paperwork
22 to do that process yourself?
23 A Involuntary commitment papers?
24 Q Yes.
25 A I have, not frequently, but I have personally.

1 Q Sure. So, I mean, you've, you've done it yourself?
2 A I have.
3 Q And you did so in that circumstance because it was your
4 belief that the person was mentally ill and had the potential
5 to cause harm to himself or others; isn't that right?
6 A If I felt that the, the patient was in imminent harm to
7 themselves or others and I felt at, at that time, you know, it
8 was in the, in the best -- in their best interest then, yes,
9 normally we would commit the patient if that's what we felt.
10 Q And keep in mind, Doctor, no, no one is suggesting that
11 you should have committed Matthew. You understand that;
12 right?
13 A I understand that.
14 Q But that's a process that's available and it's at the
15 hospital, it's there to prevent injury to patients and to
16 other people if they pose a risk of harm to themselves or
17 others?
18 A That's a process that's available.
19 Q And just because a patient came in voluntarily does not
20 mean that that cannot convert to an involuntary admission if
21 the circumstances arise that make that necessary?
22 A Well, the patient came in voluntarily. Certainly if
23 something changes in that situation, you know, it's, it's a
24 moment-by-moment decision, you know, if the physician
25 evaluating the patient at the time, you know, depending on how

1 they feel, what their evaluation indicates, they feel that the
2 patient needs to stay then, you know, they need to start that
3 process. If they feel that the patient doesn't need to stay
4 and is able to make decisions for themselves, then, then
5 they're -- they have to honor the wishes and, and not commit
6 the patient, depending on what the, the wishes are at the
7 time.
8 Q You described a little bit earlier, Doctor, the process
9 by which you -- I think you said you still do some dictating?
10 A Sorry.
11 Q Others don't, they're typing, but you, you still do the
12 dictation?
13 A Correct. I still dictate almost all of my history and
14 physicals.
15 Q And I still do some dictation occasionally. I -- but
16 when you do it you, you pick up a piece of equipment and you
17 speak into it; right?
18 A Correct.
19 Q And you're, you're saying what you want to be transcribed
20 into the medical record; correct?
21 A That's correct.
22 Q All right. And you -- when you do that, I mean, you have
23 an obligation as a physician to do that truthfully and
24 accurately; correct?
25 A That's correct.

1 Q Now, you also in this case, Doctor --
2 MR. PADGET: Your Honor, if I may approach.
3 THE COURT: Yes, sir.
4 MR. PADGET: May we approach?
5 (Whereupon, a bench conference is held in the presence,
6 but out of the hearing of the jury.)
7 BY MR. PADGET:
8 Q And Doctor, you have Exhibit One as well we talked about
9 earlier, that's the medical record?
10 A Correct.
11 Q And this is your, this is your discharge note that you
12 dictated the following morning when you came back to work and
13 we're talking October 3rd sometime around 8 a.m.
14 A Now, which page are you on? On, on --
15 Q I'm sorry, page 54?
16 A Okay.
17 Q Are you with me?
18 A Yep.
19 Q All right. This is your discharge summary for Matthew
20 that you completed the following morning?
21 A That's correct.
22 Q Okay. And just like you testified to a moment ago, when
23 you do a medical record you talk into a machine and you put
24 what you believe is truthful and accurate information about
25 his care into your record; isn't that true?

1 A That's correct.
2 Q All right. Now, you wrote down at the bottom there 54,
3 you see, are you with me? I'm beginning with, "The patient,"
4 it's the second line from the bottom?
5 A "The patient", correct.
6 Q [As read], "The patient left against medical advice later
7 that night"?
8 A Uh-huh.
9 Q Do you see that?
10 A I see that?
11 Q That's what you wrote, [as read], "And all questions were
12 answered to the best of my ability"?
13 A Correct.
14 Q You see that?
15 A I see that.
16 Q Okay. And you went on to write, shortly thereafter, [as
17 read], "The discharge planning took greater than 25 minutes."
18 Do you see that?
19 A I see that.
20 Q All right. Now, in this note, you're -- excuse me,
21 you're saying that you answered all of his questions at
22 discharge to the best of your ability?
23 A That's not correct. The questions that I --
24 Q That's not correct.
25 A -- the questions that you are referring to are the

1 questions that I would have talked to with the patient on
2 admission and with David, and that's the time that -- what I'm
3 referring to questions to the best of my ability. That's a
4 normal statement I put on all of my discharges. As I said
5 earlier, we dictate discharge summaries that summarize the
6 course of events of a patient throughout the hospital whether
7 that may be a few hours, a few days, that may be 400 days. So
8 if I'm the attending physician of record of that day on the
9 day the patient leaves it's my job and we've decided that it's
10 just the attending physician that does that, not the person
11 that was on at the time the patient left or anything of that
12 sort. We felt that the person who has the best information is
13 to -- is the one that should do the discharge summary. So in
14 this case that was me, and it so happens I was also the one
15 that admitted the patient the previous afternoon. So we
16 typically come in, we review everything, the notes, the labs,
17 once again, any other information that may come in, anybody
18 else who spoke to, that sort of thing, and that's where that
19 comes in in terms of the discharge planning took greater than
20 25 minutes. That's basically just a general summary of all
21 the time that you may have spent not just dictating the report
22 but reviewing everything that, that occurred. Sometimes it
23 can be a lot more than that if the patient's been here for 400
24 days, of course, but in this case that's about how long a
25 typical discharge summary takes. I think -- I, I usually

1 dictate a discharge summary anywhere from, I don't know, five
2 to 10 minutes or so. So that, that generally depends on that.
3 Just to kind of work backwards, the patient was, again, do you
4 have more questions or should I -- do you want me to --
5 Q Sure. Let's direct the questions, keep it specific.
6 A All right.
7 Q You wrote in your note that discharge planning took
8 greater than 25 minutes; correct?
9 A I see that. Correct.
10 Q That's not preparing the discharge summary, that's
11 discharge planning. That's done by a doctor who sends them
12 out the door; correct?
13 A It can be referred to that way, but typically we refer to
14 discharge planning is everything that took place at the time,
15 whether it may be, you know, whether you were present or not.
16 Again, you may not be present at the time, but the discharge
17 planning, again, involves looking over everything, talking to
18 whoever was around, nurses, reviewing test results and all of
19 those things, and again, it's a general summary about how long
20 if you were present, estimate how long it would take or how
21 long it may have taken if you were not present to plan a
22 discharge. Again, a discharge may be a patient going home,
23 going to another facility, you know, whatnot, but that's
24 generally a statement of a rough estimate of how long it took.
25 Q But you certified in your record it took greater than 25

1 minutes. That's exactly what you wrote?
2 A I see that there, yes.
3 Q And we all agree, as you confirmed in your affidavit,
4 that you were not present at the hospital when that discharge
5 planning took place?
6 A I was not present at the time, and again, as I stated
7 earlier, the 25 minutes is a summary of going back and looking
8 at in my review of the notes what happened over the course of,
9 of that time, and as we probably seen earlier, there was some
10 events overnight that took and over -- in the course of
11 approximately 30 or 40 minutes or so, and from that I have to
12 kind of glean exactly, not exactly, but about how long that
13 took. So that's what that summary is.
14 Q Now, you went -- you were employed by Southern Myrtle
15 Inpatient Services in October of 2015; correct?
16 A EmCare, correct.
17 Q EmCare and Southern Myrtle's one of the entities under
18 EmCare; right?
19 A Yeah. I, I believe so. I don't know.
20 Q All right. And your paycheck said Southern Myrtle at
21 that time?
22 A I don't recall specifically, but --
23 Q But you don't dispute that you're an employee of Southern
24 Myrtle Inpatient Services at that time?
25 A At that time if that's what the, I guess, all of the, the

1 legal hierarchies of every, of the businesses entail, I, I
2 don't know, but if that's the case that's the case.
3 Q You were working for -- all right. The -- earlier we
4 went over your credentials and your training --
5 A Uh-huh.
6 Q -- about where you, where you trained and where you went
7 to school and all those things; correct?
8 A Correct.
9 Q Now, you, you omitted that you went to medical school
10 down in Grenada; is that correct?
11 A That's correct.
12 Q Down in the Caribbean?
13 A That's correct.
14 Q And the reason you went to medical school in the
15 Caribbean was because you were not accepted to any medical
16 schools in the United States?
17 A I was not accepted to a medical school in the United
18 States.
19 Q Doctor, you have been a party to a number of different
20 lawsuits; isn't that true?
21 MS. SPEARS: Objection. Objection.
22 THE COURT: I sustain the objection.
23 Q It's not your first time today testifying, is it, Doctor?
24 A In trial.
25 Q Testifying.

1 A I've done depositions.
2 Q Sure, and in those depositions you were testifying about
3 the facts in other wrongful death cases; correct?
4 MS. SPEARS: Objection, Your Honor. Can we approach?
5 (Whereupon, a bench conference is held in the presence,
6 but out of the hearing of the jury.)
7 THE COURT: Members of the jury panel, disregard the last
8 questions about lawsuits and Dr. Patel.
9 Q Dr. Patel, we all agree Matthew Scheer never got any of
10 the care that you ordered; isn't that true?
11 A I would say that that's not true. He received some of,
12 again, some of the laboratory workup that we had ordered. He
13 received some of the imaging, it was completed that we
14 ordered.
15 Q Testing was done. I mean, testing was done. We agree.
16 MS. SPEARS: Your Honor, can he finish?
17 THE COURT: Yeah. Don't interrupt his answer.
18 Q I was trying to shortcut it, Your Honor, that's all.
19 A I'm sorry. I would disagree with that just because
20 based on part of the reason that he came in to the hospital
21 was for medical evaluation. So testing was definitely part
22 of that medical evaluation and that's part of his care
23 there, diagnostic testing is part of one's care. So, no,
24 I would disagree with the statement that he received no
25 care.

1 Q And Dr. Battisti spoke to two different physicians about
2 Matthew's care on the phone and you spoke with nobody about
3 his care downstream; correct?
4 A I did not speak to a physician when I left the hospital,
5 before I left the hospital, no.
6 MR. PADGET: That's all the questions I have, Your Honor.
7 THE COURT: All right. Redirect.
8 MS. SPEARS: Briefly, Your Honor.
9 REDIRECT EXAMINATION
10 BY MS. SPEARS:
11 Q Dr. Patel, did you see any documentation in the medical
12 records for -- that the nurses asked for Ativan at 1:13 in the
13 morning when the patient became agitated?
14 A No. I did not.
15 MR. PADGET: Objection, leading, Your Honor.
16 THE COURT: Yeah. Rephrase your question.
17 Q In your review of the medical records, was Ativan ever
18 requested by the nursing staff?
19 A It was not.
20 Q Was it appropriate for the nurses to call a physician
21 when the patient became agitated?
22 A If they felt that the patient exhibited signs that needed
23 a medication of any kind as needed it's within their power to
24 request that or request an evaluation by a physician to see if
25 it's necessary.

1 Q Thank you, Dr. Patel.
2 MS. SPEARS: Nothing further.
3 THE COURT: You can, you can step down and have a seat.
4 Members of the jury panel, we'll take about a 15-minute break.
5 It's -- we've been at it about an hour and a half, a little
6 over an hour and a half, close to an hour and a half. We'll
7 be at ease till about ten after.
8 (Jury exits courtroom.)
9 OFF THE RECORD
10 (On the record. The following takes place outside the
11 presence of the jury.)
12 THE COURT: All right. We can bring in the jury.
13 (Whereupon, the following takes place in the presence of
14 the jury.)
15 THE COURT: Call your next witness.
16 MR. GRESH: Your Honor, at this point the Defense would
17 call Dr. Rachel Ash-Bernal to the stand, please.
18 THE COURT: All right.
19 Whereupon, Rachel Ash-Bernal is called to the stand, duly
20 sworn by the clerk and testified as follows:
21 THE CLERK: Please say your first and last name and spell
22 it for the record.
23 MR. GRESH: Okay.
24 MS. ASH-BERNAL: Sure. My name is Rachel Ash-Bernal, R-
25 A-C-H-E-L, A-S-H, hyphen, B-E-R-N-A-L.

1 DIRECT EXAMINATION
2 BY MR. GRESH:
3 Q And good morning, Dr. Ash-Bernal.
4 A Good morning.
5 Q I know you've already endured two hours of cross-
6 examination that we watched yesterday.
7 A Yes.
8 Q But I did want to call you up to the stand to kind of go
9 through some things that may not have been asked in that.
10 It's not my intention to re-plow any of the ground that was
11 covered there, but really give you an opportunity if one is
12 necessary to explain some things.
13 A Yes.
14 Q Okay. So why don't we start kind of in the beginning and
15 tell us a little bit about yourself, where you grew up, that
16 kind of thing.
17 A Sure. I was born and raised in the Boston area. My
18 mother is from Colombia, South America. That's what the
19 Bernal is from. I grew up in a bilingual household. My
20 father grew up in Detroit. He did high school on a military
21 base because my grandfather was in the Army, went to Lexington
22 public school systems, went to public high school. Then I
23 attended college at the Pennsylvania State University. I had
24 a partial volleyball scholarship at Penn State. I did two
25 degrees while I was in college. I did a bachelor of arts in

1 Spanish literature and bachelor of science in biology. After
2 I graduated from Penn State, I worked as a laboratory
3 technician and a research assistant for several years and then
4 I applied to medical school. At that time I was really
5 interested in doing a lot of research because I had been in a
6 research lab for a few years, really loved it, and I was
7 awarded an MD PhD, full scholarship to go to medical school.
8 So that was doing basically two degrees concurrently.
9 While I was in medical school in my clinical years I did
10 some volunteer work in Honduras and Peru with underserved
11 people in those areas. Some of those places were pretty
12 remote, too, and about halfway through medical school and
13 halfway through my PhD program I decided that I loved clinical
14 medicine, I loved taking care of patients and that's what I
15 wanted to focus on, and so I dropped the research and just
16 decided I couldn't be so good at so many things and stuck with
17 that.
18 After I finished medical school, which I was in for five
19 years because of my PhD program, too, I had the honor of going
20 to internship and residency at Johns Hopkins in Baltimore,
21 Maryland. This was definitely a very formative time in my
22 life. I still look back at my attending physicians with great
23 respect and love.
24 After Johns Hopkins I went and did a heart failure,
25 cardiac transplant fellowship at Columbia Presbyterian

1 Hospital in New York City. I applied to cardiology fellowship
2 in my third year of residency and was accepted at Washington
3 University in St. Louis, actually outside of the match. They
4 offered me the position without going through the match
5 process, which was a great honor, and doing the heart failure
6 transplant program was sort of a fill in year for me as I
7 wasn't going to attend general cardiology fellowship until the
8 following year. At that point, you know, I, I could have done
9 something else but I, I chose to do something that I was
10 interested in and that I would learn more. So I went to New
11 York. I moved around a lot when I was in training. I really
12 had the attitude that I wanted to go anywhere where I could
13 get the best training possible to become the best doctor I
14 could become.
15 After New York City, I moved to St. Louis and went to
16 Washington University in St. Louis where I did four years of
17 cardiology fellowship. The second half of my fellowship there
18 was mostly research based on imaging studies. The first two
19 years were clinical based.
20 Q Did you for a time practice in the role of a
21 cardiologist?
22 A Yes. Absolutely. As happens in many people's lives, I
23 had something very difficult happen to me in general
24 cardiology fellowship. My father was diagnosed with leukemia,
25 and I'm sorry, I told myself I would not do this on the stand

1 because I'm not trying to elicit sympathy, but he was
2 diagnosed with leukemia, and I was the only doctor in the
3 family, and I was very involved with his care. He lasted 21
4 months. There were many dramatic moments with that. He
5 almost died several times, and I was actually at his deathbed.
6 In fact, I pronounced my own father.
7 Q Did that experience kind of help you move away from the
8 cardiology world and into the, the world of an internal
9 medicine physician?
10 A Absolutely. I mean, I can honestly say I felt very
11 selfish at his funeral because I thought to myself if I only
12 thought I had 20 years to live like when my dad died would I
13 be doing what I'm doing, and I was working a hundred hours a
14 week, you know, really didn't have a personal life and I
15 really decided at that moment I'm going to change this. So,
16 you know, when, when things are going in a certain direction
17 it can be really hard to turn them around. You know, it takes
18 years. So that's what I did. It took a little while. I
19 practiced in cardiology. I enjoyed it but, you know, that was
20 definitely kind of an epiphany for me, going through the
21 medical system with my own family.
22 Q Have you received any type of board certifications?
23 A Yes. I'm board certified in internal medicine. I did
24 that right after I finished residency and then I recertified
25 in 2014.

1 Q Are you also certified with the -- a fellow with the
2 American College of Physicians?
3 A Yes.
4 Q Tell us what -- I don't think I've heard that this week.
5 Tell us a little bit about what that is, please?
6 A Sure. That's when you see the credentials FACP, I have
7 noticed that, that's an honor bestowed on someone for having
8 great acumen in internal medicine and because of your
9 achievements and publications I was nominated by my colleagues
10 at Johns Hopkins for that.
11 Q And you have a medical license in the State of South
12 Carolina?
13 A I have multiple medical licenses.
14 Q Where, where are you or have you been so licensed to
15 practice medicine?
16 A South Carolina, North Carolina, Missouri, New York State
17 and Maryland and currently Kentucky and Georgia as well.
18 Q Have you also published any articles that would be
19 recognized in the peer review literature?
20 A Yes. I've published five or six articles in the peer
21 reviewed journals and a number of posters. I was the first
22 author on a couple of those at least.
23 Q There, there came a time where you were practicing as a
24 hospitalist. We've heard a lot about that, won't go into that
25 again, but when I was listening to your deposition testimony

1 you used the word locums?
2 A Yes.
3 Q And I'm not sure that I have a real good appreciation for
4 what that is. Can you just briefly describe for us what it
5 means to be a locums physician.
6 A Sure. Locum tenens is a Latin word for placeholder, and
7 it's basically a travel doctor. If there's a hospital such as
8 Grand Strand Hospital that was growing like gangbusters, as we
9 all know the population around here has really grown, their
10 needs were pretty heavy that they needed extra help, and then
11 they hired a lot of locum tenens doctors in 2014, 2015 to come
12 here and help them out.
13 Q If a doctor wants to come to Grand Strand and, and see
14 patients do they get to just come on the floor and see
15 patients?
16 A No. Absolutely not.
17 Q Tell us a little bit about the process by which a
18 physician might be able to see patients at a particular
19 hospital like Grand Strand?
20 A The process is long. I'd say on the short side it would
21 be four months. On the long side it could be six or eight
22 months to get credentialed at a hospital.
23 Q When you talk about the word credentialing there --
24 A Uh-huh.
25 Q -- do you have familiarity with what that process is?

1 A Yes.
2 Q Can you give us just a, just a, a flavor of what the
3 hospital goes through to credential a physician?
4 A Sure. They independently have to confirm all of my
5 credentials, every single one.
6 Q Do they check your references?
7 A Absolutely.
8 Q When you get -- I assume at the end of that process the
9 goal is to be credentialed by the hospital?
10 A Yes.
11 Q Once you are credentialed by the hospital are you then
12 able to see patients at that hospital?
13 A Absolutely.
14 Q But before you see patients at that hospital will a
15 hospital provide you orientation or training?
16 A Yes. Every hospital that I've been at I had to go
17 through their orientation.
18 Q Does it also include HIPAA training?
19 A Yes.
20 Q Do's and don'ts?
21 A Yes.
22 Q In, in looking through your CV, do you have an estimate
23 as to the number of hospitals at which you have received
24 credentials to treat patients?
25 A At that time in 2015 it was probably upwards of nine to

1 11 or 12 hospitals. Now it's even more.
2 Q And at each one of those you would have received training
3 on HIPAA policies, procedures and the like?
4 A Yes. Some of them were long. They could have been an
5 entire week, five days, you know, a business week, some of
6 them are shorter.
7 Q And also in looking at, at your CV oftentimes when you
8 would go to a particular hospital and get credentialed you
9 might also be working with a group like you were here Southern
10 Myrtle Inpatient Services?
11 A Yes.
12 Q From time to time does that group have maybe different
13 contracts with different hospitals, different groups do?
14 A Yes. The group that I was with was called EmCare, that
15 was just the name of the company, and Southern Inpatient
16 Services was, I believe, the overriding corporation, I
17 suppose.
18 Q With all of those different locum tenens companies that
19 you were with, would they also provide you education and
20 training on, on HIPAA policies, procedures and the like?
21 A Sure. I mean, I've worked for many of the big locum
22 tenens companies, Staff Care. Locum Connections was a local
23 one here. I actually worked for Loris Hospital, Seacoast,
24 Georgetown. I worked at McLeod in Florence as well as Grand
25 Strand.

1 Q The training that you received from Southern Myrtle
2 Inpatient Services was that any different, better, worse than
3 the training that you got from the other places that you
4 worked?
5 A When I started at Grand Strand I remember sitting down
6 with a nurse for an entire day. It was me and another
7 physician, and we went through a slideshow with her, and she
8 read each slide. I, I remember it was quite cold in the
9 physician room, and it was about seven hours long.
10 Q Dr. Ash-Bernal, for how long have you been practicing as
11 a hospitalist?
12 A Approximately five years.
13 Q And you've had a medical license since when?
14 A I graduated from medical school in 2000.
15 MR. GRESH: Your Honor, at this point I would tender Dr.
16 Rachel Ash-Bernal as an expert witness competent to opine as
17 to what a hospitalist would do.
18 MR. HINSON: No objection.
19 THE COURT: I find she's qualified.
20 BY MR. GRESH:
21 Q Dr. Ash-Bernal, I'd like to move to the morning hours of
22 October 3rd of 2015, and if I could, I want to put in front of
23 you what is already into evidence, has been marked as
24 Defendant's Exhibit One.
25 A Okay.

1 Q And if I could show you on the bottom here there are page
2 numbers that are GSRMC and it's a one through 139?
3 A Yes.
4 Q And from time to time I may talk about a particular page
5 number. I'm going to do my best to put what I'm showing --
6 what I'm asking you to look at --
7 A Sure.
8 Q -- I'm going to put it up here, but that means you can't
9 see it because it's perpendicular to you?
10 A I understand.
11 Q If that causes confusion would you let me know and I'll
12 do my best to figure a solution; okay?
13 A Yes.
14 Q All right. To, to start with, as you, as you sit here
15 today, do you have an independent recollection of that evening
16 in question?
17 A Generally, no, but there are some things that were very
18 familiar to me when I read through the -- some of the nursing
19 notes.
20 Q And Bethany Bell's deposition?
21 A Yes.
22 Q And there are -- are there things that when we look at on
23 the screen might -- you might be able to explain what those
24 terms mean and what those would signify?
25 A Yes.

1 Q Would you also as a physician having all the licenses and
2 all the training that you have, have you developed certain
3 habits and routines and practices that you would employ in the
4 care and treatment of certain patients under certain
5 circumstances?
6 A Absolutely.
7 Q To the extent you need to rely on your habit, routine,
8 the nurses' notes or your notes feel free to do that, but I
9 want to walk through the care and treatment that was provided
10 to Matthew Scheer. You understand that you were the
11 nocturnist or the night hospitalist on that day?
12 A Yes.
13 Q Was -- what was your first encounter with Matthew Scheer?
14 A I was walking down the hallway because there was another
15 patient I was going to see, and the, the nurses asked me for
16 help with him.
17 Q All right, Dr. Ash-Bernal. Excuse me, you all, you're
18 good. You're good. I have up on the screen here a nursing
19 note which you can find at page 116 of the records in front of
20 you. Just for everyone's benefit this is the nursing note
21 from Nurse Freeman, and just let me know when you've got that
22 time.
23 A Yeah. At 1:13 a.m. that it occurred till 1:44.
24 Q Now, there's two times there on Nurse Freeman's note?
25 A Yes.

1 Q There's 0113 and a 0144. Do you see that?
2 A Yes.
3 Q The -- it's noted occurred at 113. Is that, based on
4 your education, training and experience, how a nurse would
5 record that an event happened at a particular time?
6 A Sure. It would be common to sort of record the range of
7 time that that occurred in.
8 Q And if, if the nurse was not at the, at the computer
9 typing contemporaneously, might they enter that note sometime
10 later?
11 A Absolutely. I mean, obviously you can't be typing and
12 documenting while you're doing things.
13 Q And just for everybody's benefit, the -- under the
14 occurred time is a recorded time is 0144. Is that your
15 understanding that's about the time that Nurse Freeman would
16 have started typing her note?
17 A Probably. Yeah.
18 Q All right. And this says, [as read], "The patient
19 approached nursing station, is pacing shirtless. Patient
20 ripped off armbands and threw them on the floor, started
21 yelling stating that we could not control him nor could Obama.
22 Patient accusing staff of being devil worshipers, on-call MD
23 Dr. Ash-Bernal called to see the patient." Dr. Ash-Bernal, do
24 you believe this at about 1:13 in the morning would've been
25 the first time that you would have been involved in the care

1 and treatment of Matthew Scheer?
2 A Yes.
3 Q In reviewing the chart did you also see that Nurse Bell
4 was involved in the care and treatment of Matthew Scheer in
5 and around this same time?
6 A Yes. She's the author of the note above and below
7 Jacqueline Freeman's.
8 Q That's right, and there -- one that I've just put up on
9 this screen is the note that is occurred at around 1:31 in the
10 morning and it's recorded about 1:38 that tries to lump in
11 everything that had happened up to this point; is that fair?
12 A Yes.
13 Q All right. When the nursing staff came to get you, did
14 you talk to the nursing staff?
15 A Yes.
16 Q Why?
17 A I, I would always talk to the nursing staff to find out
18 what was going on.
19 Q What are you trying to elicit from the nursing staff?
20 A I'm trying to elicit their perspective on what was going
21 on with the patient, what do they need help with, what types
22 of behaviors the patient is exhibiting, why are they
23 concerned.
24 Q You know, once the nurses come to get you do you then go
25 rush into the patient's room?

1 A No. I mean, it really depends on how much time I'm
2 taking with the nurse. It depends how articulate they are,
3 what they're really telling me, what they think the problem
4 is, the relevant information that they're telling me. You
5 know, I have to weigh that before I go and talk to a patient.
6 Q There could be instances that your attendance at the
7 bedside is absolutely critical, you got to be there right now;
8 fair?
9 A Absolutely. Like in a code situation, I would be running
10 to the room to be at the bedside. They'd have to give me
11 information while I was running there. I've gotten it in
12 elevators. I've gotten it running down the hallway. I've got
13 it at the bedside during a code.
14 Q In a, in a situation like this where the patient is at
15 the nursing station saying, "I know my rights. I'm here
16 voluntarily. I want to leave," is that a situation where you
17 would run in to see the patient or might you take time before
18 you get there?
19 A Although it sounds bizarre and concerning, if the patient
20 wasn't exhibiting things that were threatening or violent,
21 this would not be something that I would just rush into. I
22 would take my time with the nurse and find out what was going
23 on.
24 Q After you've talked with Nurse Bell and Nurse Freeman,
25 would you do anything else before you went in to see the

1 patient?
2 A I apologize. I'm having a hot flash. Yes. I, I, I
3 would typically review the chart. It's part of my habit to do
4 that. I can remember a number of times particularly as a
5 medical student where I really got a talking to by the
6 patients because I wasn't familiar with their chart and it was
7 embarrassing. So my routine and habit is to review everything
8 that I can before I go see a patient.
9 Q Now, in your, in your deposition testimony, I remember
10 some back-and-forth questions about, you know, would, would
11 this page have been available or that page have been
12 available. Can you tell us based upon your habit, routine and
13 practice what information you would have looked at prior to
14 going in to see Matthew Scheer?
15 A Sure. You know, I've never given a deposition before.
16 It's a very stressful and frightening experience actually, and
17 you know, in, in my deposition I didn't really get to explain
18 a lot about what I was thinking at the time. I was mostly
19 limited to yes and no questions, answers. You know, if a note
20 is incomplete that a nurse has open on her computer and it's
21 not signed yet, I don't think I would be able to see that
22 necessarily, but I would count on them to give me verbal sign-
23 out of what these important features were of what they wanted
24 me to deal with.
25 Q In your review in this case --

1 A Yes.
2 Q -- did you see that Dr. Patel dictated the note that he
3 just went over with everybody else and that that was
4 transcribed and available on the chart six or seven hours
5 before this 1:00 o'clock encounter; correct?
6 A Yes. I actually remember reviewing his note and he is
7 known for his very speedy and timely dictations.
8 Q Would you have reviewed Dr. Patel's note prior to going
9 in to see Matthew Scheer?
10 A Yes. At that time or if I had questions after talking
11 to the patient, I would also go back and review if I needed
12 to.
13 Q Are there any other parts of the chart that you believe
14 you would have looked at prior to going in to see Matthew
15 Scheer and talk to him?
16 A Sure. I mean, a lot of this is like trying to describe
17 parallel processing, you know. You're trying to look at
18 multiple things and start to get a feel, a flavor for what is
19 going on independently. So laboratory studies, imaging
20 studies, vital signs, ED notes, very important, see if there
21 were any other notes from -- I'm trying to think of anybody
22 else. Anytime I see that there's any sort of conflicting
23 information, I would go searching through the nursing notes
24 that were available to get their opinion and would also ask
25 the nurses. I had been working at Grand Strand for a while.

1 I had a good working relationship with the nurses. I think
2 one of the reasons they felt so comfortable coming and talking
3 to me when they saw me walking down the hallway was that I was
4 one of the helpful doctors.
5 Q In a situation like this where in the chart Bethany Bell
6 does a lengthy initial assessment, but there's no nursing
7 notes from her until the 1:15 timeframe, I guess there would
8 be no nursing notes for you to have reviewed to kind of catch
9 up on this?
10 A Probably not.
11 Q Is that when -- that why you would rely on the nursing
12 staff to report to you?
13 A Absolutely.
14 Q But you would have had access to Dr. Patel's note and you
15 would have read Dr. Patel's note?
16 A Yes.
17 Q Did reading Dr. Patel's, I think it's a three-page
18 history and physical, did that give you sufficient information
19 about Matthew Scheer in to whose room you're just about to
20 enter?
21 A I'd say it was adequate. I mean, you always hope for
22 more, you know, but in, in, in the moment, you know, just as
23 you're sitting here in court and you're going to be making
24 decisions, this is what you got.
25 Q But in addition to Dr. Patel's note, you also had Dr.

1 Battisti's two --
2 A Yes.
3 Q -- ER department notes?
4 A Yes.
5 Q Did you -- in your habit and routine and practice in a
6 situation like this would you have also reviewed the emergency
7 department notes?
8 A Yes.
9 Q Armed with the information you learned from the nursing
10 staff, from Dr. Battisti's two notes and with Dr. Patel's
11 note, did you feel that you had enough information to
12 intelligently talk with Matthew Scheer and address the nurses'
13 concerns?
14 A Yes. I felt prepared to go and talk to him.
15 Q In your review of the chart that evening, looking through
16 the emergency department notes, the nursing notes, Dr. Patel's
17 -- whatever you would have looked at, did you see any
18 indication from any provider that Matthew Scheer had ever
19 expressed homicidal ideations?
20 MR. HINSON: Objection, leading, Your Honor.
21 THE COURT: Rephrase your question.
22 Q In preparation for your going into Matthew Scheer, did
23 anybody note anything of concern regarding homicidal
24 ideations?
25 A Yes. I think Dr. Patel and Dr. Battisti both noted it.

1 Q Both noted that the patient had no --
2 A Had no homicidal or suicidal ideation.
3 Q Did you see anybody who affirmatively stated that Matthew
4 Scheer was having homicidal or suicidal ideations?
5 A No. I did not.
6 Q Doctor, in a situation like this, and you heard Dr. Patel
7 testify earlier today; correct?
8 A Yes.
9 Q In a situation like this where Dr. Patel went off shift
10 at around 7:00 o'clock that evening and was there anything
11 that the nighttime hospitalist, the nocturnist was going to
12 have to follow up on that evening?
13 A Not that I was told about.
14 Q And as you looked through the chart was there anything
15 that would have required your attention unless a nurse came
16 and brought something to your attention?
17 A I did not notice anything.
18 Q In a situation like that, and where you have Dr. Patel's
19 note transcribed, would a handoff have been of any benefit to
20 you prior to seeing Matthew Scheer?
21 A You know, typically, the daytime hospitalist would tell
22 the nocturnist about what they were concerned about, "I have a
23 CT scan that needs follow-up," "there's a patient that, you
24 know, I think there might be a problem," and one of the things
25 that I've noticed, you know, going through all of this and

1 reading through all these notes again is often what's notable
2 is what's absent, you know. Dr. Patel didn't give me signout
3 because, you know, I trust that he was not concerned that this
4 patient was going to be a real, a real problem overnight, you
5 know.
6 Q And when you went into Matthew Scheer's room you had
7 enough information at your disposal at that point to address
8 the situation?
9 A I believe so, and if I didn't feel that it was complete I
10 would continue asking about it.
11 Q I want to talk a little bit about -- oops, I'm sorry.
12 For the record, a picture of a, a boat popped up on the
13 screen, got nothing to do with the case. Talking a little bit
14 about Ativan.
15 A Yes.
16 Q When the nursing staff came to get you at 1:13 in the
17 morning with -- and we just read the concerns that they had
18 observed with Matthew Scheer, did they ask you for an Ativan
19 order?
20 A They did not.
21 Q Did they ask you to prescribe Ativan so that they could
22 give it to the patient?
23 A No. And nurses can ask me for a verbal order. I don't
24 even need to go and put it in the computer, take a verbal
25 order from me and they can execute that order based on that.

1 Q Is that -- is, is an order like Ativan is that something
2 that the nursing staff from time to time would just call and
3 ask you for?
4 MR. HINSON: Objection. Leading, Your Honor.
5 THE COURT: I sustain the objection.
6 A The typical types of questions --
7 Q He sustained it.
8 THE COURT: He's going to rephrase the question.
9 A Okay.
10 Q Let me try it again.
11 A Sorry.
12 Q Doctor, in your experience in working at the hospitals
13 for as long as you have, what are some examples of types of
14 orders that a nursing staff might come to you and ask for?
15 A So overnight I might have many nurses calling me, cross
16 cover for other patients. There were three of us physicians
17 on that night. So these duties were divided up among us, and
18 it really depends on the nurse. If the nurse is concerned
19 about a patient being agitated or anxious, they might just
20 call and say, "This patient is really agitated and anxious or
21 they're having trouble sleeping can I -- can you prescribe
22 something to help them sleep?" Some nurses are sort of much
23 more assertive and say, "This patient is really anxious and
24 can you give them some Ativan?" Most of the time when a nurse
25 asks me that it is not an immediate yes. It is, "Well, tell

1 me about the patient a little bit," because I don't want to go
2 and sedate people just because a nurse is telling me, "Hey,
3 you know, we need some Ativan." These are medications that
4 can have adverse reactions. You want to be careful who you
5 give them to.
6 Q When the nursing staff observed what they observed at
7 around 1:13 in the morning, did they appropriately get you
8 involved to evaluate the patient?
9 A Yes.
10 Q After you talked with the nursing staff and reviewed
11 Matthew Scheer's chart, what did you do next?
12 A Went in and talked to him.
13 Q What was your goal when you entered Matthew Scheer's room
14 at or around 1:13 in the morning on October 3rd?
15 A Whenever I go to see a patient that I've never seen
16 before, my goal is to ask open-ended questions and try and
17 find out what the truth is. That's it.
18 Q In a situation like this where Matthew Scheer has
19 presented to the nursing station demanding to leave against
20 medical advice, kind of walk us through some of the questions
21 -- well, first off, have you been trained, whether it's at
22 Hopkins or Philly or New York or wherever it was, have you
23 been trained on how to handle patients who desire to leave the
24 hospital against medical advice?
25 A I would say in general this is something that's routinely

1 covered multiple different times during my education. Yeah.
2 Q It's not something with which you -- were you familiar
3 with the process --
4 A Sure.
5 Q -- of going in and talking to a patient? Okay.
6 A People leave the hospital against medical advice, you
7 know, I wouldn't say it's routine, but it's not uncommon.
8 Q When you went in to talk to Matthew Scheer you said your,
9 your goal was to ask open-ended questions. Give us some
10 examples of the types of questions you might ask a patient in
11 your habit, routine and practice like Matthew Scheer who
12 desires to leave the hospital against medical advice.
13 A Yeah. I try and be very cognizant of, you know, a lot of
14 patients don't like doctors, and that doctors can be really
15 scary. So I try and approach people in a very just kind of
16 relaxed way and say, "Hey," introduce myself, "I'm Dr. Ash-
17 Bernal. Why don't you tell me what's going on."
18 Q How long does this process take?
19 A It all depends on the patient. Some patients it can be
20 really quick. Some patients it can be long.
21 Q Is there a set time that you shoot for to spend with a
22 patient?
23 A No. I'd say most of my colleagues say I talk too much
24 though, so.
25 Q Now, Doctor, you don't have an independent recollection,

1 we covered this earlier, of exactly the questions you asked
2 Matthew Scheer; correct?
3 A Only the questions that I would ask by routine and habit.
4 Q Okay. I know you said they were open-ended questions.
5 Can you give us a couple of examples of the questions? You
6 said, "What's up? Why, why are you here? Why do you want to
7 leave?" Are there any other kind of open-ended type questions
8 you would ask as a matter of habit, routine and practice?
9 A Sure. Introduce myself. Identify myself as a physician.
10 I know that I had the nurse come in with me. I routinely
11 would have that so that she could be there to fill in any
12 information I needed, and as we walk down the hall, I do
13 remember that she said that he didn't want his father called.
14 So, you know, going in there and talking to him, the first
15 thing I do is, I mean, it's a basic thing that they teach you
16 in medical school, look, listen and feel. What does the
17 patient look like? What are they acting like? Are they
18 answering questions appropriately? Do they seem to know where
19 they are? Can they tell me their name? Can they tell me what
20 the date is, what the time is? Can they tell me what the
21 general places that they are? This is a hospital. You know,
22 why you're here, you know, and based on those types of things
23 I gauge what further questions I would ask.
24 Q Do you have an independent recollection of exactly the
25 answers that Matthew Scheer would have given you in this

1 circumstance?
2 A Yeah. I know that when I'm asking these questions in my
3 mind I am going through a checklist of things that I would be
4 concerned about, and because it's not a set amount of time,
5 especially people who have been in and out of hospitals
6 before, I'm sure you've known, as you know, going to see a
7 doctor, you know, you get tired of all these routine questions
8 and stuff. Some people answer really quickly, and you know, I
9 certainly remember that there wasn't any red flags. There
10 wasn't anything that jumped out at me that said, "You know
11 what, this person is a danger to themselves or others," you
12 know, and there were other things that I would observe going
13 into the room. First of all, he wasn't in one of the
14 psychiatric lockdown rooms. That's remarkable because, you
15 know, for the nurses they have to remove everything from a
16 room that is for a psychiatric patient. Okay, and this stuff
17 sounds like not such a big deal, you know. It's like, okay,
18 EKG leads, IV, IV tubing or anything like that, but it's
19 something that I notice when I go into a room because my
20 internship year at Johns Hopkins University I was in the
21 emergency department and a suicidal patient that was literally
22 10 feet away from the nursing station successfully hung
23 himself with EKG leads from a surgical lamp with the curtain
24 closed and his girlfriend was in the room. So you have
25 experiences like that you really start to notice, you know.

1 You look around and you see, "Is this a regular room,
2 psychiatric room," okay.
3 Q Are you also observing the patient and their behaviors?
4 A Absolutely.
5 Q Some -- is it, as a physician talking to a patient in
6 this circumstance, you're asking questions but also observing
7 the conduct?
8 MR. HINSON: Objection. Leading, Your Honor.
9 THE COURT: That's leading. Rephrase.
10 MR. GRESH: All right.
11 A Sure. So some of the things --
12 BY MR. GRESH:
13 Q No, no.
14 THE COURT: Well, he's going to --
15 A Sorry.
16 THE COURT: -- he's going to ask you another question.
17 A Okay.
18 Q I'm going to -- yeah. Let's go to your cross cover note
19 that you just referenced. In the stack in front of you, Dr.
20 Ash-Bernal, that is page 89.
21 A Yes.
22 Q We talked a little bit ago that you became involved with
23 Matthew Scheer at about 1:13. When is this note dictated?
24 A It's signed at 1:40 in the morning. The time at the top
25 is 1:29.

1 Q The -- kind of -- first off, when you went into Matthew
2 Scheer's room did you want him to leave?
3 A No. I, I --
4 Q Is it, is it easier just to let folks leave?
5 A No. And I do not think it's a good idea for anyone to
6 leave the hospital, I mean, unless it's a scheduled transfer
7 to a higher level of care. I mean, that's the one exception.
8 I've transferred people to MUSC or to other parts, even down
9 to Emory University in the middle of the night, but in
10 general, I don't think it's a good idea to leave the hospital
11 in the middle of the night, and I would do everything I could
12 to try and keep the patient in the hospital.
13 Q You were there with Nurse Bell and Nurse Freeman?
14 A Uh-huh.
15 Q Did they express a desire to you that they wanted the
16 patient to just leave?
17 A No. In fact, I think both nurses seemed, you know,
18 distressed. I mean, they don't want the patient to leave, and
19 you know, the usual thing is to try and figure out, "Well, why
20 the urgency? Why do you want to leave at 1:30 in the
21 morning," you know. "Is it because you're hungry, you're
22 cold, you're uncomfortable?" "Is there anything that I can do
23 to alleviate that?"
24 Q You have your cross cover note there in front of you,
25 page --

1 A Yes.
2 Q Okay. The patient begins, if I could, "Patient refused
3 IV and PO Keppra." Let's kind of stop there for a second.
4 A Okay.
5 Q Dr. Patel had ordered, you just heard this, Dr. Patel had
6 ordered Keppra to be given to the patient at about 9:00
7 o'clock or so that evening?
8 A Yes.
9 Q Did the nursing staff at nine, 10, 11, 12, one or any
10 time up until this come to you and say the patient has refused
11 to take the IV Keppra?
12 A No. They did not tell me that.
13 Q The first -- is it --
14 A I, I saw it in the notes.
15 Q That the patient had refused?
16 A Yes.
17 Q Did you see anywhere in the notes where the nursing staff
18 took efforts to inform you that the patient had not taken the
19 IV Keppra?
20 A I don't recall getting called about this patient before I
21 saw --
22 Q Did you see anywhere in the nursing notes where they
23 documented that they told you about the patient refusing IV or
24 IV fluids?
25 A I think I saw that in the, in the notes previously, but I

1 don't remember exactly who was writing that.
2 Q The fact that the patient had refused those actions?
3 A Yes.
4 Q Okay.
5 A Yes.
6 Q But I want to be clear, did the nursing staff ever tell
7 you as the nocturnist that the patient had refused Keppra, IV
8 lines or IV fluids?
9 A No. I believe I read that reviewing the chart.
10 Q Right. All right. So your, your note is there -- this
11 is a note -- tell me when in the timeline this note would have
12 been dictated? I mean, are you dictating while you're in
13 Matthew's room?
14 A No. I can't do that.
15 Q Okay. Is this note designed to be a chronological step-
16 by-step outline of what occurred?
17 A No. Not really. I, I can certainly do a better job at
18 that, but what I was trying to hit was the salient points.
19 Q Does this note -- when you're doing a cross cover note at
20 1:15 or 1:30 in the morning and the patient is desiring to
21 leave, are you trying to write down all of the questions that
22 you asked the patient?
23 A No. It's, it's not really possible to do that.
24 Q Are you trying to write down in your note all of the
25 responses that the patient gave you in response to your

1 questions?
2 A No. You know, typically, the types of things you look
3 for is sort of the pertinent positives, you know, as opposed
4 to listing everything that was negative.
5 Q Okay. In the about midway through your note it says, [as
6 read], "Patient indicated he understood that it was
7 recommended he remain in the hospital for further evaluation
8 of his psychiatric issues but he refused to stay." Did I read
9 that right?
10 A Yes.
11 Q Doctor, are you telling us that you talk to Matthew
12 Scheer about his psychiatric issues?
13 A I can only rely on my, my notes because I don't have a
14 particular recollection, but yes, if I documented that I did.
15 Q Would you have written something like that if you hadn't
16 talked to Matthew Scheer about his psychiatric?
17 A No. I would not.
18 Q Would you have written something like that if Matthew
19 Scheer didn't refuse to stay? That's a terrible question.
20 Don't answer that one.
21 A Sorry. You lost me there.
22 Q Let me, let me, let me start that one over. You wrote in
23 there that you've talked to him about the psychiatric issues
24 and he refused to stay. Is that your way of recording at
25 least that one nugget that occurred during the conversation?

1 A Yeah. I'd, I'd say this, this note is kind of more like
2 nuggets.
3 Q Okay.
4 A Yeah.
5 Q It then continues, [as read], "Patient seemed able to
6 weigh the information, [he interrupted his religious rant to
7 think about the question]." Let's kind of pause there for a
8 second.
9 A Uh-huh.
10 Q First off, do you remember the religious rant? Can you
11 tell us any of the specifics that Matthew Scheer offered up
12 that you characterize as a religious rant that evening?
13 A I, I really don't remember. If it was something really
14 unusual I think I would document it though.
15 Q As a, a hospitalist and trained as you are, what -- when
16 a patient pauses a rant and thinks about a question and
17 responds appropriately to that question, what does that mean
18 to you?
19 A To me it means that they're really thinking about what I
20 asked them and they're making choices.
21 Q Is that something that you would look for as a
22 hospitalist in this situation?
23 A Absolutely.
24 Q Is that a bad sign or a good sign?
25 A No. It's a good sign.

1 Q It then continues, [as read], "And it was explained to
2 him that he could die from infection, seizures or as a result
3 of the psychiatric illness, and he insisted on leaving";
4 correct?
5 A Yes.
6 Q Are those more nuggets of the conversations with you and
7 Matthew?
8 MR. HINSON: Objection, Your Honor. Leading.
9 THE COURT: Rephrase your question.
10 MR. GRESH: I shall.
11 BY MR. GRESH:
12 Q Doctor, that sentence there, describe what that -- what
13 you've written and why you wrote it.
14 A Yeah. I'm sorry. Which line?
15 Q Yes, ma'am. It starts, [as read], "And it was explained
16 to him he could die from infection, seizures or as a result of
17 psychiatric illness"?
18 A Right.
19 Q What are you trying to convey there?
20 A I'm trying to impress on the patient, really trying in
21 any way I can to try and keep them in the hospital.
22 Sometimes, you know, I'd say it's sort of like a, a graded
23 thing. You know, you go in, you talk to them, you find out if
24 there's something that you can fix for them that would help
25 them immediately feel like, "Okay, I'll stay until the

1 morning." Things look different in the light of morning after
2 some rest, you know. That's what I always tell patients. I
3 feel that way myself, you know. "Why don't we just kind of
4 wait and see what happens", try and meet their immediate
5 needs. By the time I'm getting to saying something like this,
6 I am more desperately trying to keep this patient in the
7 hospital by saying, "You understand that if you leave the
8 hospital that you could die, that you could have a seizure,
9 that you could have an infection? We haven't finished the
10 workup. Do you understand that?"
11 A Based on your communication with Matthew Scheer, did he
12 still want to leave?
13 A Yes.
14 Q At that point are there any other tools that are
15 available to you as a physician to encourage a patient to
16 stay?
17 A Directly in front of him, probably at that point I've
18 used up almost everything I've got. At that point you can
19 hope that you can maybe bring in the family. However, in this
20 particular situation he told us that he did not want his
21 family called, did not want his father called. That starts to
22 put me in a real bind. It's not something I'm happy about.
23 It's not something I agree with, but I have to respect the
24 patient's wishes, and I really think that signing a form like
25 that against medical advice it's sort of like the last resort,

1 you know.
2 Q Let's talk about that for a second. Throughout your
3 career you've had probably lots of patients that wanted to
4 leave against medical advice?
5 A Tons of patients, and in particular more here because I
6 think it's a destination. People have lots of things that
7 they want to do.
8 Q Now, help me with this.
9 A Uh-huh.
10 Q If, if, if this represents all of the people --
11 A Yeah.
12 Q -- that have ever approached you about leaving against
13 medical advice, you go in, you talk to them, does some of them
14 change their mind?
15 A Most of them do.
16 Q With just the oral communication?
17 A Yep. And when I, and when I've talked to patients, you
18 know, sometime it's really interesting the reasons that they
19 say, "I couldn't get childcare." "I've got a dog at home
20 that, you know, no one has taken care of for two days." "I
21 have my mother with Alzheimer's disease that there's no one to
22 take care of her and I'm scared something's going to happen to
23 her." Sometimes it's just, "I want to leave and I don't want
24 to tell you why." I can't make them tell me.
25 Q So you have this oral conversation that narrows it down

1 here. Does filling out a form sometimes, as silly as it
2 sounds, filling out a form, does sometimes that help keep more
3 folks?
4 A Absolutely.
5 Q Describe for us your experience about what happens
6 sometimes after, the patient still wants to leave and it's
7 just oral, and now you bring out the form?
8 A So I think this kind of speaks to when people are triaged
9 in the emergency department, one of the things that the triage
10 nurse asks is, "How do you learn best," and they document
11 that. That's something that we're all attuned to. Some
12 people learn best with auditory information. Some people
13 learn best with visual information. Some people learn best by
14 actually having like a graphic memory and writing things.
15 For, for me it's writing.
16 Q Did you instruct Nurse Bell to go get the AMA form?
17 A I would have had to because I don't have the AMA form.
18 Q When she -- does she return to you with the AMA form?
19 A Yes.
20 Q Walk us through, and, I apologize, I don't know which one
21 is easier to read. Kind of walk us through, if you can, what
22 this paperwork says, and more importantly, what it's designed
23 to do in a patient such as this with -- like Matthew Scheer,
24 and if you need it for the, the note there in front of you,
25 page 87, 88 are the page one and page two. It's front and

1 back of the AMA form.
2 A Sorry. Orient to where you are. Sorry. There seems
3 like there's two sets here.
4 Q You see an 87 and 88?
5 A Yeah. I'm sorry. Maybe you can help me.
6 Q Yeah.
7 A Okay.
8 Q So you've got 87 in your hand right there, which I'll --
9 two different sets, 85 and this one is 87 right there.
10 A Yes. Yes.
11 Q And just so we're oriented there's two parts to this, and
12 this is the bottom part, but talk to us a little bit about the
13 partial refusal of care. We're not going to spend a lot of
14 time on that, but were there some things that the medical
15 staff and the nurses wanted to do for Matthew that he
16 partially refused care?
17 A Yes.
18 Q What are some of the things that, that Matthew partially
19 refused that October 2 into 3?
20 A Well, what I listed and I recognize my handwriting it
21 says he, he refused an IV peripheral line, he refused taking
22 Keppra that was prescribed for him.
23 Q And you say just above that, [as read], "I acknowledge
24 the treatment option, the risk of refusal." Kind of read that
25 for us.

1 A Okay.
2 Q What, what that's designed to do.
3 A [As read], "I acknowledge that I have begun receiving
4 medical screening examination and have decided that I do not
5 want these tests, exam, exams or treatments listed below. I
6 acknowledge that I have been informed and do understand that
7 the risks associated with my refusal of the test, examinations
8 and/or treatments or my withdrawal of consent to these -- this
9 tests, examinations and/or treatments may seriously harm my
10 health or life, and I am -- if I am pregnant the health and
11 life of my unborn child. I acknowledge that treatment
12 options, the risks, refusals of tests, examinations and/or
13 treatments listed below and the purpose and benefit of these
14 tests, examinations and/or treatments listed below were all
15 explained to me."
16 Q And would you have, based on your habit, training and
17 experience, and based on the documentation would you have
18 talked to Matthew Scheer about the risks and benefits?
19 A I would specifically have talked to him about what I
20 wrote here in particular.
21 Q Did he understand what you were saying?
22 A I believe so, yes.
23 Q If he didn't understand what you were saying, what would
24 be different about it?
25 A If I felt convinced that he did not understand what I was

1 saying to him, that would take me down a different clinical
2 pathway.
3 Q Okay.
4 A Just as someone with Alzheimer's, you know, like your
5 mother with memory problems, you're not just going to go and
6 have them sign some form if they don't seem to understand
7 what's going on.
8 Q Okay. Beyond partial refusal of care, this form
9 indicates that Matthew Scheer desired to leave the hospital
10 against medical advice?
11 A Yes.
12 Q You don't need to read the entirety of that there.
13 Describe -- there's a section an A, B and a C?
14 A Yes.
15 Q Describe the examination or specific treatment modalities
16 that you recommended that Matthew Scheer declined to have.
17 A Right. Well, right above that it says, [as read], "I do
18 understand -- I also understand that I may return to this
19 hospital at any time in the event that I change my mind or if
20 my condition worsens." That's something that I go over with
21 people that are leaving. They are -- I'm not mad at them.
22 They should feel free to come back for treatment at any time
23 or any moment. "Describe the -- describe examination or
24 specific treatment modalities recommended by physician and
25 refused by individual." Physical exam, to me that says, "I

1 tried to perform a physical exam and he would not allow me
2 to." An IV line, his medications.
3 Q Were there certain risks that when Matthew declined those
4 things that that put him in jeopardy for?
5 A Yes. And I -- they're listed below. You know, that he
6 acknowledges and understands refusing recommended examination
7 or treatment or "My refusal to consent to recommend, to the
8 recommended examination or treatment by the emergency
9 physician and/or specialist may result in injury to me
10 including death or severe and permanent disability or
11 deformity as otherwise specified below," and I listed
12 seizures, psychosis, infection.
13 Q Turn to the next page, if you don't mind of the AMA form,
14 do you as the physician, who's there at the bedside with the
15 patient, make a certification. You see it there on 88?
16 A Uh-huh.
17 Q Read for us what you certify after talking to Matthew
18 that, that morning.
19 A [As read], "The signature," it states, "The signature of
20 the physician certifies that the patient or the individual
21 acting on the patient's behalf has the mental capacity to
22 understand the risks and benefits of a partial refusal of care
23 and/or leaving against medical advice and that the patient or
24 caregiver has had an opportunity to ask questions about the
25 benefits and risks of refusal of care and/or leaving against

1 medical advice."
2 A Doctor, in your interactions with Matthew Scheer did you
3 assess whether he was able to appreciate the nature and
4 implications of his condition?
5 A I, I believe he did.
6 Q Did you also assess whether Matthew Scheer could make
7 reasoned decisions with his healthcare?
8 A I believe he did.
9 Q And in talking to Matthew Scheer about his healthcare,
10 was he able to talk to you in an unambiguous and clear manner?
11 A Yes. He was calm and was able to tell me what he was
12 thinking, and I don't want anyone to misunderstand. That
13 doesn't mean I agree with it.
14 Q It's still against medical advice?
15 A Yes.
16 Q All right. Would you have signed your name on this AMA
17 form if you didn't think Matthew Scheer had the competency to
18 understand what you all had been discussing?
19 A No.
20 Q Dr. Ash-Bernal, did you, did you hurry through your time
21 with Matthew Scheer?
22 A Not that I recall.
23 Q Is that something that you've ever done in a patient
24 trying to leave against medical advice?
25 A Jack, I'm sure as you know, dealing with me for several

1 months, I don't really rush through things.
2 Q Doctor, in your interactions with Matthew Scheer if he
3 had told you anything that led you to believe he was in
4 imminent danger to himself or to others, what would you have
5 done?
6 A I, I could have involuntarily committed him.
7 Q Are you familiar, generally, with the involuntary
8 commitment process?
9 A Yes. I've done it several times.
10 Q There was talk from the other experts maybe in the MD --
11 excuse me, the ER it might require two signatures, but up on
12 the floor that night who had the power, if you believed that
13 he was an imminent harm to himself or others, who had the
14 power to involuntarily commit Matthew?
15 A I could have done it in a New York minute.
16 Q Why didn't you involuntarily commit Matthew Scheer that
17 evening?
18 A When I'm interviewing a patient like Matthew Scheer, I
19 can try and press him. I can try and advise, and I can push,
20 but if a patient doesn't exhibit that they are an imminent
21 danger to themselves or others, it's like pulling a trigger,
22 you know, and looking, looking through this medical record, I
23 think there were many people that were trying to help Matthew
24 and documented and were trying and suspected something's
25 there, something's there. They pressed. They questioned.

1 They documented, and pulling that trigger, it just didn't
2 happen. It didn't, didn't happen at Lighthouse, didn't happen
3 with Dr. Patel, didn't happen with Dr. Battisti, and just to
4 put some context in that, there's a lot of psychiatric
5 patients that go to Grand Strand Hospital. Generally there's
6 four rooms down in the emergency department that are around-
7 the-clock, 24-seven have psychiatric patients awaiting
8 disposition to a psychiatric hospital down there, and we have
9 to sign, the hospitalists have to sign to continue keeping
10 them involuntarily committed. Okay. So this is not something
11 that the people at Grand Strand Hospital are completely
12 unfamiliar with or at Lighthouse, for that matter.
13 Q But Doctor, do you concede that Matthew had at least by
14 history delusional thinking?
15 A Yes. Although, I, I do not recall him doing any of this
16 in front of me.
17 Q In your examination of Matthew there, was there any
18 dangerous delusional thinking offered up by the patient?
19 A Not that I witnessed and not that was explained to me by
20 the nurses, and I can give you some examples of the types of
21 things that I would be looking for.
22 Q Okay. What are some of the things, what are some
23 delusions that a patient might complain of that you would find
24 dangerous?
25 A Well, like, "I can't be cut. I can't be hurt," you know.

1 I've seen patients break mirrors, cut themselves, hang
2 themselves, taking things that you would never imagine they
3 could do that with, you know, pull out their IVs and just be
4 bleeding all over the place and act like they don't even
5 notice that they're bleeding.
6 Q Did Matthew Scheer ever demonstrate or suggest any of
7 those types of dangerous delusional behavior?
8 A He did not.
9 Q If he had, if he had, what would you have done?
10 A I would have involuntarily committed him.
11 Q Even if that means taking away his, his rights?
12 A That's exactly what involuntary commitment means. It is
13 detention. It is like jailing someone.
14 Q They can never own a firearm again?
15 A They can't wear what they want. They can't walk in the
16 hallways. They can't leave their room. They may not be able
17 to get out of bed.
18 Q Doctor, was there any indication to you that Matthew
19 Scheer had an intent or a plan to harm himself or others?
20 A No.
21 Q Was there any indication that Matthew Scheer, despite his
22 religious talk, wasn't able to understand his healthcare needs
23 and take care of those as an outpatient?
24 A No.
25 Q And if there had been, what would you have done?

1 A I would have involuntarily committed him.
2 Q Would you have allowed Matthew Scheer to leave and sign
3 this AMA form?
4 A No. I can call a security officer to the bedside at any
5 time, and I have many times at Grand Strand when it was
6 necessary.
7 Q Doctor, looking back, from 1:13 in the morning when you
8 first got involved, Bethany Bell signs the form at 1:29, you
9 dictate your note at 1:40, so in that timeframe, looking back,
10 was the care and treatment that you provided to Matthew Scheer
11 consistent with or in excess of what would be required under
12 the standard of care?
13 A Yes.
14 Q Nothing further, Your Honor.
15 THE COURT: All right. Cross.
16 MR. HINSON: Thank you, Your Honor.
17 CROSS EXAMINATION
18 BY MR. HINSON:
19 Q Not as tall as Mr. Gresh, can't do this.
20 MR. HINSON: One moment, Your Honor. The perils of being
21 vertically challenged. Let's just try it this way.
22 BY MR. HINSON:
23 Q Good afternoon, Dr. Ash-Bernal.
24 A Good afternoon.
25 Q Would you agree with me that you claim to remember a lot

1 more today in this courtroom than you did when I took your
2 deposition in December of 2017?
3 A Not necessarily.
4 Q Okay. Well, let's get your deposition out.
5 A Uh-huh.
6 Q Do you remember giving a deposition in December of 2017?
7 A How could I forget it?
8 Q All right.
9 A Sure.
10 Q We played some of your video earlier?
11 A Uh-huh.
12 Q Here it is right here. Dr. Ash-Bernal --
13 A Yes.
14 Q -- let's, let's reread some of this testimony from
15 December of 2017. So that was -- when I took your deposition
16 we're just a little over two years after Matthew's death;
17 right?
18 A Yes.
19 Q All right. If you would turn to page 18.
20 A Okay.
21 Q Let's read lines eight through 12. I'll read the
22 question. You read the answer, please. I asked, [as read],
23 "And do you have any independent recollection? I know we can
24 read the note."
25 A Yeah.

1 Q [As read], "But do you have any independent recollection
2 of your encounter with Matthew in the early morning hours of
3 October 3rd, 2015," and your answer was?
4 A [As read], "I don't recall."
5 Q Okay. Let's turn to page 21. Let's read lines nine
6 through 15. I asked you, [as read], "And as I understand you
7 don't have an independent recollection of being called by the
8 nursing staff to Matthew's room; correct," you answered?
9 A [As read], "I get many calls."
10 Q And I asked, [as read], "And so you don't have any", and
11 you answered?
12 A [As read], "So at this particular time, no, I don't
13 remember."
14 Q Okay. Dr. Ash-Bernal, let's look at page 22. Let's look
15 at lines five through 17.
16 A Sure.
17 MR. GRESH: Your Honor, this is improper impeachment.
18 MR. HINSON: Your Honor, she's come to court and claimed
19 to have some memories of this night.
20 THE COURT: Well I, I -- I'll allow it.
21 MR. GRESH: Thank you.
22 MR. HINSON: Thank you, Your Honor.
23 BY MR. HINSON:
24 Q Lines five through 17.
25 A Yes.

1 Q I asked, [as read], "Okay, suffice to say, you don't have
2 an independent recollection of that conversation with Matthew;
3 correct?"
4 A [As read], "Not, the, not the specifics, no."
5 Q [As read], "Well, do you have any general recollection?"
6 A [As read], "It's difficult. It was a long time ago."
7 Q [As read], "Okay. Do you have any, I mean, this is my
8 opportunity, Doctor, to find out what you remember, if
9 anything, about this encounter, and as I understood you to say
10 a minute ago you have no recollection, independent
11 recollection of Matthew," and you answered?
12 A [As read], "No."
13 Q [As read], "So you", and then you said?
14 A [As read], "I don't remember."
15 Q [As read], "Okay. So you don't remember that
16 conversation with him?"
17 A At that time?
18 Q What's your answer? I said --
19 A [As read], "No."
20 Q -- [as read], "So you don't remember that conversation
21 with him," you said?
22 A [As read], "No."
23 Q Okay. And I asked you, [as read], "You have any general
24 recollection," and your answer to those questions was?
25 A Can you tell me where?

1 Q Just generally, I asked you in that deposition several
2 times do you have any even general recollections and what was
3 your response?
4 A You would have to tell me exactly where you're saying in
5 the notes.
6 Q What I'm asking -- I'm not talking about a specific line.
7 Would you not agree, Dr. Ash-Bernal, that I asked you on
8 multiple occasions do you have even a general recollection and
9 at each occasion you told me no, that you had no general
10 recollection?
11 A I would have to defer to my deposition on that.
12 Q Well, let's read it again, Dr. Ash-Bernal.
13 MR. GRESH: Your Honor, the, the rule of completeness.
14 At some point I must be able to, to put into context that
15 which he said.
16 THE COURT: All right. We'll -- I'll allow you to do it
17 after he's through with examination.
18 MR. GRESH: Thank you.
19 Q Dr. Ash-Bernal?
20 A Yes.
21 Q Do you not agree that I asked you on multiple occasions
22 at your deposition, which was back in 2017, much closer to the
23 events in question if you had any independent recollection and
24 you answered on multiple occasions no?
25 A I would defer to what I said in my deposition.

1 Q Okay.
2 A Uh-huh.
3 Q Dr. Ash-Bernal, you are -- you have a pedigree of an
4 education; do you not?
5 A I don't know what you mean by that.
6 Q Well, I've got your CV here.
7 A Yes.
8 Q You went to Penn; correct?
9 A No. I went to the Pennsylvania University. That's a
10 state college.
11 Q Okay. You went to Johns Hopkins?
12 A Yes.
13 Q You've done --
14 A I, I did my internship and residency at Johns Hopkins.
15 Q Johns Hopkins would be generally considered to be one of
16 the best medical schools in the country; would it not?
17 A I believe it's very highly regarded, yes.
18 Q And you've done training at Harvard even; have you not?
19 A No. I worked at Harvard.
20 Q You did a post-baccalaureate program from '91 to '94?
21 A While I was working as a research assistant, one of the
22 benefits of working at Harvard was taking free classes, and so
23 I took a medical ethics class at the Harvard Divinity School
24 and some immunology classes that I did not have in college.
25 Q Okay. You've done training at Harvard; correct?

1 A Yes.
2 Q Thank you.
3 A Well, I had education at Harvard, distinguish that.
4 Q You had -- you were -- part of your education and
5 training came from Harvard?
6 A Yes. Those specific classes that I mentioned, yes.
7 Q Okay. And included in those classes at Harvard you said
8 was medical ethics?
9 A Yes.
10 Q Is that right? Doctor, the -- there are medical ethics
11 that a physician is supposed to follow; is that correct?
12 A Yes.
13 Q And who -- what boards or organizations promulgate those
14 medical ethics?
15 A Well, as a physician, when you graduate -- well, when you
16 get admitted to medical school you swear to uphold the ethics
17 of the medical profession.
18 Q Okay.
19 A That's the beginning of it, but there are other times
20 where medical ethics was a required course in medical school
21 and it's something that, you know, is part of general
22 teaching. Certainly at Johns Hopkins we could call a medical
23 ethics consult if we needed to.
24 Q The AMA -- what's, what's the AMA?
25 A American Medical Association.

1 Q And it, it promulgates, publishes principles of medical
2 ethics; correct?
3 A I'm not as familiar with the American Medical Association
4 as I am with the American College of Physicians that I belong
5 to.
6 Q Are you aware that the American Medical Association's
7 principles of medical ethics says a physician's primary
8 ethical obligation --
9 THE COURT: Well, whoa, whoa, whoa, is she a member of
10 that?
11 MR. GRESH: Your Honor, I --
12 A I am not a member of the American Medical Association.
13 I'm a medical -- I'm a member of the American College of
14 Physicians.
15 THE COURT: All right. Then you can't ask her about --
16 MR. HINSON: Okay.
17 BY MR. HINSON:
18 Q Well, the American College of Physicians do they have an
19 ethical obligation under their, their promulgated ethics that
20 patients or, excuse me, physicians should protect the most
21 vulnerable patients and patient populations?
22 A I, I can't say I remember seeing that on their website.
23 Q Are mentally incapacitated patients vulnerable, Dr. Ash-
24 Bernal; would you agree with that?
25 A I'm sorry. Could you repeat the question?

1 Q Are mentally incapacitated patients vulnerable?
2 A I think it depends on what their degree of incapacitation
3 is.
4 Q Can they be vulnerable?
5 A They can be vulnerable, yes.
6 Q Thank you. And you've held licenses to practice in five
7 different states?
8 A Let's see, Maryland, Georgia, South Carolina, North
9 Carolina, Kentucky, Georgia, Missouri, seven.
10 Q Seven, seven different states?
11 A Yes.
12 Q Medical school requires a lot of memorization; doesn't
13 it, Dr. Ash-Bernal?
14 A A tremendous amount.
15 Q You have a pretty good memory; don't you?
16 A I don't know if I'd say that. I try. I try.
17 Q Dr. Ash-Bernal, who was your employer on October 3rd,
18 2015?
19 A My employer was EmCare, and the corporation over EmCare
20 was Southern Medical Services. We would commonly just refer
21 to ourselves as EmCare physicians, however.
22 Q Okay. Dr. Ash-Bernal, let me show you a chart of your
23 employer's hierarchy there.
24 MR. GRESH: Huh-uh.
25 MR. HINSON: Your Honor, may I approach?

1 (Whereupon, a bench conference is held in the presence
2 but out of the hearing of the jury.)
3 THE COURT: This is over objection I'll allow it.
4 BY MR. HINSON:
5 Q Dr. Ash-Bernal, can you identify that document?
6 A It says Exhibit 7(A). There's a bunch of boxes with
7 arrows going from one box to another. On the left it says
8 hospital. It says contract. Shows EmCare, Inc. An arrow
9 going above it says Envision. It says remote parent. Another
10 arrow which has two arrowheads goes from EmCare, Inc., to
11 shows administrative services contract. Then it says
12 Inpatient Services of South Carolina, P.A. That box has a
13 double-headed arrow that says sole shareholder. That goes to
14 another box that says South Carolina EM One. That goes to
15 another double-headed arrow that says sole shareholder and
16 that goes to physician owner box. Below Inpatient Services of
17 South Carolina, P.A., there's another double-headed arrow that
18 says sole member. There's another box that says South Myrtle
19 Inpatient Services. There's a double-headed arrow before that
20 that says employees. There's a box below that that says
21 employed hospital medicine physicians, and at the bottom it
22 says Exhibit 7(A) on 12-5-2018.
23 Q Doctor, I represent to you, this was a corporate
24 structure chart that was provided by your employer Southern
25 Myrtle Inpatient Services in the deposition I took of your

1 employer, Southern Myrtle Inpatient Services, and according to
2 the chart of your employer, Southern Myrtle Inpatient
3 Services, EmCare over here is not your employer; isn't that
4 what this document would show?
5 A Well, I'm, I'm -- I wasn't involved in the, in the
6 business of this company. I note as a physician they were
7 very proud to say that we were EmCare physicians.
8 Q During -- Southern Myrtle Inpatient Services' involvement
9 with you was so little that you didn't even realize that that
10 was who your employer was when I took your deposition in 2017;
11 did you, Dr. Ash-Bernal?
12 A Yeah. I don't think I could agree with that statement.
13 Q Okay. Let's look at your deposition again, please.
14 A Uh-huh.
15 Q Dr. Ash-Bernal, let's look at page 10 of your deposition
16 that you gave under oath in 2017. Let's start on line two --
17 MR. GRESH: Your Honor, could we approach?
18 THE COURT: Well --
19 Q -- at the end of line 19.
20 MR. GRESH: Can we approach?
21 THE COURT: Yes.
22 (Whereupon, a bench conference is held in the presence,
23 but how the hearing of the jury.)
24 Q Dr. Ash-Bernal --
25 A Yes.

1 Q -- would you read to yourself --
2 MR. GRESH: That's not --
3 Q -- lines --
4 MR. GRESH: Right.
5 Q -- would you read to yourself lines two through 19, and
6 my question is at the time of your deposition you didn't know
7 who your employer was; did you?
8 A I, I don't.
9 THE COURT: Whoa, whoa, whoa, lay the proper foundation.
10 Q Well, Doctor, at the time I took your deposition in
11 December --
12 THE COURT: Well, ask her what the question and answer
13 was and then show if it's different today.
14 MR. HINSON: Well, Your Honor, I, I --
15 THE COURT: Come on back up.
16 MR. HINSON: Bear with me for one second.
17 THE COURT: Come on back up.
18 MR. HINSON: Well --
19 (Whereupon, a bench conference is held in the presence,
20 but out of the hearing of the jury.)
21 MR. HINSON: Thank you, Your Honor.
22 BY MR. HINSON:
23 Q Sitting here today, Dr. Ash-Bernal --
24 A Yes.
25 Q -- who do you understand your employer to be?

1 A I understood my employer to be EmCare.
2 Q Okay. And sitting here today you still understand your
3 employer to be EmCare?
4 A That was my understanding of who my employer was.
5 Q Okay. Sitting here today, you understand your employer
6 to be EmCare, this, this one over here?
7 A Not now.
8 Q Okay.
9 A At that time in 2015.
10 Q Okay.
11 A It's much like someone who works for Walmart and there's
12 some large corporation over it that they may not have even
13 really ever heard of.
14 Q Doctor, my question is sitting here today in this
15 courtroom --
16 A Yes.
17 Q -- who do you understand your employer to be today?
18 A EmCare.
19 Q So you disagree with this chart?
20 A I can't see what you're looking at.
21 Q I'm pointing at the chart that's in your hand?
22 A Yes. Can you specify where, please?
23 Q Well, Doctor, at the bottom of the chart --
24 A This is -- you mean --
25 Q -- it says employed by --

1 A -- my deposition? That's what you're referring to?
2 Q No.
3 A No.
4 Q Dr. Ash-Bernal --
5 A Okay.
6 Q -- I'm talking about the chart in front of you.
7 A This chart.
8 Q The one I just handed you, this, this, this graph or
9 chart --
10 A Okay.
11 Q -- of employers --
12 A Yes.
13 Q -- and employees?
14 A Yes.
15 Q Sitting, sitting in this chair under oath today who do
16 understand your employer to be?
17 A My understanding of who my employer was was EmCare. I
18 have not seen this before, and I would not know how to
19 interpret this.
20 Q Okay. So you do not believe your employer to have been
21 Southern Myrtle Inpatient Services. Is that your testimony?
22 A As I recall my employer was EmCare.
23 Q Did Southern Myrtle Inpatient Services have any
24 involvement with you in October of 2015?
25 A I don't recall that.

1 Q Did you recall Southern Myrtle Inpatient Services
2 providing you any training?
3 A The only thing that I slightly remember is that might
4 have been the name that was on the deposit slip.
5 Q What deposit slip?
6 A For my salary.
7 Q Your paychecks?
8 A The paychecks, yeah.
9 JUROR: Sir, I need to go to the bathroom.
10 THE COURT: Okay. That's fine. We'll take a break.
11 MR. HINSON: Your Honor, I'm going to clean up these
12 cords while we take this break.
13 THE COURT: Okay. Thank you. Okay. Members of the jury
14 panel I'll stop you right now. We'll go ahead and -- I think
15 lunch is about here. So we'll -- I hate to break up your
16 examination, but why don't we go ahead and do lunch at this
17 time. So we'll take till a little -- till around 12:30 for
18 lunch, and if you're not through by then let me know, not
19 12:30, 1:30. I looked -- I, I dropped my glasses and I can't
20 find them.
21 (Whereupon, the following takes place outside the
22 presence of the jury.)
23 THE COURT: All right. We'll be at ease then till around
24 1:30 and --
25 A I'm sorry. May be --

1 THE COURT: You can step down. Of course you can step
2 down and don't, don't discuss your testimony with your --
3 with, with anybody, Doctor.
4 MR. GRESH: But she's a party to the litigation and she's
5 my client. She's not just a witness.
6 THE COURT: That's right. You're not just a witness.
7 MR. HINSON: But Your Honor, wouldn't it be the same as
8 during the deposition?
9 THE COURT: Well, well, subject -- she's subject to cross
10 though. She's subject to cross. So I -- I'm going to
11 restrict her from not talking to you because it's, it's, it's
12 a -- it's subject to cross.
13 MR. HINSON: Thank you, Your Honor.
14 THE COURT: Okay. So don't, don't, don't -- Mr. Gresh is
15 not going to try to talk to you, nor is Ms. Spears.
16 A Okay.
17 THE COURT: All right.
18 OFF THE RECORD
19 (On the record. The following takes place outside the
20 presence of the jury.)
21 THE COURT: I think we've got a couple of jurors still
22 using the facilities and Mr. Ropp is going to let us know when
23 they're ready. All right. We can bring in the jury.
24 MR. HINSON: Thank you.
25 THE COURT: And have the doctor take the stand. All

1 right. Dr. Ash-Bernal, you can go ahead and take the stand.
2 A Sure.
3 (Whereupon, the following takes place in the presence of
4 the jury.)
5 THE COURT: Counsel, you may proceed.
6 MR. HINSON: Thank you, Your Honor.
7 BY MR. HINSON:
8 Q Dr. Ash-Bernal, with regard to Matthew Scheer on October
9 3rd, 2015, you never spoke to Dr. Patel; is that correct?
10 A As I recall, that's correct.
11 Q All right. And you understood from Dr. Patel's testimony
12 and from reviewing the record, that Dr. Battisti in the ER had
13 picked up the phone and been in contact with Lighthouse to
14 talk about Matthew?
15 A That's what I understand from the record. Yes.
16 Q All right. And then there was a phone call from the ER
17 to Dr. Patel at the time Matthew was being admitted to the
18 hospital and actual communication, two people talking;
19 correct?
20 A Yes.
21 Q All right. But you never talked with Dr. Patel. He
22 leaves and there's no call to you or an in-person conversation
23 with you?
24 A As far as I recall, that's correct.
25 Q And there's no conversation ever between you and

1 Matthew's dad, David?
2 A Not that I recall. No.
3 Q Okay. And Dr. Ash-Bernal, did you see anything in the
4 record that says Matthew revokes David Scheer being the person
5 to contact, the person to notify?
6 A I don't recall anything about that.
7 Q Dr. Ash-Bernal, as a hospitalist at Grand Strand Regional
8 Medical Center, you have a duty to be familiar with and follow
9 the policies of the hospital; is that correct?
10 A Yes. To the best of my ability I do.
11 Q Okay. And Exhibit Number Six, what are we looking at
12 with Exhibit Number Six?
13 A At the top it says Grand Strand Health, origination 4-13-
14 2004, approved 6-6-2014, last revised 4-13-2004, next review
15 6-5-2017, Owner David Brooks, VP Operations, Risk Management,
16 Policy Area, Patient Rights, References, this is informed
17 consent.
18 Q This is the informed consent policy; correct, Dr. Ash-
19 Bernal?
20 A It looks like it, yes.
21 Q Okay. And this defines and sets forth the mental
22 capacity that a patient has to have in order to consent for
23 treatment and in order to be able to consent to leave against
24 medical advice, it sets forth both of those things; right?
25 A Can you point to exactly where you're referring?

1 Q Sure. I'm looking under definitions.
2 A Sure.
3 Q And it's A.
4 A Okay. It says informed consent --
5 Q And then there's B.
6 A -- has two elements. Informed, informed reference to
7 information given to the patient and/or surrogate and a
8 proposed operation, procedure, sedation, analgesia or
9 treatment. Consent refers to the patient's voluntary and non-
10 coerced acknowledgment of receipt of the information and
11 agreement to the operation, procedures, sedation, analgesia or
12 treatment.
13 Q Okay. And Doctor, what I was trying to get to was under
14 -- well, unable to consent, according to this policy at Grand
15 Strand that would apply to the hospitalists working there,
16 which would include you, a patient is unable to consent if
17 there are any of these three, it's not an and, it's an or;
18 isn't it?
19 A It says, [as read], "Unable to consent, a patient is
20 defined as unable to consent when unable to appreciate the
21 nature and implications of his or her condition and proposed
22 healthcare, make a reasonable decision discerning the proposed
23 healthcare or communicate that decision in a clear and
24 unambiguous manner."
25 Q Okay. But, but my question was, Doctor, it's an or,

1 isn't it? They fall into any of these three categories
2 they're unable to consent; isn't that correct?
3 A Actually, number one doesn't -- it just has a semicolon
4 at the end of it.
5 Q They have to fall in -- if they fall into any of these
6 three categories they're unable to consent; isn't that right,
7 Dr. Ash-Bernal?
8 A Yes.
9 Q Okay. What is the chain of command? Generally speaking,
10 what is a chain of command?
11 A It's who you go to, your superiors when confronted with a
12 problem you're not sure what to do with.
13 Q Okay. And the chain of command at Grand Strand and any
14 hospital in this country goes all the way up to the CEO if
15 necessary; doesn't it?
16 A I suppose, yes.
17 Q And so if you have a question about permissible patient
18 disclosures for patient safety, you're not sure about an
19 answer you have a tool, you and all doctors have a tool
20 available to you to get an answer; don't you?
21 A I can tell you at Grand Strand what I would do if I
22 didn't have an answer to something that was procedural in the
23 hospital, I could talk to the nurses, I could talk to the
24 charge nurse on each of the units, I could talk to the nursing
25 supervisor.

1 Q At Grand Strand you have a tool called the chain of
2 command --
3 A Uh-huh.
4 Q -- by which you can get an answer to a question you might
5 have if you -- about permissible disclosures of healthcare
6 information for patient safety purposes? That tool is
7 available to doctors 24-seven; isn't it?
8 A If I had that question, possibly, yes.
9 Q Okay. And the administration at Grand Strand will find
10 an answer for you any time of day, any time of night if it
11 deals with patient safety; correct?
12 A Exactly who are you referring to in the administration?
13 Q If you have a question --
14 A Uh-huh.
15 Q -- if you're unsure about what the law will allow for
16 disclosures for the purpose of patient safety --
17 A Uh-huh.
18 Q -- you have a question about that, the administration,
19 the chain of command somewhere in there will be that answer,
20 the person who knows those type things?
21 A I'm sure there's multiple people that could help,
22 including risk management, if necessary.
23 Q Okay. They're part of the chain of command; correct?
24 A Yes, uh-huh.
25 Q Dr. Ash-Bernal, you said earlier, as I understood on

1 direct, that you would have reviewed Matthew's chart, done a
2 thorough review of Matthew's chart before you discharged him?
3 A I don't know that I said that I would do a thorough
4 review. I explained how I would review a patient's chart that
5 I was unfamiliar with that I was going to talk to.
6 Q Well --
7 A I explained that I would review the emergency department
8 notes, the history and physical, the laboratory studies and
9 imaging studies and anything else that seemed irrelevant at
10 the time to that particular patient.
11 Q Okay. So do you believe you would have done a thorough
12 review of Matthew's chart before discharging him at 1:30 in
13 the morning during a storm?
14 A I did not discharge him. I'm sorry. I didn't mean to
15 interrupt you. He left against medical advice. That's
16 different than discharging.
17 Q It's, it's --
18 A Discharging is I fill out paperwork, discharging a
19 patient saying DC home, patient has other paperwork that goes
20 with him. It's completely different than a patient leaving
21 against medical advice. That's exactly what it sounds like.
22 I'm not saying I think he should leave. In fact, he's leaving
23 against my advice and against my better judgment. I don't
24 think he should leave and he is choosing to do so.
25 Q Dr. Patel dictates a discharge summary in this case;

1 doesn't he? The name of the document is a discharge summary?
2 A Yes. That's what he put that under, yes.
3 Q This was an AMA discharge; isn't it, an against medical
4 advice discharge?
5 A I think Dr. Patel was just sort of trying to summarize
6 things, you know. That's -- I, I, I don't think he was -- I
7 mean, I, I can't particularly speak to what he was doing with
8 that, but in general, a discharge summary is really to sort of
9 summarize what happened so that there's sort of a complete
10 circle of what happened to the patient. It's particularly
11 useful the next time the patient comes into the hospital that
12 they can sort of see what happened.
13 Q Before you let Matthew go --
14 A And, and -- I'm, I'm sorry. I wasn't quite done with
15 that.
16 Q You got more to say?
17 A When we're looking through the medical records one of the
18 first things we look for if something -- somebody is
19 readmitted to the hospital would be the previous discharge
20 summary. That is one of the first places we would look to
21 just get a general summary of what happened in that patient's
22 stay at the hospital and that's just common procedure.
23 Q Before you permitted Matthew to leave, you had him sign
24 the AMA form; didn't you?
25 A I did.

1 Q You told him, "You can't leave until you sign this form"?
2 A Actually, technically, because he was a voluntary
3 admission he could have walked out of the hospital at any
4 time.
5 Q A patient who comes in as a voluntary admission can still
6 be made or put on a temporary hold; can't they, Dr. Ash-
7 Bernal?
8 A If I felt a patient was an imminent threat to themselves
9 or others, I could involuntarily admit the patient to the
10 hospital.
11 Q Okay. And you could do that?
12 A And I could prevent him from leaving, not just the
13 hospital, but his room.
14 Q Let me finish my question, Doctor. If a patient comes in
15 as a voluntary admission, they can be transferred, changed
16 over to a temporary hold, yes or know?
17 A If the clinical situation was changing and it was
18 evolving and the patient was an imminent threat to themselves
19 or others, I could involuntarily commit them to the hospital.
20 Q There was a change in Matthew at 1:30 in the morning;
21 wasn't there, Dr. Ash-Bernal?
22 A From my review of the records, I think many of the things
23 that were going on with Matthew were actually very consistent
24 with what happened earlier in the day.
25 Q Well, let's talk about that for a second then. Prior to

1 approximately 1:15 in the morning was Matthew at any point in
2 time pacing shirtless?
3 A From what I recall from what the nursing note is, the
4 note said that, yes.
5 Q But my question is this, prior to 1:13 in the morning had
6 Matthew ever been seen pacing shirtless?
7 A According to what I remember from one of the nursing
8 notes, that's what it said.
9 Q It's -- Dr. Ash-Bernal --
10 A I, I would have to refer back to the notes that the nurse
11 wrote.
12 Q Okay. We'll --
13 A Okay. Because I did not see him pacing shirtless.
14 Q Okay. This is my question, Doctor, listen to my
15 question. Prior to this 1:15, 1:30 incident on October 3rd,
16 2015, there had never been an occasion that was recorded by
17 any doctor or nurse where Matthew was taking off his shirt and
18 pacing in the hallways; had there?
19 A Again, I can only go by what's in the notes.
20 Q Dr. Ash-Bernal, prior to 1:15 in the morning there had
21 never been an occasion where Matthew was becoming aggressive
22 with the staff; had there?
23 A Again, I can only go by what was documented in the notes.
24 Q Doctor, prior to 1:15 in the morning there had never been
25 recorded an occasion where Matthew was becoming aggressive

1 with the staff; was there?
2 A Again, I can only go by what's recorded in the notes.
3 Q Doctor, prior --
4 A If you could show me or indicate where you're looking I
5 would appreciate it.
6 Q Well, Doctor, I'm looking at the one --
7 A No. If you could just tell me the page that you're
8 looking at.
9 Q I'm looking at Defense Exhibit 116.
10 A I'm sorry. It just that when you're, when you're facing
11 it that way I just can't see it. That's all.
12 Q Do we have Defense 116 or --
13 A This one?
14 Q -- right here, Doctor.
15 A Okay.
16 Q Defense Number One.
17 A Uh-huh.
18 Q Turn to 116, but I'm not asking you about this page. I'm
19 asking about everything else, Doctor. Prior to 1:15 to 1:30
20 in the morning there had never been anything recorded about
21 Matthew becoming aggressive; had there?
22 A I'm sorry. I'm still looking for the page.
23 Q Take your time.
24 A Okay. I'm on 116 with --
25 Q All right.

1 A -- Bethany Bell's note and Jacqueline Freeman's note.
2 Q Okay.
3 A Yes. Yes.
4 Q Doctor --
5 A Could you repeat the question, please?
6 Q -- I'll be happy to. Doctor, prior to 1:15 in the
7 morning --
8 A Uh-huh.
9 Q -- before 1:15 in the morning --
10 A Uh-huh.
11 Q -- there had never been anything recorded in this medical
12 record by any nurse or any doctor where Matthew was becoming
13 aggressive with the staff; had there?
14 A I, I would have to read through all of these medical
15 records to actually say yes to that.
16 Q Okay.
17 A And I, and I will do that if you want me to do that.
18 Q Did you read through the medical record thoroughly before
19 discharging Matthew?
20 A I read through what was available to me at the time.
21 Q Do you have any reason sitting here today to think that
22 the medical record wasn't available to you at 1:15 in the
23 morning?
24 A As I explained earlier, there are times when there are
25 some things that not are available, for instance, a nursing

1 note that is in process or has been started and has not been
2 signed. Some of the information from the hardcopy paperwork
3 from the emergency department it's possible.
4 Q So you think it's possible that you may not have had all
5 the information available to you?
6 A I think I had sufficient information to go and talk to
7 the patient and assess him.
8 Q Assessing the patient you need to know his prior hospital
9 course during that, during that time; don't you?
10 A It's helpful.
11 Q It's important; isn't it?
12 A There are times when I'm called to emergencies in the
13 hospital where I don't know anything about the patient until
14 I'm at the bedside. For instance, a code patient can't talk
15 to me.
16 Q Was this an emergency?
17 A Is what an emergency?
18 Q Was the incident with Matthew between 1:15 and 1:30 in
19 the morning an emergency?
20 A Not the way it was presented to the -- to me by the
21 nurses.
22 Q You had time -- but you would agree the record reflects
23 that Matthew at some point calmed down at the time he -- and
24 was calm at the time he was discharged? At the time he walked
25 out of the hospital he had calmed down a little bit from what

1 he had been just a few minutes earlier?
2 A As I recall, yes.
3 Q Okay. So this wasn't an emergency?
4 A Well, you and I might define emergencies differently. To
5 me an emergency is something that is immediately life-
6 threatening, for instance, somebody is not breathing,
7 somebody's heart has stopped, they have gone into a lethal
8 arrhythmia. There is less than one minute to respond to it.
9 In fact, you know, in cardiology a hundred milliseconds can
10 seem like an eternity.
11 Q You had time, Dr. Ash-Bernal, to say, "Matthew, I might
12 let you leave, but let me take," --
13 A I'm sorry. I would not say that like that.
14 Q What would you say?
15 A I, I explained earlier the way I approach patients --
16 Q Okay.
17 A -- with open-ended questions and seeking the truth.
18 Q Okay. You had a patient --
19 A And I introduce myself to the patients when I walk in the
20 room. I identify myself. I bring a nurse with me, and I sit
21 down and I talk with them.
22 Q Okay. You -- the record would reflect, and I understand
23 you have some recollection, no recollection -- actually I
24 don't know. I'm still unsure what your recollection is, but
25 at the time you came into Matthew's room sometime after 1:13,

1 and sometime before 1:27 because that's when we know you were
2 signing this form was at 1:27, which is what, less than 15
3 minutes, at the time you walked into his room you knew that
4 just moments earlier a patient who had come to the hospital
5 with acute psychosis, had just moments earlier been yelling
6 that everyone was Obama or, excuse me, everyone was with the
7 devil and Obama could not control him and had been aggressive
8 with the staff, you were aware of that at the time you walked
9 into Matthew's room?
10 A Well, I'm aware of what I put in my note. Okay.
11 Q So you don't think you would have been aware of that at
12 the time?
13 A I don't, I don't know what you mean.
14 Q My question is you don't think -- is it your testimony
15 that you don't believe you would have been aware of Matthew's
16 behavior just minutes earlier? Is that your testimony? You
17 don't think the nurses would have told you?
18 A I would refer back to my note, what I wrote there. Okay.
19 Q Doctor, I don't, I don't know that, that you're answering
20 my question. The nursing note reflects a patient outburst,
21 can we agree with that?
22 A Could you please refer to the page again?
23 Q 116 on Defendant's One.
24 A Okay.
25 Q Would you agree with the general concept that this is a

1 patient outburst at approximately 1:15 in the morning?
2 A What I see is the nurses documenting multiple things.
3 Okay.
4 Q Okay.
5 A I mean, Bethany Bell documented, [as read], "Patient
6 arrived at Two North via stretcher from the ED, awake, alert,
7 oriented times four. Patient denies chest pain, shortness of
8 breath, pain. Patient on room air." That's what RA stands
9 for. "Lung sounds clear bilaterally. Respirations even and
10 unlabored. Patient ambulating in the room with a steady gait.
11 No telemetry. No, no telemetry. No IV. Patient refusing IV
12 insertion. Patient denies suicidal ideation." That's what SI
13 means. "Patient oriented to bed, room call bell unit.
14 Patient denies needs at this time. Call bell within reach.
15 Will monitor," and then that was at 19:15. The next note from
16 Jacqueline Freeman at 1:13 in the morning on 10-3, [as read],
17 "Patient approached nursing station and was pacing shirtless.
18 Patient ripped off armbands and threw them on the floor.
19 Patient started yelling stating that we could not control him
20 nor could Obama. Patient accusing staff of being devil
21 worshipers. On-call MD Ash-Bernal called to see the patient."
22 There's another note from Bethany Bell on 10-3, 2015 that
23 occurred at 1:31 in the morning. [As read], "Patient pacing
24 in the hallways, approaching nursing unit saying that we
25 cannot control him. Patient escorted back to room. Patient

1 very verbal with staff, becoming aggressive with staff stating
2 that we are all with the devil. Security at bedside. Patient
3 verbalizing that he is here voluntarily and we cannot keep him
4 here. Staff tried to calm the patient and reinforce that we
5 are here to help him. Staff offered to call patient's father
6 for him to speak to. Patient refused. Dr. Ash-Bernal in to
7 see the patient. Patient stated he wants to leave. AMA paper
8 signed by Dr. Ash-Bernal, patient and this RN. Patient
9 escorted off the unit by security." That's what's on page 116.
10 Q Okay. Doctor, my question was --
11 A Uh-huh.
12 Q -- do you agree that there was a patient outburst between
13 1:15 and 1:30 in the morning?
14 A I, I wouldn't characterize it as an outburst. I'd
15 characterize it the way the nurse described it.
16 Q Okay.
17 A Because I did not witness the outburst as you're
18 describing it.
19 Q Okay. Well you, you wrote it in your own note and you
20 said, [as read], "I was called to the patient room" --
21 A Uh-huh.
22 Q -- "by nursing staff since patient was yelling at nursing
23 staff stating they were all devil worshipers and Obama is
24 Satan?"
25 A That is what the nurses told me and that is what I

1 documented. I cannot say that the patient did that in front
2 of me.
3 Q Okay. But if that is what occurred, if that is what
4 occurred, Dr. Ash-Bernal --
5 A Uh-huh.
6 Q -- would you agree that that was a patient outburst?
7 A I mean, you're, you're sort of using a, a layperson's
8 term that I would not necessarily use. Okay. I mean, are you
9 a doctor?
10 Q No. Dr. Ash-Bernal, I'm not.
11 A Okay. So, I mean, it's sort of semantics. That might be
12 how you describe it. What I would describe it as is as I am
13 reading it I trust the nurses of what they observed. That's
14 all I can say.
15 Q All right. Thank you, Doctor. At the time you allowed,
16 allowed Matthew Scheer to leave the hospital at 1:30 in the
17 morning during a storm, you were aware that he had come to the
18 hospital for treatment of psychosis; correct?
19 A That was one of the diagnoses. Yes.
20 Q Okay. And at the time you allowed Matthew Scheer to
21 leave the hospital at 1:30 in the morning during a storm you
22 knew that he was an epileptic who hadn't been taking his
23 Keppra; correct?
24 A Yes.
25 Q At the time you allowed Matthew Scheer to leave the

1 hospital at 1:30 in the morning during a storm, you knew that
2 he had been dehydrated at the time of his admission and had
3 not received any IV fluids?
4 A Yeah. Dehydration is a diagnosis.
5 Q Okay. Did his labs reflect dehydration?
6 A Not severe dehydration. No. They did not.
7 Q Did, did they reflect dehydration of any level?
8 A The types of things that I would look for for dehydration
9 is on physical exam skin tenting, which means that the skin
10 sort of stays up because you're so dehydrated. I would look
11 at the laboratory studies and look for an elevated BUN and
12 creatinine, which he did not have. It was not outside of
13 normal. Okay.
14 Q What would be normal for BUN and creatinine?
15 A Creatinine, someone in his age group would be one or less
16 and creatinine -- BUN depends on muscle mass. Someone who is
17 pretty muscular, I don't know, low 20s. So typically, if
18 somebody is getting really dehydrated, their BUN and
19 creatinine elevate. That's one of the things we look for.
20 The other types of things on physical exam that I would look
21 for is dry mucous membranes, somebody's mouth almost like
22 sticking together. You know, these are all signs and symptoms
23 that I would look for.
24 Q Seizures can be dangerous; correct?
25 A They can be.

1 Q Seizures can be deadly at times; correct?
2 A Oftentimes seizures that can really be dangerous are
3 somebody having a seizure doing a particular activity such as
4 driving.
5 Q Okay. A seizure alone can kill someone; correct? There
6 are -- people die of, of seizures; do they not?
7 A I don't, I don't know that I would characterize it like
8 that. There's lots of people who have epilepsy, lots of
9 people have seizures and they're not dying all over the place.
10 Many people have seizures. Oftentimes they're very short.
11 They may even be very brief, seconds. The ones that -- the
12 types of seizures that people really notice are like and what
13 people, laypeople outside of medicine typically think of is
14 more like a grand mal seizure where you have arms shaking, leg
15 shaking, tongue biting and, in fact, there are many different
16 sort of flavors of seizures. You can have a petit mal seizure
17 where it's just sort of like staring and, and eye fluttering
18 for just a second or two and you just sort of notice the
19 absence of the person, and the other end of that is like a
20 grand mal seizure where somebody would fall to the floor or
21 crash their car, where they're shaking their arms, shaking
22 their legs, and they have -- they're confused afterwards and
23 don't have any memory of the event, and there's everything in
24 between.
25 Q At the time you discharge Matthew, at the time you

1 discharge Matthew, did you have any idea of what types of
2 seizures he would typically have if he didn't take his
3 medication?
4 A I did not observe him having a seizure, and I did not
5 notice anything in the medical record that described observing
6 him having any seizures in the hospital.
7 Q That's different than my question, Dr. Ash-Bernal. My
8 question is this, at the time you discharged him did you know
9 anything about what types of seizures Matthew would have, had,
10 had had in the past related to his epilepsy? Did you know
11 that?
12 A Again, you're saying I discharged him. He left against
13 medical advice. The process that I go through for a patient
14 for discharge is very different than the process that he went
15 through.
16 Q Okay.
17 A And --
18 Q I'll be happy to --
19 A -- I did not see a characterization say from like a
20 neurological consult or any other prior records that would
21 indicate the exact type of seizures that he had.
22 Q Okay. So I'll be happy to rephrase my question then. At
23 the time you chose to allow Matthew to leave AMA, you were
24 unaware what types of seizures he had had in the past related
25 to his epilepsy?

1 A I was not aware of the types of seizures that he had.
2 Q Would that be prudent information to know?
3 A It can be helpful. It really depends on the type of
4 seizures.
5 Q Dr. Ash-Bernal, at some point after Matthew's -- after
6 you allowed Matthew to leave AMA at 1:30 in the morning, did
7 you and Dr. Patel exchange any text messages?
8 A Not that I recall.
9 MR. GRESH: Objection. May we approach?
10 (Whereupon, a bench conference is held in the presence,
11 but out of the hearing of the jury.)
12 BY MR. HINSON:
13 Q Dr. Ash-Bernal, you, you at times place temporary holds
14 on patients as your -- in your career as a physician; correct?
15 A You're referring to involuntarily committing someone?
16 Q Yes. Temporary holds, involuntary commitments, that type
17 thing, yes, you do that; correct?
18 A I have in the past and I have co-managed patients in the
19 emergency department, particularly at Grand Strand Hospital,
20 that were psychiatric admissions and holding and waiting for a
21 transfer to other facilities. Yes.
22 Q And Dr. Ash-Bernal, you -- when, when you make the choice
23 to do that, you do that for the safety of patients and the
24 safety of others; correct?
25 A I would involuntarily commit someone because they are an

1 imminent threat to themselves or others.
2 Q Okay. And you agree with me that a person can be an
3 imminent threat to himself or others obviously if they're
4 suicidal; right?
5 A If they express that. Yes.
6 Q Okay. If they're homicidal; correct?
7 A Yes.
8 Q Or if they have delusions of thought that make them a
9 risk to themselves or others?
10 A Could, could you repeat that?
11 Q Is a -- you think -- you would commit someone or put them
12 on a temporary hold --
13 A Uh-huh.
14 Q -- if they were suicidal, homicidal or if they had
15 delusions of thought that made them -- put them at great risk
16 to themselves or others?
17 A It, it would, it would really depend on what the
18 delusions are.
19 Q I, I understand there's a lot of depends, but in general,
20 those are the three categories by which you can commit them?
21 A So in other words everyone having, I'm sorry, I didn't
22 mean to interrupt you, but --
23 Q Doctor, my question is this.
24 A -- anyone, anyone having delusions that does not mean
25 they automatically get committed.

1 Q I didn't ask you that, Doctor. My question is the three
2 categories for which a physician can put a temporary hold on a
3 patient, in the third category is patients with delusions of
4 thought that are so great they can't care for themselves and
5 may be a threat to others?
6 A I believe by South Carolina State law it says that the
7 third party is -- involves self-neglect, severe self-neglect.
8 Q Is a patient who isn't taking his Keppra, is that a
9 patient that's exhibiting self-neglect?
10 A Not necessarily.
11 Q Is a patient who isn't eating exhibiting self-neglect?
12 A I'd really have to qualify that with how long they
13 haven't been eating and whether or not they had clinical signs
14 and symptoms of say like malnutrition or kidney failure
15 because they were so dehydrated.
16 Q Would a patient --
17 A That's what, that's what I would consider severe. I
18 mean, people can go a day or two not eat much, not drink much
19 and if they're young and healthy I would say this would not
20 have a severe adverse effect on their health. Now, if a 90-
21 year-old went two days without eating or drinking and became
22 dehydrated and fell at home because they were dizzy and had a
23 fractured hip or something like that, I'd say, wow, yes, very
24 dangerous.
25 Q Dr. Ash-Bernal, what about a patient who hasn't eaten and

1 they're exhibiting anorexia due to hallucinations, is that
2 patient exhibiting severe neglect?
3 A Anorexia is a general term in medicine to indicate that
4 people are -- that the patient does not have much of an
5 appetite.
6 Q No further questions at this time --
7 A Is not eating.
8 Q -- Dr. Ash-Bernal.
9 THE COURT: All right.
10 MR. GRESH: Briefly, Your Honor.
11 REDIRECT EXAMINATION
12 BY MR. GRESH:
13 Q Dr. Ash-Bernal --
14 A Yes.
15 Q -- I tried to be very careful when I was asking you
16 questions earlier --
17 A Yes.
18 Q -- about you don't have an independent recollection of
19 Matthew Scheer; correct?
20 A That's correct.
21 Q You're not here to say exactly, "Here's the 40 questions
22 I asked Matthew"; correct?
23 A Correct.
24 Q Or, "Here's the 30 responses that he gave back to me"?
25 A Correct.

1 MR. HINSON: Objection, leading, Your Honor.
2 THE COURT: I sustain the objection. Rephrase your
3 question.
4 Q But you -- are you here to talk about your habit, routine
5 and practice in taking care of patients like Matthew Scheer?
6 A Yes, and I have tried to share that with the jury.
7 Q And we all watched this TV yesterday?
8 A Yes.
9 Q Did you try to go through your habit, routine and
10 practice on the TV yesterday like you did today?
11 A As best I could. Yes.
12 Q You told me you'd go in, you try not to let them leave.
13 You ask everything you can. This is all stuff that you had
14 talked about before.
15 MR. HINSON: Objection, leading, Your Honor.
16 THE COURT: Don't lead.
17 Q Dr. Ash-Bernal --
18 A Yes.
19 Q -- have you come up with new creative memories or are you
20 trying to talk about the habit, routines and practices?
21 A No. I'm trying to --
22 MR. HINSON: Objection, Your Honor, leading.
23 THE COURT: I overrule your objection.
24 A I tried to share with the jury what my habits are, what
25 my routine is.

1 Q When you're in there talking to Matthew -- I know you
2 don't remember exactly what you said or what he said -- were
3 there anything in that conversation lead you to the conclusion
4 that Matthew was mentally incapacitated?
5 A No.
6 Q Or that he was a danger to himself or to others?
7 A No.
8 Q Whether he was so gravely ill and if -- let's not guess
9 what South Carolina law says -- [as read], "that he was so --
10 a very substantial risk of physical impairment or injury to
11 the person himself as manifested by evidence, the person is
12 gravely disabled and that a reasonable provision for the
13 person's protection is not available in the community," was
14 there was anything like that that was indicated to you?
15 A No.
16 Q Because if there had been what would you have done?
17 A I would have involuntarily committed him.
18 Q There was, just real briefly, there was a lot of
19 questions, is there a corporate compliance officer?
20 A I have not ever seen anything like that before.
21 Q The education and training and experience -- excuse me,
22 the HIPAA training and the other things that you got, was it
23 on behalf of EmCare?
24 A Yes.
25 Q One of the affiliates of EmCare do you know to be

1 Southern Myrtle or do you see right here that it's Southern
2 Myrtle?
3 A Yeah. As I said before, I believe what I saw it on was
4 the paycheck stubs.
5 Q Dr. Ash-Bernal, I appreciate your time. Thank you.
6 THE COURT: You can step down and have a seat at counsel
7 table.
8 A Thank you.
9 THE COURT: Call your next witness.
10 MR. GRESH: Your Honor, at this time the Defense would
11 call Dr. Oscar Lovelace to the stand, please.
12 Whereupon, Oscar Fred Lovelace, Jr., is called to the
13 stand, duly sworn by the clerk and testified as follows:
14 THE CLERK: Please state your name and spell your first
15 and last name, please.
16 MR. LOVELACE: I'm Oscar Fred Lovelace, Jr., and my
17 spelling of my first name is O-S-C-A-R, last name is L-O-V-E-
18 L-A-C-E.
19 DIRECT EXAMINATION
20 BY MR. GRESH:
21 Q Dr. Lovelace, introduce yourself to the jury, please.
22 A I am Oscar Lovelace. I'm a family doctor in a small
23 town, Prosperity, South Carolina, been there for, in August,
24 it'll be 31 years.
25 Q And tell us a little bit about what kind of work you do

1 as a physician there in Prosperity?
2 A Prosperity is in Newberry County, which is about 30 miles
3 from my hometown of Columbia. It's where my grandparents were
4 when I got there, and I am, as described, I have described
5 myself as an old school type primary care doctor. I take care
6 of people in our community in the office, in the hospital, in
7 the nursing home and we occasionally do home visits.
8 Q All right. Tell us a little bit about your educational
9 background, please.
10 A I went to Clemson University, graduated from public
11 schools in Columbia, then went to Clemson, then went to MUSC,
12 University of Virginia and came to Prosperity.
13 Q And when were you at the Medical University of South
14 Carolina?
15 A I graduated in 1985.
16 Q And then after graduating medical school from MUSC did
17 you go on to complete your fellowship, excuse me, your
18 residency?
19 A Residency at the University of Virginia.
20 Q And that was 1985 to 1988?
21 A That's right.
22 Q Are you -- do you have any licensures, state licensures,
23 the ability to practice medicine?
24 A I have a license to practice medicine in South Carolina
25 and still an active license in Virginia that was renewed

1 recently to help a friend.
2 Q Are you board certified?
3 A I am.
4 Q In what, please?
5 A Family medicine.
6 Q And Doctor, we've heard a lot from folks who were
7 internal medicine physicians, and you are by training what
8 type of physician?
9 A A family physician.
10 Q Tell us the distinction, if any, between those two areas
11 of medicine.
12 A Family medicine and internal medicine are probably the
13 most similar two fields. When I trained at the University of
14 Virginia as a second-year family medicine resident, I
15 supervised internal medicine interns and taught internal
16 medicine interns as a family medicine resident. This case
17 today involves the practice of caring for patients in the
18 hospital and the field of hospitalistism or hospitalists'
19 practice, and today about 60 percent or 70 percent of
20 hospitalists are typically internal medicine doctors, and the
21 remainder of those are family doctors. There might be some
22 emergency room doctors that also do hospital medicine.
23 Q Does the care and treatment that a patient receives from
24 a hospitalist, whether they be board certified in internal
25 medicine or family practice, differ?

1 A No. At our hospital the hospital has a contract with
2 family physicians and internal medicine physicians to provide
3 the hospitalist services for our hospital.
4 Q Do you also, on occasion, teach to medical students?
5 A I'm the director of student medical education at our
6 county hospital for the Edward Via Osteopathic School of
7 Medicine out of Spartanburg, South Carolina.
8 Q Talk a little bit about your awards and honors. Were you
9 the chief resident in family medicine at the University of
10 Virginia?
11 A I was.
12 Q I also note from your CV that you were the chairman of
13 the Governor's Healthcare Task Force in South Carolina; is
14 that right?
15 A Yes, sir.
16 Q You were the South Carolina Department of Health District
17 Physician of the year in 2005?
18 A Yes.
19 Q The family physician of the year in '11 and '12?
20 A Yes.
21 Q One of six finalists for the American Family Physician of
22 the year in '13?
23 A Yes.
24 Q And you were the family physician of the year in 2015?
25 A That's correct.

1 Q You've authored publications and done lectures around the
2 country?
3 A Yes.
4 Q All right. And how long have you been practicing
5 medicine as a hospitalist?
6 A Since I started my practice on August 1st of 1988.
7 Q Doctor --
8 MR. GRESH: Or, excuse me, Your Honor, at this time I
9 would seek to qualify Dr. Oscar Lovelace as an expert witness
10 and hospitalist.
11 THE COURT: Any voir dire?
12 MR. HINSON: Very briefly, Your Honor.
13 EXAMINATION BY MR. HINSON (RE: QUALIFICATIONS)
14 Q Dr. Lovelace, you are not board certified in internal
15 medicine like these two doctors over here; are you?
16 A That's correct.
17 Q Okay. Family medicine has a board; correct?
18 A Yes. It does.
19 Q And internal medicine has a different board exam;
20 correct?
21 A Yes. It does.
22 Q And these two doctors over here they work full-time in a
23 hospital. They don't have a clinical practice outside.
24 That's your understanding?
25 A At present I think that's correct. Yes.

1 Q And you, you have a practice; don't you?
2 A I do.
3 Q And you have a, a building that you're the -- do you have
4 any medical partners that work with you?
5 A I do.
6 Q Okay. And you all see patients, you're a primary care
7 physician for, for many people in, in that little town; right?
8 A That's correct. Internal medicine physicians and family
9 physicians are considered primary care doctors.
10 Q And you only come to the hospital to see patients on the
11 occasion where the hospital calls you and asks you to come;
12 right?
13 A No. That's not correct.
14 Q Well, you don't hang out at the hospital waiting for a
15 patient to come to the hospital; do you?
16 A I don't hang out at the hospital, no. I, I practice
17 medicine in the hospital. So I'm in a practice with three
18 physician who take call and every third night on average I'm
19 in the hospital. This past weekend I was on call Friday,
20 Saturday, Sunday and Monday, and I spent most of the weekend
21 in the hospital.
22 Q Okay. But normally you're in your freestanding building
23 where you see your primary care patients?
24 A When I'm in the office I'm in the office, but I spend
25 probably as much time in the hospital as I do in the office.

1 Q How many beds does Newberry County Memorial Hospital
2 have?
3 A Fifty.
4 Q And that's where, where you practice; right?
5 A That's correct.
6 Q And how many beds does, excuse me, Grand Strand Regional
7 Medical Center have?
8 A I'm sure it has hundreds.
9 Q If I represent to you it has 369 beds would you take
10 issue with that?
11 A But not as big as MUSC or Charlottesville, yeah.
12 Q But Grand Strand is approximately 369 and 48 it's, it's a
13 good big bigger, more than four or five times bigger than your
14 hospital; correct?
15 A But much smaller than MUSC and, and Charlottesville's
16 hospital, yeah.
17 Q And smaller than Johns Hopkins and smaller than Mayo, but
18 --
19 A Exactly.
20 Q -- it's much bigger than, than Newberry.
21 MR. GRESH: Your Honor.
22 A I, I, I'm not arguing with you. I think we've agreed
23 that there are 50 beds in Newberry and you say about 400 at
24 Grand Strand.
25 Q And you do a somewhat different job than these two

1 physicians; do you not?
2 A When I'm in the hospital I'm doing the same thing they're
3 doing.
4 Q But only at the times you're at the hospital?
5 A Right. When I'm in the hospital I'm doing the same thing
6 they're doing.
7 MR. HINSON: No, no objection.
8 THE COURT: All right. I find he's qualified as a
9 hospitalist and family practice hospitalist.
10 MR. GRESH: Thank you, Your Honor.
11 DIRECT EXAMINATION (CONTINUED)
12 BY MR. GRESH:
13 Q I, I think you were saying you did about half the time in
14 the hospital and about half the time in family practice
15 outside office setting?
16 A Well, you know, it's, it's all medicine. The fact is
17 that when I'm on call I'm pretty much in the hospital all the
18 time. Well, I should say the majority of the time. I -- you
19 know, when, when I'm on call I, I typically tell my wife,
20 "I'll see you when this call cycle's over."
21 Q All right. Through your 30-year career have you been
22 involved in educating other physicians and medical
23 practitioners on various topics?
24 A We have a family medicine resident, a nurse practitioner
25 or a medical student or two in our office pretty much all the

1 time since 1988.
2 Q And I just note here on your CV, [as read], "Since 1988
3 our practice has instructed 153 medical students, 77 residents
4 and other professional students as well." Is that pretty
5 accurate still?
6 A No. That's a bit outdated. I mean, I was educating a
7 nurse practitioner yesterday at work so.
8 Q As part of the education and supervision you have of
9 medical students, residents, doctors, nurse practitioners and
10 others have you also undertook to educate them on certain
11 things like HIPAA?
12 A Of course.
13 Q And I know that you not only have to -- would have to
14 give that type of education do you also receive that type of
15 communication or education from hospitals and other places?
16 A We have to -- well, we have an annual get-together once a
17 year with a compliance officer that comes and reviews a lot of
18 the governmental alphabets.
19 Q Have you reviewed, at my expense, the PowerPoint that
20 EmCare put on for its affiliate doctors like Southern Myrtle
21 Inpatient Services that kind of walk through the HIPAA
22 training?
23 A I did do that.
24 Q Did you come to an opinion about whether that was a
25 sufficient part of their educational process?

1 A I thought it was reasonable. The fact is is that HIPAA
2 has been around for quite a while and, and doctors have had to
3 get continuing education on this from a variety of different
4 sources. Even people that work in our office part-time is
5 something that they have to go through, people that aren't
6 doctors.
7 Q And just to be clear, was the PowerPoint that Southern
8 Myrtle by way of EmCare provided to its doctors, did it comply
9 with the standard of care necessary for those who are
10 educating folks on HIPAA, meet the requirements?
11 A I didn't, I didn't see any gross deficiencies in it.
12 Q And when you -- did you see any deficiencies that were
13 below the standard of care for HIPAA education of other
14 providers?
15 A Well, I don't want to hold myself out as an expert in
16 HIPAA, but I'm, I'm just saying it was, it was consistent with
17 the training I've had in the Healthcare Insurance
18 Affordability Act.
19 Q Whether that's from MUSC, Virginia or anyplace else?
20 A Right.
21 Q All right. So, you're here today as an expert witness.
22 You were not there actually taking care of Matthew Scheer at
23 any time; correct?
24 A I was not there.
25 Q But you have reviewed a lot of the deposition transcripts

1 in this case?
2 A I have.
3 Q And the medical records, you reviewed stacks of medical
4 records as well?
5 A I have.
6 Q At this point have you reviewed enough information
7 whether it's from deposition -- before that, you've also been
8 here in the courtroom all day today?
9 A I have.
10 Q And you got to hear the direct examination and the cross
11 examination of Dr. Patel?
12 A I have.
13 Q Did you also hear the direct examination and cross
14 examination of Dr. Ash-Bernal?
15 A I did.
16 Q Both of those were under oath just a like a deposition
17 testimony. You understood that?
18 A Yes.
19 Q Based upon your review of the medical records in this
20 case, plus the deposition testimony that you reviewed, plus
21 the live in-court testimony that you reviewed today, have you
22 formulated opinions as to the quality of care and treatment
23 provided by both Drs. Ash-Bernal and Patel?
24 A I wouldn't be here today if I didn't feel that Dr. Ash-
25 Bernal and Dr. Patel met the standard of care. It's my

1 opinion they did not deviate from the standard of care.
2 Q And I want to be clear, all of the opinions that you're
3 going to offer today must be to a reasonable degree of medical
4 certainty. Do you understand that?
5 A That's right. I'm not clairvoyant.
6 Q And you're not going to come in and, and guess and do all
7 those kind of things, reasonable degree of medical certainty;
8 okay?
9 A That's correct.
10 Q All right. Just take things serially, chronologically,
11 if we could, when Matthew Scheer presented to Grand Strand
12 Regional Medical Center, and you reviewed the chart from the
13 initial emergency department visit?
14 A Yes.
15 Q Dr. Battisti and the physician's assistant saw him there.
16 What were some of -- kind of your takeaways, your highlights
17 from that initial encounter?
18 A Well, it was my understanding that Matthew was brought to
19 the emergency room because he did not have a, a doctor in the
20 community. He had not been there apparently long enough to
21 have a, have a doctor. So his father chose to bring him to
22 the Grand Strand ER for an evaluation of concerning thoughts
23 that they had heard him express by phone.
24 Q And was the workup in the emergency department, did you
25 see anything that was improper or inappropriate about the care

1 and treatment provided by Dr. Battisti or the PA?
2 A I didn't see any deficiencies. I think basically it was
3 clear to Dr. Battisti that the primary problem was that there
4 was some mental health issues and that he had, he had stopped
5 taking his medications. He did have some medical
6 abnormalities, but in the absence of those lab abnormalities
7 being associated with abnormal vital signs or something that
8 required an inpatient hospital stay, the feeling was that they
9 had done enough of an evaluation to say that he could safely
10 now be evaluated in a mental health facility, Lighthouse.
11 Q One of the things that they did in the emergency
12 department visit was a CT scan of the head?
13 A Whenever there's a change in mental status that's a very
14 fast test that can be done. It can be done actually in about
15 five minutes now, and so he could get a CAT scan of the head.
16 Q Is, is that looking for structural things in the brain
17 that might explain medically what's going on with the patient?
18 A Anything from a tumor to a tumor, brain tremor. I saw --
19 had, had a little girl one time cause a personality change.
20 So anything from a brain tumor to a hemorrhage to a stroke
21 would typically be what we would be looking for in a CAT scan.
22 Q Then the CAT scan that they did was normal?
23 A Normal. Right.
24 Q Did they then send or arrange with Lighthouse to send
25 Matthew Scheer over there for voluntary outpatient mental

1 health?
2 A Typically what happens is in that situation when there's
3 going to be a transfer from the hospital to a mental health
4 facility, the social worker, who that's the group of folks
5 that are involved in making sure that that process goes well,
6 and in this case I believe her name was Teresa Abrams became
7 involved in Matthew's care and, and actually facilitated that,
8 that transfer and made sure that the information got to
9 Lighthouse.
10 Q But you understand from -- you've recently reviewed the
11 Lighthouse records as well?
12 A I didn't have access to those at the time of my
13 deposition, but they have -- they were provided to me within
14 the last two weeks.
15 Q I think they were only produced in the last couple of
16 weeks, but since they were produced by Lighthouse have you had
17 a chance to review those records?
18 A I have.
19 Q And when you look at those records do you have -- can you
20 kind of give us a flavor of what happened when Matthew Scheer
21 presented to Lighthouse?
22 A Well, it was a little different than what I had thought
23 based on the affidavit statement by Matthew's dad. He
24 apparently was not seen by Dr. Oduwole at --
25 Q He's a psychiatrist at Lighthouse?

1 A Right.
2 Q Okay.
3 A So a referral was made to Lighthouse where a
4 psychiatrist, Dr. Oduwole was, but it's my understanding that
5 the lab results were sent by fax sometime between or after
6 they agreed to say, "Okay, send him over here. We'll, we'll
7 evaluate him," and when Dr. Oduwole saw the lab results he
8 felt like he needed to still be in an environment where he
9 could get medical care, that he needed further medical
10 evaluation or management of those laboratory abnormalities.
11 Q And Lighthouse didn't want to manage the medicine part of
12 this. So they told the patient to go to a hospital for
13 medical clearance?
14 A It was my understanding that the social worker, again,
15 that's often who is involved in the intake and transfer of
16 patients at the facility at Lighthouse, spoke with Dr. Oduwole
17 and Dr. Oduwole said, "Tell them to go to Conway Hospital and
18 I will further manage him there."
19 Q And do you have an understanding as to how close Conway
20 Hospital is to Lighthouse?
21 A It's my understanding it's like right in the same
22 vicinity, you know, you -- hundreds of yards from each other.
23 Q Okay. And the -- however it came to be, Mr. Scheer and
24 Matthew Scheer left Lighthouse and came to Grand Strand. Is
25 that what you saw in the records?

1 A That was my understanding and, and the affidavit
2 statements said that, that they were told to go to Conway, but
3 they, they went back to Grand Strand.
4 Q Okay. When the patient comes to Grand Strand and we've
5 all heard he's again evaluated by Dr. Amanda Battisti. Did
6 you see that as well?
7 A I did.
8 Q She thought his condition was essentially the same as it
9 was when she had seen him earlier that morning?
10 A I think she used the words there's been no significant
11 change.
12 Q Okay. When a patient is admitted to a hospital from --
13 and from the emergency department, did you see in the notes
14 where Dr. Battisti talked to Dr. Oduwole to develop a plan?
15 A I think a call was placed to Dr. Oduwole and it took
16 about an hour and a half for him to, to get back in touch
17 because there apparently was some back and forth between the
18 hospital and Lighthouse to kind of figure out what, what took
19 place because he was, he was supposed to go to Conway I think.
20 Q Eventually Dr. Battisti, the emergency room physician,
21 and Dr. Oduwole, the psychiatrist, were able to collaborate
22 about Matthew Scheer. Is that what it looks like from the
23 record?
24 A And my understanding that's why there was like an hour
25 and a half while all that was being figured out.

1 Q Did they develop a plan at that point for Matthew Scheer
2 to be admitted to the hospital?
3 A The second ER note outlines that a plan was developed.
4 Q And that he was going to be admitted to the hospital, and
5 Dr. Patel, as the hospitalist, would essentially medically
6 clear Matthew to go back eventually to Lighthouse. Was that
7 the plan?
8 A That was the plan.
9 Q Okay. Have you -- you've served in that capacity where
10 you're the physician in the hospital trying to get medical
11 clearance on a patient who not only has medical problems but
12 also has potentially psychiatric problems as well?
13 A This weekend on Sunday I had a patient come in that was a
14 400-pound male with schizophrenia who had stopped taking his
15 blood pressure medicine. His blood pressure was 240/130, and
16 I had a 72-year-old male who said that he was going to buy a
17 gun and shoot everybody he could see, who had lost 93 pounds
18 in four months and had a history of depression in the past.
19 Q In the hospital from time to time you have to evaluate a
20 patient as to whether or not they're a danger to themselves or
21 others?
22 A It's actually pretty frequent especially in rural
23 counties where there are few, if any, psychiatrists.
24 Q Let's -- before we jump into that, let's talk a little
25 bit more about the medical clearance. We heard testimony that

1 some instrumentalities that we might use commonly in the
2 hospital might be dangerous in a psychiatric unit. You
3 understand that, IV tubing, EKG leads, those types of things?
4 A I wasn't familiar with the term instrumentalities.
5 Q I'm sorry.
6 A Yeah.
7 Q That's my word.
8 A Okay.
9 Q Talk to me about what Dr. Patel did. He's there for
10 medical clearance. Did Dr. Patel appropriately evaluate
11 Matthew Scheer? Did he appropriately formulate a plan? Kind
12 of walk me through that.
13 A In my opinion when Dr. Patel received the report from Dr.
14 Battisti it was that he had come back from Lighthouse and that
15 they wanted further medical clearance, and so Dr. Patel said,
16 "Okay, well, we'll, we'll do that." One thing that was pretty
17 impressive is he responded immediately according to the
18 record. There was an hour and a half delay, and he came and
19 evaluated the patient and decided, okay, for the
20 hyperbilirubinemia we'll get an ultrasound, abdominal
21 ultrasound. Sometimes high bilirubin is caused by gallstones
22 trapped in a common bile duct, but again, he had no complaint
23 of right upper quadrant pain. He had no fever to suggest he
24 had cholecystitis, but he said, "Okay. We'll, we'll evaluate
25 that," and so he orders an abdominal ultrasound. The

1 abdominal ultrasound is done and it is unremarkable, and then
2 the other, the other aspect was the elevated white blood cell
3 count, and white blood cells are made by your bone marrow. If
4 you're under a lot of stress, you get in a car accident, you
5 have been upset, you get shocked by something, you fall, your
6 white blood cell count can go up, especially if you're a
7 healthy person, but obviously, we always get concerned when
8 the blood white blood cell count is elevated, does someone
9 have an infection, and in Matthew's case he didn't have a
10 fever. His blood pressure was normal. We weren't really
11 concerned that -- I should say they were not really concerned,
12 I think, that he was septic. So he, again, I believe was
13 considered to be medically stable. He's put on a general
14 medical floor. He wasn't put in the intensive care unit, and
15 you know, by virtue of that they didn't feel like he needed
16 like one-on-one direct supervision.
17 Q Was Dr. Patel's physical examination of the patient and
18 plan of the patient appropriate?
19 A It's consistent with standard medical practice.
20 Q The -- did Dr. Patel seek to appropriately medically
21 clear Matthew Scheer?
22 A I think he did. I think one of the other things that's
23 important to, to bring out here is that when Dr. Patel sees
24 Matthew he's described as being calm, cooperative. He's not
25 actively hallucinating, and so, he's trying to take care of a

1 patient based on the history that is being provided to him,
2 but he certainly doesn't see Matthew as a threat to himself or
3 others, and another point that, that I would just make is
4 that, you know, Matthew came into the emergency room saying,
5 "I've been born again. I've been cured. I don't think I need
6 my medicine anymore," and so it doesn't really strike me as,
7 you know, especially if you're talking to someone who is not
8 actively hallucinating or combative or aggressive at you that
9 that seems to be, you know, a, a person that you need to put
10 in the ICU or on one-on-one supervision. So I think that Dr.
11 Patel he, he provided the history of what had been provided
12 and the appropriate referral based on the history given by his
13 father and, and the findings in the ER, but it was not, it was
14 not what he was seeing.
15 Q It was stuff he had heard by history?
16 A And right, and was in the medical record from what was in
17 the emergency room.
18 Q Dr. Patel writes in his note PRN Ativan but doesn't
19 actually order the PRN Ativan.
20 A Well, this weekend, I, I, I had to use PRN Ativan on the
21 patient that I wound up putting in the intensive care unit who
22 said he was going to get a gun and shoot everybody and he was
23 cursing at the nurses and he was resisting all the care and
24 very combative. So I had to use something to sedate him, but
25 in this case, if someone's calm and cooperative, you may put

1 in your note may use PRN Ativan, but you don't just put the
2 order in. It's just something that you're saying you may do.
3 Q Was there any requirement under the standard of care
4 applicable to Dr. Patel in these circumstances that he had to
5 actually go write an order for PRN Ativan?
6 A Absolutely not. When a doctor writes their admission
7 history and physical they, they basically outline what they
8 feel like is the plan, but if I admit someone with chest pain
9 and I may think that I'm going to -- I, I, I might say I'll do
10 a stress test. I may wait till the next day to write the
11 order for the stress test because I want to make sure that I
12 rule out myocardial infarction by enzyme and EKG criteria
13 first. So just because you put something in your admit note
14 of a medicine you might use or some intervention, it doesn't
15 mean you -- it's a -- it's, it's not a deviation not to write
16 the order for that, for that test or treatment.
17 Q When Matthew is calm and cooperative with Dr. Patel is
18 there any indication to give Matthew Scheer Ativan at that
19 point while Dr. Patel is there with him?
20 A No, and I mean, I think it would be inappropriate
21 actually. One of the things that we do when we admit people
22 to the hospital and it is difficult. It is more difficult
23 because I function both as a hospitalist taking care of people
24 I don't know and then taking care of people that I've taken
25 care of for 30 years, and that is that you don't want to knock

1 someone out or just sedate them if you really don't, don't
2 know how they're presenting. You, you just don't put someone
3 under, and I, I think Dr. Ash-Bernal was saying that, you
4 know, or it may have even been in her, in her -- I'm not sure
5 if I read it in her deposition or if I -- or she said it
6 today, honestly, but even when a, when a nurse calls us and
7 says, "Hey, I want to give this person some, some IV Ativan,"
8 you, you don't just say, "Okay, fine," you know, because you,
9 you don't want someone just to be knocked out. If they have
10 sleep apnea they may, they may become hypoxic and have more
11 problems.
12 Q In, in a situation like Matthew where you know you're
13 going to have a psychiatric consult is that maybe one more
14 reason not to give Ativan?
15 A Well, you know, Ativan is a benzodiazepine. It's, it's a
16 Valium drug. It has a little bit shorter half-life than
17 Valium. Valium has about an eight-hour half-life. Ativan has
18 a four to six-hour half-life. So it's, it's --
19 Q What's half-life?
20 A Half-life is like essentially it's the, the time it takes
21 that the medicine is going to get in the system and out the
22 system. So, you know, if a medicine has a half-life of, of
23 eight hours you're going to give it about every eight hours.
24 If it has a half-life of four to six you're going to get it
25 every four to six, but what, what I would, I would just say is

1 that he is saying this is a patient who apparently has
2 psychosis, which the definition of psychosis would just be not
3 being in touch with reality, and so if their behavior
4 manifested itself before the psychiatrist gets here and
5 becomes disruptive or whatever, then I could use PRN
6 benzodiazepine or Ativan.
7 Q Is another option that would be available in that
8 circumstance get the physician involved?
9 A That's the best, that's the best option because then
10 you've got an evaluation of the patient.
11 Q Let's, before we jump to that real quick, the other
12 allegation as I heard it against Dr. Patel is the, the handoff
13 or signout that hospitalists do. Let's talk about that real
14 quick. When Dr. Patel left that evening were there any
15 critical outstanding labs or tests that had not yet been
16 completed that the nighttime hospitalist would have to follow
17 up on?
18 A No, and I think if you look at Bethany Bell's note from
19 sometime right before 7:30 after Dr. Patel left, he was
20 described as being calm, cooperative and not having any
21 abnormal speech.
22 Q In a situation like that is a handoff physician-to-
23 physician, hospitalist-to-hospitalist, is that required?
24 A You know, this term, excuse me, this term of, of handoff
25 typically what, what we call that in medicine is a signout,

1 and we sign out the patients who are unstable or patients who
2 are in the middle of an evaluation for something that would
3 require some follow-up that night. Dr. Ash-Bernal gave a
4 pretty decent example of that which would be someone that
5 comes in short of breath and you're wanting to rule out a
6 pulmonary embolism, and you may have done a chest x-ray, but
7 you're waiting on a pulmonary angiogram to come back and that
8 would be something you would sign out to, to the other person
9 who's coming in to take call, but as far as in the hospital
10 environment functioning as a hospitalist, frankly, there's
11 more information available within that system. I mean,
12 they've already mentioned there's 132 pages worth of
13 information and there's no way you're going to go over 132
14 pages of information on 20 patients before you leave and so,
15 have a good 12 hours.
16 Q Was there any requirement under the standard of care for
17 Dr. Patel to give a handoff to Dr. Ash-Bernal?
18 A In my opinion he was clinically stable, and he's -- he
19 was described by the nurse within 30 minutes of Dr. Patel
20 leaving the hospital that he was calm, cooperative and, and
21 that he had no abnormal speech.
22 Q We know that at around 1:13 in the morning or so there's
23 a -- Matthew Scheer has a change in condition.
24 A Right.
25 Q And we, we heard earlier that before Dr. Ash-Bernal would

1 have went in and talked to Matthew Scheer that by way of her
2 habit, routine and practice she would have read that which was
3 available to her in the chart prior to going and visiting the
4 patient. Did you see that in her deposition?
5 A Well, I don't think you ever want to walk into a room
6 cold without having some information and especially, you know,
7 one of the things that we -- I even teach -- taught my four
8 children the last thing you want to do is when there's drama
9 is elevate the drama. You want to try to assess the situation
10 and before walking into that, and so what, what Dr. Ash-Bernal
11 describes is, and believe me if you're a resident and you
12 don't to listen to the nurses you'll, you'll, you'll learn
13 fast not to do that. She, she went to speak with the nurses,
14 and said, "All right, what's going on," gets a history from
15 the nurse, and then says, "Okay, I'm going to look in the
16 computer at these pages," and describes the pages that she's
17 going to look at. She's not going to look at the pages and
18 pages of labs that are already listed in the H and P note from
19 Dr. Patel or in the ER note. She's going to look at the, the
20 ER evaluation, the doctor's admission note and she's going to
21 talk to the nurses, and so, that's what she did because there
22 had been a change in status.
23 Q Is there anything that she would -- let's assume there
24 had been a handoff between the two physicians. Is there
25 anything that she would have learned from that handoff that

1 wouldn't have been available in Dr. Patel's three-page
2 dictated history and physical?
3 A I think it would be unlikely that he would communicate
4 everything that would be readily available to her in a
5 signout. There's just no way that she -- that he would have
6 communicated all that information, especially all the back-
7 and-forth between Lighthouse and --
8 Q And she would learn more from reading a chart than she
9 would from a signout?
10 A I, I, I think so.
11 Q Okay. Well, let's -- talk to us real quick -- let's kind
12 of before we get there, looking back at everything Dr. Patel
13 did from the moment he first saw Matthew Scheer until he left
14 that, that evening, is there any action or inaction that he
15 took that fell below the applicable standard of care?
16 A I would just reiterate he got the call. He responded
17 within the same minute. He said, "I agree to take the
18 patient. I understand you have talked to Dr. Oduwole." He
19 dictates an H&P before he leaves. I mean, frankly, I don't
20 know what was going on with him that, that night, but you
21 know, I had five admissions on Sunday. I had to do one of the
22 admissions the next morning. So before he leaves he's got a
23 history and physical in the chart, and he basically, in my
24 view, is describing what everyone else is saying is going on
25 with this person, but he's not seeing.

1 Q Is there anything that Dr. Patel did or failed to do that
2 you believe deviated from the applicable standard of care for
3 a hospitalist in that circumstance?
4 A No. I don't think he deviated.
5 Q Okay. Then let's move on to Dr. Ash-Bernal. We've all
6 seen it, the 1:13 note from Charge Nurse Freeman and the
7 Bethany Bell note after that. We heard Dr. Ash-Bernal get up
8 on the stand and talked about what her habit, routine and
9 practice would have been in handling a patient like Matthew
10 Scheer. Based on what you've read in her deposition testimony
11 and what you saw here firsthand today, do you think anything
12 that she did in the handling of Matthew Scheer in this change
13 in condition at around 1:13 in the morning deviated from the
14 standard of care applicable to hospitalists under the same or
15 similar circumstances?
16 A No. I don't, and if you don't want me to explain it,
17 I'll, I'll --
18 Q Yes. Please.
19 A Okay. So this is actually a pretty common scenario that
20 someone says, "I'm not staying here. I'm getting out of
21 here," especially if they don't have a relationship with their
22 doctor in the hospital, and frankly, most of the time in my
23 experience, there's not this thorough process. Most of the
24 time a patient says, "I'm leaving," they get up and walk out.
25 They say, "Wait, wait, wait, wait. I want you to sign this

1 form." "Hell no, I'm not signing a form. I'm getting out of
2 here." They leave. In this case, and, and frankly, I think
3 it's because Dr. Ash-Bernal was on the hall, she's on the
4 hall, they go to her and say, "Hey, we got a patient that just
5 came up here," and had taken his shirt off and threw his
6 wristband off and said, "I'm getting out of here," and so she
7 goes, "Okay. Well, I'll come in and evaluate," and by this
8 time she goes in his room. He's got his shirt back on and
9 he's just saying, "I'm leaving," and you know, I have to say,
10 a, a young seemingly healthy male patient saying, "I'm, I'm
11 not staying in here," that is not that uncommon, and then to
12 have a patient, though, say, "Okay, well, let me talk to you,"
13 somebody that will, will talk to you, it is true that the, the
14 person that will talk to you might be one that you can
15 convince, but it's, it's, it's a little bit uncommon for you
16 to be in a situation where someone says, "I'm leaving," but
17 you can sit down and go through the whole process with them,
18 primarily, because you're generally not there. You're taking
19 care of something else. You might be in the middle of
20 admitting somebody in the ER. You might, in my case, I might
21 be in the office and they call me and say, "Somebody says
22 they're leaving," and frankly, the nurse can have the patient
23 sign the AMA form, but sometimes the patient says, "I'm not
24 signing any form. You don't own me. You know, I'm out of
25 here."

1 Q The efforts that Dr. Ash-Bernal undertook with Matthew
2 Scheer to get him to stay that night, was that reasonable,
3 appropriate and in compliance with the standard of care?
4 A I think the point that I'm making is, A, pretty common
5 that the patient just walks out, B, more common if they don't
6 just walk out that -- and they do sign an AMA form, that
7 that's the only thing in the chart, the AMA form, and then the
8 next day the doctor comes in and dictates a story saying,
9 blah, blah, blah, "patient left against medical advice," they,
10 they did or did not sign the form. It's, in this particular
11 situation, she was summoned. She happened to be right there.
12 She used her own best medical judgment to assess the
13 situation. She has him sign the form, and she dictates a note
14 about it, not just having him sign the form, she, she dictates
15 a note stating what happened.
16 Q And based on what she testified to in her deposition and
17 what she testified to today from the stand, overall opinion is
18 what she did in the handling of Matthew Scheer in compliance
19 with the standard of care?
20 A I think it's beyond the standard of care in the sense
21 that it would be perfectly within the standard of care for a
22 person who says, "I'm leaving against medical advice, you
23 can't keep me here," they can choose, they can choose to or
24 not to sign the AMA form and that the AMA form, in most of the
25 cases of against medical advice that I have addressed, there

1 has not been a separate physician assessment and note.
2 Q Dr. Ash-Bernal described that when she was going to the
3 patient's room or talking to the nurses the nurses relayed to
4 her that the father wasn't to be called by the medical staff.
5 Did you see that in the deposition and hear that today?
6 A I saw that the patient was asked, "We would like to call
7 your father," and he refused, he said no.
8 Q In a circumstance, in a circumstance where the patient is
9 present and you as the physician believe the patient has
10 mental capacity, do you have to honor the patient's request?
11 A You don't have to, but I mean, what I'm saying is that
12 we, we don't, we don't know the whole story. As I -- we're
13 not clairvoyant. I don't -- we don't know the relationship
14 between this father and son, and he's brand-new to us, and
15 especially in a situation like this if he says, "Do not call
16 my father," and you're an adult and you don't seem like you're
17 overtly psychotic or not able to, to listen to what your --
18 someone's telling you, it would be, it would be uncommon that
19 that you would be, "Well, I don't care what you're going to
20 say, I'm going to call your dad."
21 Q Were there any behaviors that were noted in the chart
22 that would lead a reasonably prudent physician to believe that
23 Matthew Scheer posed an imminent harm to himself?
24 A Again, the point that I want to make is if Matthew
25 presented to the ER and said, "I've been born again. I've

1 been cured," that may not necessarily be in touch with
2 reality, but what I will say is that we don't take -- when
3 you, when you, when you talk -- when you're talking with
4 someone just because they say something that you think may not
5 be fully based in reality, you don't call and invoke the chain
6 of -- the, the chain of command or, or, or involuntary
7 commitment. I've, I've done that before, and involuntary
8 commitment is a traumatic process. I've done it in the
9 office. I've done in the hospital. You know, law enforcement
10 comes in, puts patients in handcuffs and have an officer in
11 the room with them. That's the way it works at our hospital.
12 You know, if there -- if somebody is, is refusing treatment,
13 and I say, "You're a threat to yourself or others," then my
14 next call if I'm in my office is to the county sheriff. If
15 I'm in the hospital emergency room it's to the, it's to the,
16 to the chief of police because if I, if I've got to invoke
17 chain of custody, that patient cannot, and especially, you
18 know, I will, I will say, I will say this, most of the time
19 those people are overtly acting out. They are threatening
20 themselves or others.
21 Q Whether it's traumatic or not, if it's indicated you
22 would involuntarily commit somebody?
23 A Exactly, but you have to understand when, when you say to
24 someone, "You are not leaving," especially to a young healthy
25 male, you know, that could turn into a traumatic experience.

1 Q In your view of the chart and looking at deposition
2 testimony and what you heard today, was there anything that
3 should have put Dr. Ash-Bernal on notice that he was an
4 imminent danger to himself or to others at that time?
5 A I don't think in my opinion, and I said this in my
6 testimony, that there were at least 10 people who interacted
7 with Matthew from the time that he presented to the emergency
8 room in some way, shape or form, and any of those 10 people
9 could have said, "You know, he is so mentally unstable we need
10 to involuntarily commit him because he's a threat to himself
11 or he's threatening someone else," but no one in the emergency
12 room on the first visit, no one at Lighthouse psychiatric
13 facility, no one in the emergency room when he came back on
14 the second visit, no one when he got admitted to the hospital
15 on the medical floor, including the nurse caring for him, the
16 director of nursing and now, in, in the final analysis, Dr.
17 Ash-Bernal felt, "I need to put him under involuntary
18 commitment."
19 Q Was sufficient amount of time, was enough questions
20 asked, etcetera, for a physician like Dr. Ash-Bernal to come
21 to the conclusion that Matthew Scheer was competent to sign
22 himself out AMA?
23 A My, again, my statement is that this was, in my
24 experience, as thorough as the process gets. "Please go back
25 to your room." He goes back to his room. He puts back on his

1 shirt. They say, "We're calling the doctor." The doctor
2 comes in and makes an assessment. The doctor says, "Are you
3 sure you want to leave?" "Yes. I want to leave." "I want
4 you to sign this form." "Okay. I'll stay and sign the form."
5 Stays and signs the form. "Okay. Now we'd like for the
6 police officer to escort you downstairs." He, he cooperates
7 with that. He's escorted downstairs and he leaves.
8 Q Throughout that entire experience was there anything that
9 was observed by the nursing staff or Dr. Ash-Bernal that would
10 have precluded allowing him to leave against medical device?
11 A I'm sorry. Restate that.
12 Q That may not have been a good one. Is there anything
13 that was observed by Dr. Ash-Bernal or the nursing staff at
14 around 1:30 in the morning which would have precluded allowing
15 Matthew Scheer to leave against medical advice, danger to
16 himself or others, suicidal or so --
17 A Yeah. I, I -- sounds like there were a lot of double
18 negatives in there, but the bottom line is, I, I, I feel that
19 he did not manifest behavior that in 30 years of experience
20 that I would have given the same set of information said, "I
21 am putting you under involuntary commitment. You are not
22 leaving this hospital."
23 Q And looking back at all of the care and treatment that
24 Dr. Ash-Bernal provided to the patient, whether it was
25 documented in the chart or testified to, taking it in its, in

1 its totality, do you believe Dr. Ash-Bernal in all respects
2 complied with the standard of care applicable in that
3 situation?
4 A I do.
5 Q Appreciate your time. Thank you. Please answer any
6 questions that Mr. Hinson may have.
7 CROSS EXAMINATION
8 BY MR. HINSON:
9 Q Good afternoon, Dr. Lovelace.
10 A Good afternoon.
11 Q All right. You're not a member of the Society of
12 Hospital Medicine; is that correct?
13 A That's correct.
14 Q And you're not a member of the American Board of Internal
15 Medicine; are you?
16 A That's correct.
17 Q Dr. Lovelace, how much are you charging to come here
18 today and testify on behalf of the Defendants?
19 A I think I get $5000 a day because I'm out of the office.
20 Q Okay. And you charged a $5000 retainer; correct?
21 A I don't think I was paid a $5000 retainer, but I might
22 have been.
23 Q If, if you told --
24 A I mean, you could get my invoice. I don't know.
25 Q But you took a -- you gave a deposition in this case?

1 A If I, if I got a $5000 retainer I got a $5000 retainer.
2 That's all right.
3 Q All right. And you were under oath when you gave that
4 deposition?
5 A As I am now.
6 Q Okay. So you think you may have charged a $5000
7 retainer?
8 A I may have.
9 Q And at the time I took your deposition -- well, how many
10 hours have you spent on the case at the time you gave your
11 deposition?
12 A I mean, if this is a quiz game I'm happy to, to play the
13 quiz game, but I think I said 20 hours. I'm not positive.
14 Did I say 20?
15 Q You did indeed. You said 20 hours, Dr., Dr. Lovelace.
16 A Did you --
17 Q And how much do you charge per hour?
18 A I think it's 400 depending upon when I got this case, but
19 I think it is 400 an hour.
20 Q All right. So then you would have charged $10,000 for
21 your review?
22 A Four hundred times --
23 Q Times 20 --
24 A I don't think that's 10,000. I think that's 8000. Is
25 that not right?

1 Q Is that right? Four hundred times 20. I think you may
2 be right.
3 A Med school helps you a lot at math.
4 Q Well, you charge more -- I'm sorry. You charge 600, more
5 for a deposition. You charge differently for your deposition
6 than you do for review; don't you?
7 A Right. Because that's real intense like this is.
8 Q How much total have you billed in this case to come here
9 and testify today, Dr. Lovelace?
10 A I, I, I don't -- my office manager gets a sheet saying
11 this is how much, how much, how much time I've spent, but I, I
12 don't walk around with that in my pocket.
13 Q All right. And Dr. Lovelace, I sent you a subpoena in
14 this case for a copy of your billing; didn't I?
15 A I knew that was coming. I did not comply with your
16 request.
17 Q Okay. That's right, and took your deposition that day
18 and I wanted to get back home, and I said, "Dr. Lovelace,
19 that's fine. If you'll promise to get me a -- to get the
20 court reporter," there's a court -- at a deposition there's a
21 court reporter; right, the lady who's taking down all the
22 testimony, sometimes it's a man, but usually it's a, it's a
23 lady.
24 A Yeah. As, as I recall I offered to take a break from the
25 testimony, go to my office and get the information that you

1 requested, and you said you had a commitment in the evening
2 and I could just send it to you later, and unfortunately that
3 was about three weeks ago, and I haven't had a chance to get
4 around to it.
5 Q Now in a trial, Dr. Lovelace. So we had your deposition,
6 you didn't comply with the subpoena, you didn't bring your
7 billing, and I said if you would just get a copy to the court
8 reporter so that she would make it an exhibit to your
9 deposition then I'd know how much you had billed total, but
10 you didn't do that either; did you?
11 A If, if the billing information has an impact on this
12 matter I will stop right now and we can take a break and I'll
13 try to get it for you.
14 Q You've, you've billed more than $20,000 in this case;
15 haven't you, Doctor?
16 A That I believe, sir, is erroneous.
17 Q How would much would you estimate you've billed?
18 A I would imagine somewhere around 15, but I'm, I'm not
19 positive. I think this case, I think I got this material I
20 think I got it in 2018.
21 Q But you haven't provided me any way to know that because
22 you didn't provide me your bills?
23 A I've already admitted that, sir.
24 Q And Dr. Lovelace, you've testified in court quite a bit;
25 correct?

1 A Yes. I have.
2 Q And you've been doing expert reviews for 25 years now?
3 A I have.
4 Q And you typically review on average 10 to 15 cases a
5 year, depends on the year; right?
6 A As I said it's been more lately.
7 Q Okay. So more than, more than -- in the last few years
8 it's been even greater than 10 to 15 a year?
9 A I'm getting almost two or three a week now.
10 Q Okay. Well, I was figuring 25 years, and I had figured
11 an average of 12 per year, which would be 300 cases; is that
12 right, yeah, 300 cases, but it would be a little more than
13 that that you've, that you've testified in?
14 A What I'm saying is lately this seems to be a, a real
15 issue and I'm getting sometimes two, sometimes three a week.
16 Q And in those hundreds of cases in all but one out of
17 hundreds in all but one you've testified on behalf of the
18 doctor; is that correct?
19 A That actually a misstatement, sir.
20 Q Okay. Well, correct me.
21 A Yeah. We -- yeah. When I review cases the case is sent
22 to me and, and they say, "What do you think about this case,"
23 and many of the cases that I look at I will say, you know,
24 "I'm not going to serve as an expert for the doctor who's
25 providing this care because I think it fell below the

1 standard," I send it back to the attorney. Your, your
2 statement about -- in one case I told you that just before my
3 deposition I had been in North Carolina and given a, a, a
4 deposition and court testimony in a wrongful death case about
5 a young woman who died of a pulmonary embolism and that that
6 was the case that I had been in court on.
7 Q You've testified in court and at deposition numerous
8 times; correct?
9 A That's correct.
10 Q And of those numerous, numerous times you've testified
11 every single time, save that for one, it's always been on
12 behalf of the doctor; is that correct?
13 A State that question one more time.
14 Q Of all the times you've testified, all the times you've
15 been -- you've come to trial and been willing to testify, all
16 the times, every, every single time except for that, except
17 for one has been on behalf of the doctor?
18 A And it's important for the jury to know that often the
19 way that -- no --
20 Q If you'd answer my question first and then you can
21 qualify it if you need to.
22 A I will say I think I'm -- I think you're correct in that,
23 but what I want the jury to understand is that often when I
24 see a case where there's been a deviation from the standard of
25 care, the lawyer will go back to the hospital or whoever is

1 being sued and they'll lay out the plan and say, "I, I have
2 had this reviewed by a doctor and I think, you know, you
3 better, you better pay up or we're going to have to take this
4 through the court system," and many times those cases are
5 settled.
6 Q You said earlier that involuntary commitment is a
7 traumatic process. Were those your words?
8 A It is.
9 Q It takes some, takes some work to do that; doesn't it?
10 A It, it actually is pretty quick to, to draw the trigger
11 to do that. What I'm saying is it's traumatic for the patient
12 and it's traumatic for everybody around because it's like
13 turning a person into a nonperson. I mean, the, the last time
14 I did it I had a, a patient who had become manic and he would
15 not get off his bulldozer because he was digging a deeper and
16 deeper crater, and we went out to the site where this was
17 happening, talked him off the bulldozer, talked him into the
18 ER and put him in handcuffs.
19 Q He was having some sort of delusional thinking, the
20 fellow on the bulldozer?
21 A That was a threat.
22 Q All right. Thank you, Dr. Lovelace. No more questions.
23 MR. GRESH: Real briefly.
24 REDIRECT EXAMINATION
25 BY MR. GRESH:

1 Q Dr. Lovelace, the fees that, that you've charged in this
2 case, you read all the depositions, the Plaintiff's experts
3 and the other experts, is it pretty commensurate with all the
4 fees that all the experts get paid in cases to do like this?
5 A I'm actually a little below. Depending upon where you're
6 from you can get paid a little bit more. I think that the
7 truth is is that I'm a -- I'm an independent practitioner, and
8 we have 50 employees, and when I'm not working in my office
9 I've got to be working somewhere.
10 Q That's all I have. Thank you.
11 THE COURT: All right. You can step down and be excused.
12 We appreciate your time, Doctor.
13 A Thank you.
14 THE COURT: Where, where are we? That --
15 MR. GRESH: I've got one witness tomorrow, Judge.
16 THE COURT: Okay. All right. We're going -- we've got
17 one more witness in the case who's coming in the morning.
18 We're going to work on getting ready for things we have to get
19 ready. Rather than wait till in the morning to do it, we're
20 going to do it this evening so we'll have that out of the way.
21 So be back at 9:30 and we'll hopefully get started around 9:30
22 in the morning. Have a pleasant evening. Keep in mind you're
23 not in a position yet to make up your mind or discuss the
24 case. Thank you.
25 (The following takes place outside the presence of the jury.)

1 THE COURT: All right. I'm going to say we'll take a
2 short break. Just wait a minute, wait a minute, we've got one
3 other thing, short break, and then maybe we can meet back in
4 my office or a conference room back here. The reason I said
5 wait a minute, we've got -- I've got this notice of motion to
6 hold Defendant in contempt and charge the jury about the --
7 that the Defendant, Spartan [sic] Myrtle, I guess it is, can
8 pay any judgment that's awarded.
9 MR. HINSON: Your Honor, I don't know that it's, it's
10 ripe just yet. Since the time that motion was filed
11 Defendants have, have moved to bifurcate the case, and I mean,
12 as much as I'd, I'd like for you to hear it at this point, I,
13 I do think if, if, if the jury doesn't come back finding that
14 anybody was grossly negligent since we now have a bifurcated
15 trial I don't know that it's, it's -- needs to be heard at
16 this point.
17 MR. GRESH: Well, Your Honor, I'd just as soon hear it
18 now. Here's what happened because I mean, I find this, this
19 interesting, and I'm surprised we're even -- I'm surprised he
20 filed it and I'm surprised we're still arguing it. There was
21 an order from another --
22 THE COURT: I saw the order. I've, I've read it.
23 MR. GRESH: Yeah. And so I take over the case and didn't
24 know about the order. Brink does the honorable thing. Emails
25 me, says, "Hey, just in case you didn't see this, don't forget

1 to get me this stuff before trial," appreciated the, the heads
2 up, professional courtesy. I expressed my thank you for that.
3 Immediately reached out to Southern Myrtle and to Dr.
4 Patel and Dr. Ash-Bernal and told them, "Hey, I need tax
5 returns and those types of things." Sent Brink an email back
6 saying, "Here's this time and update. Just I'm working but
7 here's what I've got. Here's Dr. Patel's stuff according to
8 the order. I assume you've got everything that you need from
9 Southern Myrtle because you took the 30(B)(6) deposition
10 there, and I've just talked to Dr. Ash-Bernal who's going to
11 get some, some documents for you. Appreciate your time."
12 The next day I sent over Dr. Ash-Bernal's stuff. So I'm
13 under the assumption that everything is good. Then I get the
14 motion, and I said, "Lord, have mercy." I get on the phone
15 the same day, that morning. I'm on the phone by lunch. I've
16 gotten the information that night and it's in Brink's hands
17 the next morning.
18 Judge, there's been no intentional hiding of any sort of
19 thing. I turned over 200 and something pages of documents
20 within 24 hours when it was called to my attention that
21 something was missing. He's had it for essentially a week at
22 this point, and I think the motion was to hold us in contempt,
23 and there just really isn't anything to it, and I appreciate
24 Your Honor's time on that issue.
25 MR. HINSON: Well, Your Honor, and I, I'm glad Mr. Gresh

1 wanted to hear this now because I do think, I do think it
2 needs to be heard in the event that the jury comes back with
3 a, a verdict that finds recklessness or, or gross negligence
4 and that then there they would be a bifurcated trial with,
5 with punitives, and I don't remember the exact dates off the
6 top of my head, but more than a year ago we asked the
7 Defendants for their financial information because it's, Your
8 Honor, I'm sure is aware, ability to pay is a relevant factor
9 in punitive damages, and Judge -- I believe it was Judge Seals
10 ordered that essentially just before trial in time adequate to
11 prepare the Defendants were to produce this information.
12 Obviously, that wasn't the ideal situation for me, but I said,
13 "As long as we get it in time for trial that I can read it
14 and, and process it, and if I need a, a financial analyst or
15 some, some, some kind of accountant or financial advisor to
16 come in and tell the jury what these numbers mean, that'll be
17 fine."
18 Your Honor, the 30(B)(6) deposition was nothing about
19 financials. It was all about corporate processes and things
20 like that, and even if it had been about financials, which it
21 wasn't, the order didn't say produce the -- produce these
22 documents unless the 30(B)(6) deposition is sufficient. The
23 order from Judge Seals said produce them, and Your Honor, now
24 at this point in trial Mr. Padget and I, as I'm sure Mr. Gresh
25 has been, have been up till two, three in the morning every

1 night, waking up at six. There is no possible way I could
2 have analyzed these -- he tells you it's 300 pages of
3 information. This is something I needed the opportunity to do
4 last week or week before last, and Your Honor, I would
5 suggest, and this is something that, that my friend Costa
6 Pleicones had mentioned to me when we were having lunch the
7 other day, not over this, just different issues, we were
8 telling war stories, and he said that he had an occasion where
9 someone refused to provide financial information and that his
10 solution to the problem was that he would just charge the jury
11 that they are to presume that the Defendant has the ability to
12 pay whatever punitive judgment they may impose and that that
13 was -- that was the way to, to resolve the problem, and that's
14 the, the resolution we're asking because I don't know what
15 else would be sufficient at this point. I don't have time to
16 go -- I mean, literally my financial guy, Charlie Alford, out
17 of Greenville, he's on vacation this week. If I had had it
18 last week I could have given it to him, but now I don't know
19 what to do with this, this 300 pages of information that
20 should have been provided two weeks ago.
21 THE COURT: All right. Well, I'll consider it if we get
22 there. Now, you still think we can finish tomorrow even with
23 the --
24 MR. GRESH: Uh-huh.
25 MR. HINSON: Oh, yes, sir.

1 MR. GRESH: Yes, Your Honor.
2 MR. HINSON: Yes, Your Honor.
3 THE COURT: All right. Well, let's -- while it's on my
4 mind and we'll -- I'm sure I'll go over it when we start the
5 -- I made some notes, when we start looking at the charges.
6 Do I need to charge the jury on -- I mean, do they have to
7 make a finding of agency relationship? Is it, is it -- does
8 the Defendant admit the agency relationship between -- I
9 haven't read the answer.
10 MR. GRESH: I checked on that before trial. We admitted
11 in our answer that Southern Myrtle was vicariously liable for
12 the conduct of Ash-Bernal and Patel.
13 THE COURT: Well, I still have to charge them what an
14 agency relationship means. I think that's in one of the
15 charges.
16 MR. GRESH: I don't know why we need it but if it -- if
17 the Plaintiff requests it.
18 THE COURT: Well, I think they need to know why that they
19 can be -- that the principal can be responsible for the
20 servant, for lack of a better way to put it.
21 MR. PADGET: Your Honor, I -- we agree and I think the,
22 the complexities now with the new statute requiring with the
23 differentiation of percentage of fault we've got two
24 allegations here. We've got the direct corporate liability
25 allegations, but also you've got the, the typical respondeat

1 superior issues and what we're, we're trying to do is give the
2 jury as much information as we can about that. It's going to
3 be confusing no matter what we do, but -- because -- it's
4 confusing to me, but I think that that's the best way to do it
5 is to charge that, that Southern Myrtle can be liable for the
6 acts of, of the physicians and also has the potential
7 allegation of independent direct liability.
8 THE COURT: All right. Let's take a break and then we
9 can take a look at the jury charges and the verdict form. All
10 right. You all can come out in about, say in about 10, 10 or
11 so minutes. If you all would come down the hall you'll see my
12 door open. It's a good ways down.
13 (Adjourned for the day.)
14
15
16
17
18
19
20
21
22
23
24
25

1 (On the record, May 24, 2019. The following takes place
2 outside the presence of the jury.)
3 THE COURT: Does -- do we have a final draft on the
4 charge? I mean, if we don't, I think mine's pretty well
5 marked up, but it would be nice to --
6 MR. PADGET: Yes, Your Honor. I think there's only, I
7 think, two issues remaining from the charge that we marked up
8 yesterday.
9 THE COURT: All right.
10 MR. PADGET: There's one additional charge that's been
11 sought by the Defense, which I'm happy to take up now or
12 perhaps we can discuss. They're seeking a charge as to, as to
13 habit, routine and custom.
14 THE COURT: All right. Why don't -- can you hand it up
15 and I can be looking at it, at both of them and let's take
16 them up later so we can get started with the jury.
17 MR. PADGET: Okay. Very well.
18 MR. GRESH: Yeah.
19 THE COURT: Because it -- because I'm going to have to
20 look at them. You don't -- do you have them?
21 MR. GRESH: We're just going to hand -- Judge, they're
22 really essentially Rule 406. I was just going to try and make
23 it where they could understand it, but I'll hand write out
24 something, just --
25 THE COURT: All right. Well, I'll look at the rule. I

1 know what habit means, but I, I've never given a charge on it,
2 but I don't know -- what's the other one just generally?
3 MR. PADGET: The other one, lastly, Judge, is the
4 competency instruction at the end of the comparative
5 negligence section.
6 THE COURT: All right. I don't have my -- I've, I've
7 read over the form.
8 MR. HINSON: Your Honor, I have a final verdict form.
9 There was one errant comma in the one we handed you last
10 night.
11 THE COURT: Okay. I hate an errant comma.
12 MR. HINSON: I, I -- people get hung up on things like
13 that so.
14 THE COURT: Despise them. Well, I majored in English,
15 and sometimes I pick out typos where -- be kind of finicky,
16 but I didn't notice that one. All right. You ready?
17 MR. GRESH: We are, Your Honor. Thank you.
18 MR. HINSON: Yes, Your Honor.
19 THE COURT: All right. Bring in the jury, and we're still
20 on tap to get it to the jury around lunchtime, you reckon?
21 MR. GRESH: Yes, Your Honor.
22 MR. HINSON: Yes, Your Honor.
23 THE COURT: Good.
24 (Whereupon, the following takes place in the presence of
25 the jury.)

1 THE COURT: All right. Mr. Gresh.
2 MR. GRESH: Your Honor, we would call Dr. Jim Ballenger
3 to the stand.
4 THE COURT: All right. Please come up and be sworn.
5 Whereupon, James C. Ballenger is called to the stand,
6 duly sworn by the clerk and testified as follows:
7 THE CLERK: Please state and spell your first and last
8 name, please.
9 MR. BALLENGER: I'm Dr. James C. Ballenger, B-A-L-L-E-N-
10 G-E-R.
11 DIRECT EXAMINATION
12 BY MR. GRESH:
13 Q Good morning, Dr. Ballenger.
14 A Good morning, sir.
15 Q Just tell the ladies and gentlemen of the jury what your
16 occupation is.
17 A I am a psychiatrist. I have for about 20 years ran the
18 psychiatry department at the medical school and taught, did
19 research, treated patients. I'm retired from that, and now I
20 see patients in an office, adult psychiatric patients, and I
21 also do this kind of work more now since I retired because I
22 have the time to do it.
23 Q Let's kind of walk-through real quick your educational
24 background. Where'd you go to college?
25 A I went to the University of North Carolina in Chapel

1 Hill, have a BA in psychology with minors in chemistry and
2 philosophy and English.
3 Q And graduated from there in 1966?
4 A I did.
5 Q And did you pursue any additional education following
6 graduation from UNC?
7 A I did. At the horror of my friends I went to Duke
8 Medical School and graduated from Duke in 1970, and at that
9 point I accepted their very rigorous internal medicine
10 internship residency for a year because at that point I knew I
11 was going into psychiatry, and I went to Boston and trained in
12 psychiatry at Harvard at the Massachusetts General Hospital
13 where I was chief resident.
14 Q And when did you finish your training at Harvard?
15 A 1974, I had a two-year commitment to the Navy at that
16 point. They had deferred me through college and med school,
17 and I went to the National Naval Medical Center, on the
18 faculty there. It's the big one in Bethesda where the
19 president goes for his healthcare, and then for three years
20 after that I went to the National Institute of Mental Health,
21 which is also in Bethesda, and was ward chief of the -- one of
22 the groups that studied manic depressive illness, bipolar
23 illness, depression.
24 Q Following your stint at the National Institutes of Health
25 generally where did you go following there?

1 A I went to Charlottesville, Virginia. My wife joined the
2 law school faculty, and I joined the med school faculty, and,
3 and I was there for four years as -- in the Department of
4 Psychiatry and Behavioral Medicine as director of research and
5 director of inpatient psychiatry. I also was -- had the same
6 titles and responsibilities at Western State Psychiatric
7 Hospital, which was a big state hospital in the western part
8 of Virginia that our department -- was part of our department.
9 Q And did you, thereafter, come to South Carolina?
10 A I did. In, in 1983 I was recruited to be the new chair
11 of psychiatry at the Medical University of South Carolina in
12 Charleston, and I was chief and there until 2000, stayed on
13 for several years after that as a professor there. I also
14 built and ran the Institute of Psychiatry sort of the best, we
15 think, psychiatric hospital in the southeast, and, and then I
16 also wrote another grant and got the money to build the Center
17 for Drug and Alcohol Programs, which is the best because it's
18 the only one in the southeast where we study and treat
19 substance abuse, alcoholism and other substance abuse
20 problems.
21 Q And for how many years did you train residents and
22 fellows at MUSC?
23 A Well, at MUSC for 20 years.
24 Q Okay. Are you board-certified?
25 A I'm boarded in psychiatry and neurology. I am also

1 boarded in forensic psychiatry and re-certified in that.
2 Q And you have state licensures, licensed to practice
3 medicine?
4 A I do in South Carolina and that's the one I pay the fees
5 to, but I have previously been licensed in North Carolina,
6 Massachusetts, Maryland and Virginia.
7 Q Doctor, I'm, I'm looking at your, your CV and it
8 certainly is not my intention to kind of go through all of
9 this, but can you tell us a little bit about maybe a couple of
10 the honors that you've received over your almost 50 year
11 career in psychiatry?
12 A Sure. I was named to best psychiatry and you get a
13 plaque for that, and I've been told I was the first
14 psychiatrist in South Carolina to receive that honor, and I
15 have gotten it every year since, also best, best doctor, best
16 physician there, other peer opinions that, that lead to that
17 designation. I, I also had a national designation, very
18 similar to that as a master in psychiatry. There were only
19 five of us. The one before me was president of the APA. The
20 one after me was the smartest man in psychiatry. He was a
21 professor at Harvard and Yale and Cornell, but he also ran the
22 National Institute of Mental Health, the National Institute of
23 Drug Abuse in, in Washington.
24 Q Have you written any books in the field of psychiatry?
25 A Yeah. I've written 16 books and about, about pushing 300

1 professional papers and journals. I've edited the Yearbook of
2 Psychiatry, the clinical psychiatry and the psychopharmacology
3 parts of it for 15 years.
4 Q Do you have an estimate of the number of presentations
5 that you've given in the field of psychiatry?
6 A I stopped counting when it passed a thousand, but --
7 Q I read a statistic that you're one of the 12 most cited
8 authors in all of medicine?
9 A Yes. I was told that, which means that people cite my
10 papers a lot.
11 Q In your, in your lectures and in your presentations, are
12 you always lecturing or educating psychiatrists on issues in
13 psychiatric medicine?
14 A No. I, I enjoy and I've spent a lot of those thousand
15 plus lectures talking to psychiatrists, but a subspecialty of
16 mine has been to talk to non-psychiatric physicians, and it,
17 it grew out of a study one of my fellow residents and a friend
18 of mine did where he determined that 85 percent of the
19 evaluation and treatment of psychiatric patients in America,
20 85 percent is done by non-psychiatric, non-mental health
21 people, general practitioners, internists, surgeons,
22 ministers, and it became very clear that if we were going to
23 improve that situation that's the system. We, we -- the
24 mental health system is just a small amount of mental health
25 centers and a small number of psychiatrists relative to the

1 population and one out of five people in America, I called it
2 the best kept secret in America. I, I did a -- formed a
3 foundation to try to do something about this, but the best
4 kept secret is what percentage of Americans have a major
5 psychiatric condition in their lifetime, I mean a major one,
6 schizophrenia, bipolar illness, addiction, alcoholism or drug
7 addiction, the depression problems or dementia. Now, those
8 are really serious illnesses. I'm not even counting
9 personality disorders, ADHD, that you had cancer diagnosed
10 last year. It's one out of every two people in America. So
11 it's a huge number of people. If 85 percent of those people
12 are evaluated and treated by non-psychiatric physicians and
13 other people, nurses, ministers, then I should be talking to
14 them about how to -- how they should do their job because
15 they're doing it more often than I am.
16 Q In this setting, obviously, we have Dr. Ash-Bernal.
17 She's seated next to Dr. Patel.
18 A Right.
19 Q Are Dr. Ash-Bernal and Patel as hospitalists --
20 A Yes.
21 Q -- are they part of that 85 percent of medical doctors or
22 other treaters who are evaluating and treating mental health
23 who aren't psychiatrists?
24 A Absolutely, all day long, every day in every hospital.
25 Q Are -- you know, when you're going out and lecturing,

1 would your audience be filled with people just like Drs. Patel
2 and Ash-Bernal trying to help them understand mental health
3 issue, evaluation, diagnosis and treatments?
4 MR. PADGET: Your Honor, it's a leading question.
5 THE COURT: Leading question. I sustain the objection.
6 A Yeah. I, I, I --
7 Q Let me ask it -- ask that a different way.
8 A Sure.
9 Q How many times have you, A, spoken to non-psychiatrists
10 about the evaluation and treatment of mental health disorder?
11 A Since I also do consult psychiatry and it's very
12 pertinent to some of the things that are in this case and that
13 I'll say today, I have no idea, tens of thousands. What --
14 it's sort of -- the, the lectures start with saying to the
15 primary care doctor, the family practice doctors, "When you
16 walk out in the morning and you see a full waiting room know,
17 know that one-third to two-thirds of the people sitting there
18 have only a psychiatric problem. They don't have a medical
19 problem, one to two-thirds, and, and, and sometimes that grabs
20 them and they say, "Well, maybe I really should listen to what
21 you're getting ready to say."
22 Q Do you have an estimate on the number of times you've
23 talked to internal medicine doctors, family practice doctors,
24 GP type people on the issues of evaluation of mental health,
25 and particularly as it might be helping them determine who's a

1 danger to themselves or others?
2 A Thousands. Part of what psychiatry does in a big medical
3 center -- you know, I was chief of psychiatry in that big huge
4 medical center -- is that we evaluate people, and in
5 particular, when, when I came to Charleston and, and saw what
6 was here and what needed to be done, Jim Edwards was my boss,
7 and he said, "I want the best psychiatry department in the
8 country," and I said, "Okay, Jim, I'll do my best," and we did
9 a good job. We, we did get in the top 10, but the system
10 needed fixing and the system needed a really expert hospital
11 that could consult the rest of the, the system, including the
12 hospitals and the Department of Mental Health. They could --
13 they sent people to us. We would do expert evaluations, but
14 also needed an outpatient system, and we built one, needed a
15 -- since the, the other people giving care were the Department
16 of Mental Health, and the, the community mental health
17 centers, we affiliated with them, put our faculty in there,
18 put our residents in there, and then they hired our people and
19 they graduated, and so if you go to one of those centers now,
20 the odds are that it'll be an MUSC grad. That system entry
21 place was our emergency room. So if you had a mental health
22 emergency, wherever in South Carolina, they might bring you to
23 MUSC, which meant you came to our emergency room that I both
24 ran, but also then in rotation with my other faculty
25 supervised the resident care there every night, and that's

1 what they did, every night evaluating people with serious or
2 not serious psychiatric problems to help figure out what
3 needed to be done with them. The kind of questions of whether
4 people should be committed or not happened all the time, every
5 night, many times a night.
6 MR. GRESH: Your Honor, at this time we would tender Dr.
7 Ballenger as an expert in the field of psychiatry and mental
8 health treatment and evaluation.
9 THE COURT: Voir dire?
10 MR. PADGET: None, Your Honor.
11 THE COURT: I find he's qualified.
12 MR. GRESH: Thank you, Your Honor.
13 BY MR. GRESH:
14 Q Dr. Ballenger, I have in front of you, this is the
15 medical record. If you need it at any time, feel free to
16 refer to that. We -- I'm going to ask you certain questions
17 today about the thoughts and opinions that you have on the
18 care provided. Will you please only tell the ladies and
19 gentlemen of the jury those opinions that you hold to a
20 reasonable degree of medical certainty or probability. Okay?
21 A Of course.
22 Q And you, obviously, were not involved as a treating
23 physician with Matthew Scheer; correct?
24 A No. I never had the honor to meet him.
25 Q You, you are here today as an, as an expert witness at my

1 request, and I've sent you certain medical records to review
2 and certain deposition testimony. Kind of give us a little
3 flavor of what all you have reviewed in connection with this
4 case that helped you formulate the opinions you're going to
5 offer today.
6 A Well, I certainly studied and restudied all of the
7 medical records that were pertinent to his encounter with
8 Grand Strand Hospital and the other people that day, what his
9 medical records were from the past. He had a long history of
10 epilepsy from birth. I also reviewed a lot of depositions
11 from people who were fact witnesses or, or opinion witnesses,
12 other experts involved, police reports, things -- about
13 everything I could get my hands on that seemed pertinent.
14 Q Having the opportunity to review all of those deposition,
15 sworn deposition transcripts and the medical records, do you
16 feel that you have an adequate basis upon which to offer the
17 opinions that you're going to offer today?
18 A Yes. I do.
19 Q You're here as an expert witness. I assume you have done
20 expert witness work in the past?
21 A Yes.
22 Q This is a civil case. I know you -- have you done civil
23 expert witness work?
24 A Yes. About 75 percent of the forensic work like this
25 that I do, 75 percent of it is civil cases like this.

1 Q Would the other 25 percent be in the criminal context?
2 A Yes.
3 Q Have you been expert witnesses for Plaintiffs in civil
4 cases and Defendants on civil cases?
5 A Absolutely. I'm retained by people who call me who ask
6 other lawyers or judges, and I at this point it's almost 50
7 percent the Defense lawyers and 50 percent Plaintiffs. What
8 I've been retained over my whole career more by Defense
9 attorneys, so about 70 percent of the cases I've actually
10 worked in over my whole career is Defense, but now it's sort
11 of shifted more 60-40.
12 Q And the -- just real briefly on the criminal. Have you
13 worked for both the, the State or the Prosecution as well as
14 for the criminal Defense?
15 A Absolutely. I like doing that, and so I, I work both for
16 the Prosecution and for the Defense.
17 Q There's a third type of expert witness that I don't think
18 we've heard about so far this week, and it's what's called a
19 court's expert. What is a court's expert?
20 A It's when the, the court, specifically the judge asks for
21 an expert opinion and that happens in a handful of different
22 situations in my experience. Sometimes a judge will have
23 experts that absolutely disagree with each other, that's
24 complete and he'll hire me, retain me to see the patient, and
25 tell him what -- to resolve the dilemma, and I've done that

1 kind of thing. Had a very recently the judge said, "Okay, you
2 -- this side, pay for him. This side" --
3 MR. PADGET: Your Honor, I'd object to what the judge
4 said.
5 THE COURT: Yeah. Don't go, don't go into that.
6 A Oh, I'm sorry.
7 THE COURT: That's okay.
8 Q And to be, to be clear, you're not here today --
9 A No.
10 Q -- at the request of any judge?
11 A No. No. I'm not.
12 Q You're my request today; correct?
13 A That's right, and the, and the other instance is when the
14 judge says, "I need help with a case." My 15 minutes of fame
15 was the judge in the Dylann Roof case called me, asked me to
16 do the competency exams of Mr. Roof.
17 Q When you do this type of forensic work, whether it's in
18 the criminal context, the civil context or at the request of
19 judges, do you charge for your expert witness services at a
20 rate that's commensurate with other peers in the field?
21 A Yes. I do. I charge per hour for the time involved
22 whether it's reading records, testifying in court and that's
23 how I pay my mortgage, but yes, I do that, and my rate is
24 probably a little more than some, a little less than others.
25 Q In over your 50-year career, can you estimate the number

1 of times that you have been involved in or consulted in
2 helping with a decision to involuntarily commit a patient?
3 A The actual yes, no of commitment?
4 Q Or just the picking up the phone and calling you as an
5 expert in this field, "What do I do"?
6 A Hundreds, probably pushing and over a thousand times.
7 Q Have you over your 50 years had to actually involuntarily
8 commit folks?
9 A I've personally committed people over that almost 50
10 years hundreds of times, but as I've said earlier, the -- I've
11 supervised residents for 30 years, and that question they
12 always kick upstairs for advice and confirmation because
13 committing somebody's a very big deal.
14 Q In your career as a psychiatrist have you also been
15 involved in the decision to medicate patients with mental
16 health conditions, whether it's Ativan or other stronger types
17 of antipsychotic drugs?
18 A Medicate people, just period?
19 Q Yeah.
20 A Yeah. I'm -- you go to the internet I'm an international
21 expert on what -- on using medicines with psychiatric
22 patients.
23 Q One of the, the issues that we've heard about all week is
24 that Dr. Patel encountered Matthew Scheer, thought about
25 administering Ativan but did not actually write an order for

1 PRN Ativan. Have you seen that in the medical records?
2 A Yes.
3 Q Have you evaluated the sworn deposition testimony from
4 both sides and from Dr. Patel on that issue?
5 A Yes.
6 Q Talk to us about your expert opinion about Dr. Patel's
7 thought process there and his ultimate conclusion and whether
8 you think that was appropriate or inappropriate?
9 A Well, I think it was very appropriate, just exactly what
10 he should have done. He was confronted with a young man that,
11 if I can give a little background, Dr. Battisti in the
12 emergency room heard from the father, and as best I can
13 analyze it, I've been over it again and again, her
14 phraseology, he -- Matthew Scheer told the emergency room
15 doctor, "I've had -- I'm having some trouble with
16 hallucinations." Now, they must not have been particularly
17 vivid because she, unlike usual, didn't say, "He's hearing the
18 voice of his dead grandfather," or something else. None of
19 the hallucinations in her record were described at all. So I
20 don't -- but he apparently told her and, and father certainly
21 told him, but he was the records say pretty calm and
22 appropriate even so and all day long going to Lighthouse and
23 back, even in the emergency room. When he left the emergency
24 room and went into the hospital to be admitted, Dr. Patel's
25 note says he's, "Calm, appropriate, in no acute distress,

1 answered my questions, denied hallucinations, any suicidal
2 ideation," and so his diagnosis was possible psychosis because
3 he didn't see it, but he heard about it from the emergency
4 room eight hours earlier, and then Bethany Bell said the same
5 thing that --
6 Q She's the night nurse?
7 A She's the night nurse who admitted him and supervised him
8 from after Dr. Patel saw him at seven to -- until he left --
9 that he was appropriate. She asked all kind of psychiatric
10 problems and he denied everything repeatedly, and, and
11 essentially, Dr. Ash-Bernal said the same thing. This is an
12 adamantly, fervently speaking young man, but was logical,
13 "answered my questions appropriate". So when Dr. Patel saw him
14 about 7:00 o'clock he said, "Possible psychosis, consider the
15 use of Lorazepam, Ativan if he gets upset." He could have
16 written Lorazepam PRN, but I tell you Lorazepam, Ativan is in
17 the water in hospitals. You -- any doctor -- every doctor uses
18 it if somebody's upset. Now, if somebody is psychotically
19 upset, sometimes we use Ativan and something like Haldol, but
20 the person really has to be very clearly psychotic. Now, Dr.
21 Patel testified something I really liked hearing because it
22 was really expert, he said, "I want Dr. Oduwole to see him
23 tonight or tomorrow, and I don't want to have him be asleep or
24 abnormally calmed down by medicine now. I want him to see what
25 there is," because one of the things that's really clear about

1 this is that this young man was headed into some psychiatric
2 thing in my opinion, probably, probably a manic psychotic kind
3 of picture or some other psychotic kind of picture or at the
4 very least a major religious experience, but probably
5 something in the psychotic range, but he was in and out of it.
6 I mean, when he talked to his mother all night he was not
7 making sense, not himself, but he got better as they talked,
8 the more they talked. Father had the same experience when he,
9 when he came there, he was really odd, but got better over
10 time. So when Dr. Patel saw him and he was in a good place.
11 He didn't see anything to treat. So he didn't leave any -- he
12 didn't start treatment for anything, wanted Dr. Oduwole to
13 evaluate him and decide what treatment he wanted, and so he
14 waited and that was entirely appropriate.
15 Q So Dr. Patel's decision, do you have an opinion whether
16 Dr. Patel's decision to not actually write the order for PRN
17 Ativan was in keeping with the standard of care for this
18 situation?
19 A Absolutely. If the nurses wanted to use it they would
20 call a doctor to see the patient because he's just into the
21 hospital. I mean, if he had been in the hospital four weeks
22 and they knew they might give it to him before they call the
23 doctor, but the night of admission if, if he became upset they
24 would call a doctor, and that's exactly what they did, and
25 then that doctor could within milliseconds prescribe Ativan or

1 anything else that she wanted to.
2 Q We understand, having been here all week and looked at
3 the chart, that Mr. Scheer left the hospital around 7 p.m. and
4 so did Dr. Patel.
5 A Yes.
6 Q And that Bethany Bell, the nurse you mentioned earlier,
7 kind of came on and was what we call the night nurse from 7
8 p.m. onward. When you look at the medical record and the
9 deposition testimony that's been offered in this case, can you
10 give the jury a sense of how Matthew Scheer was after his
11 father left and before what happens at 1:13 in the morning?
12 What's that intervening time like?
13 A I think it's fair to assume when he left the emergency
14 room that till 1:13 he was more or less the same. He
15 cooperatively went to Lighthouse. He cooperatively came back,
16 cooperative -- cooperated in being admitted to the hospital,
17 and if anybody's been admitted to the hospital you know what a
18 hassle that is, but he sat still for that and was calm and
19 cooperative throughout that process. When Nurse Bell took him
20 as her patient, she never, I mean, one of the issues is she
21 didn't know he was a psychiatric patient. Either nobody told
22 her, but she also didn't think he was a psychiatric patient.
23 I mean, they put him in a room. They had rooms right next
24 door that were for psychiatric patients, and she didn't put
25 him in one of those because to her eyes, as to Dr. Patel's

1 eyes, there was nothing going on that was abnormal. He asked
2 for a Bible, said he was Catholic and he'd like to have a
3 Bible and she said, "That's nice. Here's a Bible," and he
4 read his Bible. From seven to midnight they had hourly
5 checks. She and the clinical nurse assistant had hourly
6 checks, didn't see anything abnormal. He didn't come out of
7 the room, cause any problem, asked anything abnormal. So
8 nothing happened other than they have a cooperative, polite
9 young man. Now, he refused an IV. He's very intelligent.
10 He didn't have any IV orders. Why in the world should he have
11 an IV? He refused that politely. He refuses oral Keppra, the
12 anticonvulsant he'd taken for many years when he took it. He
13 was off and on about that, but he hadn't taken it for several
14 days, but he refused it, and she didn't think it was a big
15 deal. I mean, that's just something the doctor the next
16 morning could, could deal with because it -- he had seizures
17 once every year or two that were usually in bed at night.
18 They, they would last a short period of time and they, they
19 weren't harmful, harmful. So and he did that politely. So,
20 essentially, nothing happened until 1:13 when he appeared at
21 the nursing station.
22 Q And talk to us, yeah, and talk to us about what happened
23 in and around 1:13 from your review of the records and the
24 sworn testimony.
25 A What the, the records say is he ripped his -- he took his

1 shirt off. He ripped off his patient bracelets and threw them
2 on the ground and appeared at the nursing saying -- station
3 saying he wanted to go home, he wanted to leave the hospital
4 now and that he was a voluntary patient. He also had a whole
5 series of statements about people, nursing staff being devil
6 worshipers, that Obama had -- said it, it was, was sort of
7 back and forth but apparently Obama said the right thing to
8 him that, "Your epilepsy is not cured. You should stay on
9 your medicine," but anyway, that Obama was bad and a devil and
10 Obama couldn't control him either, and continued this
11 religious talk until they called Dr. Ash-Bernal and she came
12 within minutes -- she was nearby actually -- to evaluate him.
13 Q From your review of the records and the deposition
14 testimony, did Dr. Ash-Bernal respond quickly to the nurses'
15 calls?
16 A Very quickly.
17 Q Dr. Ash-Bernal testified yesterday that after talking
18 with the nursing staff her habit, routine and practice, just
19 like she said in her deposition, would have been to review the
20 pertinent medical records before going in to speak with the
21 patient. Is that reasonable and appropriate, in compliance
22 with the standard of care for folks like Dr. Ash-Bernal?
23 MR. PADGET: Your Honor, he --
24 THE COURT: That's a leading question.
25 MR. PADGET: Object to leading.

1 Q What would a reasonably prudent hospitalist do when
2 confronted with this situation at 1:13 in the morning before
3 going in to see the patient?
4 A Would talk to the staff who'd interacted with him and
5 look at the records to see what it was, look at the med sheet
6 to see what medicines the patient was on and then after having
7 read the record talk to the staff, go in to evaluate the
8 person.
9 Q And in your review of the deposition testimony, is that
10 what Dr. Ash-Bernal did?
11 A Yes.
12 Q Is that reasonable, appropriate and in compliance with
13 the standard of care for the evaluation and treatment of folks
14 that have these types of situations at 1:13 in the morning?
15 A It's absolutely standard. It's what every good doctor
16 should do.
17 Q All right. So when she goes -- Dr. Ash-Bernal testified
18 yesterday that when she goes in she asked a series of
19 questions but doesn't recall exactly what questions she asked
20 or exactly the information she received. Talk to us about how
21 you train other non-psychiatrists to go in and handle
22 situations like this.
23 A Well, these -- people who go to med school tend to be
24 good students and smart and want to do the right thing, and
25 they -- if they have experience, they already know many of the

1 things. So I tell them to go -- to do what we just talked
2 about, read the record and see what other people have observed
3 what's been going on for hours, and then when they walk in the
4 room, as we're getting toward the room, begin the evaluation
5 seeing what's happening. Now, look at the person. Before
6 anybody says anything, look at them, and what do they look
7 like? How are they acting? Many psychiatric conditions you
8 can diagnose from across the street. Mania, for instance, I
9 teach residents you can diagnose from across the street
10 because the person's waving their arms, they're too close to
11 people, they're in, you know, they're violating another
12 person's space, and they can see that. People with psychotic
13 processes also you can just see. I had an exercise in my
14 training program where we would have a patient come in and
15 then our teacher would politely interrupt them and say after
16 30 seconds, "Would, I'm sorry, would you let us, let us
17 doctors talk for a second. We'll be right back," and, and,
18 and Dr. Lazaro [spelled phonetically], we'd go outside and
19 he'd say, "All right. Young Dr. Ballenger, tell me what's
20 wrong with this person," and it was an amazing exercise.
21 After 30 seconds, we, all of us, would pretty much have a real
22 good idea because we'd been watching, we listened to the first
23 thing out of the person's mouth. Mr. Scheer put his shirt
24 back on, walked without security back to the, the room, and
25 when she walked in what she said in the records that I've seen

1 was he was a -- he was fervent about his religious talk, even
2 used word like a rant. He was really adamant about that, but
3 when she talked to him it was appropriate. He listened to
4 her. He stopped talking about his religious ideas and he
5 listened to her. He considered what she had to say and then
6 answered appropriately, and we have not only her observation
7 of that but Bethany Belly who, in reading the record, seems
8 like a competent person. I haven't met her either, but she
9 said that's exactly what happened. Mr. Scheer's responses
10 were appropriate. He listened to Dr. Ash-Bernal and responded
11 appropriately, answered her questions. Now, he had his ideas.
12 He wanted to leave. He was voluntary and he wanted to leave
13 and he had religious ideas. Interestingly, to me, part of
14 what Ash-Bernal must have been seeing is the reactions of the
15 nurses who'd been there with him through the 1:13 to 1:30
16 something when she arrived, that the nurses thought what he
17 said was sort water off a duck's back kind of an idea that
18 they get insulted by patients and are irritated by, by the
19 patients who are irritated at them and they say things to
20 them. It seemed that kind of ballpark. It wasn't -- didn't
21 seem crazy to them. I mean, Bethany Bell testified in her
22 deposition that he didn't, he didn't seem psychotic to her.
23 Q And let's talk about that for a second. We know when we
24 look at the chart that Matthew is pacing in the hallway. I
25 think there's even a nursing note he's getting more aggressive

1 with staff. In your review of the nursing depositions from
2 the nurses who were there, how did they describe that
3 encounter?
4 A Well, the word aggressive was used, and there was some
5 attempt to clarify what that meant. I mean, it did not mean
6 anybody felt they were in danger. So they -- security was not
7 there to make him go back to the room or to protect anybody.
8 Nobody felt the need of protection from security and security
9 didn't see any need for muscle either. The, the nurses -- the
10 charge nurse and Bethany Bell sensed that this was not a
11 psychotic, this was not dangerous and that he could calm down.
12 Now, they, they did also explain that he was adamant about
13 what he was talking about. He really strongly felt. Now,
14 what that tells me as a psychiatrist, I mean, he's either
15 really believes his religious stuff or is -- he's headed into
16 some psychiatric thing that has religiosity as part of it, but
17 it's really not clear at that point.
18 Q Would the standard of care have allowed Dr. Ash-Bernal to
19 involuntarily commit Matthew Scheer at 1:13 to 1:30 that
20 morning?
21 A Answer it two ways, absolutely not -- to -- not if she
22 were going to practice ethical medicine or even legal
23 medicine. To retain him at this point there was no grounds
24 because the grounds that have evolved in psychiatry in general
25 in South Carolina and, and specifics are you can't hold

1 somebody against their will unless they are imminently
2 dangerous to themself or others and what imminently has been
3 defined, much to our difficulty, these are hard rules, legal
4 rules, ethical rules to live with for people who want to --
5 went to med school to help people, imminent means today or
6 maybe tomorrow. It's been defined in case law in various
7 ways. It usually means they're suicidal or homicidal and we
8 have reason to think they're going to do it right away. Now,
9 if we think somebody's going to do this in six months, we
10 can't commit them, can't hold them in the hospital for six
11 months.
12 Q Even if you think they're going to kill somebody in six
13 months?
14 A No. Now, what we would do is notify the police we have a
15 dangerous person, they need to be watched, need to be
16 evaluated. We would have to handle it that way because their
17 freedoms don't allow us in America to hold people before they
18 do something or before they are, and this is one exception, if
19 they're imminently dangerous to themself or others in the
20 opinion of a doctor. Now, you can be picked up, if anybody in
21 the jury said, "Pick up Uncle Fred and take him to the
22 emergency room for evaluation by a doctor," and if a doctor
23 says, "Yeah, I think this person needs to be held because they
24 are imminently dangerous to themself or others," that will
25 happen in South Carolina.

1 Q Was Dr. Ash-Bernal's decision to talk to the nurses,
2 review the medical records and talk to the patient and
3 ultimately allow him to leave against medical advice all done
4 in compliance with the applicable standard of care?
5 A Yes. To do anything else would be to practice unethical
6 medicine, actually illegal hold to somebody against their will
7 without proper grounds. The only way we can prevent a patient
8 or anybody else from leaving this room would be if a doctor,
9 initially anybody and a policeman, but ultimately a doctor
10 says this person is imminently dangerous, imminently dangerous
11 to self or others and so they have to be held against their
12 will.
13 Q Could Dr. Ash-Bernal picked up the phone and called David
14 Scheer, the father?
15 A No. And this is a difficult issue perhaps for people in
16 a jury to understand. All of this, when I said earlier, me
17 personally, my problems with there's a -- what we call parens
18 patriae. There's that view of those things, standing in for
19 parents. I want to stand in for the parents and say, "Look,
20 son, you need to stay here, you really do," and if the man is
21 of legal age and understands what I'm saying and is not
22 imminently dangerous to himself or others, I have to let him
23 go. People refuse medical treatment all day long in America.
24 There's an AMA form on every ward in America. There's a stack
25 of them because it happens all day long every day, and what

1 the AMA form just says it's against medical advice. So what
2 -- when you sign it what it says is, "I'm leaving but you
3 have, in fact, told me the pros and cons of staying or
4 leaving. So here it is. Thank you very much. I'm out of
5 here." It's really sort of irrelevant to whether or not Dr.
6 Ash-Bernal says to the policeman, "Don't let him go because
7 I'm going to put him on pink papers and I'm going to send him
8 to a place that accepts committed patients," and I don't know,
9 and I don't know if there is a place in Myrtle Beach. Many
10 times it means Columbia. They go in a police car there to be
11 held until a judge, some and it varies, but seven days, four
12 days, later says -- hears from doctors who say, "Yes. This
13 person really is imminently dangerous. Still is. Please keep
14 him here, judge," and the judge says, "I agree with you."
15 Q And to be clear, was Dr. Ash-Bernal's decision not to
16 call David Scheer at around 1:30 in the morning --
17 A I'm sorry.
18 Q -- in keeping with the standard of care applicable in
19 this situation?
20 A Yes. I'm sorry.
21 MR. PADGET: Your Honor, we object to leading.
22 THE COURT: All right. Just rephrase your question.
23 Q How would you characterize Dr. Ash-Bernal's decision not
24 to call the father around 1:30 that morning?
25 A Painful, but appropriate. In that situation, I'm sure

1 you guys have learned about HIPAA, but HIPAA rules the world
2 in hospitals and in outpatient now, and, and many, many good
3 things have happened from HIPAA protecting people's privacy of
4 their medical records, and this kind of case is the painful
5 end of HIPAA, which is HIPAA protects people who are saying,
6 "You know, I don't get along with my parents. Don't call
7 them," and in people with psychotic problems that's actually a
8 frequent situation. Now, that doesn't seem to have been the
9 case here. The Scheers, from what I see, seem to be really
10 good people and had a great relationship with their son, but
11 it, it was Matthew Scheer's right to say, "Don't call him. I
12 don't want to talk to him, and I don't want you to talk to
13 him." They can only overrule this for the same reason that
14 they can tell him he could not leave because he was also
15 saying from the very beginning very clearly, "I'm a voluntary
16 patient. You cannot keep me here." So the -- for the doctor
17 to say, "Oh, yes, I can," the doctor has to be able to say, in
18 this case Dr. Ash-Bernal, "You cannot leave because you are,
19 in my opinion, imminently dangerous to yourself or others,"
20 and she did not reach that judgment. So she couldn't do it
21 ethically, legally and meet the standard of care.
22 Q There's been an assertion that even if Dr. Ash-Bernal
23 couldn't pick up the phone and call David Scheer, that she
24 could have picked up the phone and said, "I can't tell you
25 why, David, but come to the hospital." Would that be -- do

1 you have an -- what's your opinion on that?
2 A That, that would be a HIPAA violation because obviously
3 what the meaning of that -- Mr. and Mrs. Scheer are
4 intelligent people. They would say, "This has to do with my
5 son, and obviously trouble. I'll be right down," and that's
6 exactly what he didn't want to have happen.
7 Q Does the standard of care, do the medical ethics rules
8 permit a doctor like Dr. Ash-Bernal to pick up the phone and
9 say, "I can't tell you why but come down to the hospital
10 now"?
11 A No. In my opinion, no. This is a very painful end.
12 It's part -- and I teach residents it's a very -- because the
13 resident says, "But wait a minute. I'm worried about this
14 person, you know." I mean, he doesn't really have -- Dr. Ash-
15 Bernal's opinion was he doesn't really have any real, real
16 danger. He's not been eating, not been sleeping, not taking
17 his anti-epileptic pill. That, that's okay. Nothing really
18 acute, but sometimes what the present, the resident presents
19 to me is worse, and I say, "You still can't do it," and they
20 say, "That doesn't make sense to me," and I say, "I'm sorry.
21 In some ways it doesn't make sense to me," because I want to
22 take care of people, the parens patriae idea, but our society
23 has made it very, very clear over the last 10 to 20 years,
24 South Carolina included, that, "No. We're going to -- this is
25 America and people can determine what they want to do whether

1 their ideas are good or bad or indifferent or actually
2 psychotic unless they are imminently dangerous."
3 Q When you looked through Matthew Scheer's records from the
4 time that David Scheer gets to Myrtle Beach to be with his son
5 until Dr. Ash-Bernal allows him to leave against medical
6 advice, did you see any indication in the chart from anybody
7 that Matthew Scheer was in imminent danger to himself or to
8 others?
9 A I saw no evidence. In fact, I saw a lot of evidence to
10 the contrary.
11 Q Dr. Ballenger, with your almost 50 years of experience,
12 looking back at all of the care and treatment provided by Drs.
13 Patel and Dr. Ash-Bernal, do you have an opinion to a
14 reasonable degree of medical certainty as to whether their
15 care complied with or deviated from the applicable standard of
16 care?
17 A I think it met the standard of care and didn't even get
18 close to being not standard of care.
19 Q Thank you very much.
20 THE COURT: All right. Cross?
21 MR. PADGET: If I may I approach, Your Honor?
22 CROSS EXAMINATION
23 BY MR. PADGET:
24 Q Dr. Ballenger, this is just a copy of your deposition if
25 we need it.

1 A Okay.
2 Q Good morning, Dr. Ballenger. My name's Bill Padget.
3 I'm one of the attorneys representing the Scheers in this
4 case.
5 A It's good to meet you, sir.
6 Q In your opinion, sane people run out into the woods naked
7 fighting demons; isn't that right?
8 A You can take one or two of the negatives out of that
9 sentence and ask me a question.
10 Q In your opinion do sane people run out into the woods
11 naked to fight demons as Mr. Scheer described to the doctors
12 that night?
13 A You have to put that statement in context. It, it is
14 smoke that would raise my eyebrow. A lot of people play
15 dungeons and dragons and run out in the woods fighting demons.
16 I mean, so we really need more context about what that means
17 and what it is for right now.
18 Q Well, let's talk about some more of the context. How
19 about a patient are they sane if they refuse to eat because
20 they believe that all of the food in the world is poisoned?
21 You believe they are; is that right?
22 A Again, again, you've phrased it in a nonsensical fashion.
23 It is smoke that they might be psychotic. It has little to
24 nothing to do with sane, that sane is whether you know right
25 from wrong. That's the usual meaning for that, using an

1 entirely different context.
2 Q You --
3 A It's smoke that there's something going on
4 psychiatrically.
5 Q Sure. You believe that sane people like Matthew Scheer
6 accuse the staff at Grand Strand Regional Medical Center down
7 here at the hospital of being devil worshipers and that that
8 is sane behavior; correct?
9 A Again, it's, it's a question I can't answer. The issue
10 is not whether sane or not. Sane is did he know right from
11 wrong. I assume he did. I didn't, wasn't asked to make that
12 opinion.
13 Q The same question with competency.
14 A What question? You didn't really ask a question with
15 that one, I mean. What --
16 Q Sure. The same question but instead of sanity let's talk
17 about competency. Do competent people accuse all the staff of
18 Grand Strand Regional Medical Center of being devil
19 worshipers?
20 A Competent to do what?
21 Q To make decisions --
22 A Sign a will?
23 Q -- about their healthcare.
24 A People can be -- let me just sort of cut to the chase.
25 People can be psychotic and be competent to decide their

1 medical care.
2 Q Do sane or competent people have reasonable beliefs that
3 the president of the United States is seeking to control them
4 at 1:13 in the morning in Myrtle Beach, South Carolina, in a
5 hospital?
6 A I can make a question out of that. Is that reasonable?
7 It is not reasonable and it is smoke that something's going
8 on, which I have testified before. Is that -- does that
9 answer whether or not he's imminently dangerous, no.
10 Q Do sane or competent people run into the ocean in the
11 face of a hurricane offshore with their hands shaking and
12 yelling things as they strip off all their clothes and go into
13 the water?
14 A That's even thicker smoke. Now, is it -- I don't know if
15 it's been established that it was Matthew Scheer who ran in
16 doing and doing what you said. Did anybody here? So I, I
17 don't know, but again, the, the smoke is thicker that that
18 might have to do with a psychiatric phenomena that was
19 evolving but not fully there and it's -- falls -- it's using
20 the retrospectoscope to look at an event and going backwards.
21 Dr. Ash-Bernal didn't know anything about what was going to
22 happen. If he'd showed up at the pancake house the next
23 morning we wouldn't be here and nobody would be criticizing
24 her.
25 Q I'm not asking about hindsight, Doctor. I'm simply

1 asking about competency at this stage.
2 A Competency to do what?
3 Q To make medical decisions about one's care.
4 A Part of the complexity of the question or non-question
5 here is that people cannot be held in a hospital against their
6 will unless they are imminently dangerous to themself or
7 others. Now, they --
8 Q If some -- if somebody can't make an informed decision
9 about --
10 MR. GRESH: Your Honor, I think he was --
11 THE COURT: Let him finish his answer.
12 Q I'm sorry. I thought, I thought we were done, Doctor.
13 Go ahead.
14 A People -- why we have AMA forms, people make medical
15 decisions all the time for weird reasons that, that well-
16 meaning other people can totally disagree with. I mean, the
17 Christian Scientists they have a lot of strong ideas. Some
18 people really agree with them. Some people really disagree
19 with them, but they make decisions all day long that a lot of
20 us think are really the wrong decision because it's really not
21 based on what we believe in or even science, but we let them
22 die with that right unless it's their child and they're making
23 a decision for a child, and the legal system has decided to
24 intervene in that instance. If they're saying, "No, you can't
25 give my son chemotherapy," and a judge hears that the 10-year-

1 old will die without chemotherapy, he says, "Give the boy
2 chemotherapy. Now, mother and father, you can decide not to
3 have chemotherapy, but your son can't. You can't decide for
4 your son." That's, again, the very special circumstances
5 where we overrule people's rights.
6 Q Well, if, Doctor, unable to consent to informed
7 healthcare means unable to appreciate the nature and
8 implications of a patient's condition and proposed healthcare,
9 to make a reasoned decision concerning the proposed healthcare
10 or to communicate that decision in an unambiguous manner, if
11 that's the definition of giving informed consent, to refuse
12 healthcare, if that's the decision you have to -- a patient
13 like Matthew has to be able to make a reasoned decision
14 regarding that healthcare?
15 A What's the question?
16 Q My question is if that's the standard that this jury is
17 going to be asked to apply in this case your opinion is that
18 Matthew Scheer, in light of all these circumstances, was able
19 to make reasoned decisions concerning that proposed
20 healthcare?
21 A Dr. Ash-Bernal's assessment at the time was that he was
22 hearing, thinking about and making appropriate responses to
23 the pros and cons of refusing the medical care and to stay in
24 the hospital that she proposed. She made a judgment that he
25 understood well enough the consequences from a medical and

1 psychiatric point of view that could happen if he left and
2 believed he understood that well enough. Now, if -- it could
3 be even more extreme. I mean, he could have said, "I'm not
4 going to take it because the rays from Mars in my head tell me
5 not to do it," if she didn't think he was in imminent danger
6 she still couldn't hold him.
7 Q You said, Doctor, there's -- was -- you described, I
8 believe, some of those earlier descriptions as smoke. Is that
9 right?
10 A That's a way of describing the uncertainty of what was
11 going on with Matthew Scheer.
12 Q Well, at some point smoke -- let's talk about fire for a
13 second. The patient who's, who's got this reported history,
14 every doctor who's seen him has written the word psychosis,
15 father has driven down from New Jersey, which was reported to
16 the physicians because he was concerned about his son, brings
17 the child, brings the 26-year-old to the hospital, makes those
18 reports about fighting demons in the woods and others, and now
19 that same patient comes out of his room, takes off his shirt,
20 rips, doesn't just remove, rips off his medical bracelet,
21 throws it, begins yelling at the staff, accusing them of being
22 devil worshipers, accusing -- bringing up the president as we
23 talked about, isn't that a psychiatric sign, as you've
24 indicated, that there's something more serious going on with
25 Matthew Scheer?

1 A Yes. I think there's -- I'll say two things about that.
2 First, every doctor who has seen it has used the word -- has
3 not used the word psychosis. After Dr. Battisti, Dr. Patel
4 said possible psychosis, didn't see any evidence of it except
5 the history from the emergency room and Mr. Scheer. Dr. Ash-
6 Bernal didn't see it, any psychosis and Bethany Bell didn't
7 see any evidence of psychosis.
8 Q Why order a psych consult?
9 A Because he needed evaluation. That's why he was in the
10 hospital.
11 Q Why contact a psychiatrist if you're not concerned about
12 psychosis?
13 A He was concerned whether it was there or not. To hold
14 somebody against their will --
15 Q I'm not talking about that.
16 A -- unless you're going to -- let me finish my answer.
17 Q Certainly.
18 A To hold somebody against their will you are making a very
19 specific statement that they are imminently dangerous now, not
20 maybe they might be, maybe, maybe, maybe, maybe because --
21 maybe he's psychotic. It's a very specific thing. Now, as
22 I've said, there's a lot of evidence -- I'm sorry, there's a
23 lot of what I call smoke. There's a lot of suggestion that
24 something was going on with Matthew Scheer, but he would clear
25 up and do better, and he was in the right pace of getting

1 treatment for evaluation, evaluation of what was wrong with
2 him. I mean, you know, I've spent however now 50 years. I'm
3 not sure what's -- was wrong with Matthew Scheer. I have some
4 suggestions. I can do a differential diagnosis that includes
5 possibly a manic psychosis, possibly an early schizophrenic
6 type psychosis, that he was taking hallucinogens, although his
7 drug screen was, was negative for his, his age, and where he
8 -- the kind of work he did, that's -- has to be in the
9 differential or he was having a genuine religious experience,
10 wanted to live a purer life. We don't know what was wrong
11 with him, but we wanted Dr. Oduwole to see him that night or
12 the next morning to help find out. Now, my guess what Dr.
13 Oduwole would have done would be to put him in the hospital
14 for a day or two and talk to him and decide.
15 MR. PADGET: Your Honor, I would object to a guess.
16 THE COURT: Yeah. You can't speculate to what the other
17 doctor, another doctor would do.
18 BY MR. PADGET:
19 Q Doctor, let me, let me go back just to be clear. Matthew
20 Scheer by Dr. Battisti was ordered and transferred to a
21 psychiatric care facility, Lighthouse; is that true?
22 A Yes.
23 Q Okay. Doctor, you, you also have opined that the HIPAA
24 laws would have prevented any contact of Matthew's father that
25 morning, painfully, I believe as you described. HIPAA allows

1 us or as we do every day in hospitals a patient can designate
2 somebody to get their health information; isn't that right?
3 A Yes. They take you right back.
4 Q But they fill out those forms; correct?
5 A Yes.
6 Q Okay. And earlier in the day Mr. Scheer had been with
7 Matthew at every point in time during his care up until the
8 time he left around 7 p.m. or so on the evening of the 2nd?
9 A Yes.
10 Q And at that time, of course, none of the physicians had
11 any issues with sharing any of the -- Matthew's medical
12 information with Mr. Scheer.
13 A No. He was -- Matthew was clearly saying it's okay. He
14 had written it was okay. He was saying that with his
15 everything when his father was there.
16 Q And the next morning when Mrs. Debbie Scheer contacted
17 the hospital after Matthew had gone, and as she testified the
18 hospital told her that, "Matthew's not even a patient here
19 anymore. He's left. He's gone." They didn't have any
20 trouble sharing his health information with her then.
21 A Well, they shouldn't have.
22 Q They didn't have an issue with it then; did they?
23 A It was different people making different judgments.
24 We're talking about Dr. Ash-Bernal, not the admissions records
25 people.

1 Q And let's --
2 MR. PADGET: If I could approach, Your Honor?
3 THE COURT: Yes.
4 BY MR. PADGET:
5 Q I just want to hand you, if I could, Doctor, Plaintiff's
6 Exhibit Five and show you and you're welcome to look at the
7 whole thing. This is the hospital's privacy practices --
8 A Uh-huh.
9 Q -- that they give to every patient and that's, that's
10 common; right?
11 A Something like this because HIPAA's so complicated,
12 everybody needs to be explained.
13 Q And what this is is this is a simplification of a long
14 law put into words that patients and everyday folks that we
15 can all understand about when they can disclose certain health
16 information. Is that fair?
17 A Well, yes.
18 Q In part, but there's a lot of it.
19 A Yes.
20 Q And I'm only referencing the one section here over on
21 this page, Doctor, after the as permitted by law right here.
22 Are you with me?
23 A I'm at that section.
24 Q All right. And the policy reads, [as read], "As
25 permitted by law we may also use and disclose health

1 information for the following types of entities, including but
2 not limited to," and there's a long list, and you're welcome
3 to read them out loud if you want, but there's a long list.
4 The jury has seen this big form already, but the very last
5 thing there that it says is that, [as read], "We may disclose
6 to a person or persons able to prevent or lessen a serious
7 threat to health or safety." Is that what the policy says?
8 A That's what this piece of paper says.
9 Q Okay.
10 A It's not my understanding of what HIPAA rules say about
11 when you can do it over a person's objections.
12 Q You believe that Grand Strand and, and their lawyers have
13 drafted a poor privacy policy?
14 A I wasn't asked to come to such an opinion.
15 Q And you're a doctor, not a lawyer. I understand that.
16 Now, let's talk a little bit about -- I think we've got some
17 agreements too, Doctor. Let's talk about --
18 A About what?
19 Q Some agreements?
20 A Oh, okay.
21 Q A particular set of opinions. You have -- you, you say
22 that Matthew could have probably been helped with psychiatric
23 treatment. That correct?
24 A Absolutely, but I also say that about almost everybody,
25 but he needed evaluation. Yes.

1 Q Okay.
2 A He could have benefited from an evaluation.
3 Q Yeah. And let's talk a little about checkouts or sign
4 offs between physicians. Right. You, I believe you testified
5 that you've been doing checkouts or handoffs between
6 physicians for decades; is that correct?
7 A I don't remember saying that.
8 Q Okay.
9 MR. PADGET: Your Honor, may I approach?
10 THE COURT: Yes.
11 MR. PADGET: Permission to unseal his original, Your Honor.
12 THE COURT: You may.
13 BY MR. PADGET:
14 Q I'm going to hand you your original testimony. Just ask
15 you to turn to page 50. All right. On page 50, Doctor, of
16 your deposition, line five, Mr. Hinson actually asked you, [as
17 read], "Do you have occasions where you have to essentially
18 pass the baton to another physician in your line of work?"
19 You answered, [as read], "Oh, I have decades of doing that."
20 Mr. Hinson says, [as read], "Okay. What term would you use?
21 I would -- we've seen the term handoff and I think checkout
22 has been used. What would Dr. Ballenger's term be?" "Both,
23 both of those are appropriate. I would say checking out." Was
24 that your testimony?
25 A Yes.

1 Q And the purpose of those checking outs, I believe as you
2 call them, is so that you can give the best care to the next
3 patient, the next doctor can be informed and give the best
4 care; isn't that right?
5 A Yes. Whether I said that or not that's the right
6 answer.
7 Q All right. And we -- it is undisputed here in this case
8 that there was no handoff between Dr. Patel and Dr. Ash-Bernal
9 on the evening of the 2nd. We agree on that; right?
10 A My answer, the answer is, no, not in the old-fashioned
11 way that I used to do it where a doctor talked to another.
12 The standard of care has shifted where the medical record does
13 that. Doctors generally, unless there's some specific reason,
14 hospitalists, in particular, leave the hospital and someone
15 takes over, somebody comes at 7:00 o'clock. Somebody leaves
16 at 6:59 somebody at 7:00 o'clock has complete and total
17 responsibility for that patient, and that's the standard of
18 care, which we're here to talk about the standard of care.
19 That's what's done in, in hospitals with hospitalists all over
20 South Carolina and the United States.
21 Q And you're not a hospitalist and you've never been a
22 hospitalist; correct?
23 A The easy answer to that is no.
24 Q And you're not board certified in internal medicine?
25 A No.

1 Q Now, one such important clinical fact in a situation like
2 this with Matthew and his father that evening on the 2nd would
3 have been that his father had been accompanying him during all
4 of that care earlier; isn't that important?
5 A Important?
6 Q For the physician to consider?
7 A Dr. Patel actually met Mr. Scheer, I think.
8 Q Sure.
9 A And he provided part of the history to Dr. Patel.
10 Q All right. Going back to the privacy law issues just for
11 a moment, Doctor, do you agree in a case like this and in
12 hospitals every day across this country that the life and
13 death decisions that physicians make should not be left to
14 misunderstandings of the law?
15 A If we say the law meaning all of the laws of the nation.
16 Q I'm referring to the privacy law specifically?
17 A I -- we, we would hope not.
18 Q You testified that Matthew instructed the doctor and the
19 nurses not to contact his father. That your testimony?
20 A That's my understanding of the record. It's not clear
21 all of what he said. He said, "I don't" -- one, in one record
22 it says, "Do you want to talk to your father," and he said no,
23 and another it implied or said that, "Do you want us to call
24 your father for you?" He said no.
25 Q We agree that the actual record said, "We asked if he

1 wanted us to contact -- to speak," excuse me. Let me get it,
2 let me get it right, "to speak with his father," and he said
3 no?
4 A Correct.
5 Q And that language is Matthew wanted to speak to his
6 father and he said no. We agree on that?
7 A I, I agree that that's what it says in at least one place
8 that he said, "I don't want to," which certainly implies that
9 he has strong feelings, but the other half of what we can't
10 agree on because the records aren't clear on this point that
11 he also didn't want -- he didn't want to talk to him but he'd
12 be fine if the nurses or the doctor called his father and told
13 him to come in because it'd be real clear what -- that's what
14 they would want to say, that that's not clear. We're not
15 agreeing about that.
16 Q And we agree that, that David's phone number and contact
17 information as the emergency contact was readily available and
18 in the chart?
19 A Yeah. That's all the more frustrating because I would
20 have wanted to call his father because maybe his father could
21 have talked him into staying there long enough to see Dr.
22 Oduwole, which is what I would have been really concerned
23 about. So that was sort of the issue. That was the issue
24 that was there. There was no sense that he was imminently
25 dangerous or even dangerous. It's he needs to see a

1 psychiatrist, and if he -- if he's leaving here, you know, he
2 needed to get there the next morning or the next day or
3 something.
4 Q If you're a doctor like that and you're, you're -- you
5 believe you're painfully hamstrung by the law in light of the
6 current situation, but you believe he -- it would really be
7 better for him to get some care, you're in that situation and
8 you're not certain, wouldn't it have been prudent and
9 reasonable to contact somebody who knows more about the
10 privacy laws to make sure you're right before you let that
11 patient walk out the door?
12 A I don't have uncertainty. I don't hear any evidence -- I
13 haven't seen any evidence that Dr. Ash-Bernal had any
14 uncertainty about that.
15 Q None, no evidence, no evidence of that?
16 A I'm not aware that she was confused about that.
17 Q She also wrote in her note that, "The patient says he's
18 here voluntary and that we cannot keep him." Do you see that?
19 A Yes.
20 Q That's just wrong. If a patient comes in the door
21 voluntarily but manifests the need that they are a substantial
22 danger to themselves or others, a doctor can absolutely place
23 a temporary hold on them at that time?
24 A Is if he think -- he or she thinks he's imminently
25 dangerous. So the rest of the sentence is, "He's here

1 voluntary and we can't keep him unless I make a new
2 determination that he's imminently dangerous to self or
3 others," and she didn't think that.
4 Q If the people on that floor did not believe Matthew to be
5 dangerous why were two security guards up there?
6 A Because it's hospital policy to involve security when,
7 when something like this happens. Otherwise security's just
8 sitting on a chair somewhere not doing anything. Also they
9 knew they'd need him -- well, they ultimately did need him to
10 show him how to, to leave the hospital.
11 Q Somebody called security.
12 A Isn't there a security -- I think -- I don't know, maybe
13 this is a misunderstanding, but there's a security guard just
14 hanging around any unit that has psychiatric patients or beds.
15 I don't know that for sure.
16 Q But the note says security was at bedside, Matthew's
17 bedside?
18 A He was called --
19 Q That had he --
20 A -- and he walked into the room where everything was
21 happening, yes.
22 Q So somebody called security?
23 A But they didn't say stand at the bedside. They did
24 comment that they did not use him to make Matthew go back to
25 his room. Matthew put his shirt on and went back to his room

1 on his own politely, and of course security is going to come
2 and stand at least in the door. It's his job.
3 Q And not only was security called, Dr. Ash-Bernal was
4 called?
5 A Of course. They needed a doctor for evaluation.
6 Q All right. And one of the reasons I think you said you
7 can call a doctor if you're a nurse in that situation is to
8 give Ativan; right, to calm the patient down? Is that one
9 reason a nurse can call?
10 A Of many, yes, absolutely.
11 Q Sure. Well, in this case Dr. Patel thought it, it, it
12 might be appropriate later; fair?
13 A Yes.
14 Q And the nurses, but though they didn't have an order to
15 give any Ativan, and so they contact Dr. Ash-Bernal. Do we
16 agree on that sequence of events?
17 A I think so.
18 Q Okay. And you said --
19 A Didn't realize you were testifying, but go ahead.
20 Q You said a moment ago when Mr. Gresh was asking you
21 questions that Ativan was like water in hospitals. I think
22 that's what I heard?
23 A I was joking, not testifying, that Ativan is easily
24 available in every hospital on every floor.
25 Q Sure. And that's the point of it.

1 A Yes.
2 Q Fair enough, Doctor, but you also said that every doctor
3 gives it when a patient is upset to calm them down.
4 A No. I did not testify to that. I said the medicine that
5 we use to help most, if not all patients, first is Ativan.
6 That's what I testified to, whether I was unclear or not, but
7 I want to be clear with the jury. Just saying that doctor
8 reaches into his black back for something, Ativan has become
9 the, the medicine, and two milligrams has become the dose, and
10 we give it by mouth or by shot. That's really what I'm
11 testifying to.
12 Q Nobody ever gave Matthew Ativan that night, we can agree
13 on that?
14 A No. Nobody thought that was appropriate. Imagine how
15 easy it would be for Dr. Ash-Bernal to say, "Let's give Mr.
16 Scheer some Ativan pill, please." The nurse would have it in
17 60 seconds and then they could talk, and if she thought he
18 needed it and their conversation would be better she could
19 easily have done that, no skin off of her nose.
20 Q And that likely would have helped Matthew calm down a
21 little bit?
22 A I don't know. It helps everybody calm, but if you and I
23 get upset, I don't want any Ativan. Don't try to give me any.
24 You probably don't want it either.
25 Q I'm just asking you about the pharmacological effect,

1 Doctor, of a drug you give and have given I'm sure thousands
2 of times.
3 A Yes.
4 Q Would it have likely calmed down Matthew?
5 A As it would have calmed down anybody and everybody.
6 Q All right.
7 A Probably, if it were enough.
8 Q Doctor, you made a lot of -- I'm sorry. That's your CV.
9 You made a good many notes about your review of this case; is
10 that right?
11 A Yes. It's my custom. I always do that.
12 MR. PADGET: If I may approach, Your Honor?
13 THE COURT: You may.
14 BY MR. PADGET:
15 Q Give you the entirety, Doctor, but I've just got one
16 question about this page. I've highlighted a little section
17 there. Would you just read your handwriting for me so I can
18 understand what it says?
19 MR. GRESH: What, what page are you looking at?
20 MR. PADGET: I'm sorry. Page five.
21 BY MR. PADGET:
22 Q You just decipher for me your handwritten notes there,
23 Doctor?
24 A It's -- it was talking about Dr. Malone's testimony and
25 the preceding sentence where parens, it says Dr. Malone had

1 previously declined a case from Attorney Hinson and then the
2 part you've highlighted said, [as read], "Malone didn't take
3 any notes of the records." That's where it stops, but the
4 rest of the sentence is [as read], "as he read them like I
5 do."
6 Q Yeah. And --
7 A And then it said, [as read], "Dr. Malone has been an
8 expert in two cases and he did not know how much he charges
9 for that work."
10 Q Okay. Thank you. So according to his deposition
11 testimony Dr. Malone wasn't, wasn't even sure what he charged
12 for his work; correct?
13 A Correct.
14 Q Did you ever consider whether -- because you wrote that
15 in your notes -- did you ever consider whether or not Dr.
16 Malone was testifying for reasons other than money?
17 A That statement is about his general practice, at least
18 that's the way I understood it, he doesn't know what he
19 charges in any cases. Now, if you're bringing new information
20 that he decided not to charge in this case because of some
21 other reason, that's total news to me.
22 Q Well, let's just talk about your charges, Doctor. You,
23 you charge $680 per hour for your services?
24 A In South Carolina, yes.
25 Q In South Carolina. Yeah. You get a -- I think it was a

1 $4,000 retainer to get started in, in this case?
2 A I do. It simplifies billing and that I should really go
3 ahead and start and then I apply that to the first $4000 work.
4 Q You at the time of your deposition, which has been a
5 little while now --
6 A And that's standard. Excuse me.
7 Q I'm sorry. You had spent 30.5 hours on the case at the
8 time of your deposition. You remember that?
9 A Yes. I do.
10 Q Okay. And if we do the math that is just a little over
11 $20,000?
12 A That's, that's exactly right.
13 Q And there's -- I assume you had to prepare for trial and
14 talk with Mr. Gresh and do all those things?
15 A Yes.
16 Q And you've -- going to be paid to come to trial here
17 today as well --
18 A Uh-huh.
19 Q -- for your time? Would you agree that you're going to
20 be paid approximately $30,000 or so for your opinions in this
21 case?
22 A I, I, I, I think something in the 27, 28 range.
23 Q Okay. Fair enough, Doctor.
24 MR. PADGET: That's all the questions I have, Your Honor.
25 THE COURT: All right. Redirect?

1 MR. GRESH: Just real briefly, Your Honor.
2 REDIRECT EXAMINATION
3 BY MR. GRESH:
4 Q Can patients listen carefully to a physician, understand
5 what the physician is saying and make reasoned decisions about
6 their healthcare that aren't reasonable decisions?
7 MR. GRESH: Objection, Your Honor, leading.
8 THE COURT: Leading question.
9 Q When you look through the medical records and the sworn
10 deposition testimony in this case, you saw that Dr. Ash-Bernal
11 went over the against medical advice form. You remember that?
12 A Yes. I'm sorry.
13 Q And that within that form she certifies, and we've all
14 seen this, certifies that Matthew Scheer had the mental
15 capacity; correct?
16 A Yes.
17 Q To make the decision?
18 A Yes.
19 Q Can we -- describe for us having this mental capacity to
20 make a healthcare decision, does that mean all medical
21 decisions that person makes are reasonable?
22 A Where it's --
23 Q Or are they two different things?
24 A Totally different and were it so practicing medicine
25 would be a whole lot easier. People have all kinds of ideas

1 about their healthcare that I disagree with and that I'm not
2 recommending and actually I might even disagree about it but
3 they still hold them and they've learned them from the
4 internet. They've learned them from relatives. They've
5 learned them from their own experience. They've learned it
6 from television ads, and they -- they're, they're frequently
7 not right. I ask my patients, "Please not read, read the
8 medical stuff on the internet, 50 percent of it's wrong."
9 It's, it's frequently not prudent, and sometimes it's,
10 frankly, irrational. You know, "I'm not going to take
11 chemotherapy because my favorite aunt had cancer. She did
12 chemotherapy and she died." Well, she died from the cancer
13 not from the chemotherapy probably, I would think. That's not
14 rational. Well, a person can still say, "I'm not going to do
15 chemotherapy," and I -- I'm left with trying to talk them into
16 it, doing whatever I can do and I do a lot of that all day
17 long, talking people into what I think is best for them. Now,
18 and I -- but I teach doctors, both psychiatrists and non-
19 psychiatric physicians, that the real issue is not deciding
20 which medicine and what does. It's getting the person across
21 the desk from you to actually take it because people get up
22 and leave the doctor's office and it would maybe astound you
23 that two-thirds of them never even fill the first
24 prescription. The people who do fill the first prescription,
25 the one-third that fill them, they never fill it again. Now,

1 that's all against the doctor's advice, and that's the main
2 thing -- that's two-thirds of people.
3 THE COURT: Doctor, I think, I think you kind of strayed
4 from the question.
5 A Oh, I'm sorry.
6 THE COURT: I'm going to ask you to be more specific in
7 your answers, please.
8 A I'm sorry, sir.
9 Q And, and this'll be just a real, a real easy one. When
10 Matthew Scheer was evaluated by Dr. Ash-Bernal does he have
11 his shirt back on?
12 A Yes.
13 Q Is he calm at that point?
14 A Yes. He's still -- I think still strongly believing his
15 religious beliefs.
16 Q Is there any indication for Dr. Ash-Bernal to give
17 Matthew Scheer Ativan under those circumstances?
18 A No.
19 Q And looking back at the entirety of the care provided by
20 Dr. Ash-Bernal and Dr. Patel, at any time did you feel that
21 their actions or inactions deviated from the applicable
22 standard of care?
23 A No.
24 Q Thank you.
25 THE COURT: All right. You can step down and be

1 excused. We appreciate your time, Doctor.
2 A Thank you.
3 THE COURT: Members of the jury panel we're going to take
4 our morning break. I'm going to try to keep it around 10 to
5 12 minutes and so we can stay on track, along the track. The
6 next part of the trial will be the closing arguments of the
7 attorneys. I think that's the last -- your last witness?
8 MR. GRESH: Yes. The Defense rests.
9 THE COURT: Yeah. I'm sorry. Any reply?
10 MR. HINSON: No reply, Your Honor.
11 THE COURT: Maybe I'm off track, but we have a few
12 matters to take up outside your presence. I don't think
13 they'll take long, so 12 to 15 minutes. When you come back
14 you'll hear the arguments of the attorneys, then my charge on
15 the law. We probably won't have lunch until after we do those
16 three things, depends on how long it takes. We don't have any
17 particular time limit set on either of those three things, but
18 we hope to have this in your hands by, by mid-afternoon. So
19 I'm going let you go to the jury room at this time. Don't,
20 don't start discussing the case yet.
21 (Whereupon, the following takes place outside the
22 presence of the jury.)
23 THE COURT: All right. Anything from the Plaintiff?
24 MR. HINSON: Nothing, Your Honor.
25 THE COURT: Defense motions?

1 MR. GRESH: Yes, Your Honor. For the, for time sake if
2 Your Honor would allow me, I would like to adopt and
3 reincorporate all of the previous motions in limine that were
4 made at the close of the Plaintiff's case, and if Your Honor
5 would like me to reargue any of those?
6 THE COURT: No. Not motions in limine, directed verdict.
7 MR. GRESH: Thank you, Your Honor, directed verdict
8 motions that I made at the close of the Plaintiff's case. I'm
9 happy to reargue any of those.
10 THE COURT: I, I think I, you know, I'm, I'm, I'm
11 flexible but I'm not going to change my mind on any of those.
12 So I want to -- you -- you're on record as renewing all those
13 DV, directed verdict motions, and I'm going to put myself on
14 record as incorporating my earlier rulings and denying each
15 and every one for the reasons set forth earlier. So let's
16 take a break, and I, I said let's try to keep our arguments to
17 about an hour. Is that -- an hour?
18 MR. HINSON: I would not anticipate that being a problem,
19 Your Honor, not at all.
20 THE COURT: Because we -- and I've got the, the -- just
21 told the clerk that we're shooting for around -- oh, I --
22 around 2:00 o'clock maybe for lunch. We might be a little
23 later than that. Do you -- do you all -- do you have my --
24 the charge ready?
25 MR. GRESH: Yeah. Let me show it to Plaintiff's counsel.

1 THE COURT: I'm talking about the whole charge.
2 MR. GRESH: Oh, the whole charge. Yeah.
3 THE COURT: We'll -- also we need to go ahead and deal
4 with --
5 MR. GRESH: Your Honor, may I approach? This is a
6 supplemental charge that we requested.
7 THE COURT: The one on habit?
8 MR. GRESH: Yes, Your Honor. There's been ample
9 testimony and lots of witnesses that didn't remember something
10 but were able to talk about -- the jury needs to know that
11 under the eyes of the law one does not have to remember
12 everything, one can rely on their habit, routine and practice,
13 and that either of those scenarios are admissible.
14 THE COURT: Well, that's not the way I rule - read Rule
15 406. It's an evidence rule, and it's where somebody else
16 could testify, a third party could basically testify as to
17 your habit or my habit. I don't see it as a, a shield sort of
18 a -- with a -- for a party to where it's saying, "Here's my
19 habit. That's, that's why I did X, Y and Z because that's my
20 habit, the way I do it." I think it's -- under the -- as I
21 read 406 it's an evidence rule giving a third party the right
22 to say, "Jack Gresh eats breakfast at 8:00 o'clock every
23 morning because I see him because we eat at the same place."
24 MR. GRESH: Okay. I, I just am, Your Honor --
25 THE COURT: I know. We'll make it part of the record.

1 MR. GRESH: Thank you, Your Honor.
2 MR. HINSON: Thank you, Your Honor.
3 THE COURT: And, and the charge? Well, if we can just
4 get that so I can have it in a couple of hours. All right.
5 We'll be at ease till -- let's say 20 after, about 20 after.
6 That's about 10 minutes.
7 MR. PADGET: Thank you, Your Honor.
8 MS. SPEARS: Thank you, Your Honor.
9 OFF THE RECORD
10 (On the record. The following takes place outside the
11 presence of the jury.)
12 THE COURT: In the old dogs new tricks category, I don't
13 know why I just happened to think about this, would either
14 side object to me giving a -- when I get to the verdict form
15 giving a copy to the foreman so he can have it in his hands to
16 look at as I go over what's on there? I've never done that
17 before but it just made sense to me that the foreman's the one
18 who's got to understand it. Anybody object I won't do it.
19 MR. HINSON: No objection from the Plaintiff, Your Honor.
20 MR. GRESH: None.
21 THE COURT: All right. Well, I'll -- can, can I -- I
22 need, need a copy. All right. Plaintiff ready?
23 MR. HINSON: Yes, Your Honor.
24 THE COURT: Defense ready?
25 MR. GRESH: We are, Your Honor.

1 THE COURT: All right. Bring in -- well, we don't --
2 still don't have a bailiff. Okay. And have I got the, the
3 final draft of the charge?
4 MS. SPEARS: I believe we're going to print it. Mr.
5 Padget was working on adding some language.
6 THE COURT: Okay. Well, you can just -- I'll get, I'll
7 get it. We'll, we'll take a break probably between arguments
8 and charge. Thank you.
9 (The following takes place in the presence of the jury.)
10 THE COURT: All right. Members of the jury panel, you'll
11 now hear the closing arguments of the attorneys. Keep in mind
12 they're not witnesses. They're not giving you testimony.
13 They're giving you their position on and, and summing up the
14 case and the facts and the -- they'll tell you some things
15 about the law, I feel sure, keeping in mind that I'm going to
16 charge you the law and you take the law as I give it. An
17 attorney would not misrepresent the law intentionally. If you
18 hear something from the attorney and you don't hear it from
19 me, just disregard what the attorney said, and if an attorney
20 does that I'm sure it'd be inadvertent and they would not,
21 obviously, try to mislead anybody. Counsel.
22 MR. HINSON: May it please the Court?
23 THE COURT: Yes, sir.
24 MR. HINSON: Ladies and gentlemen of the jury, on Monday
25 morning you came here, parked in the Conway or, excuse me, the

1 Horry County courthouse parking lot. You walked by the
2 American flag to come do your duty as jurors. You weren't
3 alone. There were several hundred people in that jury pool.
4 There's other juries that have done other things this week,
5 and even the collective of you was not alone. All across
6 America people came and served as jurors and did their duty.
7 It is an imperfect system, but it's the best one there is, and
8 I'm sorry that we had to have you -- keep you here all week,
9 but sometimes to do something right takes time, and after a
10 week we've now reached that crucial day. No longer will the
11 12 of you consider this case as individuals, but you will come
12 together and you will decide the case as one jury. You sit as
13 representatives of this community given the duty, given the
14 task of reaching a verdict that speaks the truth and speaks
15 for the safety of the people of Horry County, and through this
16 voice you will speak about what the standards this county will
17 accept, the way of living in our system of determining what is
18 the acceptable way to treat a patient who's suffering from
19 mental illness.
20 When you entered this courtroom you already had all the
21 tools you needed. You didn't need fancy arguments from
22 lawyers. You didn't need statements from the witness. You
23 had your 581 years of collective experience. That's what you
24 have, added up your, your ages, 581 years right here of living
25 on this earth, many of which, most of which are living in this

1 community, and you have learned and you've gained common sense
2 and logic and reason, and you know what's right and what's
3 wrong and you know when somebody is telling you the truth and
4 when someone is putting up a show, when someone's making
5 excuses.
6 On Monday morning I mentioned a few safety rules to you.
7 A physician should never be hasty and should take time to make
8 a safe decision for her patient. I want to talk about this a
9 little bit more, but when people are hasty they forget to do
10 things. When people choose haste over their duty to properly
11 do their job, bad things happen. When people choose to speed
12 on the highway, bad things happen, and you may be able to get
13 away with it for a while, but if you choose to speed every day
14 you not only might get a ticket, it's foreseeable that you'll
15 be in a wreck.
16 Doctors should communicate with other doctors. We've had
17 a lot of talk about this, and I believe almost everyone that's
18 taken the stand in this case has told you that signoffs or
19 handoffs or passing the baton, signouts, whatever you want to
20 call them, that that's what happens in medicine. It's for
21 patient safety.
22 Dr. Ash-Bernal took the stand, and after more than two
23 years of litigation, the case been filed more than two years
24 ago, this day certain for this trial, we've known, we've known
25 this trial would start on May 20th for more than five months,

1 and she didn't know the record. She couldn't answer the
2 questions of wasn't this a dramatic change in Matthew at 1:14
3 in the morning. She couldn't answer that question. You can
4 decide what that means, whether she really knew the answer or
5 not or whether she just didn't want to answer it, but
6 regardless, it shows the importance of a handoff because if
7 the conversation had happened between Dr. Patel and Dr. Ash-
8 Bernal, had he chosen to do his duty and just spend a few
9 minutes to talk with the next physician on staff, she would
10 have had all of this to look through, didn't have to be long.
11 "Got Matthew Scheer here has been with his dad. I've talked
12 with his dad, seems like it's a very supportive family.
13 They're very concerned with him. His dad drove all the way
14 down from New Jersey. He's been having some really, really
15 serious delusions. He's hearing voices. I think they're
16 command hallucinations. He's, he's had this episode in the
17 woods fighting demons. He's been pretty calm and cooperative
18 with me, but if he changes we need to really put him on some
19 antipsychotics quick for his safety and for the safety of
20 everybody around him." How long did that take? Less than 30
21 seconds?
22 The testimony you heard was, "We only do that if there's
23 a concern." Think there was a concern about Matthew.
24 Everybody else was concerned about Matthew. The ER doctor was
25 concerned about Matthew. The ER doctor said take him

1 immediately to Lighthouse, immediately, not let's make an
2 appointment, not you need to see the doctor real soon, see
3 them today if they can get you in, go immediately, and you
4 know what else she did? Excuse me. She picked up the phone.
5 She called Lighthouse. She communicated with Lighthouse. She
6 gave a handoff. Dr. Battisti gave a handoff to Lighthouse
7 because that's the standard of care and that is what
8 physicians who are not being hasty who are looking out for the
9 safety of their patients do.
10 Lighthouse couldn't see him. We know that. There were
11 problems with his blood work. He had chemical problems likely
12 related to his extreme anxiety. It had raised his white blood
13 cell count, likely related to not eating and drinking for
14 several days. It was beginning to infect -- impact his
15 organs. The record shows he was anorexic. That's a concern,
16 and what did Lighthouse do? They arranged for a transfer
17 back, and there was the confusion between Conway and, and
18 Grand Strand, but Lighthouse still made effort to contact
19 people because there's nothing better than just having a
20 conversation. That's why I'm giving you a closing statement
21 right now. You know, I could have written something down and
22 the Judge could have handed it back to you, but that's not the
23 way we do it because it's not as effective and it doesn't
24 communicate well.
25 Matthew comes back to Grand Strand. Dr. Battisti sees

1 him again, and guess what she does? When she admits him to
2 the hospital she talks to Dr. Patel. She gives a handoff.
3 She passes the baton. She does a signout. Everybody else in
4 this case did a handoff except for Patel to Ash-Bernal.
5 Nobody else failed to do that, and now the Defense wants you
6 to believe that, oh, that's not really done, although they
7 can't quite admit that it's not really done. They just say,
8 "Well, we don't do them unless there's a concern," and then
9 now they won't admit there's a concern? Ask yourself if that
10 makes sense. Was there not a concern about Matthew?
11 Doctors should communicate with their patients. You
12 don't go to the doctor and just fill out the form, sit there
13 in the waiting room, and then have an answer come back about
14 what the doctor's going to do. The doctor sits down and he or
15 she talks with you, and they ask you lots of questions, and
16 depending on what your problem is then they ask you a lot of
17 questions and depending on how important it is they may do a
18 lot of tests.
19 It was 1:30 in the morning during Hurricane Joaquin.
20 It's coming. It's battering the East Coast, and Dr. Ash-
21 Bernal doesn't ask those questions of Matthew. She doesn't
22 sit down with Matthew. She doesn't say, "Matthew, you really
23 got me in a bind here. You know, I, I want to respect your
24 privacy, of course, but I also care about you. You're my
25 patient and I'm going to put your safety above everything.

1 Your safety is very important to me. So let's talk." Since
2 Dr. Patel didn't give her the benefit of the signout because
3 he didn't take the time to do that, Dr. Ash-Bernal would have
4 had to taken the time to really look through the record, and
5 if she'd done that, she would have seen that she had a patient
6 who had a lot of problems.
7 Dr. Ballenger just said he sees a lot of smoke. Where
8 there's smoke there's fire. Sure Matthew hadn't done --
9 hadn't harmed anyone yet. He hadn't taken his own life yet,
10 but it's foreseeable that's coming. A man who is out in the
11 woods fighting demons can do something very irrational. It
12 might not just hurt himself. It might hurt others, and you
13 have to sit down with that patient and talk with him, and Dr.
14 Malone came and talked to you about that. He talked to you
15 about the types of things that he -- that a physician should
16 ask in a situation like this. This isn't a patient wanting to
17 leave the hospital with a gallstone or a patient wanting to
18 leave the hospital with an appendicitis. This is a patient
19 with psychosis. If the -- a patient with appendicitis who has
20 all of his wits about him wants to make a horrible decision,
21 that's entirely a different picture than the psychotic patient
22 not based in reality who wants to make a bad decision.
23 Doctors must protect patients who do not have the mental
24 capacity to protect themselves. That's their duty.
25 The Hippocratic Oath we often just hear that says do no harm.

1 It's much longer than that. It's an oath. It's not just one
2 little sentence. It's an oath, and the Hippocratic Oath
3 begins, "I swear to fulfill to the best of my ability." Dr.
4 Ash-Bernal has a pedigreed education, Johns Hopkins, Harvard.
5 She got a full scholarship to medical school. There is no
6 doubt that she is eminently qualified, none at all, and do you
7 think -- ask yourselves is what happened between 1:15 and 1:30
8 in the morning on October 3rd, 2015, was that the best of her
9 ability? Is that the best she could do with all this training
10 and education or did something else prevent her from doing her
11 job? Her own decision, her own haste, her own desire to get
12 rid of a loud and disruptive patient who was, as she put it
13 herself, disrupting other patients' rest time. Her own note
14 would reflect the reason why Matthew was discharged from the
15 hospital against medical device. Her own note makes no
16 comment about HIPAA, no comment about wanting to call
17 Matthew's dad. It makes no comment about talking with him and
18 saying, "Matthew, I really think" -- if she really thought
19 HIPAA was a problem, she really thought that, wouldn't the
20 note say something like, "I sat down with the patient and I
21 said to him I really needed to call his dad. I, I said, 'Is
22 there somebody else I could call then, maybe a good friend of
23 yours? Do you have a roommate? Do you have a girlfriend?
24 You have a good buddy at work? Is there somebody else I could
25 call if you don't want to talk to your dad?'" Wouldn't that

1 be something that a physician would do if they were working to
2 the best of their ability, and if that had really occurred
3 wouldn't this note say, "I asked him was there anybody else he
4 could call, I could call for him then." It doesn't mention
5 anything about that. In fact, the only thing that you will
6 find in this medical record is simply the nurses asking,
7 "Would you like to speak to your dad?" That's it. HIPAA did
8 not stop -- was not even in anyone's thought that night, that
9 -- in anyone's mind that night.
10 The Judge is going to charge you when closing statements
11 are done and he's going to talk to you about the preponderance
12 of the evidence, the greater weight of the evidence, and what
13 he's going to tell you is that all Plaintiff has to prove, all
14 the Plaintiff has to do is move the scale slightly, that when
15 we started off this case, the Plaintiff and the Defense, you
16 were to consider us at an equal standing, and as the case went
17 on, if we've tipped the scales ever so slightly then you
18 should find for the Plaintiff, and so if you find yourself in
19 the jury room saying things like, "I'm not convinced," or,
20 "I'm just not certain," then you're not applying the greater
21 weight of the evidence standard. All we have to do as the
22 Plaintiff is convince you that it's more likely than not.
23 Another analogy we might use is a football analogy. Plaintiff
24 does not have to score a touchdown to win this case. We don't
25 have to score a field goal. We don't even have to get a first

1 down. If we were on the 50-yard line, that's where we started
2 in this case, and if we have moved the ball one inch forward
3 you should find for the Plaintiff. If we haven't moved it at
4 all or if we've gone backwards and lost yardage, you should
5 find for the Defense, but if we have moved the ball even an
6 inch, the greater preponderance of the evidence standard would
7 say you should find for the Plaintiff.
8 There's been some discussion in this case about Southern
9 Myrtle Inpatient Services, SMIS. They're a Defendant in this
10 case. They are the employer of Drs. Ash-Bernal and Patel, and
11 I will remind you and if you recall, we had a witness come and
12 they played the part of the 30(B)(6) deponent, which is the
13 corporate representative who comes and stands in the shoes of
14 the corporation and speaks for the corporation. Their words
15 bind the corporation, and I took the deposition of the
16 corporation in this case, and I asked, "Does Southern Myrtle
17 Inpatient Services have any specific knowledge of the training
18 provided, and by that I mean, would they," speaking of Drs.
19 Rachel Ash-Bernal and Patel, "would they have, have received,"
20 excuse me, "and by that I mean would they have received notice
21 such as that on December 2nd, 2015, Dr. Patel attended such and
22 such a seminar provided by X, Y, Z entity," and the
23 corporation said, "I'm not certain," and I asked, "Do doctors
24 report -- does Dr. Patel and Ash-Bernal when they worked for
25 Southern Myrtle Inpatient Services did they report any ongoing

1 continuing medical education that they receive? Do they
2 report those to SMIS?" "I'm not certain." This corporation
3 doesn't even know if its doctors report to them. Then I
4 asked, "So am I correct to interpret that as SMIS never took,
5 undertook to provide any education or training to Drs. Ash-
6 Bernal and Patel regarding exclusions to HIPAA that would
7 permit the disclosure of health information for patient
8 safety?" The answer, "To my knowledge, correct." The
9 corporation has admitted they undertook no effort to ensure
10 that their doctors were properly trained, and you heard from
11 Dr. Robert Robinson, been a while since we heard from him, he
12 -- some Monday, Tuesday, Tuesday morning, and Dr. Robinson is
13 a hospitalist. He is the only expert you heard from in this
14 case who is board-certified in hospital medicine. He, excuse
15 me, he's a member of the American Society of Hospitalists.
16 He's board certified in internal medicine, and Dr. Robinson
17 explained to us the duties that an employer has to make sure
18 its physicians are properly trained. We all have experience
19 with this, with whatever job you have, whether you're -- in
20 any job you do. The employer makes sure that the employees
21 have the training they need, and that's particularly important
22 with people's safety when their lives are at issue, and Dr.
23 Ash-Bernal took the stand in this case and I asked her who her
24 employer was. She said EmCare, who isn't her employer.
25 This lawsuit has been going on for more than two years.

1 This trial has been scheduled for more than five months, and
2 she still doesn't know who her employer is. She said that she
3 thought she might have seen the name on her paycheck, and when
4 it came to money it kind of reminded her. Does that sound
5 like an employer who's properly involved in their physicians?
6 And I kind of talked about this earlier. I got a little
7 ahead of myself, I guess, but all the way through as David
8 Scheer does to the best of his ability what he can do for his
9 son, David's not a doctor, doesn't have any training in the
10 medical profession, taking his son to Grand Strand, to
11 Lighthouse, back to Grand Strand, everybody all the while is
12 doing signouts and handoffs, but where did the ball get
13 dropped? It got dropped from Drs. Patel and Ash-Bernal.
14 Let me jump back to the concern idea. Dr. Ash-Bernal
15 said she would only, would only be necessary if there was a
16 concern. Well, setting aside all the psychiatric issues,
17 there's concerning labs. See the H here, you can see this in
18 the record, the H stands for high, high, high. You have high
19 white blood cell count, a high total bilirubin and a high BUN,
20 creatinine level and remember she talked about BUN and
21 creatinine and talked about how it would mean dehydration,
22 that that's what -- those are the, the measures you look for
23 for dehydration was BUN and creatinine. This is a dehydrated
24 patient.
25 The Judge is going to charge you that you may consider

1 the way the witness acts on the witness stand, and that's
2 another tool that you came into this courtroom with with your
3 581 years of experience watching how people react, the way
4 they -- their body language, the way they, the way they react
5 to questions, and I want you to take that into great
6 consideration when you think about the different testimony
7 you've heard, who was changing their testimony from their
8 depositions. Did Dr. Robinson ever change his testimony? Did
9 you ever see an occasion where Defense counsel came up to Mr.
10 -- Dr. Robinson and said, "I took your deposition. You said
11 something different there; didn't you?" Did you ever see them
12 do that to Dr. Malone? "Changed your testimony; didn't you?"
13 That never happened. Think about the other folks you've heard
14 from in this case, how many times their testimony differed
15 from what they said earlier.
16 Dr. Ash-Bernal, this is an exact quote when she took the
17 stand. She said, "There were no red flags." When you go back
18 and deliberate in this case I implore you to look at this
19 medical record. Plaintiff embraces this medical record. Who
20 showed you things from this medical record? Who wants to talk
21 about the medical record in this case? Plaintiff,
22 Plaintiff's, Plaintiff's doctors and who just wants to talk
23 about, "Trust me, this isn't the way we do it and trust me
24 this, trust me that." Who wants to talk about the evidence,
25 the facts? There were no red flags? Anorexia due to

1 hallucinations isn't a red flag? Flight of ideas? That's not
2 a red flag? Pressured tangential speech? He's all over the
3 place. He can't, he can't have a linear thought. That's not
4 a red flag? He has been having visions. That's not a red
5 flag? Where there's smoke, there's fire. Visual
6 hallucinations, auditory hallucinations, tactile
7 hallucinations, what would she consider a red flag? Does he
8 have to be holding a gun to his head for it to be a red flag?
9 Does he have to be pointing it at others? And I want to make
10 sure that it's clear, the need to treat a patient for
11 psychosis doesn't -- they don't have to be homicidal or
12 suicidal. It can just be based off of that they're a danger
13 due to their misunderstanding of reality, and so all this --
14 one of the first things Defense counsel did with Dr. Robinson
15 is he tried to get him to say that the only two ways you
16 could, you could hold someone one, the only two ways were if
17 they were suicidal or homicidal. That's not the truth.
18 That's not the law, and that's not medicine. Someone can be a
19 danger to others and never intend to be and don't understand
20 what's going on around them and they're having paranoid
21 thoughts, paranoid thoughts that others are against him.
22 People who are having delusional paranoid thoughts that others
23 are against them are not safe people.
24 As you go to deliberate, if you would just spend a minute
25 more looking at this record than Dr. Ash-Bernal did, just a

1 minute, you will understand that much more was needed for
2 Matthew on the morning of October 3rd, 2015, and I want to make
3 clear that this case is not about involuntary commitment.
4 That's not what this case is about because if what was
5 supposed to happen had occurred, had Dr. Patel not made the
6 decision to hurriedly leave the hospital without doing a
7 signout to the next physician, had he not made the decision
8 that wherever he had to go was more important than his
9 patient's safety, this would not have occurred, and had Dr.
10 Ash-Bernal first just sat down and talked to her patient,
11 tried to calm him down, all the things that she learned in her
12 immense training, if she had employed those skills, taken the
13 time to do so, Matthew most likely would have stayed. The
14 record reflects that he had calmed down by the time he left.
15 So take the time to care for your patient, be concerned about
16 their safety and the safety of this community and say,
17 "Matthew, let's talk," actually wants to calm down, and Dr.
18 Malone told you that in the vast majority of patients when
19 something like this occurs the vast majority of times that's
20 successful, that alone is successful, take the time to figure
21 out what the law says about patient disclosures because
22 apparently your employer hasn't taken the time to make sure
23 you knew. So take it upon yourself. You don't know, there's
24 a chain of command available with this answer.
25 When you go back in the jury room, when you have

1 questions about what does the law allow? "I've heard
2 different things from different people." Dr. Ballenger
3 basically said nobody ever gets to tell anybody anything.
4 Read the letter from the United States Department of Health
5 and Human Services. Please read this letter. It's addressed
6 to our Nation's healthcare providers. It's addressed to the
7 Defendants.
8 Had that phone call happened and we're talking about
9 communication again, the decision to pick up the phone and
10 find an answer. Had that phone call happened, what Dr. Ash-
11 Bernal would have learned is, "Oh, yes, if you have a mental
12 -- a patient with, with some mental problems and there's a,
13 there's a family member that's able to or able to lessen this
14 threat and you think he might be a danger?" Well, we know
15 that he thinks he might -- she thinks he might be a danger.
16 She -- we know this. He's at risk of death. "Oh, you think
17 he's at, he's at serious risk of death?" He's got a seizure
18 disorder. He's not taking his medication. The answer would
19 have been yes. You can call the family member. Dr. Malone
20 said, "I would never let some privacy law stand in the way of
21 patient safety," and so even if you still somehow are
22 misinformed, do what's right. Do your ethical duty. Do what
23 you took a Hippocratic Oath to do and pick up the phone, call
24 this dad who would have done anything for his son. He would
25 have jumped out of bed, been down here in just a few minutes.

1 "Mr. Scheer, this is Dr. Ash-Bernal, and I'm -- just come down
2 to the hospital," that's all she got to say. Nobody had any
3 problem sharing Matthew's health information at any other
4 time. Debbie calls the next morning and wants to speak to her
5 son and they say, "He was discharged at 1:30." Debbie's not
6 even listed as the emergency contact and they're willing to
7 tell her that. Just saying come down here or even just saying
8 he's about to be discharged, that's not patient health
9 information. Patient health information is the details. He's
10 about to leave isn't patient health information.
11 Talked about weighing witness credibility and how you're
12 armed with that tool from all of your experience, and when you
13 go back and deliberate I want you to remember and when Dr.
14 Ash-Bernal took the stand and I said, "Do you agree there's a
15 sudden change in Matthew?" I was shocked and I would imagine
16 you were, too, when she wouldn't agree that there was a change
17 in Matthew at 1:15. She wouldn't agree there was an outburst
18 at 1:15. Look at this record. Look at these nursing notes
19 when you get back there. Now, this one right here, this one
20 that you're seeing, this is in Defense One. It's -- it is in,
21 in Plaintiff's One, but it looks a little different. I just
22 wanted to point this out to you all. This right here when you
23 get back and there's going to be Plaintiff's One and
24 Defendant's One. They're both the medical record. They're
25 just in different order. Plaintiff's version of this document

1 looks like this. It's just a different way the printer or the
2 computer system printed the information, but you can find this
3 on page 100 of the Plaintiff's record, of Plaintiff's One.
4 It's got all the same words, all the same times. The same, it
5 just looks a little different, but the easier copy, the easier
6 one is Defendants 116 and it will show you here what time
7 these events occurred and what times they were recorded and
8 the nurses are recording this stuff contemporaneously. It's
9 not like they went back and did it a day later or two days
10 later. By 1:44 Matthew was long gone and they were sitting at
11 the -- at their desk charting what happened, and Defendant
12 Ash-Bernal won't admit that this was an outburst. 581 years
13 of experience should say that's not true.
14 The record shows how quickly she made the decision to
15 discharge Matthew AMA. She won't even admit it's a discharge.
16 Look at this record. It calls it a discharge at every single
17 turn, an AMA discharge. He didn't run out of the hospital.
18 They let him go. They had him sign this is a discharge. It
19 just happens to be an AMA discharge. She discharged him from
20 the hospital, and the record will show that the most this was
21 was this difference between 1:13 and 1:27. She is signing for
22 him to leave by 1:27. How much review of this record could
23 she have possibly done? She wasn't even there at 1:13. At
24 1:13 she's being called. Is that a hasty decision to let a
25 psychotic patient out, and let's not forget the circumstances,

1 too, what's going on outside. In the hospital there's
2 security. There's drugs that have -- hundreds of millions of
3 dollars have gone into researching. There's all kinds of
4 lifesaving equipment, MRIs, CTs, just a mountain of things
5 able to help Matthew, literally millions and millions of
6 dollars of medical equipment right there to help him, and
7 outside there's a hurricane going. Where is her patient
8 safest? What makes the most sense and what duty is owed in
9 that type of situation? And when you weigh witness
10 credibility, I want you to remember Greg Phaebus's testimony.
11 Mr. Phaebus, again, was the security guard. He doesn't work
12 for Grand Strand. He works for an independent security
13 company. He doesn't even work for them anymore. He's moved
14 to Maryland, and we went to Maryland and we took his
15 deposition under oath, a man who has no dog in this fight
16 whatsoever. Okay. If you -- and I wanted to remind you of
17 what he said.
18 MR. GRESH: Can't play it. He can talk about it.
19 THE COURT: Yeah. I sustain the objection. You can talk
20 about what he said but don't, don't, don't play it.
21 MR. HINSON: Play it. Yes, Your Honor.
22 Remember what he said. He said this took two to four
23 minutes, the entire interaction between Dr. Ash-Bernal and
24 Matthew was two to four minutes. I've been talking with you
25 all already a tremendous amount longer than she spent, and

1 patient safety, the safety of the community was at issue. She
2 spent two to four minutes. I asked him, "Did you ever see Dr.
3 Ash-Bernal do any sort of psychiatric evaluation or
4 questioning of Matthew," and he said no. I said, "Did you
5 ever see Dr. Ash-Bernal talk to Matthew about why he was
6 believing all the food in the world was poisoned?" He said
7 no. I said, "Did you ever see Dr. Ash-Bernal ask Matthew why
8 he had just accused the nurses of being devil worshipers," and
9 he said no. And then I asked him, "So she just walked up,
10 said, 'Do you want to stay or do you want to go,' and then let
11 him leave," and he said, "That's what it boils down to.
12 That's what it boils down to. "
13 Then after Matthew has been released into the hurricane,
14 later Dr. Patel comes back. Talk about witness credibility.
15 He writes a medical record, you'll see this in, see this in
16 Plaintiff's One. He writes what's called a discharge summary,
17 and his discharge summary states, this is at the end of his
18 summary. This discharge, and this is in, you'll find the page
19 number. I'd be happy -- well, the discharge summary you'll
20 find it at the -- this -- let me back up for a second.
21 Plaintiff's Exhibit One is divided and there may not be a blue
22 page for you all, but it's divided into two sections
23 essentially. The first is the first ER visit, and that's
24 pages one through 42. That's the first ER visit, and then the
25 second half, pages 43 through 132, is the rest of the hospital

1 stay. So as you look through it understand it's divided into
2 two parts, one through 42 and then 43 through the rest, but
3 anyway, the discharge summary that you'll find from this
4 second hospital stay, again, page 54, page 54 you'll find
5 this. At the end of the summary he writes, "All questions
6 were answered to the best of my ability." How could that be
7 true? He wasn't there, and then he tries to explain this to
8 you all by saying, "Well, at the time I saw him all questions
9 were answered to the best of my ability." Well, he wasn't
10 doing a discharge summary at the time he saw Matthew. At the
11 time he saw Matthew the plan was for Matthew to stay in the
12 hospital. How could he have been doing discharge, answering
13 discharge questions when he never saw Matthew in a discharge
14 capacity? Ask -- read this note and ask yourself if that's
15 truthful, and again, at the end he writes discharge planning
16 took greater than 25 minutes. 1:13 and 1:27, I'm not all that
17 great at math, actually, but that is not 25 minutes. This
18 isn't true.
19 Remember we played the deposition testimony under oath of
20 Defendant Ash-Bernal and asked her questions, "All food in the
21 world poisoned?" She said, "Possibly. I don't know." Asked
22 her questions like, "Were all the -- were all the nurses devil
23 worshipers"? She said, "I -- possibly, I don't know," and I
24 showed her the handwriting. Let's remember that the ER staff,
25 the only time they could -- the only time Matthew was ever

1 discharged other than the one that Ash-Bernal did, the only
2 time he was ever discharged was when Battisti discharged him
3 to go to Lighthouse because Lighthouse never admits him. So
4 there's no discharge to happen. The only time he's ever
5 discharged other than Ash-Bernal Battisti has David sign
6 because she knows that Matthew doesn't have the mental
7 capacity to sign himself out. Signing yourself in is
8 different. You're -- if a person comes to the hospital and
9 they're in need of help, the hospital isn't going to say,
10 "We're not going to sign you in because you don't have the
11 mental capacity to sign in." They'll, of course, let you come
12 in and get you treatment. They owe you that. That is, that
13 is their duty.
14 But anyway, I asked Dr. Ash-Bernal in her deposition, "Do
15 these look -- do these look like the same signatures to you?"
16 And remember her response was, "I don't know. I'm not a
17 handwriting expert." I'm also not a handwriting expert. I
18 can state with great competency that these are not the same
19 signature. Think about that when you're weighing credibility
20 in this case, and there's certainly a lot of legal questions
21 that you're going to have to -- well, the, the Judge is going
22 to charge you on all kinds of different legal matters, but one
23 thing he's going to speak with you about is a patient's
24 ability to consent, and you're actually going to have all that
25 information available to you through Plaintiff's Exhibit Six.

1 Remember who's the one giving you the evidence? Who's the one
2 presenting information to you? The Defense has one exhibit.
3 It's the same medical record. Who's trying to arm you with
4 the truth, and when you get back in deliberations please look
5 at this policy, Plaintiff's Exhibit Six, and it says, "A
6 patient is defined as unable to consent when unable to," and
7 there's three. Any one of these three, it's not an and. It's
8 an or. So if a patient -- they don't have to be all three,
9 just one of them and they're not able to consent, and if
10 they're not able to consent they can't even be discharged.
11 They can't sign an AMA, and they read, number one, [as read],
12 "Unable to appreciate the nature and implications of his or
13 her condition and proposed healthcare." "Patient indicated he
14 understood that it was recommended he remain in the hospital
15 for further evaluation of his psychiatric issues." How you
16 can understand if you're having active psychiatric issues, and
17 we know that he is because minutes earlier he was having this
18 outburst. Again, she justifies this by saying, "Patient
19 seemed, seemed, seemed able to weigh the information and
20 interrupted his religious rant to think about the question."
21 Does that sound like somebody who's able to appreciate the
22 nature and implications of his condition and proposed
23 healthcare? When you're weighing witness credibility remember
24 that Dr. Ballenger called it a religious discussion, a
25 religious discussion. This wasn't a religious discussion. It

1 was a man that had mental illness that needed treatment who
2 believed that demons, he needed to fight demons. This wasn't
3 a religious discussion. A religious discussion is what I have
4 at 10 a.m. at the Methodist Church. This was not a religious
5 discussion. This is not Sunday school. This is a man raving
6 and ranting. So who's being truthful to you about the
7 evidence? Consider that.
8 The second prong, unable to make a reasonable decision
9 concerning the proposed healthcare. When you get back into
10 deliberation not only all the things we've already talked
11 about from Plaintiff's One, take a look at Three, Two, Two and
12 Three. So Two is the notes from Matthew's time at Lighthouse
13 which had just been a few hours earlier, early in the day
14 before because now we're on the third, it would be on the
15 second. Look at these notes, and they're hard to read.
16 Somehow or another I don't know how Lighthouse's printing is
17 so off. Look at this note. Read this note. They don't say
18 he's a little bit delusional, which is what the Defense wants
19 you to think, he's just a little, just a little, just a little
20 bit of smoke. That's not what this note says. This note
21 says, the term they use is very delusional. They make the
22 effort to include the word very and then they go on is very
23 delusional and confused. He had very disorganized thinking,
24 and then look at Three. Three is the transfer back to the
25 hospital. He is actively psychotic is the way it reads. He

1 is actively psychotic with delusions and disorganized thought.
2 Can an actively psychotic patient make a reasonable decision
3 concerning the proposed healthcare?
4 Dr. Ballenger just took the stand and said that Dr. Patel
5 wasn't real sure it was a psychosis. It might be a psychosis.
6 Everything in this record says psychosis. Lighthouse says
7 primary diagnosis psychosis.
8 So I want to talk about this HIPAA excuse again. This is
9 a made up defense. It has come only after years of litigation
10 that they -- "Maybe we can argue HIPAA wouldn't let us call
11 Matthew's dad. That's it. We'll use, we'll use HIPAA.
12 Everybody knows that term. They've heard of HIPAA." There's
13 nothing in the record about HIPAA. They didn't say, "We
14 wanted to but HIPAA wouldn't let us." Matthew's dad's name is
15 right there in the record. It would have taken minimum amount
16 of effort, just decide to go over to the computer, look it up,
17 find his name and number. "The staff offered to call
18 patient's father for him to speak to." That is totally
19 different than, than a note that says, "He refuses to let us
20 call anybody." When you're back there, again, I want to read
21 this. I just can't, I can't emphasize this enough. What
22 you've been told by the other side about HIPAA isn't true.
23 Plaintiff's Exhibit Seven, "HIPAA does not prevent" --
24 this is to the Nation's healthcare providers. "HIPAA does not
25 prevent your ability to disclose necessary information about a

1 patient to law enforcement, family, members of the patient,
2 family members of the patient." I think that I have a typo
3 there, sorry, "or others when you believe the patient presents
4 a serious danger to himself or other people." This, this
5 fellow that they paid nearly $30,000 to come here wants to
6 tell you different, got paid 27, $28,000 to come here and tell
7 you that somehow the Department of Health and Human Services
8 doesn't know what they're talking about. This letter to the
9 Nation's healthcare providers says, [as read], "HIPAA protects
10 the privacy of patients' health information but is balanced to
11 ensure that appropriate uses and disclosure of the information
12 may still be made when necessary to treat a patient to protect
13 the Nation's public health and for other critical purposes
14 such as when a provider seeks to warn or report that persons
15 may be at risk of harm because of a patient." That's what
16 this letter says. Doesn't say that it has to be immediate,
17 that it has to be within the next moments. The person is at
18 risk of harming themselves or others, common sense takes over.
19 It's balanced. We have to balance between privacy and safety.
20 Nobody in our government said let's put privacy way above
21 people's safety. Thank God they didn't say that. It goes on
22 to say, [as read], "Healthcare provider may disclose patient
23 information including information from mental health records
24 if necessary to law enforcement, family members of the patient
25 or any other person who may reasonably be able to prevent or

1 lessen the risk of harm." That's what it says. That's what
2 our government says. When you get back there, you're going to
3 have a copy of Grand Strand's notice of privacy. It's number,
4 number five. It looks just like this. It's just a copy of
5 this one. That's my -- I stopped by the hospital and got one
6 before I came into court this week. They've been using this
7 one for years. It hadn't changed in years. It's the same.
8 Matthew's -- and you'll see in the record that Matthew
9 signed that he got one. Everybody gets this. Everybody is
10 supposed to know this. The effective date, it hasn't changed.
11 This was what was in place in 2015. The effective date is
12 September 23rd, 2013, and Grand Strand's got it right. This
13 thing perfectly mirrors what the Department of Health and
14 Human Services has said that they may disclose health
15 information to a person or persons able to prevent or lessen a
16 serious threat to health or safety. I don't think there's
17 been any argument in this case that Dave was not a person able
18 to prevent or lessen a threat to Matthew's safety and the
19 safety of other people. As tragic as this case is it could
20 have been worse if he had hurt other people, and as you
21 consider this case, and you consider the weight of different
22 witnesses, think about Dr. Tim Malone. I don't know if you
23 noticed, he had a big ring on his finger. It's the Women's
24 National Basketball Championship the Gamecocks won a few years
25 ago because he's the, the director of medicine for the -- for

1 all the Gamecock sports teams, and so whenever they win a
2 national championship he gets -- because he's the team doctor.
3 He goes with the team. He got the ring. The Gamecocks trust
4 him for 650 something student athletes. Dr. Malone is
5 passionate about vulnerable, vulnerable individuals, people
6 with mental health. The Defense never asked you -- never
7 asked him how much he was being paid. Why do you think they
8 didn't ask him that? You think it's because Mr. Gresh forgot?
9 He's a good lawyer. Maybe it's because he didn't want to
10 highlight the real reasons Dr. Malone was willing to come
11 testify about how he feels that people with mental illness
12 deserve better treatment, that they shouldn't be taken away
13 from safety and cast out into the rain, that people, that
14 doctors with a duty to do so take the time. Maybe he's tired
15 of other physicians who aren't psychiatrists treating mentally
16 ill people as if there's something wrong with them in the
17 sense that they're not people and just wanting to be -- get
18 rid of their disruptive behavior because in their minds the
19 fact that a mentally ill person is disrupting other patients'
20 rest time is somehow relevant. Why is that even in the
21 record? What difference did it make that he was disrupting
22 other people's rest time? It's not relevant. What do you
23 think was relevant to Dr. Ash-Bernal at that time of night?
24 Apparently was relevant to her to put it in the record. I've
25 already talked about the notice of privacy practices.

1 The Judge is going to, is going to charge you on what
2 likelihood of serious harm means, and again, the Defense wants
3 you to believe it has to be a substantial risk of suicide or
4 homicide. That's not it. There's a third prong. Certainly,
5 of course a substantial risk of suicide or homicide is, is a,
6 is a likelihood of serious harm, but there's also the third
7 which is a substantial risk of physical impairment or injury
8 to the person himself as manifested by evidence the person is
9 gravely disabled and that reasonable provision for the
10 person's protections are not available in the community. Now,
11 Dr. Ash-Bernal said she would, that she would hold somebody in
12 a New York minute if they were gravely disabled. Well, the
13 definition is the inability to provide reasonable provisions
14 for oneself. Is an epileptic who's not taking his Keppra able
15 to reasonably provide provisions for himself? Is a man who's
16 not eating because he thinks the devil has poisoned all the
17 food on the earth able to reasonably provide provisions for
18 himself? Is a man who's given away all of his worldly
19 belongings? Dave testified that he had to go dig them out of
20 a Salvation Army donation bin. Is that somebody who's
21 reasonably able to provide for themselves? Matthew's mental
22 illness was so severe that at that time he wasn't able to
23 provide for himself. Dr. Ash-Bernal wouldn't agree that a
24 person with a seizure disorder who was refusing to take Keppra
25 because of delusions, a belief that they've been cured of an

1 incurable disease is a person unable to care for themselves.
2 Gravely disabled means a person -- this is what the Judge will
3 charge you, gravely disabled means a person who due to mental
4 illness lacks sufficient insight or capacity to make a
5 responsible -- to make responsible decisions with respect to
6 his treatment and because of this condition is likely to cause
7 harm to himself through neglect. He's anorexic. Inability
8 to care for himself, personal injury or others. Is he
9 reasonably likely? He's already there. We're not talking
10 about something in the future. He's there on October 3rd,
11 2015. He's already exhibited that he's unable to care for
12 himself.
13 This is the verdict form in the case. This is what's
14 going to go back with you into the deliberation. It's got
15 five questions. The first question, truly the most important
16 question, "We, the jury, unanimously find in favor of the
17 Plaintiff, and we, the jury, unanimously find in favor of all
18 the Defendants." You check for the Defendants you're done,
19 but if we have tipped the scales ever so slightly and you
20 think what happened here wasn't right, you think that doctors
21 -- if Dr. Patel should have actually entered the order that he
22 said he was going to enter, could have entered an order for
23 Ativan, that he didn't do it, if you think that should have
24 occurred, if you think a signoff or a handoff should have
25 occurred, if you think that Dr. Ash-Bernal owed something more

1 to Matthew than, "Do you want to stay or do you want to
2 leave", then check the top box.
3 The Judge is going to charge you on what negligence
4 means. This is Plaintiff's burden to prove that the
5 Defendants were negligent. It's a long charge, but I want to
6 read some of the highlights of it. [As read], "Negligence is
7 the failure to do what an ordinary careful doctor in the
8 Defendants' field of medicine would do under the same or
9 similar circumstances. When medical authorities are divided
10 with regard to a specific portion of treatment or care, then
11 the doctor is bound only to exercise his or her best judgment
12 in determining which course on the whole is best for the
13 patient," best judgment, not just some judgment. She used
14 some judgment. She had an obligation to use her best
15 judgment, a lady with a pedigree education, as good as any
16 doctor you've heard from in this case, her resume is just as
17 good. Is this the best she could do? That's what she owed to
18 Matthew. That's what she owes all her patients, the best she
19 can do. Take your 581 years of experience and ask yourself
20 is, "Do you stay, do you want to stay or do you want to go,"
21 is that the best she could do? The best she could do was
22 something much more, much, much more.
23 Remember the guy from Newberry, the one who wouldn't
24 answer the subpoena? Didn't answer at his deposition, and his
25 deposition under oath he told me he'd provide it to me later,

1 his bills. He didn't do that either. Under oath he said he
2 would, still didn't do it. He came here and told you that
3 this was above the standard of care. That's what he says,
4 this went above and beyond. Ask yourself, is that, is that
5 believable? What part of this is above and beyond?
6 I want you to look through this medical record. You've
7 been told by the Defense that there was care and treatment
8 provided. Then when crossed about that, the next question
9 was, "What is some care and treatment that was provided to
10 Matthew," and the answer was, "We ran some labs." Labs
11 doesn't -- don't provide any treatment. They don't, they
12 don't do anything but tell you more information. They told
13 more information that he's very sick, that his psychosis has
14 now impacted his body physically, his organs. So they ran
15 some labs, but that's not treatment and that's not care. He
16 never got a psych consult. Nobody ever picked up the phone,
17 said, "Dr. Battisti [sic], I know there's a hurricane coming.
18 I mean, I understand some people are actually evacuating the
19 area. Are you going to be able to come tonight? Okay. Well,
20 what would you have me do in the meantime?" There was no care
21 provided. Matthew refused an IV. Matthew refused medication.
22 Nobody came and ensured that he did those things.
23 Again, what we have in this, this case, "Well, maybe it's
24 kind of the nurses' fault. The nurse never" -- Dr. Patel
25 said, "Well, the nurse never told me." Then it also came out

1 with this -- in the trial of this case that the nurse was
2 unaware that Matthew was a psychotic patient because obviously
3 it's different like he talked about. If the person's in there
4 for a kidney stone or appendicitis wants to refuse an IV,
5 "Hey, that's their decision, that's kind of a bad decision,"
6 but when the psychotic patient is refusing one it's a
7 different story. You heard that the nurse didn't know. Well,
8 who do you think was supposed to make sure the nurse knew?
9 Who's in charge of nurses? The attending doctor. So if Nurse
10 Bell didn't know whose, whose fault is that because Dr. Patel
11 didn't take the time to make sure his nurses knew what was
12 going on with his patients. He didn't take the time to make
13 sure that that's documented, didn't take, take the time to
14 make sure his nurses knew.
15 While we're on the topic of negligence, the last question
16 on the, on the verdict form asks about gross negligence.
17 Gross negligence is a little bit different than negligence as
18 I mentioned. Negligence is just the failure to do what an
19 ordinary careful doctor in the Defendants' field of medicine
20 would have done under the same or similar circumstances, and
21 let me pause for a second on that. The Defense never brought
22 up anyone who is full-time hospital medicine, never brought up
23 a single expert who is a member of the American Society of
24 Hospitalists. They brought up somebody they've paid -- well,
25 really we don't know how much they've paid them because he

1 wouldn't send me his -- a copy of his invoices. He refused to
2 comply with a subpoena, but they brought up this guy who works
3 at a clinic, a family practice clinic in Newberry who works at
4 a hospital that's much smaller. Have they shown you what a
5 careful doctor in the Defendants' field of medicine would do?
6 So now let's talk about gross negligence. The Judge is
7 going to charge you that gross negligence is a relative term.
8 It's a relative term. It means the absence of care that is
9 necessary under the circumstances, the absence of care, and so
10 when you're deliberating ask yourself what care was provided
11 to Matthew? Gross negligence involves an intentional
12 conscious failure to do something which one ought to do or the
13 doing of something one ought not to do.
14 Now, I want to -- excuse me. I thought I had the next
15 slide up. I want to make sure we understand that an
16 intentional conscious failure to do something doesn't mean you
17 have to intend the result. There was an intentional conscious
18 failure by Southern Myrtle Inpatient Services to train its
19 physicians. It wasn't just like an accident to happen.
20 They made a conscious failure to train their physicians. Dr.
21 Patel not entering the Ativan probably isn't gross negligence.
22 That would be an example of something that's negligence but
23 not gross negligence. Not entering the Ativan, that was
24 simply -- it's still negligent because you need to do that,
25 but it's not gross negligence, but he made a conscious

1 failure, he knew that he hadn't done a signoff when he left
2 that hospital. He may have thought that he'd entered the
3 Ativan order, but he knew he hadn't done it. That's a
4 conscious failure, and Dr. Ash-Bernal knew that she had not
5 done an adequate evaluation of this patient. She chose to
6 just spend a few minutes with him, and you're going to hear
7 the Judge charge you on proximate cause. Plaintiff must show
8 that some injury from the Defendants' negligence was
9 foreseeable, but does not have to prove that the particular
10 injury that occurred was foreseeable. No one is claiming that
11 Dr. Ash-Bernal and Dr. Patel should have foreseen that Matthew
12 would go to 68 Avenue and at exactly such and such a time jump
13 in the ocean and drown. That, that's not what proximate cause
14 is. We do not have to prove that the particular injury would
15 have occurred, but was it foreseeable that something might?
16 It is absolutely foreseeable that if you release a psychotic
17 man with delusions during a hurricane at 1:30 in the morning
18 some harm should or might come. You might not know what. It
19 might be that he jumps out in front of traffic and causes a
20 horrible car wreck. It might be that he grabs a gun and goes
21 and, yeah. There's all kinds of possibilities, and it's
22 certainly foreseeable that some injury would occur.
23 The second question on the jury form is number two, and
24 it's the allocation of fault, and it has to add up to a
25 hundred percent, can't have 101 percent fault. So you can

1 decide that Southern Myrtle's, whatever it's in, it's in your
2 discretion, 25 percent at fault, 25 for Patel, 50 for Ash-
3 Bernal. I would submit that there's none for Matthew because
4 the Judge is also going to tell you that if you find Matthew
5 to have been mentally incompetent at the time he left the
6 hospital, then he cannot be assigned any fault for his death.
7 A person isn't in his right mind, they're not at fault, but I
8 want to be clear, you don't have to find Matthew to have been
9 mentally incompetent to even find for the Plaintiff. You can
10 still find for the Plaintiff by just saying more was owed to
11 him. You could decide, it's in your purview to say, "Maybe
12 Matthew had the mental competency to do that, but still more
13 was owed to him to try to convince him to stay, and certainly
14 it was owed to him to just pick up the phone and call his
15 father." Dr. Malone said, "Bring on that lawsuit. If I get
16 sued for" -- well, he was speaking there on, on, on an
17 involuntary hold, but so what if you violate HIPAA? But you
18 wouldn't. Which is more important, patient safety, patient
19 safety or some, some little reg?
20 Now let's talk about damages. The third question on the
21 jury form is Matthew's damages. So there's essentially two
22 lawsuits, more or less. There's Matthew's case for what he
23 suffered and there's his parents' case, and so for Matthew
24 this is called the survival claim. It's for his injury during
25 the time he survived after the Defendants' negligence. So in

1 this case it would be all that he endured from the time he
2 left the hospital till his lungs filled with water and his
3 brain finally shut off.
4 And number three gives you the elements of a survival
5 claim. It's the mental anguish and emotional distress.
6 That's one element. I, I, I want you to consider the mental
7 anguish that this young man went through. Of course we don't
8 know what path he took, but we know he got from here to here
9 alone, somewhere between 1:30, two or so in the morning
10 thinking that demons were after him.
11 You heard from Mr. Doherty, a man who did more for
12 Matthew than Dr. Ash-Bernal ever did, a man who had no duty to
13 Matthew at all, still did more for him, tried his best, but
14 you heard Mr. Doherty say that he saw this young man, saw
15 Matthew, as we now know, come down to the beach and take off
16 all his clothes, pumping his fists in the air and carrying on.
17 That's mental anguish and emotional distress. Matthew
18 suffered agony, agony in his head because he thinks he's being
19 called to cleanse himself in the ocean during a hurricane, and
20 Matthew suffered pain. Dr. Robinson talked to you briefly
21 about that. The way when we die or when we -- if we were to
22 drown that, that our throat goes through a spasm trying to
23 keep because you probably don't want to let water into your
24 lungs, it's your natural reaction not to. There's a spasm
25 until finally your lungs fill with water. Think about it, how

1 horrible it is just when you -- when a little liquid goes down
2 the wrong pipe. Imagine your whole lungs filling with water.
3 You don't die instantly. The brain has to eventually shut
4 off, and Matthew suffered pain before he died.
5 The fourth question on the jury form is for the wrongful
6 death damages. Wrongful death is different than a survival
7 claim. The wrongful death under South Carolina law in this
8 case it's for Dave and Debbie. They each have a claim. They
9 each are claimants in this, in this action. You'll find a
10 blank for Dave's damages and you'll find a blank for Debbie's
11 damages and you can decide if they're different. I would
12 submit to you that those two are so tight-knitted I don't how
13 they could be, but that's up to your purview.
14 The Judge is going to tell you that one of the elements
15 is shock, and let's talk about shock with Dave. Dave went
16 home thinking he was doing, thinking what he was doing was
17 best for his son. He thought his son was in a safe place, in
18 a hospital with doctors and nurses and security guards and
19 whatever he would need. Dave made sure to tell the nurses,
20 "Hey, you got my number just in case something," "Yeah, yeah,
21 I got, I got your number." He went home to do what he thought
22 was best for Matthew, get Matthew some clothes. Debbie said
23 he was getting him some deodorant and toothbrush and other
24 things you might need. You're sitting in the hospital. You
25 don't want your breath to stink and be smelly. Dave was doing

1 what he thought was best for his son, and he'd thought he
2 maybe was going up here, take him back to New Jersey and he
3 can't drive. He'd be up for almost two days, and let's think
4 about the shock when Debbie calls him that next morning and
5 says in that voice, "Matthew's not in the hospital," imagine
6 that's your -- that's a compensable damage for Dave, and he
7 would have another shock when the police called and say,
8 "Dave, we need you to come down here, Mr. Scheer," and show
9 him a picture of the clothes that Matthew was wearing, and
10 they tell him what Mr. Doherty has seen.
11 I've got two daughters. Kids are sometimes hard to keep
12 up with. If I lose my seven-year-old in the grocery store for
13 a minute I freak out.
14 MR. GRESH: Your Honor.
15 THE COURT: Yeah. I, I sustain the objection.
16 MR. HINSON: Dave and Debbie, before they get the call
17 from the police, can you imagine their grief driving around
18 Myrtle Beach looking for their son and driving around in a
19 terrible rainstorm? That's a compensable damage for Dave
20 Scheer.
21 Grief and sorrow, grief is what you feel at a funeral.
22 Grief is the immediate feeling of sadness. After somebody
23 dies you grieve for them. Dave grieved in the days following
24 Matthew's death and grieves today, but grieved at the memorial
25 service, grieved driving back to New Jersey without his son.

1 Wounded feelings, the wounded feelings Dave has in the
2 way the Defendants let him down, go with him all of his life.
3 The next bullet point, the loss of Matthew's
4 companionship. Debbie talked about how Matthew wanted to be
5 like dad. You heard how they were golfing buddies, how Dave
6 watching Philadelphia sports teams because they liked the
7 teams from the area, and when the Eagles or whoever does
8 something great he wants to text Matt and realizes he can't
9 text Matt anymore. He doesn't have Matt's companionship
10 anymore.
11 And this last one, loss of Matthew's advice on family
12 matters. 26-year-olds probably don't give a lot of advice to
13 their, to their parents, maybe on technology and how to handle
14 this computer problem or whatnot, but that changes later in
15 life. It changes as parents get older, and children start to
16 give their parents advice. Dave and Debbie will never get
17 that with Matthew. One day they may need help with things.
18 They won't be able to get that from their son, and they said
19 -- I don't remember if it was Dave or Debbie, but one of them
20 very selflessly said, "I worry how that's going to impact
21 Erik," and that really struck me. Instead of saying, "I
22 wonder how that's going to impact me," they said, "I wonder
23 how it's going to impact Erik," that now he's all alone to do
24 this, and they're now worried about Erik, that he's going to
25 feel a bigger burden. They've lost Matthew's advice on family

1 matters. That's Dave, and Debbie's are similar, but she has a
2 view different, different aspects of it. Debbie's shock in
3 that phone call to the hospital where they told her Matthew's
4 not here, he was released, he was discharged at 1:30 a.m., the
5 shock that she had.
6 Her grief and sorrow, you heard how Matthew was a hugger.
7 She misses his hugs. You heard about her dreams that she
8 dreams that Matthew's still with her and then wakes up and
9 realizes that's not true and loss of Matthew's companionship.
10 She told you about how often they spoke on the phone, that
11 they went to the movies together. She was -- he was her movie
12 buddy. She's lost that companionship, and the last element,
13 Matthew's advice later in life for her.
14 When you're in the deliberation room, when you consider
15 each one of these, these are all elements, and the law of
16 South Carolina doesn't let me demand or request a number. I
17 don't get to say the Plaintiffs want $10 million. I don't get
18 to say that in South Carolina. We don't get to ask for a
19 specific demand. It's up to you in your wisdom, and some of
20 you may decide that $3 million is a reasonable number to
21 consider for all this and others may think it's five and
22 others may think it's six, and you have to decide together
23 what a reasonable figure would be, and when you think about
24 that, compensate Matthew for his damages for the way he died
25 and his pain and suffering and agony, the Scheers, the Judge

1 is going to tell you what Dave and Debbie's life expectancy is
2 because the longer Dave and Debbie live the longer they have
3 to go through these things, what we don't know, but the law
4 has a formula we use what a person's age is and there's an
5 estimate of how long they would live, and the Judge is going
6 to tell you that for Dave it's 16 more years and for Debbie
7 it's 23. So that'll be 23 more years the dreams about her son
8 only to wake up and realize that he's not still with her, 23
9 more years of wounded feelings and sorrow, 23 more years of
10 sadness.
11 In this case, you can choose to believe that doctors
12 never do anything wrong, that we must just totally defer to
13 their claims of what happened out of -- in every respect or
14 you can choose to recognize that doctors can also choose to
15 break some basic safety rules that should be followed, and you
16 can choose to hold them accountable for Matthew Scheer's
17 death. The Scheer family asks that you find justice for
18 Matthew.
19 THE COURT: Members of the jury panel we'll take a short
20 break before we hear from the Defendant. This will just be a
21 refresher break. So as soon as everybody's used the
22 facilities if the bailiff will let me know we'll bring you
23 back in.
24 (The following takes place outside the presence of the jury.)
25 THE COURT: All right. Do we have a charge for me yet?

1 (Ms. Spears and Mr. Padget confer.)
2 THE COURT: Yeah. We're going to, we're going to take a
3 break. Yeah. (Lodging discussed.)
4 THE COURT: Just in general, Mr. Gresh, do you know about
5 how long you're going to take?
6 MR. GRESH: Less than Brink.
7 THE COURT: Well, I --
8 MR. GRESH: I promise that. It'll probably be 45 minutes
9 is my, is my hope, Your Honor.
10 THE COURT: All right. Take a short break.
11 OFF THE RECORD
12 (The following takes place outside the presence the jury.)
13 MR. HINSON: Your Honor, I apologize. I did not realize
14 it was as long as it was after I told you I didn't think I'd
15 be in excess of an hour, and I, I apologize to the Court.
16 THE COURT: Well, if you get a recovery maybe you can buy
17 a watch with it. I say that in all good humor. It's an
18 important case. I'm going to let -- I didn't stop you.
19 MR. HINSON: Thank you, Your Honor.
20 THE COURT: If I'd, if I'd thought you had been --
21 crossed the line somewhere I would have stopped you, but it's
22 an important case and, and you did a good job.
23 MR. HINSON: Thank you, Your Honor.
24 THE COURT: Somebody going to get me the charge or is it
25 already -- no, it's not up here yet.