THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable John C. Hayes, III

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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
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Q No further questions, Mr. Doherty.

THE COURT: All right. You can step down and be excused. Mr., Mr. Doherty, you can step down and be excused. We appreciate your time.

A Beg your pardon?

THE COURT: You can step down and be excused. We appreciate your time.

A I'm, I'm a little hard of hearing, sir.

THE COURT: All right. You, you're through testifying. So you can step down.

A Okay.

THE COURT: And you're excused. Thank you. All right. Call your next witness.

MR. HINSON: Plaintiff calls Dr. Tim Malone.

Whereupon, Timothy Malone is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: If you'll please state and spell your first and last name.

MR. MALONE: Dr. Timothy Malone, T-I-M-O-T-H-Y, M-A-L-O-N-E.

DIRECT EXAMINATION

BY MR. HINSON:

Q Good morning, Dr. Malone.

A Good morning.

Q Would you please tell the jury what you do for a living?

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

degree in physics. I then traveled to Columbia where I went to medical school at the University of South Carolina. After finishing there, I did my postgraduate training in psychiatry at the William S. Hall Psychiatric Institute, which is actually no more. It's actually a ballpark now, but in any event, that program is now the University of South Carolina. So I did my general psychiatry training and child and adolescent psychiatry training at the William S. Hall Institute in Columbia.

Q And did, after you finished that, what was your next step in your education and work history?

A Well, I proceeded to get myself board-certified in both general and child and adolescent psychiatry. I also did additional training in addiction medicine and became board-certified in the area of addiction medicine and also did additional training and sat for my forensic psychiatry board certification which I, too, completed.

Q And for those of us who aren't physicians or psychiatrists, what generally is forensic psychiatry?

A Forensic psychiatry is psychiatry as it pertains to the law, so something like what I'm doing now, but also doing evaluations on criminal responsibility for criminal procedures or evaluations of individuals who have competency issues, any issue of psychiatry that pertains to the law.

Q In your career, have you had the occasion to testify in

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

you -- have you won any awards, any particular awards, fellowship awards?

A I'm not very good at that, but yes, as a resident I was a Ginsberg fellow. I had the opportunity to work hand-in-hand with one of our leaders in forensic psychiatry, Dr. Phil Resnick, and learned a great deal with -- from him about the field of forensic psychiatry. So it was quite an honor.

MR. HINSON: At this time Plaintiff would move to qualify Dr. Tim Malone as an expert in psychiatry and the forensic psychiatry.

THE COURT: Voir dire?

MR. GRESH: None, Your Honor.

THE COURT: I find he's qualified in both those areas.

BY MR. HINSON:

Q Okay. Dr. Malone, what have you reviewed in this case?

A Well, I have -- make sure they can hear me. I reviewed a number of records, depositions from too numerous physicians, nurses. I've reviewed the hospital records for Matthew Scheer, his parents' depositions. That would be the lion's share of what I've reviewed.

Q And, and Dr. Malone, I want to certainly give you the opportunity to drill down to your basis for your opinions, but do you hold any opinions as to whether Defendants Patel and Ash-Bernal met the standard of care?

A I do have an opinion.

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

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

paranoia, psychosis or other delusional ideas that, that make them unsafe.

Q So there are three, three reasons for which a patient may be put on a psychiatric hold or on a temporary hold?

A Yes.

Q Okay. And if you could summarize what are the -- just quickly those three reasons are what?

A Suicide, which is the lion's share, homicidal ideation and grave disability from a mental illness that they are not able to make appropriate judgment due to their mental illness, i.e., paranoia, psychosis and delusional thinking.

Q What does it mean for a person -- well, generally speaking, what is psychosis?

A Well, psychosis is a broad term, and it can be interpreted a number of ways. Psychosis can be responding to internal stimuli. Voices in one's head is a form of psychosis, visions, seeing things that obviously aren't in front of you is a number -- another form of psychosis. Paranoia is also a form of psychosis. So we're talking about things that aren't true. You would -- you're, you're fearful for no reason that people are either out to get you or people are -- in, in the case of Matthew, fearful that people are poisoning your food, that others are plotting against you, and if that has no basis in reality that is, in fact, an example of psychosis and paranoia.

Q What are the dangers of a patient with psychosis and paranoia not being in an inpatient or some sort of facility where they're receiving treatment?

A Well, as you can imagine, if you, in, in the case and I'll use Matthew, the last of his life he discussed or, or proclaimed that the individuals in the hospital at Grand Strand were all devil worshipers. Now, to the best of, I think, all of our, our knowledge they -- that is not true, and I think most of us would agree that wasn't true, but he believed it. In a hospital he can be managed. That can be treated and is a very treatable illness with medication, counseling and therapy, but in an outpatient setting, without the guidance and the supervision of either his family or some other entity to make sure that he is safe, you can imagine where that can go, the foreseeability of him having an altercation with a police officer, let's say, you know, whom he now thinks is a devil worshiper or some other individual could place him in, in dire harm so.

Q Are there occasions where people with psychosis have unintentionally killed someone else?

A Oh, absolutely. I mean, for example, if you are under the belief that, you know, that you can fly, you might very well jump off a cliff or you may feel that you're invincible and drive erratically and, and cause harm to others as a result of your disorganized and, and paranoid ideas,

delusional ideas, so yes.

Q Dr. Malone, from your review of the record, do you believe Matthew was suffering from psychosis?

A Absolutely, he was.

Q And, and tell us just a little about what you understand Matthew's mental state to be? What types of things was -- how was his psychosis exhibiting itself?

A Well, I think the PA put it best and it, it did not change throughout his stay, that he presented with hallucinations, which as I've described may be visual, which was described later, auditory hallucinations, which he did describe, paranoia, that he thought that his food was being poisoned, and as fact, as a fact -- as a matter of a fact, he hadn't eaten in several days because that he thought his food was poisoned. He -- on, on Monday, I believe, I recall believed that he was healed from his epilepsy. He had what we would call a religious grandiose delusion that, that he was suddenly healed and he no longer needed to take medication. So under, again, the delusional thought process, a medication that he had taken safely for quite some time, he discontinued, which, likewise, put him at risk.

Q Is there any cure for epilepsy?

A There's no cure but there's an adequate treatment.

Q And what treatment is that?

A Treatment is complying with your medication, in his case

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

October 2nd, was there any reason to put him on an involuntary hold?

A No. I don't believe so. No.

Q And why not?

A Well, he was -- despite the fact that he was clearly delusional and he was clearly psychotic at that point, he was compliant in part, I believe, because his dad was there and was a comforting influence on him, but he was not asking to leave. He was compliant with, with the request of the hospital with the exception of taking his Keppra, of course, but there was no need or urgency towards commitment at that point.

Q Matthew presents to Lighthouse, and what was your understanding of what occurred there? Was, was he treated there?

A He was not treated there. No.

Q And why, why was Matthew not able to be treated at Lighthouse?

A Well, there, there was this notion of a medical clearance that was given, and mind you, as I instructed you, I do work in a facility very similar to where Dr. Oduwole was working that night.

Q And that's -- is that -- Dr. Oduwole works where?

A At the Lighthouse. I'm sorry. At the Lighthouse, and so, much like that facility, there isn't a lab, there isn't,

you know, EKG, the ability to do IV fluids for someone who is dehydrated as Matt was, inability to care for someone with a medical illness. Dr. Oduwole's notion was that, clearly, Matthew was suffering from some sort of psychosis, but because of his concern for Matthew, I think that he did the right thing. He was concerned and did the right thing for Matthew, making sure that his medical issues were addressed, which included his elevated white count and his elevated bilirubin.

Q Did anyone at Lighthouse make any kind of finding that Matthew was competent?

A No. I did not see that, sir. No.

Q And what did the records from Lighthouse reflect was going on with Matthew mentally, psychologically?

A My recollection is the description was that he was responding to internal stimuli, that he was, essentially, psychotic at that time when he presented with his dad.

Q And when you, when you say responding to internal stimuli, what is -- what do you mean by that?

A Well, when one is responding to internal stimuli, auditory hallucinations, you may notice that they're whispering, talking to themselves, much like I think the earlier Mr. Doherty was talking, he was, you know, talking to himself, raising his hands, you know, speaking to the air, if you will, responding to internal stimuli, that kind of behavior.

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

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

just, just a second. At the -- when Matthew left, Matthew and David left the ER for Lighthouse, did you see who signed Matthew out?

A I think it was his, his father. Correct.

Q Does that have any significance to you?

A Well, I think it -- it's relevant as it suggests even though he was calm and cooperative he was not, he was not focused, alert and, and competent to sign his own signature at that time. So it is certainly relevant.

Q All right. Dr. Malone, I want to move now back to Matthew and his dad represent at Grand Strand in the afternoon.

A Right.

Q And he's again seen in the ER.

A Right.

Q What was Matthew's demeanor at that time?

A According to Dr. Patel I believe it was -- well, first, Dr. Battisti who saw him in the emergency room, and she's, she, she's interesting and important because she saw him prior to his, his departure for Lighthouse and she saw him when he returned. She notes that he is not changed, that he is still displaying evidence of psychosis and paranoia and, and, and obviously in need of treatment.

Q What was his -- was he calm and cooperative, was he agitated, how was he demeanor-wise though?

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

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

his psychosis. Mind you, it does not matter what the etiology of his psychosis is, but the fact that it remains untreated, and there was no medication placed in the record to begin to address the psychosis that ultimately Matthew suffered with that night. The other issue that I have is the handoff. I did it as I drove down here yesterday to, to appear in front of you, discussing the cases that I have in the hospital with my medical backup and, you know, this is what's going on with this person and this is what's going on with that one, and this is what you need to look out for, etcetera, and that was not done, and there, there, there is a standard of care in both psychiatry and medicine in general that the handoff must happen, and it could be, it could be a checkout list. Preferably it's a face-to-face or at least a phone call to let someone know who's covering for you or who's coming on the shift what's going on with the patients that you've been managing and that's my concern.

Q Dr. Malone, you mentioned Dr. Patel's failure to order any drugs for Matthew. What type of drugs could have been ordered, should have been ordered?

A Sure. Haloperidol, Geodon, which is one of the -- it shouldn't -- not newer now. It's been out for some time, but both are antipsychotic medications. These are medicines that regardless, again, of the etiology of your psychosis, if it were due to a urinary tract infection or if it were due to,

you know, the onset of a mental illness, these medicines can render an individual within really a matter of a few minutes either calm and cooperative and able to have a rational discussion, the delusions, again, maybe not completely eliminated, but the paranoia lessened to the point that one might eat, one might, you know, engage in conversation. One might, you know, take the medication that's being offered so.

Q How are these medications administered? Are they oral, are they through an injection?

A So they can be given, they can be given orally and we do that if, if people are -- patients are cooperative even though they may be psychotic or delusional. I have some patients who will say, "Yeah, Doc, I'll take it," and you know, so we can avoid the other method, which would be intramuscular. We can give the -- both of those medicines intramuscularly and --

Q When you say intramuscular what do you mean?

A Oh, I'm sorry, as a shot, as a shot.

Q Is one option quicker than the other as far as how fast it'll react?

A Yeah. The shot, obviously, is, is definitely has a quicker onset, but it is invasive, and if you have someone who is cooperative you certainly would, you know, opt towards using the oral version. If someone is not, the injection is certainly available to you. It can also be given IV as well.

Q Did you see in Dr. Patel's note that he mentions giving

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

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

ultimately I would have let them know if he became disruptive to the point that he was refusing to stay, this is someone that I would actually, and I have done this many times in the chart, please initiate commitment should he attempt to leave against medical advice.

Q Dr. Malone, when -- at the time that Dr. Patel was seeing Matthew, was Matthew trying to leave the hospital?

A He was not.

Q At the time Dr. Patel was treating Matthew was Matthew calm and cooperative?

A He was cooperative. Right.

Q Was there any reason to put a temporary hold at that point?

A There was not.

Q Who was with Matthew at that point in time besides Dr. Patel?

A His dad.

Q And Dr. Patel or, excuse me, Dr. Malone, approximately what time did the one physician or did Dr. Patel leave?

A I'd have to go back and review. I thought it was around five-ish or five or six somewhere in the afternoon, evening.

Q And at the time he -- well, when, when should this, this sign-out or handoff take place?

A You know, it happens simultaneously. I mean, I've actually I've done it in the hospital, I've done it on the way

home, but it needs to happen before you then turn off your pager and go about the rest of your, your day. So it has to happen succinctly.

Q You mentioned a minute ago that Matthew was, was throwing his clothes away. Tell us what you're speaking of there.

A It was reported that he had, he had thrown some -- many of his belongings away prior to his dad driving down from Ohio to check on him. Yes.

Q And Dr. Malone, was there a change in Matthew and his demeanor in the early morning hours of October 3rd?

A Yes. There were.

Q And at the time -- you've seen the nurse's notes from that. Does that have significance, this, this change around 1:30, 1:15 in the morning?

A Yes. It does. Yes. It does.

Q At what -- you mentioned a minute ago that Dr. Ash-Bernal fell below the standard of care. Tell us how, how she failed to meet her obligations as a physician.

A Well, at this point I think Dr. Ash-Bernal is called. It's 1:15, 1:20 or so in the morning, I believe. The record reads that she does come, and she spends, I think, Nurse Bell says between four or five minutes evaluating Matthew because he has ripped his shirt off, ripped off his armband and is demanding to leave and proclaiming that everyone in the hospital are devil worshipers, that Obama is the devil and,

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

with." In other words, do your best to get him talking, lower his defenses and try to get him to, to express more about what's going on with, with him at that time. At that time she should also be exploring these delusions. "So what does it mean, Matt? Tell me what does it mean that you feel like everyone is a devil worshiper?" I mean, might his next statement be, "I need to go out and kill all the devil worshipers?" I don't know? We don't know that unless we ask.

MR. GRESH: Speculation.

THE COURT: Yeah, I, I sustain the objection as to what he may have done.

Q What other types of questions should, should a proper evaluation of a patient who's come in with a diagnosis of acute psychosis who wants to leave at 1:30 in the morning, what other types questions should have been asked of Matthew?

A Well, obviously, she should be asking him about his safety and thoughts that he may have towards harming himself or others. She should be getting more information regarding, you know, his delusions about food. This is someone who's designed -- desiring to leave at 1:30 in the morning with a hurricane overhead, and he hasn't eaten, and so my concern, even though it's an A -- potentially an AMA discharge in her mind, the disposition needs to be considered. So questions about his, his judgment as it pertains to his ongoing delusions should have been further vetted.

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

Q In your experience as a physician treating patients with psychosis, do you believe to a reasonable degree of medical certainty that that would -- that a proper evaluation and conversation in your experience would that have been successful in calming Matthew down?

MR. GRESH: Objection, Your Honor, speculation.

THE COURT: Yeah. I sustain the objection.

Q Dr. Malone, in your experience, the vast -- do most patients -- are most patients able to be calmed and convinced to stay with the proper evaluation and conversation?

A Yes. Most patients are.

Q You mentioned a minute ago he wasn't in imminent risk. Explain what you meant by that comment.

A Well, you know, at this point there is an officer there. He, you know, according to her note had, had calmed down enough to have some words with her. So he wasn't physically aggressive. He wasn't, you know, combative to the point that individual staff members were being harmed. So there was the luxury of time to be able to sit and build rapport with this gentleman in the middle of the night to try to determine, you know, what is going on with his thoughts.

Q From your review of the medical record and the depositions in the case, did Dr. Ash-Bernal utilize her luxury of time that she had available to her?

A It does not appear that way, sir, no.

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

reflect that Matthew had revoked his dad as being the person to notify or the emergency contact?

A I did not see that. No.

Q Have you had occasions in your practice, Dr. Malone, when you've had to call family members?

A I have.

Q Have you had occasions where you had to call family members despite the patient not wanting the family member called?

A Yes, and, and that is predicated in, in the HIPAA document as well. The doctor using judgment, their judgment can in a situation where they feel the patient is, is not presenting themselves with appropriate judgment due to a mental infirmity can decide to contact family without the approval of the, of the patient. That certainly is there.

Q In your experience are family members oftentimes able to help the situation?

A Almost unanimously. It's amazing what mom and dad or wife or husband can do.

Q Can, can family members oftentimes prevent or lessen a threat to the patient and others?

A Absolutely.

MR. GRESH: Speculation, Your Honor.

MR. HINSON: In his experience.

THE COURT: Yeah. I, I overrule the objection.

A In my experience we do. In fact, we oftentimes will allow on some difficult cases more liberal visitation of family members if we have someone who's an agitated state to, to come and stay with the patient.

Q If adequate and proper conversation with Matthew, if a proper evaluation and discussion had taken place, and had Matthew's dad come and Matthew still not wanted to stay, still been unwilling to stay voluntarily, what other option was available to Dr. Ash-Bernal?

A Well, that's where we get to the, the 72-hour hold. So he could have been placed with the, the solo signature of Dr. Ash-Bernal at that time to place him under a hold, commitment to the hospital.

Q Did his signs and symptoms and presentations of psychosis justify a hold if Matthew was unwilling to stay?

A Absolutely. I mean, at, at 1:30 in the morning absolutely. Not earlier in the day, even though he was psychotic. He was talking to himself. He was displaying paranoia and not eating. At 1:30 in the morning he is now aggressive. He is now demanding to leave, which he wasn't doing earlier. He is proclaiming delusional rants, religious rants. So he's clearly not -- he's clearly affirmed in his mind at that point.

Q Was it foreseeable that if released by himself alone at 1:30 in the morning that Matthew might do some sort of harm to

himself or others?

MR. GRESH: Objection, Your Honor.

THE COURT: I sustain the objection. You asked if it was conceivable. I sustain it. You asked if it was conceivable. I sustain the objection.

Q Is it --

THE COURT: I sustain the objection.

Q Dr. Malone, should the physician be -- have concern about what the patient may do, what Matthew may do if, if released?

A Absolutely. In, in fact, this is the reason why the third provision with the, the state law says about civil -- about these types of commitments is allowed because under the influence of a delusional mindset, an individual, the foreseeability of an individual becoming either self harmful or harmful toward others is highly imminent, and so that is the reason why that provision is there to allow him to be held on a 72-hour hold, the minimum.

Q Had Dr. Ash-Bernal complied with the standard of care and ensured that Matthew didn't leave the hospital at 1:30 in the morning, do you believe he could have been successfully treated?

A Well, I don't think there's a question at all that he could have been successfully treated. His psychosis, you know, his medical issues clearly could have -- would have been adequately addressed, and, and with short time, yes.

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

Q And are there any opinions that he offered in his testimony under oath that you would like to address with this jury because this is my opportunity to --

THE COURT: Yeah.

MR. GRESH: Objection.

THE COURT: I -- do you object?

MR. GRESH: Yes, I do.

THE COURT: I sustain the objection.

MR. HINSON: Okay.

BY MR. HINSON:

Q Dr. Malone, Defendant Ash-Bernal came when called. She spent a few minutes speaking with Matthew. She had Matthew sign this AMA form, and she had Matthew released. Does that meet the standard of care?

A It does not.

Q Just generally speaking, why not? She, she, she came, she came, she talked to him and she filled out the form. Why does that not meet?

A As I've said before, Matthew was in an incredibly infirmed state at that point. He was delusional. He was paranoid, and he deserved and required a more thorough evaluation. To come in and spend four to five minutes doing what essentially was an AMA checklist is not in my professional opinion an adequate evaluation of him at that time.

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

physicians. So no, this was not out of the privy or the understanding of a hospitalist.

Q Dr. Malone, you've seen this AMA form in the medical record; is that correct?

A Not quite that big, but yes.

Q Not quite this big. Dr. Malone, did Matthew have the mental capacity to sign this form?

A It appears he did not, no.

Q And I could hand you or have the court reporter or hand you Exhibit One. If you could turn to page 68.

A 68.

Q 68 of the Bates numbers, and I'm looking at Dr. Ash-Bernal's cross cover note.

A You may have to help me with it.

Q I got a really big one of that, too, Dr. Malone.

MR. HINSON: May I approach the witness, Your Honor?

THE COURT: Yes, sir.

A Bates numbers on the bottom?

Q These right here.

A Got you. Okay.

Q Dr. Malone, it says on page 68 of Plaintiff's Exhibit One, [as read], "Patient indicated he understood that it was recommended that he remain in the hospital for further evaluation of his psychiatric issues but he refused to stay.

Patient seems able to weigh the information" -- then in parentheses -- "(he interrupted his religious rant to think about the question)." Do you see that?

A Yes. I do.

Q Is that an adequate assessment of a patient admitted for psychosis to determine whether they understand the risks of leaving?

A It is not.

Q Thank you, Dr. Malone. No further questions at this time.

THE COURT: All right. We'll take a break before we do cross examination. If you'd go to the jury room we'll take about a 15-minute refresher break.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: Dr. Malone, during the break you can step down.

A Okay.

THE COURT: Have some water or use the restroom but don't discuss -- just don't have any conversations with anybody about anything is probably the best way to look at it. We'll be at ease till about five after 11.

MR. GRESH: Thank you, Your Honor.

OFF THE RECORD

(On the record. The following takes place outside the

presence of the jury.)

THE COURT: Thank you. You may take your seats. Dr. Malone will come back up on the stand. We can bring in the jury.

(The following takes place in the presence of the jury.)

THE COURT: Mr. Gresh.

MR. GRESH: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. GRESH:

Q Good morning, Dr. Malone.

A Good morning.

Q I'm Jack Gresh. You and I didn't meet. We met earlier today.

A Oh, yeah, uh-huh.

Q Yeah. I wasn't at your deposition, but I, I did read it and I appreciate that. I have a copy here. If at any time you need it to refresh your recollection just let me know.

A Thank you.

Q But I wanted to kind of start where the Plaintiff started with you on the direct examination, this idea of a temporary hold, and I thought you said that's kind of a misnomer or a little bit misleading. Right?

A It is very misleading.

Q Because what happens is when a physician puts you under a temporary hold, an involuntary temporary hold, you may be held

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

leave, and you as the physician decide they can't leave, we actually would hold the patient down if necessary and give them medications to calm them down; correct?

A It would be the, the, the last resort. That's -- that is correct.

Q And they don't get any longer to decide what is in their best interest? You as the physician would make that decision for them?

A At the point that is determined that they are disorganized and paranoid to the point that they are a risk of harm to themselves out of the facility, yes.

Q The -- you had mentioned on the direct examination that you've done this other times where you leave a note or you talk to folks and say, "He's here voluntarily at this point, but if the patient tries to leave don't let them, involuntarily commit him." You've done that; right?

A I've left those. Uh-huh.

Q When you look through the medical records from Dr. Battisti and the physician's assistant who saw him in the emergency department that morning, did you see any indication from them that they gave that type of direction to anyone?

A I don't see that. No.

Q When he goes to Lighthouse and is seen by a masters level social worker, and you've seen her notes; right?

A Yes.

Q Did you see any indication from her along the lines of, "He's going back voluntarily, but if he decides to leave don't let him"?

A Right. No.

Q Instead what the social worker says is, "When he gets to Conway pay special attention to the medical issues, the white blood cell count and the bilirubin level"; correct?

A That's what I recall.

Q Earlier there was discussion about whether Lighthouse could have involuntarily committed him, Matthew Scheer, to Lighthouse, and I understood you to say, no, no, no because he has the medical issues going on; right?

A That's correct.

Q And that's within their purview. Lighthouse is a psychiatric facility and they don't have full spectrum medical capabilities. Is that your understanding?

A That is my understanding.

Q But in that same parking lot is Conway Medical Center. If Lighthouse thought this person needs to be involuntarily committed, they wouldn't commit him to Lighthouse because of his medical conditions, instead they would have involuntarily committed him right next door to Conway; correct?

A That is possible I would imagine. Sure.

Q When -- I understood you on direct to say that it was really important to you that when Matthew Scheer left Grand

Strand that morning that it was his dad that had to sign him out and that somehow that was evidence of an, an acknowledgment that Matthew didn't have capacity. Did I understand that correctly?

A It is.

Q Who signed in when they came back to Grand Strand?

A You'd have to refresh my memory.

MR. GRESH: If I could approach, Your Honor.

THE COURT: You may.

BY MR. GRESH:

Q Represent to you I can't read that but that says self. Does that say Matthew J. Scheer?

A It appears to.

Q Okay. Signed himself back in to Grand Strand?

A Uh-huh.

Q Right? And also Dr. Battisti we know, we know she's the ER doc that sees him not only in the morning but also in the afternoon. She has something called additional notes and I'll just read it with you.

A Uh-huh.

Q [As read], "Discussed with patient ED findings," and that's a good thing; right?

A Certainly.

Q [As read], "And the plan for admission. Patient understands and agrees with that plan, all questions

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

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

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

himself, even if he's here voluntarily, you would give the person who comes on behind you the benefit of your insight and let them know, "He's here voluntarily. He's not on papers, but man, I've evaluated this guy, he's a danger to himself or others. Don't let him go if he wants to leave"; right?

A I would certainly allow that doctor to make their discernment on this, but the important thing is that they understand the context in which he presented, and I wouldn't want that to be lost in the translation. So that's the purpose for that.

Q Right. And that's -- I think you and I are communicating, but I just want to make sure. The situation we have with Dr. Battisti, Matthew Scheer is feeling things crawl on his arm, he is seeing things that are not there, he is hearing voices that aren't being spoken; correct?

A That's correct.

Q When he presents to Lighthouse, you saw those records, it's essentially the same, and none of these people who actually evaluated Matthew Scheer at the time were so concerned that they thought, "You know what, I better give some of my insight to those folks coming on later"; correct? They didn't give the kind of warning or cautionary statement that you sometimes give to folks; correct?

A I, I do believe that Dr. Oduwole felt that he was very disorganized. That was the report that he received, and that

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

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

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

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

any time a nurse thought, "Wow, I need to have something to calm this patient down," what's typical is they'll pick up the phone and say, "I have a patient who's a little bit agitated. Can I get some, some Ativan," or something like that; right?

A Certainly.

Q That's what they're trained to do. They're trained to pick up the phone and say, "Wait a minute. This guy was just cool, calm and collected, no hallucinations, and now something is different." They're trained to pick up the phone and call; correct?

A Correct.

Q But sometimes nurses if they see something say, "Wait a minute, I don't want to just call and get some Ativan. I want the physician to come to the bedside"; right?

A That's certainly one, one venue of doing it. Yeah.

Q And that's exactly what happened in this case; right? Dr. Ash-Bernal, that's her over here.

A Uh-huh.

Q Dr. Ash-Bernal is just kind of walking down the hallway at about 1:15 or so when Matthew has this outburst and the nursing staff comes and gets her to come evaluate Matthew Scheer; right?

A Correct. If we had a PRN --

Q Right. They, they didn't --

A -- ordered it.

Q -- they didn't say, "Dr. Ash-Bernal, can I get some Ativan?" They said, "Dr. Ash-Bernal you need to come evaluate this patient. They're trying to leave the hospital against medical advice"; right?

A That's what they asked Dr. Ash-Bernal to do. That's correct.

Q All right. You also talked about the handoff between physicians?

A Uh-huh.

Q And that it would be important in this setting for Dr. Patel, as the hospitalist who leaves on a shift and then Dr. Ash-Bernal who comes in as the nocturnist for another shift, it'd be important that those two communicate so that Dr. Ash-Bernal would know that Matthew was here being treated for psychosis; correct?

A Correct.

Q If anybody looks at that chart, the one in front of you, the chief complaint is psychosis; right?

A It's interesting that Nurse Bell didn't know that.

Q Yeah. Yeah. But Dr. Ash-Bernal did, and any of the medical doctors and PA's, anybody that looked at the chart and saw the chief complaint would know he's there for psychosis; correct?

A One would presume so.

Q Well, now, when the attorney took your deposition I

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

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

control the speed at which Dr. Oduwole comes in and performs his psychiatric consult; correct?

A No. But they can control a delusional and psychotic patient with appropriate care, which involves an adequate mental status exam and medication to help stabilize him.

Q And you know from reading the deposition testimony I think that the father left at about seven p.m.

A I believe that's correct.

Q And that while the father was there with Dr. Patel he's cool and calmer; we know that?

A Right.

Q But that even after Mr. Scheer left at 8:00 o'clock, 9:00 o'clock, ten, 11, 12, 1:00 o'clock in the morning even without his dad there Matthew Scheer was calm and collected; right?

A Until sometime after one in the morning is my understanding.

Q Sometime after one in the morning, 1:13 I think Nurse Freeman says in her note, sometime around 1:13 Matthew presents to the nursing station, we've heard this, ripped his armbands off?

A Sure.

Q And he says he wants to leave, he knows his rights and he wants to leave voluntarily. "You can't keep me"; correct?

A That's what he said.

Q Nurse Freeman does the correct thing and runs to go get

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

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

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

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

Q Whether the checklist is useful or not in a situation like this, Bethany Bell marks that all of the questions were no, and then writes in the affirmative that patient is not at risk for suicide; correct?

A She does.

Q Nurse Bell also talked a little bit about what happens when a patient tries to leave the hospital against medical advice. You saw that; right?

A Yes.

Q And that physicians and nurses play a role in talking to patients about leaving against medical advice; true?

A True.

Q And that Nurse Bell would try and reinforce and did try to reinforce that Matthew Scheer was admitted to the hospital for some reason and that it was in his best interest to stay there; correct?

A Correct.

Q And that Bethany Bell is in the room with Dr. Ash-Bernal for at least some of her -- in the room with Dr. Ash-Bernal for at least some of Dr. Ash-Bernal's interaction with Matthew Scheer; correct?

A I believe that was documented.

Q And that Bethany Bill recalled that Dr. Ash-Bernal asked the orientation questions, do you know who you are, alert and oriented times four; correct?

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

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

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

A Paranoia and psychosis is, as I've mentioned earlier, one of the mandated reasons for involuntary holds, constitutes about 30 percent of the, of the commitments throughout this state.

Q Which is why you have to talk to the patient?

A Correct.

Q And that's why Bethany Bell is there and she's saying, "'If you leave, Matthew, you could die from infections, seizures, that Matthew listened to the questions, that he answered,' this is important, "answered Dr. Ash-Bernal's questions appropriately." You saw that; right, in her deposition testimony?

A Again, appropriately how? Does he simply say yes or does he give context to what he is speaking to. There is no context to his -- the statement of him being alert and oriented in all spheres. That is my problem.

Q And that Bethany Bell who's there with Dr. Ash-Bernal for a part and then she leaves to go get paperwork and comes back, she testified that the encounter with Ash-Bernal and Matthew Scheer was roughly 10 minutes; correct?

A No. She testified that it was about four to five minutes is -- and I could be incorrect, but that's what I recall.

Q And there was a lot of paperwork.

A Oh, my gosh.

Q I'm not trying to say you need to memorize everything.

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

allow in the event that the physician feels that the individual is not able to make appropriate --

Q If the physician feels that the patient is incapacitated --

A Right.

Q -- the physician can in her judgment or his judgment call the family member?

A That's correct.

Q But there are times that you are trained that you don't want to do that; right? You wouldn't just do that all the time; would you?

A Well, you're not able to do that all the time.

Q And in a situation where the patient just said -- a patient's now calm, put his shirt back on, you've just talked to the patient, the nurse has just talked to the patient, everybody's calm, the patient just told you, "Don't call my dad," that might be one of those times that you don't go running out and calling the dad and having the dad show up when the patient just said, "Don't to do that"?

A Are we forgetting that he just iterated that everyone in the hospital is a devil worshiper and Obama is the devil. I mean, how do we contextually place one discussion next to the other and reasonably feel this is an individual who is in his right mind? I don't understand that.

Q You'd have to talk to the patient to be able to answer

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

that he could fly or that he could jump off buildings; correct?

A Not the ones you mentioned, but it doesn't make the ones he did mention less concerning.

Q A physician would have to talk to the patient and understand in 10, 15, however long it takes to talk to the patient and say, "You got delusions," but then they have to make a judgment decision for themself to say are these delusions dangerous imminently to yourself or to others; correct? That's what you'd want to do?

A That's correct.

Q Okay.

A Matthew said, "I believe all fish could fly," you know, that would probably be a delusion that would not require his involuntary stay. The concern here is that his delusion was of a demonic force affecting everyone around him, that others were plotting against him, that his food was being poisoned, and that individual, as a result of those thoughts, is a danger to himself and potentially to others.

Q Was there anything in the medical records that you've seen where Dr. Patel or Dr. Ash-Bernal would have been on notice that Mr. Scheer would allegedly run out into the ocean in the middle of the night?

A Nor jump off of a building, no.

Q No?

A There was not, but that doesn't exclude the foreseeability of someone who has these delusions being an imminent risk of harm to himself. He was paranoid. He needed to be committed to the hospital if he wasn't willing to stay voluntarily.

Q And if you as the physician believe that the patient is not in imminent danger to themselves or others it's their legal right to leave the hospital?

A Could you repeat the question? I'm sorry.

Q If you as the physician believe the patient is not in imminent harm to themselves or others, it is their legal right to leave the hospital.

A Again, if the physician is -- does not feel after they've done an adequate evaluation feel that they are in need of a 72-hour hold, absolutely, it's a free country. They're -- they would be allowed to leave.

Q And if you wrongfully commit someone against their will they can bring a lawsuit against you for false imprisonment; can't they?

A If my judgment leads me to believe that they're -- this individual is an imminent risk of harm to themselves I'll take that lawsuit any day.

Q But it is a right that not only are you free in this country to leave the hospital, you're also free in this country to sue somebody that keeps you and you think that's

wrong; right?

A Certainly. It's a free country.

Q Do you agree that Dr. Ash-Bernal felt that Matthew Scheer had sufficient insight and capability to make a decision to leave the hospital even though she didn't want him to?

A That's what she writes. Again, I don't see the context of that discussion in that evaluation, which is what's troubling to me.

Q But we know she spent, whatever it was, 10 or 15 minutes with the patient and at the conclusion of that she would have completed this statement that, "I certify that the patient or the individual acting on the patient's behalf has the mental capacity to understand the risks and benefits of leaving AMA"; right?

A It is on the AMA checklist.

Q She certifies that she spent the time and that she made the judgment call; correct?

A She does.

Q I'm sorry. That's all I have. Thank you very much.

A Thank you.

THE COURT: Redirect?

MR. HINSON: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. HINSON:

Q Dr. Malone, I want to give you the opportunity to not

just show you select portions of, of Ms. Bell's testimony, and don't read this out loud.

A Okay.

Q But looking at the portions of Ms. Bell's testimony, how long did she testify at her deposition that Dr. Ash-Bernal's interaction lasted with Matthew Scheer?

A You're just talking about the highlighted portion, I presume?

Q Well, just how long did, did she remember the, the interaction between Matthew and Ash-Bernal lasting?

A She says 10 minutes would be a rough estimate.

Q And what did she say? She says in the section --

A I'm sorry.

Q -- also in the deposition --

A Got you.

Q -- what does she say?

A She says, [as read], "I honestly don't remember, and maybe four to five minutes." That's where I got my figure from, four to five minutes.

Q So at one point she says it may have been as little as four to five minutes?

A She says maybe four to five minutes. That's what I recalled earlier.

Q And during this time that Dr. Ash-Bernal would have to come and that this AMA form would have to be retrieved,

security would have to -- they'd be instructed to escort Matthew out, Dr. Ash-Bernal also has to look at the record.

MR. GRESH: Leading, Your Honor.

THE COURT: I sustain the objection.

Q What other things in this time period -- well, let's back up a second. Could we have Defendant's Exhibit One, please, and, Dr. Malone, I'm going to turn your attention to the, to the nursing note and the occurred time.

A Okay.

Q And what time does the record indicate that Matthew's outburst began, his psychotic rants?

A Sure wish we had larger print. So 1:13.

Q So 1:13?

A Uh-huh.

Q And then at what time is Matthew's AMA form already signed?

A It's one -- it's 1:29 I thought.

Q So one -- what time we got right here, Dr. Malone?

A Yeah. I can't see it.

Q I'm sorry. Let's see. I'm sorry, right here.

A Too many books. 1:27.

Q 1:27?

A A.M., sorry about that.

Q So the time period between the earliest she could have gotten there till the time she's already discharging him how

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

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

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

MR. GRESH: It's speculation then, Your Honor.

THE COURT: Yeah. I sustain the objection.

A Okay.

Q Dr. Malone, what are the dangers of letting him leave?

A Okay. The dangers of letting him leave, obviously, are the risk for harm to himself and others as a result of his delusions, which we knew had been present, the paranoia and the psychosis that had been present all day.

Q In your career have you heard and learned in your study and education of occasions when psychotic patients who are allowed to leave harmed others?

A Absolutely.

Q Do you have any examples of that?

A Virginia Tech.

MR. GRESH: Your Honor, relevance, Your Honor.

THE COURT: I sustain the objection.

Q Dr. Malone, Mr. Gresh asked you about the time that Bethany Bell was doing her assessment of Matthew?

A Yes.

Q Do you remember what time that was by chance? If you could turn to what -- I know we've got a lot of --

MR. HINSON: May I approach, Your Honor?

THE COURT: Yes.

BY MR. HINSON:

Q If you could turn to 114.

MR. GRESH: Your Honor, mine's up here. Can I go grab it?

THE COURT: Yes.

Q Dr. Malone, I'm looking at the timestamp at the top left-hand corner of that -- excuse me, top right-hand corner of that page. What time did Nurse Bell do her assessment of Matthew?

A So this is military time, 19:15, so.

Q So that's what time in a.m., p.m.

A That's 7:15. Thank you.

Q And what time did David -- approximately what time did David Scheer leave the hospital?

A Around 7:15.

Q So his father had --

A Seven, there, thereabouts.

Q -- had been there around this same time?

A Right.

Q And so when his father was there and Nurse Bell was assessing him he was calm and cooperative?

MR. GRESH: Leading, Your Honor.

A That is correct.

Q How was his state at the time that his father was there and Nurse Bell was, was evaluating him?

A His, his evaluation at that time was, was unremarkable. She reported that he was calm and, and cooperative at that

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

forget, it's also for the safety of others. You know, paranoia is -- has been responsible for a number of violent outbursts in the community as a result of people working and operating under paranoid delusions.

Q Can you simply ask a patient with psychosis, "Are you suicidal or homicidal"?

A You cannot.

Q Are people who are suicidal and homicidal always honest and answer that question truthfully?

A The ones in my 30-year experience that are truly suicidal are no longer on your team. They will deny. They will lie. They will not be honest with you. So the question alone is not enough to vet it out.

Q And, Dr. Malone, Mr. Gresh asked you about Matthew sign out of the ER that was signed by his dad.

A Right.

Q And then his sign in to the ER where Matthew actually initialed.

A Right.

Q Should the nurses at the ER have said, "No, you can't sign yourself into the ER," and just refused him treatment?

A No. Absolutely not.

Q If a, if a psychotic patient showed up at your facility would you say to them, "I'm sorry. You're too psychotic to sign yourself in"?

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

kind of clean up the --

THE COURT: Sure.

MR. HINSON: -- the exhibits up there before we have things all over the place.

Plaintiff calls David Scheer.

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

Whereupon, David Scheer is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: Please say your name and spell your first and last name.

MR. SCHEER: Very good. Great. Okay. I'm sorry. What did I have to do?

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

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

DIRECT EXAMINATION

BY MR. HINSON:

Q Good afternoon, Mr. Scheer.

A Good afternoon.

Q Now moved into afternoon. Could you please introduce yourself to the jury? Tell us just a little bit about yourself, your -- where you grew up and what you do?

A I grew up in South Jersey. I'm a bartender for the last 40 years. I've worked the last 35 years in the casinos in Atlantic City, first at the Trump Plaza, then Trump Taj Mahal

and now at the Hard Rock Casino. I've been married for 31 and a half years.

Q Is your spouse in this room with us?

A My lovely spouse is in the room, Debbie, and --

Q Well, let me -- Mr. Scheer -- go ahead, if you had more to say. How, how did you get into the food and beverage industry?

A I was in college, and I got my degree, but I started bartending in college, and I just liked it. I like people and I just kept going and much to the sorrow of my parents who had helped put me through college, and -- but as, as -- when I got a steady job and all that they were very pleased.

Q How'd you, how'd you meet your, your bride here?

A She moved me in below me in an apartment in Ocean City, New Jersey.

Q How old were you?

A When we met I'm going to say 28.

Q Sorry. I didn't mean to put you on the spot with your wife here.

A Well, that's when -- when I met her I'm not sure I'll say. When we married I would say.

Q Did you all have children?

A Yes. We had two sons. Matthew was the oldest and Erik.

Q And when were they born?

A Matt was January 19th, 1989, and Erik is May 20th, 1991.

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

you're from New Jersey. How did, how did you come to be in Horry County at, at times?

A Debbie's sister and husband got a place down here years ago, and we would come down with them a lot, you know, as a family and everything, spent time. We all really liked it, and eventually, we were able to buy our own place down here and spend time down here. We love the Myrtle Beach area. We're -- Debbie and I bought it with the intention of retiring.

Q And did, did the kid comes, too?

A Oh, yeah. Yes. Definitely.

Q Earlier in this case we've heard mention of, of Matt having epilepsy. When in his life was he diagnosed with epilepsy?

A Immediately after being born.

Q And through his childhood and young adulthood, was it able to be treated with medication or other, other treatments?

A Yes.

Q And what would happen if Matt wouldn't take his medication on occasions when for whatever reason it was forgotten?

A His type of epilepsy he didn't immediately necessarily have an epileptic episode, but the better medications prevented him from having them.

Q The purpose of the medication was what?

A To control the seizures.

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

when it came to -- went to mom if he had questions about life stuff, and he came to me when he had problems with a or questions about, you know, working on the car. We did -- we worked on cars together and, and stuff like that.

Q And David, approximately when did Matthew move to South Carolina? We don't need the exact day.

A I came down with him. It was over the Christmas holidays of 2013.

Q And did he find employment down here?

A Yes.

Q In early October 2015, did you and Debbie come to observe some dramatic change in your son?

A Debbie saw a disturbing posting on Facebook and, yes, I'm sorry, yes, we did become concerned about our son.

Q Why, why were you all concerned about this post?

A I did not see it. My wife had contacted Matt immediately and, and talked him into deleting the post, but apparently it was very dark in nature.

Q Was that typical of Matt to have dark posts?

A Not at all.

Q And did you all talk to Matt after this posting on Facebook in -- on -- on or about October 1st?

A Yes. Yes. We did. We called him.

Q And what did you glean from this conversation with Matt?

A We were very concerned. It didn't seem like Matt. I

mean, parents just know when there's something, you know, their -- with their child and just something wasn't right.

Q What types of things was he talking about?

A He was responding to our questions basically, and he -- it was evasive in nature, which was not the way he -- we reacted with each other, you know, Debbie, me, Matt, Erik, you know. Pretty much didn't get a straight answer, and we were not getting that. We were, we were just concerned. You know, we were talking to him about the post. We were talking about him, is, is everything all right, and you know, yes, yes, and -- but you knew -- we're a parent. We just knew something wasn't right there.

Q Do you have any training in psychiatry?

A None.

Q But it was your observation something wasn't right?

A Yes.

Q And Mr. Scheer, what did you and Debbie decide to do for your son?

A We decided, you know, we had recently moved. So we decided on a two-part plan. Debbie would stay home and prepare a room for him because we had moved and the spare room was just full of junk, and she was going, going to set up -- we wanted to get him evaluated if he needed to. So she was trying to set up things, and we decided I would drive down and get him because that was the soonest way I could get there.

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

A Then the governments were concerned. I think some of them had emergency alerts on and --

Q Approximately what time did you arrive in, in Myrtle Beach to find your son?

A 3:30 in the morning.

Q Did you work the day before?

A No. But I had been up since 5:00 o'clock in the morning. I'd worked the night -- I'd worked Wednesday night, and I got up at Thursday -- I had been up since 5:00 o'clock just I kind of get up early.

Q So when you arrived at 3:30 in the morning you had almost at that point been up how long?

A What's that? I'm going to go with the last guy about math, but I'm going to say approximately 11 hours?

Q Okay. And tell us, Dave, how did you find your son?

A Oh, is that right? No. I'm sorry. That's not 11 hours. That's 23 hours, 23 hours. I'm not the math guy. I'm --

Q You had been almost up a full day?

A 23 hours I had been up almost.

Q Almost a full day?

A Yeah.

Q And so 3:30 in the morning where do you come to find your son, like where, where do you go?

A I, I, I got there. I went up to the condo. All the lights were on, and Matthew was sitting on the couch with a

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

he thought he was a new prophet, and then he told me why he was naked because prior to me arriving he had been out, and I don't know where it was, I don't know how long it lasted, but he had been out fighting demons, and he had come home and gotten in the shower to clean off and apparently had been rolling around, I, I don't know exact, I can't say exactly. This was -- that's what he told me.

Q What was your understanding? What was your understanding though from your discussion with your son, that -- well --

A That something was seriously wrong here.

Q And so did you -- what did you observe about his eating habits?

A I'd, I'd asked, you know, during the parts of the conversation I'd asked if he'd been eating, because in the back of my head was, you know, you know, what's going on, and he said no, and then I checked the -- there, there was like no food in the house, everything was gone.

Q Did he tell you why he hadn't been eating?

A He said he needed to cleanse himself. He needed to lead a, a pure life, and, and that he -- the reason he got rid of everything is he wanted to live off the land.

Q And did he seem to be, in your observation of your son, was he in the same reality that you were?

A Not at all.

Q And so did you continue with your plan to take him back

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

have grabbed the wheel. He could have, you know, there could have been a number of bad things happening that could have hurt him or me.

Q Did you think it would have been safe to put him in the car and put him on a road trip of several hundred miles?

A Oh, no. Not at all. Absolutely not.

Q So where did you take Matt?

A I did take him first to -- he hadn't been eating, and I, I, I figured it's going to be a long day. He's calm. I, I took him over to Dino's, which is our favorite breakfast spot.

Q Did he eat a meal there?

A And, and he, and he just pushed his food around with his fork and everything, and then we, from there we went to the -- I took him to the hospital. I was hoping I could get some food in him just because I knew from when he had seizures younger you get, you get in a hospital it's -- becomes a long day, and, and but --

Q Dave, where'd you take him?

THE COURT: All right. Before we get into the events of the day, I think our lunch is here, the jury's lunch. So while it's still warm we'll break for an hour till about one, a little after 1:30. So we'll take a break at this time.

(The following takes place outside the presence of the jury.)

THE COURT: All right. We'll take a break for an hour. Mr. Scheer, of course you can step down and have lunch. Now,

he's not just a witness. He's a client. So I think he can talk to counsel.

MR. GRESH: I -- yeah. I think that's the rule, and just real quickly, we had approached to Your Honor during the direct examination of Mr. Scheer, and we had previously made a motion to keep out the Dead Man's Statute stuff, and I respected the Court's ruling on that issue. The first time I thought that the testimony might be in contravention, different than the Dead Man's Statute I think allows objected but really just wanted to have a running objection with the consent of Plaintiff's counsel that I think a lot of the testimony about the conversations between the father and his son that led up to the death would be disallowed by that statute, and I respected the ruling, and we have agreed, I believe, that I don't have to stand up every time and make contemporaneous objections to that.

MR. HINSON: So stipulated. So agreed.

THE COURT: All right.

MR. GRESH: I appreciate the indulgence of the Court and Plaintiff's counsel on that.

THE COURT: Well, I, I ruled that you have a running objection to the extent I can based on my earlier ruling this morning.

MR. GRESH: Thank you, Your Honor.

THE COURT: All right.

MR. GRESH: And thank you.

MR. HINSON: And just for clarity, the running objection is solely to the Dead Man's Statute.

THE COURT: Dead Man's, that's, I mean, I, I ruled on something else this morning, but right now we're dealing with the Dead Man's Statute. That's, that's all.

MR. HINSON: Thank you, Your Honor.

THE COURT: Okay. We'll be at ease.

MR. GRESH: Thank you. I'm sorry, Your Honor, until which time? I apologize.

THE COURT: Let's, let's say around 1:30, give you a few minutes after that because I know it's -- you all got to get something to eat, but --

MR. GRESH: Thank you very much.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: Thank you. You may take your seats. Mr. Scheer, you can come back up on the stand. You can bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: You may proceed.

MR. HINSON: Thank you, Your Honor.

BY MR. HINSON:

Q Dave, before we broke for lunch I think the last thing we were talking about, apparently this is a microphone right here, Dave, and I tend to keep covering it, so. I believe we were going through your day with Matthew on October 2nd, 2015. Tell us what happened when you brought him to Grand Strand.

A When I brought him to Grand Strand we went into the emergency -- I took him to the emergency room, and I went up. The first person there was a guard, and I went up and told him I have -- my son needs help, and he, he got a doctor. I'm sorry, I'm assuming it's a doctor. It's just my assumption, but they came out, talked to us briefly out there, and then took us both back, both into the emergency room area, at which time they took Matthew into a cubicle area by himself. The, the gentleman who -- the doctor took Matt into the cubicle area by himself, and I went off to the side. Someone came -- I don't know if he came over to officially talk to me, but someone came then -- came over, had to wait a few minutes because, you know, all throughout the day while I was with Matthew I was -- tried to stay calm and -- around him and, you know, not get emotional, all that, and talking to him normal and everything, but the strain had almost every time like he -- when he immediately left my presence for a while like to go for a test or something I'd start crying, and --

Q Take your time.

A -- and then I'd get, you know, I wouldn't cry a lot but

I'd get back together and then I could function, but I always had to release. So then I talked to, was talking with this guy. I don't even if it was an official at all, but I was just talking with this guy, and then eventually they came and told me that they were admitting him to the ER, and from that time on I was with him whenever he was in his room. They did take him out for like some, some tests and that was the, the times that I was separated from him.

Q Mr. Scheer, I'm going to -- Dave, I'm going to show you something from Plaintiff's Exhibit One, see if you can shed a little more light on it. Can you see that from where you are? Can you all see that, too? Give a little --

A Yeah.

Q Okay. And this, this is my question for you. I'm looking at Plaintiff's Exhibit One, page 12, but it says, this is from the ER record. Says, [as read], "Father reported he had an extended complex vision last night lasting a couple of hours," and could you tell us a little bit more about what, about what, what that's about as you understood it?

A Well, that, that was the night before when I -- he started explaining to me so or explaining to me what, what was going on with him. He, you know, he told me about the voices he was hearing. He, he thought, thought God had told him to go, that he was going to go to Jerusalem on a -- I can't remember the term he used, but you know, he's on a mission.

I'll call it a mission, and he also told me about fighting demons. He had been -- that's why, you know, why, why he had no clothes on he had been out fighting demons, and, and I -- and I assumed it had gone on for a long time, and while I'm talking to him he's obviously he's still having -- I can tell this stuff's still or I think this stuff's still going on in the background the whole time.

Q And while you were in the ER, Dave, did, did they run tests and labs and things like that?

A Yes.

Q And what ultimately was the, was the disposition? What did the emergency room staff tell you to do with your son?

A They told me to take him to Lighthouse.

Q Okay. Did they tell you to take him sometime next week, sometime whenever there was an availability? When did they tell you to take him to Lighthouse?

A Immediately.

Q And what did you do at that point? Well, let me ask you, did you leave Grand Strand?

A Yes.

Q Okay. Dave, let me show you from Plaintiff's One, this is the sign-in sheet. This is the sign-in sheet for Grand Strand. Whose signature is that right there?

A That's Matt's.

Q And right there?

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

around for 10 or 15 minutes and then she came out and informed me that the physician, she didn't use a name, but she said the -- or, or I'm saying physician, I -- the doctor had said there was still medical issues that needed to be addressed and that they, they had to send me back and told me to go back to the hospital.

Q Did they tell you Matt didn't need mental health care?

A No. They didn't -- did not tell me that.

Q And you were told to take him to the hospital. Where did you go then?

A Took him to the hospital. I took him to Grand Strand.

Q Okay. Did you take him directly back to Grand Strand?

A Yes. I did.

Q Tell us what'd you do once you pulled into Grand Strand? Do you -- where, where do you take him?

A Took him back to the emergency room.

Q And what was his condition there at the emergency room?

A The same as it had been all night and all day, nothing had changed.

Q And was Matt admitted to the hospital?

A He was admitted to the emergency room. Yes.

Q All right. And then did -- was he further admitted to the hospital?

A Yes. He was.

Q And at some point you with Matt when Dr. Patel comes in?

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

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

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

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

A I hop in the car and started driving to Grand Strand Medical Center, and I got on the phone to the Myrtle Beach Police and told them I needed to -- an officer to meet me there because I had no -- that my son was missing.

Q Did a police officer come meet you?

A Yes. He did.

Q Dave, were you surprised to learn that the --

A I'm sorry. Okay.

Q -- physician at 1:30 in the morning had allowed Matt to leave without contacting you?

A I was completely startled.

Q And did the police fill out a, a missing person for Matt and launch a search or put him on the missing person?

A He, he took my information. I can't speak to whether he started a search.

Q Yeah.

A He, he took my information.

Q And then, Dave, what -- you heard today, obviously, Mr. Doherty testify. What was the next thing you learned with regard to Matt?

A The next thing I learned, myself and Debbie's sister and my brother-in-law had been searching for him all day, and around 6:30 on Saturday evening the police called me and said -- asked me if I could stop by. They, they said they had some more information on my son, could I stop by, and I said,

"Well, my wife is" -- Debbie had, as soon he -- found out missing, had caught the quickest flight she could, but it didn't come in till 7:00 o'clock that night. So I said I'd be over as soon as I pick up my wife from the airport. I picked her up and we went over to the Myrtle Beach Police station.

Q And what did the police tell you?

MR. GRESH: Hearsay.

Q What was your understanding of why they were calling you?

A Well, they didn't -- what they did first is, is they had us identify or not identify. They asked if we recognized some clothes.

Q Was it the same?

A And, and immediately recognized the clothes Matt had had on the day before.

Q It was the clothes Matt had when you had left him in the hospital?

A Yes, and I identified it as such.

Q And what was your understanding of where the clothes had been found?

A They explained to me that the clothes had been found on the beach.

Q What was your perception of the way the police were conveying this information to you?

A Well, they then told me that a young man matching my son's description --

MR. GRESH: Hearsay.

THE COURT: Yeah. I sustain the objection.

Q Mr. Scheer, did you, following your time there, so that would be October 3rd you're in the police department?

A Yes.

Q When you left the police department that day what was your understanding of what had happened to your son?

A That he had drowned in the ocean.

Q Mr. Scheer, did you ever receive a statement from the Myrtle -- excuse me. Did you ever receive a statement from the Myrtle Beach Police Department setting forth their activities, the agency's activities with regard to their search for your son?

A Yes. I did.

MR. HINSON: May I approach the witness, Your Honor?

MR. GRESH: Yeah. May I approach?

(Whereupon, a bench conference is held in the presence but out of the hearing of the jury.)

THE COURT: Well, it's kind of border-line. I'm going to allow it in over 83 -- 803(8).

MR. HINSON: Thank you, Your Honor.

THE COURT: Huh?

MR. GRESH: Everything in it?

THE COURT: Yeah.

MR. GRESH: Thank you.

BY MR. HINSON:

Q Mr. Scheer, I'm going to show you what we'll mark as Plaintiff's Exhibit Ten. Mr. Scheer, can you identify that document?

A It's -- I'm sorry, it's a document from the Myrtle Beach Police Department. It's a letter addressed to whom it may concern.

Q Did they provide this to you?

A Yes. They did.

MR. HINSON: Your Honor, we'd move this into evidence.

THE COURT: Over objection. It's in under 803(8).

(Plaintiff's Exhibit Number Ten [MBPD - Activities] admitted into evidence and appropriately marked.)

BY MR. HINSON:

Q And Mr. Scheer, I'm not going to ask you to read the whole, the whole letter, but what was your understanding of the police department's efforts over the next few weeks, months to look for Matt or his body, just generally, Mr. Scheer?

A Well, they had done a number of things. When -- to start with when we were at the police department they swabbed my wife and I with DNA, took DNA samples for which to put it in the national whatever they call it, the database that they put all that stuff in, and then they, they had a -- did extensive land search. They notified the, the Myrtle Beach lifeguards

to be on the lookout. They conducted a -- they conducted helicopter searches.

Q Were they keeping you up-to-date on their efforts?

A Yes. They were.

Q Did you have a, did you have a, a contact person, an officer who was -- that was Matt's --

A Corporal Shelton, this is her -- she's the author of this letter apparently.

Q Were you satisfied with her efforts to look for Matt's body?

A Yes. I was.

Q And Mr. Scheer, I'm going to show you Plaintiff's Exhibit Four.

A Oh, I'm sorry. Thank you.

Q Mr. Scheer, what is Plaintiff's Exhibit Four?

A It's a, a death certificate.

Q For whom?

A Matthew Scheer.

Q And Mr. Scheer, did you all have a memorial service for Matthew?

A Yes. We did.

Q Approximately how many -- was it, was it in Horry County or was it back in New Jersey?

A It was back in New Jersey.

Q Approximately how many people came?

A Over 200, you know, but maybe less stayed for the final service, but over 200 to maybe even closer to 300 came through to pay their respects, maybe a hundred, 125 stayed for the service.

Q Dave, I want to show you some pictures.

A It was probably more than that that stayed.

Q Dave, I'm going to show you Plaintiff's Nine(A). Can you see that, Dave, or we need to turn it a little bit more?

A No. I can see it fine.

Q And this was -- this Nine(A) is what we were showing to Mr. Doherty. Who is, who is this right here?

A Matthew.

Q Okay. Who?

A That, that's our family.

Q Tell me, when was this picture taken?

A It's our last family photo. Erik was going off to Oklahoma City. He'd been accepted as an air traffic controller, and we had a sendoff party for him. There was a lot more people there, and, and -- but that was our last time we were together as a family.

Q About how -- when was this, how far? That's okay, Mr. Scheer.

A I --

Q That's okay. If, if you would --

A No. I think it was June or July.

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

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

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

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

and in August of this year the rental ended and we used it a couple of times and realized it really hadn't changed anything. So we just recently sold it.

Q As a result of Matt's death are there things you worry about for your and Debbie's future?

A Well, to start with our retirement plan was Myrtle Beach. So that, that's gone, and we don't know what to do. The concern about how it's going to impact Erik down the, down the road is, going to be faced with a, you know, Debbie and I, god-willing live, you know, healthy lives and everything, but Debbie and I both went through -- three of our four parents went through extended medical care at the end, and for anyone that's been through that that's a difficult thing, emotionally, financially, time-wise. Debbie, we were fortunate in Debbie's case she has three siblings with, with spouses. I have two, and you know, everybody gets along and everybody, you know, there's times to work to make sure everybody was -- our, our, our parents, whenever it happened to them, were comfortable and taken care of, and that meant splitting the burden and, and, and taking care of these things. Well, Erik's got to -- it's all on him now, and that's -- can be a difficult things to handle. He's also he's stationed in -- on the West Coast and we're on the East Coast.

Q Dave, do you, grown man, but do you, do you still cry for your son?

A Yes.
Q Do you watch -- does your wife still cry for Matthew?
A Yes. Often.
Q Nothing further, Dave, at this point. Thank you.

CROSS EXAMINATION

BY MR. GRESH:

Q Good afternoon Mr. Scheer. You need any water or anything?
A I have some. Thank you.
Q Talking about Matthew, yet it sounds like from your testimony earlier that Matthew had moved down in maybe I think you said December of '13; is that right?
A Yes.
Q This is the date we've been talking about is October of '15?
A Yes.
Q Matt had been here about almost going on two years?
A Yes.
Q He had, thanks to you and Debbie, had a nice condo to live in?
A Yes. He did.
Q He was working at Dune's, Dune's Village?
A Yes.
Q And he had a couple of good friends there in Matt and Courtney and some others?

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

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

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

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

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

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

A To the best of my memory.
Q And it's now unlocked. You're going through the phone and you see some pictures. Do you delete some of those pictures and save some of those pictures?
A Well, not save I did -- just pictures I didn't -- there, there was a, a -- some pictures of -- that Matt had on there that were obviously private, meant only for him. I felt like I was invading his privacy even seeing them. So I deleted them.
Q And in the, the process of, of this case when everybody's exchanging documents I guess because they were deleted they weren't able to be exchanged; is that fair?
A Yeah.
Q Okay. Mr. Scheer, thank you so much for your time.
MR. HINSON: Very briefly.

REDIRECT EXAMINATION

BY MR. HINSON:
Q Mr. Scheer, the questions about you and this phone, when did you take the phone and allow Verizon to do this factory reset or approximately?
A January of 2016.
Q Nothing further, Mr. Scheer.
THE COURT: All right. You can step down. Have a seat with counsel. Thank you.
All right. You can call your next witness.

MR. PADGET: Your Honor, at this time the Plaintiffs would call Erik Scheer.

Whereupon, Erik Scheer is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: State and spell your first and last name.

MR. SCHEER: Name's Erik Scheer, first Erik, E-R-I-K, and Scheer, S-C-H-E-E-R.

DIRECT EXAMINATION

BY MR. PADGET:

Q Erik, good afternoon.

A How you doing?

Q Could you tell us where you live?

A In the Bay Area of California.

Q Okay. How long have you lived there?

A Almost four years now.

Q And to be clear, Erik, you're Matthew's brother?

A Yes. Younger brother.

Q And you and Matthew are the natural sons of your parents, Dave and Debbie Scheer?

A Yes.

Q Is that right? Are you now married?

A Yes. Got married last month.

Q Congratulations.

A Thank you.

Q Could you tell us a little bit about what you do for a

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

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

ages and became teenagers and, and started going out or out in the world on your own a little bit, did you guys stay close as a family?

A Oh, yes. We'd always, like I said, you'd have holidays together, we'd eat dinners together as much as we can with all our working schedules. Yeah. Still kept up. Still did everything as a family.

Q Did you travel together?

A Yes.

Q Did you come down to the beach together?

A Oh, yeah. Definitely.

Q Did your family, would you have fun together?

A Yeah. I mean, growing up, you'd get in your arguments, but I mean, we were a happy household. We'd eat dinner almost every night, went on lots of vacations.

Q At some point, Erik, you moved out of the house to pursue your career in air traffic control?

A Yes.

Q And he came down, at some point came down to the beach and started working in the food and beverage industry?

A Yes.

Q Even though you guys were apart geographically, did you still try to keep up with one another?

A Yes.

Q Well, tell us about the types of things you would do with

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

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

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

for myself, I mean, just last month I got married, and growing up I always pictured, you know, him being my best man standing next to me and not having him there is tough. If we decide to have kids, they won't have an uncle, and I don't have a choice to be an uncle now. Also, this past Monday was my birthday. I turned 28. I'm now two years older than my brother was when he left us, and being the older brother really sucks.

MR. PADGET: No further questions, Your Honor.

THE COURT: All right. Cross.

MS. SPEARS: No questions, Your Honor.

THE COURT: All right. You can step down. Appreciate your time. Thank you.

A Thank you, sir.

THE COURT: I think this is the time we'll take an afternoon break.

(Jury exits courtroom.)

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: Keep your seats. Take your seats. Have a seat. All right. You ready?

MR. PADGET: Yes, we are, Your Honor.

THE COURT: All right.

MR. GRESH: You know, just for, for housekeeping purposes it looks like we're going to have a quick 30(B)(6) read in of

the corporate Defendant, and then Mrs. Scheer is going to testify. I believe she to be maybe the last witness for the Plaintiffs.

MR. HINSON: That's correct, Your Honor.

MR. GRESH: Then we'd have some, some motions, obviously, and I'd prefer if the Court would indulge to start the Defense case tomorrow morning at 9:30 rather than having to call somebody at 4:30 today.

THE COURT: All right. If we get to around 4:30 then we won't start into because we got motions and that sounds good. Still look like we going to have to be here Tuesday?

MR. GRESH: No, sir. If, if we get -- if, if the Court would indulge me to start tomorrow morning, I may have one witness first thing out the box on Friday.

THE COURT: Okay.

MR. GRESH: And I would, I would anticipate resting before lunchtime.

THE COURT: All right. Well, good. Well, I can go cancel my reservation I just made at Comfort Suites. Don't forget about the charges. If you could have them for me in the morning I can start looking at them.

MR. GRESH: Yes, Your Honor.

MR. HINSON: Yes, Your Honor.

THE COURT: Thank you. All right. Bring in the jury.

(Whereupon, the following takes place in the presence of

the jury.)

THE COURT: Call your next witness.

MR. PADGET: Thank you, Your Honor. At this time the Plaintiffs, actually along with the Defendants would mutually are publishing excerpts of the deposition, the Rule 30(B)(6) deposition of the corporate Defendant, Southern Myrtle Inpatient Services.

THE COURT: All right. How are you going to do it?

MR. PADGET: Ms. Spears has been kind enough to offer to read on behalf of the corporate Defendant.

THE COURT: All right. This is a deposition, not, not a video one, but Ms. Spears will take the stand and read the verbatim answer, that is the lawyers will read the questions that were asked at this deposition when the witness I -- whose name I don't know at this point -- was under oath and asked certain questions, and for the purposes of trial they can be read into the record, and again, just like with the video, even though Ms. Spears is not the person and you're not seeing the right -- the person on a TV screen, you take her testimony or her reading the testimony just as though that witness was here testifying. Ms. Spears, you can come take the stand.

MS. SPEARS: Yes, Your Honor.

Whereupon, Lauren Spears is called to the stand, duly sworn by the clerk:

THE CLERK: Please state and spell your first and last

name.

MS. SPEARS: My name is Lauren Spears, S-P-E-A-R-S, and this --

MR. PADGET: And for the record, Your Honor, the, the 30(B)(6) designee was a gentleman named Matthew Shane Caldwell on behalf of the corporate Defendant, Southern Myrtle Inpatient Services, LLC.

THE COURT: All right.

DEPOSITION PUBLISHED

BY MR. PADGET:

Q If you would turn to page 14, please?

A Yes, sir.

Q And beginning on line 17. [As read], "Okay, Mr. Caldwell, paragraph 47 just asks if the physician has the ability to temporarily detain the patient against his will. Has Southern Myrtle Inpatient Services done any research into the legal rights of a physician to detain a patient if the patient may cause injury to himself or others?"

A [As read], "The training is done by the hospital and by the physicians themselves in the course of their education."

Q [As read], "Mr. Caldwell, has Southern Myrtle Inpatient Services done any research into a physician's ability to temporarily detain a patient against his or her will if the patient may cause injury to himself or others?"

A [As read], "No."

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

Drs. Patel and Ash-Bernal, whether promulgated by Southern Myrtle Inpatient Services, Grand Strand Regional Medical Center or some other entity, organization or individual. Do you see that?"

A [As read], "Yes."

Q [As read], "Did Southern Myrtle Inpatient Services have any policies or procedures in 2015 that it promulgated that would be applicable to Drs. Rachel Ash-Bernal and Patel?"

A [As read], "No."

Q [As read], "What efforts, if any, did SMIS take to ensure that its physicians, particularly Patel and Ash-Bernal, were knowledgeable of the policies and procedures applicable to Grand Strand Regional Medical Center?"

A [As read], "These are highly trained and educated clinicians, rely on their education and their actions as a professional, and again, they're credentialed to be approved to act in that way."

Q [As read], "Southern Myrtle Inpatient Services took no specific action to determine whether or not Dr. Patel and Ash-Bernal were adequately knowledgeable on the policies and procedures of Grand Strand; is that fair?"

A I'm sorry. I have to interrupt. That is not part of my -- I apologize.

Q I'll reread the question. [As read], "Southern Myrtle

Inpatient Services took no specific action to determine whether or not Dr. Patel and Ash-Bernal were adequately knowledgeable on the policies and procedures of Grand Strand; is that fair?"

A [As read], "Yes."

Q Turning now to page 50, beginning on line 14. [As read], "Mr. Caldwell, we just provided you what's been marked as Exhibit Six, and this is the notice of privacy practice, practices, issued by Grand Strand Regional Medical Center. Do you see that?"

A [As read], "I do."

Q [As read], "And what do you -- what you have right there is a printout from the website, which is also a little bulleted or brochure that was produced in discovery from the hospital that has the same information on it, and I represent to you this is the privacy practices, the notice of privacy practices that patients are given at the hospital. Are you generally familiar with those documents?"

A [As read], "Please clarify."

Q [As read], "Well, you're aware as Southern Myrtle Inpatient Services is aware that there are notices of privacy practices that are provided to patients in hospitals; correct?"

A [As read], "I would think so."

Q [As read], "If you would look at page four, about a third

down the page, there's a paragraph that begins, 'As permitted by law we may also use and disclose health information for the following types of entities, included, but not limited to,' do you see that section?"

A [As read], "Yes."

Q [As read], "And then there's a number of bulleted points, and the last one listed where a person's health information may be disclosed, you will read that last bullet point?"

A [As read], "A person or persons able to prevent or lessen a serious threat to health or safety."

Q [As read], "So you would agree with me that according to Grand Strand's own notice of privacy practices of the disclosure of a patient's personal health information could serve to prevent or lessen a serious threat to health or safety, health information can, in those circumstances, be disclosed?"

A [As read], "According to this document, yes."

Q [As read], "And you would and Southern Myrtle Inpatient Services would expect its physicians working at Grand Strand to generally be familiar with the notice of privacy practices document?"

A [As read], "To my knowledge, yes. They follow the policies and procedures of the hospital."

Q [As read], "Is there an exception in HIPAA that would allow for a limited disclosure of a patient's personal health

information when the patient is suffering from mental incapacity and disclosing the health information would be in the patient's best interest?"

A [As read], "I'm not 100 percent certain."

Q Page 58, beginning on line seven. [As read], "Did Southern Myrtle Inpatient Services undertake to educate their physicians on what HIPAA does and does not allow?"

A [As read], "No. We, we rely on each individual physician's education as well as the hospital's policies and procedures."

Q Turning now to page 64. [As read], "Does Southern Myrtle Inpatient Services have any specific knowledge of the training provided, and by that I mean would they have received notice such as on December 2nd, 2015, did Dr. Patel attend -- attended such and such a seminar provided by an X, Y, Z entity?"

A [As read], "I'm not certain."

Q [As read], "Do doctors -- do the doctors report, does Dr. Patel and Dr. Rachel Ash-Bernal when they worked for Southern Myrtle Inpatient Services did they report any ongoing continuing medical education that they received, did they report that to SMIS?"

A [As read], "I'm not certain."

Q Turning now to page 66. [As read], "Looking back at Exhibit 12, the third bullet point states, 'Training modules conducted online over the years by employers'. Do you see

that?"
A [As read], "Yes."
Q [As read], "SMIS didn't provide any training to Drs. Ash-Bernal or Dr. Patel; did it?"
A [As read], "I'm not, I'm not certain. We -- there are online overview compliance training."
Q [As read], "So SMIS did on occasion provide training to its employees?"
A [As read], "There is a general training, annual training, yes.
Q [As read], "Who conducted that training to Drs. Patel and Ash-Bernal?"
A [As read], "It's an online course."
Q [As read], "It was an online course created by SMIS?"
A [As read], "I'm not certain who it was created by."
Q [As read], "So my question was did SMIS as an entity providing trainings to Dr., Drs. Patel and Ash-Bernal?"
A [As read], "I'm not certain exactly what you're asking."
Q [As read], "Well, doctors have to get continuing medical education; correct?"
A [As read], "Yes."
Q [As read], "Did SMIS, as an entity, provide any training to Drs. Ash-Bernal or Patel?"
A [As read], "Not, not to my knowledge."
Q [As read], "Okay. Who -- what entity created or

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

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

Ash-Bernal had received any specific training of the do's and don'ts of HIPAA; is that fair?"

A [As read], "Through our -- depending on what, again, we have credentialing systems with, within SMIS and what is contained there. I cannot speak to the specifics of what is contained there."

MR. PADGET: That's all, Your Honor.

THE COURT: All right. You can step down.

A Thank you.

THE COURT: All right. Plaintiff.

MR. HINSON: Plaintiff calls Debra Scheer.

Whereupon, Debra Scheer is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: Just say and spell your first and last name.

MS. SCHEER: First name is Debra, D-E-B-R-A, last is Scheer, S-C-H-E-E-R.

DIRECT EXAMINATION

BY MR. HINSON:

Q Debbie, good afternoon.

A Hello.

Q Debbie, would you tell the jury just a little bit about yourself?

A I am retired now, but I worked as -- I work in the school system as a physical therapy assistant working with children with a variety of physical disabilities.

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

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

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

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

A At that point in time we didn't feel Matt, from Dave's assessment and hearing him, he was capable of taking that long drive back knowing that something could happen, maybe Matt would jump out of the car, maybe he would take the wheel, maybe -- it didn't seem in Matt's best safety for him to drive back that, at that time.

Q Earlier today, Ms. Scheer, we heard Dave tell about taking Matt to Grand Strand and Lighthouse and back to, to Grand Strand. Were you being kept informed as, as all of this took place?

A Yes. He was calling me saying, "We're on our way to there. We're in the ER. This is what they found out. They're sending us to a facility in Conway and then they're sending us back to Grand Strand." So yes, we were back-and-forth.

Q And when Matt's finally admitted to the hospital as an admitted patient, we heard Dave talk about going back to the condo?

A Uh-huh.

Q And what was your understanding why Dave was going back to the condo?

A Because he needed some sleep. He needed himself to be safe to take care of his son, and he had to go back and get -- he was going back to also get like toiletry stuff for Matt, you know, like deodorant, toothbrush, mouthwash, things like

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

"Well, Matthew Scheer left at 1:30 in the morning," and I freaked out and called Dave back and said, "He's gone, that he -- they let him go."

Q And what was the next thing that you, that you -- your next involvement in this?

A So at that point in time I had to get down to South -- I had to get down to Myrtle. So I had to catch the first flight out of there. We'll usually fly out of Atlantic City because it's a really short flight, but I had to fly out of Philadelphia. So I flew down. I, I absolutely forget what time my flight was, but it was out of Philadelphia.

Q And when you arrived what was the state that you observed of your husband, his --

A So I saw Dave. We met. You know, we cried, we cried and he said, "We have to go to the police department. They have something -- they have some information for us."

Q And what did, what did you observe in the police department?

A So in the police department they told us they had found a young man's -- a man's clothing that was matching the descriptions of Matt's clothes, and they showed us the picture of the clothes, I think I have that correct.

Q Did you recognize the clothes?

A I absolutely did because I bought them for him.

Q Where, where, where were the clothes from? You remember

--

A Excuse me.

Q You remember buying those particular clothes?

A Absolutely. I remember the underwear and the shorts.

Q Debbie, did you and Dave fly or drive back to New Jersey eventually? How, how did you eventually get back to New Jersey?

A Eventually, after, I forget how long we stayed down here, five or six days. We -- then we drove back to New Jersey.

Q How was that drive? Can you tell us about that drive?

A It was a, a long drive, a long quiet drive just quiet because we were both I just think contemplating what in the world just happened.

Q Debbie, I want to just very briefly show you a few pictures and just ask you to identify them so we can know what, what we're looking at. This is Plaintiff's Nine(J). Can you see that?

A I had come down to visit Matt before I went back to school. It was in like mid-August, maybe the end of August, and we went to Charleston, you know, and did the carriage ride and whatnot. So that was him with the horse that was on our carriage.

Q Kind of jump around in time. What about that one?

A And that would be your typical Matt picture with his arm around his dad because Matt was the kind of guy was the first

one in the family to give you a big hug. Like you'd see him and he'd just give you a big hug. He was a big hugger, kisser guy.

Q How about that?

A That's from his high school graduation with a good friend of his and that was, again, that's Charleston. I forget what area that was but that was that same trip we had just about the end of August when we went down to Charleston for the day.

Q This one?

A And that probably the last drink I had with him. We had played golf and went to the Anchor Café. So that was the mom and McGirt shot.

Q What's the McGirt shot?

A No. The picture I mean.

Q Oh, oh, McGirt meaning he's --

A That's what I meant McGirt, yeah.

Q Did you call him McGirt sometime?

A Yes.

Q Debbie, how has Matt's death impacted you? Can you tell us some about that? I know you probably can't put it into words, but to, to the best of your ability.

A It's changed our life totally. It will never be the same again. You, you lose your firstborn child, you know, they have just a different part in your heart because they're your firstborn. You know, you remember all those firsts, the first

times they rolled over, the first time they talked, the first time they rode a bike. So any of those firsts we'll never see again. I am a person who dreams a lot. I have many, many, many dreams about Matt, and in every dream I'm in the dream and I go, "Oh, my gosh, you're back, you're back," and I wake up in the dream and I go, "No. You're not here. You're really not here." That pretty much happens once or twice a week.

Dave and ours relationship has changed incredibly. We're pretty active people. We entertain a lot. So we've found that we have -- our friends have diminished somewhat. You know, friends you have when your kids are younger I really have a hard time, you know, talking to them. It's really hard. It's hard to enjoy other people's joy because you have so much sorrow. I -- we've had a hard time going to family functions because my one niece has two, you know, young boys, and it's just, it's hard. You know, our, our holidays have become like, "It's Christmas, I don't really care." You know, "Don't give me a card for Mother's Day." I don't want a card on my birthday.

Q What changes have you observed in your husband?

A You know, by nature Dave's a Norwegian. They're pretty stoic as it is, but, you know, I'm one if I'm upset I'll meet with my friends and I'll talk about it. I know Dave keeps a lot of things inside. You know, it's hard when you come home

and you hear your husband crying from the next room, but I know that's his own personal, personal way of, of dealing with that.

Q Have you -- are there things that you and Dave used to specifically do that you don't do anymore?

A There are specifically things in the area. We have a really hard time going to the movies because that -- Matt was the movie guy. We'd go, "Okay, Matt, what movie did you see," you know. So we really haven't gone to the movies, and as we were saying, we enjoyed a lot of things down in Myrtle, and that place we just found that we were really unable to keep without it being too emotional.

Q Debbie, are there things you worry about in the future as a result of Matt's death?

A I do. I, you know, we're not getting any younger, and I kind of -- I, I fear for -- not fear for Erik. I worry about Erik because of, of the stress of aging parents, you know, emotional stress, and you know how challenging it is to take care of a parent if you're living in a different state. "What am I going to do with my parents?" So I worry that can he carry that burden without his brother.

Q When was the last time you saw Matt in person?

A The last time I saw Matt in person was when I left the condo when I was down that time in August. I mean, we had gone to the Anchor Café, came back and then I probably left

like the next morning. I guess I flew down. So I probably left sometime in the nighttime, and he was like, you know, "See you mom. See you next time later. Love you," because he was also the big I love you guy.

Q How often would you and Matt talk on the phone?

A Matt and I would talk at least like once a week because I would get all the gossip from him. He was the chatty one.

Q What do you miss most about Matt?

A I miss his hugs. I miss his like he would call and say, "Hey, mom, I, you know, I found this great new band. You have to like listen to this playlist," or, you know, "Hey, mom, I finally learned how to make a new drink. I think you're really going to like it," or, "Mom, I found this recipe. I think you should try it." I just miss him.

Q Thank you, Debbie. Please answer any questions Mr. Gresh has.

MR. GRESH: No questions, Your Honor.

THE COURT: All right. You can step down.

MR. HINSON: The Plaintiff rests, Your Honor.

THE COURT: All right. Members of the jury panel, the Plaintiff is telling us they have presented their evidence. We've reached a point in the trial where I have to take up some legal matters before we move to the next stage, which would be the Defense having the right to present its evidence.

I'm told at the last break that we most likely will not go into next week, that we -- looks like we're on track to finish Friday. I say that with some caveat in case it changes, but that's what I was told the last. So we'll see you back at 9:30 in the morning, and again, we've got some matters to take up. We're going to, we're going to stop -- we're not going to stop working now, but it will probably take us a good hour to do what we've got to do and that will take us almost to five, probably take us more than an hour, but anyway, we'll see you back at 9:30.

Now, even though the Plaintiff is rested, you're not in a position to discuss the case. We hadn't reached that point. You're not to even try to make up your own mind. We haven't reached that point. So we'll see you in the morning at 9:30.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: Anything from Plaintiff?

MR. HINSON: Nothing, Your Honor.

THE COURT: All right. Mr. Gresh.

MR. GRESH: Thank you, Your Honor. We are at the point of the trial that the Plaintiff has rested their case, and I come before Your Honor making motions for directed verdict. Oftentimes I'll take this podium and say some things, I know they're going to get denied, and I just have to do it perfunctory.

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

that these cases talk about when you have a suicide case, which is what this is, that's the problem with these types of cases is a matter of law on these cases it cuts the causal connection between the tort and the outcome.

You know, for instance, in the Scott versus Greenville Pharmacy case 48 S.E.2d 324, Greenville Pharmacy wrongfully, absolutely wrongfully prescribed and administered and gave barbiturates to a kid, and the Plaintiff said the kid under the influence of these barbiturates killed himself and that that would've been foreseeable, a natural and probable consequence of the drug overdose from the barbiturates, and what our Court held is, no, that unfortunately suicide an entity is so multifactorial that it can't be foreseen. Then we had a similar discussion in the, in the Crolley case and in the Wickersham case. Your Honor, I stand before you saying as a matter of law generally when one takes all of the evidence that has been presented from the witness stand and from the documents, the conclusion is suicide, and suicide would preclude any recovery in a wrongful death case, and so I think as a matter of law, under those, under those cases, that ends the discussion.

THE COURT: All right. Let me hear from Plaintiff on that.

MR. GRESH: And Your Honor, just for the, just for the sake of argument, there's obviously more motions, but I think

it's easier to take them one at a time if the Court would indulge.

THE COURT: Yeah. And I, and if you have copies of those cases I'd appreciate it. It might take me overnight to look at them, but --

MR. GRESH: Yes. Your Honor, I will certainly -- I'll print them out or email them. We'll get them, we'll get them to the Court.

THE COURT: Don't email them. I don't have any -- I'm not going to have any way to get emails down at the office, so if you --

MR. GRESH: I'll, I'll bring them to, to Brink and Your Honor today at the hotel. That's easy enough.

THE COURT: Okay. That's fine.

MR. HINSON: Your honor, I think there's a case that's exactly on point and comparable, in fact, in many ways to the case before you, and that is Bramlette versus Charter Medical-Columbia, which is 302 S.C. 68. It's a Supreme Court case from 1990, and there's two things that it talks about in Bramlette. Bramlette is a patient with mental illness, the same as this, and Bramlette is a patient with mental illness who is admitted to an institution, and during the course of the patient's time in the, the institution, I don't think this patient's involuntarily committed either. He's -- comes willingly to the, to the facility seeking treatment, and the

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

in a sense that he was -- he had depression and wanted to, but would take his own life in -- as a result of his psychosis and delusions, and it's, it's comparable, our Supreme Court has said this -- when you, when you fail to protect the person from injury to himself and you had a duty to do so, which a physician who is the, the attending physician who discharges a patient at 1:30 in the morning had a duty to prevent him from harming himself, Your Honor, our Supreme Court has said that it recognizes a cause of action in negligence just as this, and that's the Bramlette case, and I don't think we need any other cases beside that. I'll be happy to do some more research, but I think Bramlette speaks for itself.

THE COURT: Well, do you, do you have a copy for me?

MR. HINSON: I did not expect to rest today, but I will get you one promptly, Your Honor.

THE COURT: Okay. Just leave it at the desk.

MR. HINSON: Thank you. Yes, sir.

MR. GRESH: Your Honor, as a, as a second motion, I would move for a directed verdict on the issue of entitlement to punitive damages. The Plaintiff has pled in the complaint that the actions of Dr. Patel and Dr. Ash-Bernal and, I guess, Southern Myrtle were so willful and wanton such as the imposition of punitive damages is warranted. As Your Honor knows, they must prove entitlement to that by clear and convincing evidence. What we have, taken in the light most

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

just was no testimony about willful or wanton or gross conduct or anything of the sort. Southern Myrtle is the other third Defendant in this case who is respondeat superior, liable, allegedly, for the conduct of Patel and Ash-Bernal. The thing we heard yesterday is that they didn't do enough maybe in their PowerPoints on HIPAA, but again, there's been no testimony that, that they -- they did do training. Everybody admits they did do training. Was the training such that it's willful and wanton, they turned a blind eye towards HIPAA when I've got 70 pages worth of a HIPAA PowerPoints that were produced? Your Honor, I think that the Plaintiffs may have submitted evidence of negligence, but have they submitted sufficient evidence of willful and wanton conduct to get the issue of punitive damages to the jury, I think it's overwhelmingly they hadn't. This is a tough, tough judgment call, and where they're going to have experts on one side, Your Honor, tomorrow and the day after we're going to have experts on the other side talking about how close this judgment call is, but close judgment calls are not punitive damages calls.

MR. HINSON: Your Honor, in response, and, and I'll be happy to provide you the case law that says this, that recklessness is a conscious failure to do something that is incumbent upon one to do under the circumstances, and that's what this case is about. It was incumbent upon Dr. Patel

under the circumstances, this is Plaintiff's allegation, obviously, it was incumbent upon him to have a signout to the next, the next physician. It was a -- and that was a conscious failure. This was not an accident. He chose not to pick up the phone or to have a face-to-face conversation, and that, Your Honor, under our case law in South Carolina is recklessness. Dr. Ash-Bernal chose, she made a conscious failure to spend more time with Matthew to do, to do a proper evaluation. It's not that she spent 50 minutes with him and then ultimately made the wrong choice. She made a conscious decision to spend a very short amount of time with him, and that, Your Honor, could be -- the jury should have the opportunity to consider that to be reckless, and I'll be happy to get you the case law that says that a conscious failure to do or not do what's incumbent under the circumstances is recklessness.

THE COURT: I appreciate it. Thank you.

MR. GRESH: Now, no -- there was no -- I know Plaintiff can allege that, and that's what their Plaintiff may very well say, but somebody has got to take that stand and say, "You know what, as I as an expert look at the conduct of Dr. Patel that's a conscious failure on his part," and there simply wasn't any of that. There wasn't somebody that took the stand and said Dr. Ash-Bernal and going through and only spending four minutes, five minutes, 15 minutes, whatever the time was,

there has to be evidence that says that is clear and convincing, which is the standard, and that it rises to a level of recklessness, willfulness and wantonness, and I think in the absence -- my argument is in the absence of that evidence from this witness stand, now that the Plaintiff has rested their case, they no longer may rely upon what was pled in a complaint. They've got to prove it here, and they haven't done it, and so I think that's, that's the, that's the motion that I was trying to make in front of Your Honor.

MR. HINSON: Your Honor, Mr. Gresh wants to have his cake and eat it, too. We took the deposition of Dr. Kenneth Scissors and we decided not to play it for time and, and for, for everybody's sake I think we, we've proved our case, nonetheless, but in Dr. Scissors' deposition, I asked him, "Do you believe it," and we're speaking of the Defendants' deviations, "do you believe it rose to the level of being reckless?" Mr. Gresh objected and said calls for a legal opinion and then when he -- we had our deposition designations, his objection was that the question of recklessness, Your Honor, was the province of the jury, and so that's the position he took with me just a few days ago and now he's coming before Your Honor saying the exact opposite. I don't how to keep him happy when he's telling me that I don't need to -- when he's telling me I don't need to have my experts talk about recklessness, that's essentially what he

said when he objected to it, and now when I don't come in here and talk about that because he objects to it, he's now complaining that I didn't do it. He can't have it both ways, Your Honor. He himself has said it falls into -- under the -- the, the question of recklessness falls under the province of the jury and now he should not be allowed to come in here and argue the other way around.

MR. GRESH: And I would have lost that objection. Right? If they had called Dr. Scissors to the stand and they -- and we would have had a discussion with Your Honor and he would have tried to play that and I say you can't do that and I would have lost that objection. The jury needs something to hang their hat on. This is beyond the ken of the average layperson. The average layperson all they've heard right now is judgment, judgment, judgment, judgment call. Okay. There's been no testimony that said not only is this a judgment call that was not done appropriately, this one's not close. This is something that we ought to punish Dr. Ash-Bernal for to prevent conduct like this in the future. That wasn't asked. No -- there's been no testimony. To allow a jury to simply say, "You know, what, from what I've heard that sounds like something we should punish," it just allows them to speculate, and so, this deposition of Dr. Scissors wasn't played. There is no testimony from anybody on the witness stand that would allow them to link up this punitive damages

claim, and I, in fact, that's the reason I'm moving to have that part of the allegations against the Defendants stricken.

THE COURT: All right.

MR. HINSON: Your Honor, I stand on my prior comment you can't have it both ways. You can't be objecting to it as, as something that falls under the province of the jury and then when I leave it to the province of the jury say that I -- we needed expert testimony. The question of recklessness is a question for the jury to determine. There's, there's adequate evidence in this, this, in, in this case that there was a conscious failure to do the right thing, and, and that should go to the jury whether or not they determine recklessness. This is not an issue or, or gross negligence. These -- to the -- the question of gross negligence is a jury question. It's not something that falls under the and, and what's typically brought from an expert. The jury decides if there's gross negligence in this case, and we'd submit it should go to the jury.

THE COURT: All right. Anything further?

MR. GRESH: Yes, Your Honor. As to Dr. Patel, today we heard from a psychiatrist that there were two allegations on the standard of care: one, failure to order Ativan PRN, and the handoff issue between Dr. Patel and Dr. Ash-Bernal. Those claims against Dr. Patel fail as a matter of law due to a lack of proximate cause testimony. Nobody, you know, they have two

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

Ash-Bernal only known the patient's chief complaint the outcome would have been different. Instead, the opposite happens. Of course, Dr. Ash-Bernal knows the patient's here with psychosis. The testimony elicited during the Plaintiff's case is that she looked at the chart before going in to talk to the patient. She talked to the nursing staff before going in and talking to the patient. We have two very tenuous allegations against Dr. Patel, but neither one of them are linked up by way of expert testimony to causing the outcome. This is a case where the Plaintiff alleges that Dr. Ash-Bernal shouldn't have let the patient go at 1:30. This is not a case that back at 5:30 p.m. something Dr. Patel did or didn't do could have changed that outcome. That testimony, whatever the standard of care allegations, that testimony that the outcome would have been different is wholly missing at this point in the case as to Dr. Patel, and so for that reason we would move for a directed verdict as to Dr. Patel for a lack of proximate cause testimony.

MR. PADGET: Your Honor, I suppose I'll address this one. We start with the proposition, we start with the proposition that proximate cause is typically a question from the jury. There's hundreds of cases that, that say that in our case law. There is testimony today from Dr. Malone elicited by Mr. Hinson where after he described the breaches of the standard of care by Dr. Patel, which were twofold, as, as Mr. Gresh has

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

don't believe there's any motion pending with regard to Dr. Ash-Bernal, but those two actions, the actions by each physician combined as joint tortfeasors to result in a singular injury, and that is Matthew Scheer's death. So for those reasons, Your Honor, we'd ask that the motion for directed verdict be denied.

MR. GRESH: Just real briefly on that, the last point. When Dr. Malone tried to testify just generalities that was all speculative and we stopped him from doing that because what he had to say, doesn't have to use these magic words, but what he has to say, essentially to a reasonable degree of medical certainty that whatever Dr. Patel did caused the injury and he didn't. He said, "Sometimes when I talk to folks the majority of them will, will walk out of here just fine." What that means is that some of them don't. Okay. The jury can't be left to speculate, "Well, is this one of those where, where if they had done everything Matthew Scheer would have walked out or is this one of those things where they do everything they can and the patient doesn't." It can't be left to speculate as to that. Somebody's got to take that stand and say, "I know the answer based upon 30 years of education, training and experience and as a board-certified psychiatrist I can tell you to a reasonable degree of medical certainty that had Dr. X done Y the outcome would have been different," and that's what we don't have as to Dr. Patel.

This has got nothing to do with Ativan. This has got nothing to do with the handoff, and nobody tried to link up. They didn't even try to link up the handoff or the Ativan with the later disappearance of his checking themself out AMA.

THE COURT: All right. Next.

MR. GRESH: Thank you, Your Honor. The -- at this time I would also move for a directed verdict on the issue of corporate negligence for Southern Myrtle Inpatient Services. At the time the testimony was elicited from, I believe it was Dr. Robinson, the first witness for the Plaintiff, he says that the Southern Myrtle did not do enough in its PowerPointing to educate the physicians on HIPAA as a matter of law. At the time -- before that information was adduced at trial, I objected, and I said this is not pled in the complaint, training on discharge is pled, but there is no pleading about training on HIPAA law. It's just not pled. They didn't plead it. I thought maybe it could have been kept out. It wasn't, but even once it got into the case, what he said and what everybody said is that it's not the employer's job to be the all, end-all, be-all and tell everybody that this is what they need to know, that it comes from the hospital, that it comes from general education. Okay? Somebody had to say Southern Myrtle, but for their failure to have more slides in their PowerPoint, Matthew Scheer would be alive. Who came in and said, "To a reasonable degree of

medical certainty that based on the testimony that I reviewed and the evidence before me that not only was it a breach of standard of care to not include more slides in the PowerPoint, but also had they been there Matthew would be alive," and that's testimony that we just don't have. We have testimony about, you know, did they comply with HIPAA or not comply with HIPAA, but you got to go back to Southern Myrtle because this is not against Dr. Ash-Bernal. This is against Dr. or, excuse me, Southern Myrtle Inpatient Services as a corporate Defendant that somehow they, and laying aside their potential respondeat superior liability, that they also had a duty and that they also breached that duty and the breach of that duty caused this, this, this outcome, and there was, again, a lack of proximate cause testimony on that point as well.

THE COURT: All right. Plaintiff.

MR. PADGET: Judge, with regard to the corporate liability, first of all, Dr. Robinson did plainly testify that not only does -- this was actually in cross, too, by the way, a medical entity like the many he's worked for over the years has a duty and obligation to train its physicians regarding HIPAA do's and don'ts, and he also testified in direct that based upon the information provided by Southern Myrtle Inpatient Services in discovery, that they failed to properly train their physicians on the do's and don'ts because they only trade them -- train them on the don'ts and not any of the

do's, particularly with regard to the scope of permitted disclosures of medical information in these types of circumstances. That was his testimony.

Today, we read, as well, from the 30(B)(6) deposition of Southern Myrtle, and we read that Southern Myrtle -- we asked, "Did Southern Myrtle Inpatient Services undertake to educate their physicians on what HIPAA does and does not allow?" And the answer was, "No, we rely on each individual's physician's education as well as the hospital's policies and procedures." So the answer was, "No, they do not undertake to educate their physicians on HIPAA." Dr. Robinson says the entities have a duty and obligation to do so and they failed to do so, and in this case they admittedly failed to do so according to their own 30(B)(6) witness's testimony. Now, with regard to the proximate cause element as to the corporate Defendant, had Dr. -- the issue before the jury is had Dr. Ash-Bernal and Dr. Patel, particularly Ash-Bernal in this case, in this factual circumstance, had she been properly trained on HIPAA and been informed about those laws and her ability to contact Matthew's father in that situation, had she been properly trained it is certainly more likely than not that she could have contacted and known that she had the ability to contact Matthew's father. She testified via video that she did not believe she could do so because he -- because Matthew told her or told the nurses specifically that he did not want to speak to his

father, which is a complete misunderstanding of the HIPAA provisions, and so, Your Honor, there is a -- and certainly it's a -- within the jury's province. This is not medical expert testimony that's needed had Matthew [sic] Scheer been contacted as the emergency contact for Matthew he'd come to the hospital, and just as he had in the days prior could've made sure his son was safe until he received proper treatment. That is not speculation. That is just common sense that had he gotten a phone call in that situation that he would've come to help his son and that this tragedy could have been avoided. So for those reasons, Your Honor, we'd ask this directed verdict motion be denied.

MR. GRESH: Real quick on that point, it is not enough to have a hospitalist say a corporation needs to train on do's and don'ts, not just don'ts. Okay. Because let's think about that, somebody has to say that Southern Myrtle had an obligation to tell Dr. Ash-Bernal do this particular thing, not just anything, this particular thing, to call a dad if you have somebody that has -- you think may be incapacitated.

THE COURT: Well, not that particular thing, but that specie of thing.

MR. GRESH: Yeah. But it -- but this is a training issue, right, and so the issue is I can't just generally train on HIPAA, is the allegation is I had to have trained on a particular point in HIPAA, that if I had trained on that point

that Dr. Ash-Bernal would have known that point and would have been allowed to do it. All we have is general do's and don'ts. Somebody has to say what the do is. You have to identify the duty, what was the duty on Southern Myrtle. You know, generalized duty testimony you have to include not just don'ts under HIPAA but also do's. Dr. Robinson did not say in an -- "I, in my expert capacity Southern Myrtle Inpatient Services must include in its HIPAA training the situation where you have a patient who maybe by reason of mental illness has already given you an emergency contact but now they've revoked it, what do you do." Right. There was none of that do testimony elicited from the witness. It was just a generalized you have to -- you can't -- it's not enough just to do don'ts. You have to also do do's. He didn't identify the do, and then didn't identify how that would have changed the outcome, and I think you need both sides of this. You need both the standard of care, identification of the duty, and then expert testimony that the breach of that duty proximately caused injury, and that's, that's what we're missing.

THE COURT: All right. Yes, sir.

MR. PADGET: Your Honor, I'm happy to respond if necessary, but I stand by what we previously said which is the fact it was in cross where it came across most clearly where Dr. Robinson testified that, that medical corporate entities have an obligation to inform their physicians about the

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

THE COURT: All right. That it?

MR. GRESH: Yeah. Your Honor, just to make sure that the one I did initially, the foreseeability, I think would also apply to Dr. Ash-Bernal. Right. I just want to make sure the record's real clear here, when you look at the, the chart at every step of the way it is no homicidal ideation, no suicidal ideations. There are like 10 or 15 instances of that in the chart, and he left, and the testimony is that he don't think he really committed suicide, that he went out and just like in some purification event and just washed all the way into the ocean. It has to be foreseeable, and it's -- there's just really and I just wanted to kind of reiterate just for the record make sure I started out generally but especially as to her as well there has to be some testimony that he would walk out based on the, the things that he had told her in the hospital, was recorded in the chart that somehow his death could have been foreseeable, and there just really isn't any testimony to that, to that effect. So I just want to make sure the record was clear on that.

THE COURT: Okay.

MR. HINSON: Your Honor, I just briefly want to say I think there has been so much testimony in this case that if you allow a psychotic patient who's an actually psychotic patient to leave the hospital that the danger is that they will harm themselves or others and that has been repeated

borderline ad nauseam in this, in the Plaintiff's presentation. So I, I disagree with Mr. Gresh's --

MR. GRESH: And I think that, that illuminates my exact point. This isn't enough to say there's a generalized danger of letting folks go. We have a statute directly on point, A, B and C -- will you pull that up for me -- that talks about you have to, for physical harm to yourself, you have to manifest a plan to kill yourself. There's none of that. Under harm to others, you have to manifest a plan by evidence of intending to harm others, and there's just none of that. There is no evidence manifested anywhere from the testimony of anybody that said Matthew had those kind of things. What they're trying to hang their hat on is this just generalized third one, which if I put my goggles on real quick, Your Honor, two seconds, Your Honor, because this is as a matter of law we define likelihood of serious harm means that because of mental illness there is, A, a substantial risk of physical harm to the person themself as manifested by evidence of threats or attempts at suicide or bodily harm. Not a single witness took the stand and said, "I find that there are evidence or attempts at suicide." It's not there. B, a substantial risk of physical harm to other persons as manifested by evidence of homicidal or violent behavior and a serious harm to them. Nobody took the stand and said here's the evidence of homicide, a homicidal plan. C says a very substantial risk of

physical impairment or injury to the person themself manifested by evidence that the person is gravely disabled and that reasonable provision for the person's protection is not available in the community. That's the standard. These folks can take the stand and try and make up whatever standard they want, but Your Honor is going to charge this jury as a matter of law that they are not able, you cannot hold Dr. Ash-Bernal or Patel liable for not involuntarily committing somebody unless it falls under one of these three things. Everybody's talked about we are a free society and very rarely you go with either A, B or C, "I can imprison you." They had to have done that. One of them didn't even know the law. The other one just says if you're psychotic we can lock you up. That's not the law. You have to have evidence that the person is going to do this, and they got to cite to something. What's the evidence that they can cite to? It's not just grandiose delusions or anything like that. There's got to be some evidence that would put folks on notice that they can't let them go, and nobody connected up using the law as it pertains in this state to the conduct from Dr. Ash-Bernal. They tried to come up with their own standard and they just didn't follow, didn't follow along in that regard.

THE COURT: All right. Would you provide me with a copy of the statute, too?

MR. GRESH: I shall, Your Honor.

MR. HINSON: We got one.

THE COURT: Oh, okay.

MR. PADGET: I'd be happy to hand it up, Your Honor.

THE COURT: Yeah. That's fine. I, I don't -- can I keep it?

MR. PADGET: Yes, Your Honor. We'll print out another one.

MR. GRESH: Both parts?

MR. PADGET: It's the definition section.

MR. GRESH: Where, oh, where it defines substantial harm.

MR. PADGET: It's all there.

MR. GRESH: Yeah. That's what I was arguing.

THE COURT: Section 13, likelihood of serious harm.

MR. PADGET: Yes, sir.

MR. GRESH: That's right.

MR. HINSON: Your Honor, if I could also hand up one more statute which is 44-66-20 which is -- defines unable to consent because what Mr. Gresh conveniently leaves out is that in addition other parts of Plaintiff's case is that Matthew Scheer didn't have the ability to consent to this AMA form, and I'd just like to hand up the statute on what his, what mental status he had to have per our law to consent to the AMA form.

THE COURT: All right. Well, I'll take a look at this tonight, and you'll have requests to charge in the morning for me and verdict forms.

MR. HINSON: Yes, Your Honor.

THE COURT: I think, I think that's all I need other than having some stuff to look at tonight.

MR. HINSON: Yes, Your Honor.

MR. GRESH: Your Honor, I think that would conclude the directed verdict motions. Before the Defense begins its case there is one other housekeeping matter. The Plaintiff had moved to exclude the picture of Matthew, then and the father testified today that he deleted a picture or pictures after he got the cell phone. I just want to know the Court's ruling on that. Can I call a cell phone forensics person who will testify that in January after the disappearance of Matthew somebody went in and deleted this picture?

THE COURT: What's the relevance? I still haven't quite seen the relevance.

MR. GRESH: The --

THE COURT: I know you -- we've talked about maybe as impeachment of, of Mr. Scheer.

MR. GRESH: Your Honor, I, I --

THE COURT: But I -- he didn't -- he testified that there, there was some wiping of the telephone.

MR. HINSON: And I thought Mr. Gresh had said that if Mr. Scheer takes the stand and admits that he deleted a picture of, of -- that that was the end of the issue.

THE COURT: That --

MR. GRESH: And I thought it was going to have to be that picture.

THE COURT: That was sort of what I heard, but --

MR. GRESH: Okay. Well, then I'll withdraw it, I mean, if that's, if that's what I said.

THE COURT: No. I don't want you to withdraw it. If you feel like, I mean, that's just what I heard -- remember hearing, but --

MR. GRESH: I thought it was if he had said, "This is the picture that I deleted," and I would just kind of take it down, but what I heard was he didn't -- deleted a picture or pictures.

MR. HINSON: That he said that, that he realized Matthew did not want to see, that they were private pictures. I think it got out the idea that the pictures at issue here were never intended to be seen by Matthew's father and -- or any member of his family.

THE COURT: Well, in any event, I, I -- you're withdrawing it, but on the -- well, I, I won't -- I don't need to make an alternative ruling then. All right. Well, if you all will get those to me I'll start looking at them tonight, and --

MR. GRESH: Your Honor, I promised to bring you copies of case law, but I don't know where you're staying.

THE COURT: Staying at the Comfort Suites downstairs from

them.

MR. GRESH: Is that -- okay.

THE COURT: Where are you all staying?

MR. GRESH: We're over in Myrtle Beach.

THE COURT: Oh, okay.

MR. GRESH: You all are here in Conway?

THE COURT: Yeah.

MR. GRESH: I'll work it out with Brink, and we'll, we'll get everything we need to you.

THE COURT: Yeah. Maybe you could fax it to him and then, I mean, fax, nobody faxes anymore, email it to him and he can print them out because he's right upstairs.

MR. GRESH: That'll be fantastic.

MR. HINSON: Jack, yeah, I have a printer at my hotel room. If you can let me know but please don't send them at 2 a.m. but I'll be happy to.

THE COURT: No. I, I won't be up at 2 a.m.

MR. HINSON: We'll be happy to -- we'll -- I'll coordinate with Defense counsel, Your Honor. We'll --

MR. GRESH: Thank you, Your Honor.

MS. SPEARS: Thank you.

MR. GRESH: 9:30 in the morning?

THE COURT: 9:30 in the morning.

MS. SPEARS: Thank you.

(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.,

Defendants.) VOLUME II

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
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Circuit Court Reporter

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(On the record, May 23, 2019. The following takes place outside the presence of the jury.)

THE COURT: Good morning. I had asked for requests to charge and verdict forms.

MR. HINSON: Yes, Your Honor.

THE COURT: All right.

MR. HINSON: We both, both have them. We, we have exchanged them. We have some -- well, I haven't yet seen Defense requests to charge, but I have seen the proposed verdict form from the Defense.

THE COURT: All right. Now, I asked that you all give me a complete charge since I don't have a law clerk. Remember that.

MR. GRESH: Yeah.

MR. HINSON: Yeah. Yes, sir. May I approach?

THE COURT: Okay. Yeah, and we'll, we'll -- I'll look at it today and tomorrow and then we'll fine tune it in the morning as far as --

MR. HINSON: All right. And Your Honor, Plaintiffs had two proposed verdict forms. They are identical. Other than for your discretion the first question is worded a little bit differently.

THE COURT: Okay.

MR. GRESH: Your Honor, if I could approach. Here's the Defense verdict form that I already objected. I know it's my

own, but --

THE COURT: Okay.

MR. GRESH: We'll -- I'm sure we're going to talk about it today, whether there's one beneficiary for purposes of a cap for an estate or because it's a husband and a wife is there two. I've seen an order from Your Honor, and I believe I know how that's going to turn out.

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

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

THE COURT: Well, it --

MR. GRESH: But I would just say that it -- this makes an assumption that I believe is the wrong one but if it -- we can certainly talk about it.

THE COURT: Okay.

MR. GRESH: I just don't want it to look like I stipulate to that, and Your Honor, here's a request to charge that I gave to the Plaintiff's counsel. I'm waiting on one more charge.

THE COURT: Okay.

MR. GRESH: So this -- I believe this is 95 percent complete, and as I get that one I will supplement that. I believe, you know, our law clerk clerked for Judge Hughston and he says that's the -- what he's always done. So I hope it has everything in there.

THE COURT: Okay.

MR. GRESH: At least a good starting point.

THE COURT: All right. Anything else before I rule on the directed verdict motions?

MR. HINSON: From the Plaintiff, Your Honor, yesterday and this is, this is on me without a doubt, I did not ask David and Debbie Scheer while they were on the stand for their birthdays, and I think that their statutory life expectancy is relevant for the consideration by the jury of the amount of pain, suffering and grief that they will have. The number of years they are expected to live is pertinent to the degree of pain, suffering and grief, and Your Honor, I would either ask, one, to just briefly be able to reopen the evidence to ask them one question, which is what is your birthday or, Your Honor, I'd ask that the Court take judicial notice of their birthdays.

THE COURT: Well, I can't take judicial notice of it, but would Defense stipulate to it?

MR. GRESH: Your Honor, I can't, and, and only for this reason what I think is going to happen with that evidence is that there will be a birthday that is produced, there will be probably a jury charge from Your Honor about statutory life expectancy, there will be a mathematical calculation about here's how long and then in their closing argument the Plaintiff will, will get up there and say, you know, for the

next 24.7 years here and 25.4 years here, you know, let's get a, you know, a thousand dollars a day or something along those lines. I would not be zealously advocating for my client if I said this -- Plaintiffs can open up --

THE COURT: All right. Well, I'll, I'll allow them to reopen the case just for the one question.

MR. GRESH: If the -- if it, if it pleases the Court, if we're going to do that, I think the easier way may be just to stipulate as to the, the numbers rather than the oddity of reopening the Plaintiff's case for one question.

THE COURT: All right.

MR. HINSON: That's perfectly fine with me, Your Honor, as long as we could stipulate to whatever the -- we'll calculate whatever the statute, the statute would say.

THE COURT: Life expectancy.

MR. GRESH: The, the statute is what it is and the birthdays are what they are.

MR. HINSON: Okay. Thank you.

THE COURT: Okay.

MR. HINSON: That would work.

THE COURT: All right. Thank you.

All right. As to the motion for directed verdict, as to Defendants' motion for directed verdict on the basis that none of the Defendants can be held liable for Matt Scheer's suicide based on the argument that suicide negates any causal link

between any negligence and the suicide, that is that suicide is an intervening cause, I find Scott and Crolley cases not to be controlling based on their fact pattern in, in this case, and the fact pattern in those cases. In the Wickersham case, Judge Norton denied a motion for summary judgment based on the suicide being an intervening cause. I'm told that that case is still in the pipeline. That was a motion for summary judgment, and it seems to go contra to the -- well, he discusses the, the Scott case, I -- and, and the Crolley case, but he denied a motion for summary judgment based on the same theory that Defendants have postulated here. I find Bramlette to be the controlling law in this case. Bramlette involved a suicide patient. Here we have a psychotic patient. I find this case fits within the Bramlette holding. As to Matt Scheer I find his suicide is not an intervening cause between any wrongful negligence by the Defendant, a Defendant and his death.

As to the motion for directed verdict on the issue of punitive damages, looking at, looking at all these -- I look at all these motions in the light most favorable to Plaintiff incidentally. I forgot to say that. As to motion for directed verdict on the issue of punitive damages, looking at the motion in the light most favorable to Plaintiff, I find the issue of punitive damages to be a question for the jury. I find that a jury -- it is a jury issue as to whether or not

one or more of the Defendants acted recklessly, that is with a conscious disregard for the rights of others, particularly Matt Scheer.

As to the motion for directed verdict on behalf of Dr. Patel, I find there is testimony in the record from which a jury could find that Dr. Patel should have prescribed Ativan and should have told the staff and doctor or doctors to whom Matt Scheer was handed off that he was psychotic and that, and again, I'm not finding this, but there is evidence in the record from which a jury could conclude that Dr. Patel breached that duty and that such breach was a proximate cause of Matt Scheer's suicide.

As to Southern Myrtle, I find the testimony of Dr. Robinson, coupled with the testimony of Southern Myrtle's 30(B)(6) witness creates a jury issue as to whether or not Southern Myrtle had a duty to train its physicians as to the law on permissible disclosure, whether -- and -- to, to -- let me go back, it created -- this, this testimony creates a jury issue as to whether or not Southern Myrtle had a duty to train a physician as to the law of permissible discovery, as to whether or not Southern Myrtle breached any such duty and as to whether any such breach was a proximate cause of Matt Scheer's suicide. I believe that's the four -- was that -- is that -- were there just four?

MR. PADGET: I believe that's correct, Your Honor.

MR. GRESH: I think that's correct, Your Honor.

THE COURT: All right. Now, ready for the jury?

MR. GRESH: Your Honor, just a matter of, of housekeeping, I think the Plaintiff rested a little bit earlier than I thought, which is why we trimmed it back from Tuesday till, till Friday. If it pleases the Court, I've got Dr. Patel who I believe we'll call, I believe I'm going to call Dr. Rachel Ash-Bernal immediately following Dr. Patel and then we'll call Dr. Oscar Lovelace, with a lunch in there somewhere. At the conclusion of Dr. Lovelace's testimony, I'm out of witnesses until tomorrow morning at 9:30 when Dr. Ballenger will be here to testify. If it pleases the Court, I'd like to spend the remainder of the afternoon going through the jury charges and jury verdict form and having all those lined up such that when Friday rolls around we can roll right into it.

THE COURT: All right. The only caveat or the only concern I have with that is I'm going to be listening to the testimony and kind of looking at the charges and the verdict form. So I don't know if I'll be ready to do much this afternoon, but hopefully I will and then I won't have to work on it tonight.

MR. GRESH: And I -- and what, what I was really trying to come up with is I don't have anybody else to call. Through no fault of anybody's the case I think came in faster than we

anticipated and the next expert's not available till Friday.

THE COURT: All right. Dr. Lovelace will take about an hour, two hours.

MR. GRESH: Yes, sir. And I think everybody is going to be about that range. It may not be that early but I just wanted to call to the Court's attention it may be 3:30, it may be 3:00. I don't know exactly.

THE COURT: We can work with that. Along those same lines, looking at tomorrow, I know this case has a lot of meat in it, but I'm going to ask that closing arguments try to be tailored to around an hour at the outside. I think you lose a jury after, after that. You certainly lose the Judge, but --

MR. HINSON: An hour limit will not be a problem, Your Honor.

THE COURT: Okay.

MR. GRESH: That's fine.

THE COURT: All right. Bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: Good morning. I believe they've, they've got -- here, here in Horry County they got me eating better than I eat at home so.

All right. Call your -- now, the case is up to -- is in the Defendants' side of the case, and so, they will call such witnesses as they believe, as they desire. So I'll turn it

over to counsel for the Defense.

MS. SPEARS: Thank you, Your Honor. The Defense calls Dr. Nirlep Patel.

Whereupon, Nirlep Patel is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: If you'll just state and spell your first and last name.

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

DIRECT EXAMINATION

BY MS. SPEARS:

Q Good morning, Dr. Patel.

A Morning.

Q Would you please introduce yourself to the jury?

A So I was born in Chicago in August of '78, lived there for a few years. Then we moved to a small town in northern Massachusetts, Chelmsford, Massachusetts, lived there for pretty much through high school, graduated high school there, and then went to school, went to college at Duke University. Came down here to go to school here and finished that. Then returned home for a couple of years, worked at a lab at MIT for a few years, then attended medical school after that. Actually first got a masters degree at Boston University and then attended medical school after that and between '03 and '07, graduated in '07 and then did residency in, in downtown

Philly at Hahnemann University Hospital at which point about 2010 accepted a job here at Grand Strand.

Q You said you went to Duke University; is that correct?

A That's correct.

Q What year did you graduate from Duke?

A 2000.

Q And did you get any degrees after you graduated from Duke University?

A Yes. I got a masters at Boston University when I went back home to -- when I was working for the lab for a few years.

Q And following your degree --

A Uh-huh.

Q -- masters degree at Boston did you then go to medical school?

A I did.

Q And what year did you graduate from medical school?

A '07.

Q What year did you complete your residency?

A 2010.

Q And in medical school did you receive any awards or honors?

A It was an academic honor society for first, first year and then tuition scholarship assistance first year as well.

Q And in your career as a physician, have you had a chance

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

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

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

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

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

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

psychiatric findings and the need for that evaluation. So those are the two things.

Q Okay. And is it fair to say that you were involved in Matthew Scheer's care for his underlying medical issues, including the white blood cell count and elevated bilirubin?

A That's correct.

Q And your evaluation of Matthew Scheer you were addressing the white blood cell count in what way?

A So in that sense, as a patient comes back with, with these lab values, you know, some of the things that we're going to go over and discuss is, you know, why is his -- why is his white cell count elevated and what could be causing that. You know, we've already reviewed and kind of gone over what was done in the ED. They'd done some preliminary things as they would normally do and we review those, but when he comes back from Lighthouse, their thought was, you know, and, and their concerns were, "We're still not entirely comfortable with this, this white cell count, and what's going on. Can we dig a little bit deeper," which is certainly reasonable. So in, in that sense, you know, we're going to look at his elevated white count and look for signs of infection or what else could be causing it, whether it be dehydration or some sort of substance or anything of that sort or some other process in the body, and same with the bilirubin, what could be causing his elevated bilirubin, going over the history and

everything that he's told me up till this point. We're going to probably run some tests to try and find out, you know, why his bilirubin is elevated or not. Also to -- basically also check and see if any of these labs are erroneous or if there's something we need to double check, you know, that sort of thing, if things weren't adding up.

Q As part of your workup of Matthew Scheer's medical concerns did you order fluids for him?

A We ordered fluids for him, ordered his medication, also ordered additional blood tests, repeat blood tests for the morning, additional tests that could be added on to the blood already drawn in the ED for that day to kind of further look at, you know, what else could be causing his bilirubin. They did kind of a preliminary thing, and then other, you know, imaging finding -- tests that, you know, could further look at what else could be causing his bilirubin to be up or his white cell count or both together. So that -- those are some of the things that we tried to look at.

Q Did you also order some IV nutrition to help address some of these abnormal lab values?

A We ordered some IV fluids, correct.

Q Okay. And you said some imaging. Did you order an ultrasound of the abdomen?

A So and, I mean, certainly on exam he had a pretty benign abdominal exam. There was no pain or, or anything or

tenderness elicited. You know, my suspicion was low for some sort of occult abdominal process going on, but an ultrasound is generally a, a fairly simple and readily available test and, you know, in some cases the patient may not present with obvious, you know, pain and tenderness in that situation. So starting with ultrasound to look at the liver and the gallbladder which seems to be kind of where the focus is seemed reasonable. So that's, that's what we started with.

Q And did you order a repeat blood test for the following day?

A Yes. As I said earlier we ordered a repeat, you know, general labs, you know, morning labs, typical morning labs for the following morning to see if, you know, some of the things that we looked at if they have changed, if they've improved, if things that we've tried had helped and if, you know, we're on the right track or if we're not on the right track at all and they're still abnormal or going up, well, do we need to go in a completely different direction, that sort of thing.

Q You mentioned you order some medications. Was one of those Keppra?

A Keppra is one of his home medications, and yes, I believe we ordered that.

Q And what was the reason for ordering Keppra?

A Well, as I understood from the history and other information Keppra was one of his normal medications that he's

been taking for a number of years, and per the history again, apparently he had not been taking it for some time. So it seemed reasonable that if he's supposed to be on this medication that he takes to help reduce the risk of seizures that, you know, we would put it back on. We typically -- I believe that currently we give Keppra and those medications at 2100 hours or thereabouts. So I think what I did was I ordered it to be given at the next scheduled time or next routinely scheduled time.

Q Doctor, as part of your plan did you also make a note for PRN Ativan?

A Yes. You know, certainly based on what was going on earlier in the day and after talking with him, I certainly thought about, you know, giving him, you know, potentially as needed medications. He certainly didn't need it at the time that I saw him. That's clear, but you know, in the event that it arose, you know, it was something that I thought about, thought about giving. However, at the same time, you know, I -- beyond evaluating patients, you know, like that in other admissions that I've done at this time you also want to see the patient sort of as he is or as, as she is at the time that they come in. At the time that I saw him he certainly seemed pretty reasonable, and I've been in situations where both from the ED and on the floor patients receive sedative medications and they're just pretty much out of it. They're asleep, and

you're not going to get much of a good evaluation at that time. So, sort of weighing both of those things at, at that time and also knowing that if the medication was necessary at a later date, seeing as how we and multiple other physicians are available 24-7, within a matter of minutes we could get a medication like Ativan. At that time I did not order it. Just like if someone came in with, with and had nausea sometime at 10:00 o'clock or had diarrhea or a headache or any number of things that could happen, these are medicines that a nurse would just let us know, said, you know, "Hey, Doctor, someone's, you know, having some nausea. You know, can we get Phenergan," or someone having this or that and we go, that sort of thing.

Q And if a nurse felt that Matthew Scheer or any patient needed medication for agitation what could she do or he?

A A couple of things. I mean, she could certainly page -- at that time we still had pagers. Now we have discarded our pagers for the wonderful text messaging apps that, that we now have. So now we do that, but they could text us now, but back then, you know, they could page us or the nighttime doctor or the nurse practitioner who is either on the floor or in the ED admitting patients at the hospital or if they're just kind of walking on the floor as a number of doctors typically are or in this case may be sitting right next to you while they're admitting another patient or seeing someone.

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

A It does.
Q And what does this H and P note say with regards to hallucinations?
A Well, it says the patient denies hallucinations.
Q And what does this H and P note state with regards to your findings of suicidal ideations in Matthew Scheer?
A It says denies any suicidal ideation.
Q And what does this reflect with regards to homicidal ideations in Matthew Scheer?
A And denies any homicidal ideation.
Q I'm sorry. Say that again.
A I'm sorry. And denies any homicidal ideation.
Q And at the time that you evaluated Matthew Scheer and wrote your findings in this H and P, was there anything that indicated that Matthew Scheer needed antipsychotic medications?
A There was not.
Q In your review of the medical records did it appear at any time on October 2nd that a provider ordered Matthew Scheer antipsychotic medications?
A From -- not that I could see from, you know, either ordered or executed medications leading up until that time, no.
Q Doctor, if you'll speak in the microphone.
A I'm sorry.

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

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

what we were thinking about, and so we did the ultrasound or ordered the ultrasound to look at the gallbladder specifically, but again, as I said before, generally low suspicion given his otherwise normal physical exam, and then other, again, repeat tests, other liver function tests to see if that was causing his elevated bilirubin possibly.

Q And during, throughout or throughout your evaluation Matthew Scheer was not exhibiting any signs of agitation; is that right?

A No. He was not.

Q Is this note what we looked at from page one and page two a comprehensive overview of the medical care you provided to Matthew Scheer?

A I would say it is.

Q Is this note available to any provider in the hospital who would need to reference it?

A So typically, and this was round about, you know, so we go to the, the next page, if we -- you know, I saw, saw Matthew around about 5:00 o'clock or so and I still dictate my notes. When I first started here in 2010 we just had a few typewritten templates and most of us, all the physicians dictated their notes and it was transcribed. It goes out to a company and they transcribe it and then it gets uploaded in the system, and over the years they've changed that. I'm one of the few people that probably still dictates. Most of the

newer guys they type it up or and that, and that sort of thing now, but yes, it was dictated around about 5:30 or so or that's, that's when I finished, and then it gets sent off to a transcription company and then they, they transcribe, you know, what they hear, and then it's uploaded in the system looks like around about 8:00 o'clock or so that night or 19:54.

Q On October 2, 2015, were you working day shift?

A Yes. I was working day shift that day.

Q And hospitalists in the hospital work in shifts, right, some work days and some work nights?

A Correct. I do about half-and-half. Just the Saturday/Sunday before this trial I worked the evening shift into the night shift. So yeah, we, you know, we typically work day shifts. We don't work the same shift on the same calendar day typically, but yeah.

Q So you wouldn't work 24 hours a day; right?

A Generally no, although there are some, some that do do that. All the power to them, but --

Q As a day shift hospitalist what are your typical hours?

A Typically for day shift day starts around about seven, finishes around about 7 p.m., sometimes a little before, sometimes a little bit after, just kind of really depends on the day-to-day happenings and what you need to do. You know, some, some, something may, you know, happen towards the end of

the day or it might be a, a quieter admission night, that sort of thing, so generally about seven to seven day shift.

Q And when your shift ends at seven do you get to leave the hospital right then?

A I mean, again, it just depends on the workflow. If there's something going on, you know, we might need to stay a little bit longer to address it. If everything seems to be taken care of then, you know, around 7:00 o'clock or so we, we head home.

Q And when the day shift hospitalist is going off shift and a nighttime hospitalist is coming on shift, can you describe the typical procedure of how that works?

A So typically, you know, we, as a day shift physician, we round on anywhere from, you know, 16 to 20 patients or so. It just really depends on the day to day. So we go through and have reviewed everything for the day. We've spoken to the patient, evaluated them, ordered any tests, you know, typically anything under the sun that could have happened we address those issues, and if there's anything critical or urgent or anything like that say at 6:30, you know, someone was having shortness of breath and, you know, you're the one that saw them and you wanted to make sure they didn't have a blood clot or something. So maybe you ordered a scan of their chest to, to rule that out. Well, know that's going to happen immediately. So, you know, you would put in the order and you

may pass along to the nurse practitioner who's handling cross cover or one of the night docs, "Hey, you know, we have this test. You know, if this comes back abnormal, you know, do this," or -- and I mean, in some cases we don't really have to say, I would just say, "Hey, just follow up with this test," or, "I ordered this test," because generally speaking they, they kind of know what to do. I've been in those same shoes. So, you know, that's normally what we would do. Just the, the really pressing, urgent matters is what we would focus on and highlight to pass along.

Q In your capacity when you work as a nighttime hospitalist and you come on, do you have access to all of the medical records for a patient?

A Yeah. We do. Most, I mean, these records are typically electronic. Back in 2010 we still had paper notes. Of course, you'd have to go to the chart in many cases, and you know, leaf through everything and try and decipher some things, but right now pretty much everything is generally available, you know, pretty quickly if, if we need it. It's pretty comprehensive in terms of what the goings-on of that day.

Q At Grand Strand Regional Medical Center how common is it to do a face-to-face handoff where you would talk to the oncoming physician when you leave?

A Well, in, in my 10 years probably that's a very rare

occurrence to, to go through the whole census and say, you know, you know, everything about every patient that's there. Like I said earlier, we typically focus on the highlights because those are the most important things, the most urgent things that we need to have our, our night guys or night folks focus on and, and follow up. So those are the things that we would highlight, and typically these days it's just a simple text message or pass them in the hallway and generally know kind of where they're going to be sitting so I can swing by and say, "Hey, you know, follow up on this," or, "Hey, do me a favor and check on this, you know," or I could text them if a nurse contacts me, you know, after I'm already home and say, "Hey, something happened," and then I would relay that information along, but generally speaking, that's a pretty fluid process like that.

Q When you were leaving the hospital on October 2nd, 2015, were there any concerns, findings or pending critical results for Matthew Scheer?

A No. As I said earlier, the, the labs that we order for -- that we want to check on were for the next morning and those were routine labs. There was a couple of add-on labs that we did. Again, I wasn't highly suspicious of something going on based on the history and physical to, to see anything there, but those are routine, and the ultrasound I ordered, again, was also routine, not an acute surgical abdomen, not

any acute physical exam findings. So my expectation is that, and again, at the time I don't remember if we had ultrasound 24-7, but you know, my thought was if it got done that evening, great, if not early in the morning I would be able to check on that and see if anything came of it.

Q At the time you left the hospital on October 2nd had you addressed Matthew Scheer's medical concerns to your satisfaction?

A I had.

Q And was a psychiatrist coming to address Matthew's psychiatric concerns?

A As I had put the consult in my understanding is that, you know, he would be evaluated in due course by a psychiatrist.

Q And when you went off shift or left the hospital on October 2nd, 2015, did you have any concern that Matthew Scheer may need to be involuntarily committed?

A At the time that I evaluated Matthew, no.

Q And looking back, at any point in your discussion or evaluation of Matthew Scheer did he express to you a desire to harm himself?

A He did not.

Q Did he express a desire to harm anyone else?

A He did not.

Q At any point in time when you were evaluating Matthew Scheer did you feel him to be a serious threat of harm to

himself?
A I did not feel that way, no.
Q Did you feel he was a serious threat of harm to anyone else?
A I did not feel that.
Q Is this the type of patient that you would think that antipsychotic medications are indicated?
A At the time that I evaluated, no.
MS. SPEARS: One second, Your Honor. Nothing further.
THE COURT: All right.
MS. SPEARS: Answer any questions, any questions that Plaintiff's counsel may have.
MR. PADGET: Your Honor, may I approach and just go ahead and grab --
THE COURT: You may.
MR. PADGET: -- Plaintiff's Exhibit One, the medical record to have that handy.
THE COURT: Certainly.

CROSS EXAMINATION

BY MR. PADGET:
Q I'm going to give this to you, Dr. Patel.
A Okay.
Q Good morning, Dr. Patel.
A Good morning.
Q We can all agree that a physician should never needlessly

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

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

impressions is pretty much the only recollection that I, that I have at this time.

Q All you have is the chart essentially and then your practices and your usual protocol to try to piece back together what you did that day?

A That's generally the case.

Q But you don't have any memories?

A I don't have any independent recollection, no, of Matthew, no.

Q Now, when you treated Matthew on Friday, this is the 2nd when he came to be in your care, you were aware that he had been at Grand Strand earlier that day?

A Correct, based on the ER documentation, correct.

Q He had gone to the emergency department and was seen by Dr. Battisti, had been sent to an outpatient psychiatric facility?

A He had been evaluated in the emergency room, correct, by Dr. Battisti and then he was sent over to Lighthouse, which is both inpatient and outpatient. Patients that we send over to Lighthouse are oftentimes there to be committed and they, they need inpatient psychiatric care. That's one of the main reasons that patients go over to Lighthouse, but among other things that are -- they do outpatient care, too, I believe, at the time.

Q The only time you actually interacted with Matthew Scheer

on the 2nd was during this time when you sat down with Matthew and his father, David, he was there according to the note; correct?

A Correct. When, when I saw Matthew in the ED with his father, that was the time that -- that was the only time that I interacted with Matthew when I evaluated him.

Q And that was according, I believe your testimony, about 5:30 or so on the 2nd?

A A little bit before that, yes, leading up to that. I think 5:30 or around abouts is when I dictated or finished my dictation, but give or take around there, five, 5:30, something like that.

Q And you did your evaluation and it's your testimony that you never saw Matthew Scheer ever again after that; correct?

A Correct.

Q And we are in agreement that you at no point in time ever spoke to your partner, Dr. Rachel Ash-Bernal, about Matthew's care; did you?

A That's correct, did not speak to her.

Q Never once had a conversation with her about Matthew's case?

A No. That's correct.

Q Never once had any sort of discussion with regard to the highlights, as you testified to a moment ago, of his particular situation that would be important for her to know,

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

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

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

you that he had some concerns about their son, comes down from New Jersey. He, he finds him in a condition. He decides he needs to go to the hospital. He goes to the emergency department. He tells you they've been to Lighthouse and tells you they've come back from the psychiatric care facility. They wouldn't admit him there. Back into the hospital; is that true?

A I mean, that generally kind of sums up the, the chronology of it. You know, and that's also would have -- what would be available from the ER documentation and also what the ER doctor would have summarized to me in the conversation with her just probably minutes earlier. So but that's the general chronology of it, yes.

Q In your note -- I'm on page 65 now of Exhibit One.

A Your exhibit or the original exhibit?

Q It's the one I handed you, Exhibit One.

A Okay.

Q I think it's your HPI, Doctor.

A At what -- I'm sorry, what page did you say?

Q I'm on 65 there at the bottom. It's the, the Bates number, not the page number. In addition, they told you that Matthew had been having visions; is that right?

A That's correct. It says he has been having visions.

Q And he also had what the father described as a psychotic episode where he ran out into the woods?

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

between, between evaluating, examining the patient is, is about, about how long it would take. Again, it depends on many factors, you know, you know, if they have a long history, if they have a lot of medications, you know, if it's an 82-year-old patient with a lot of things going on, then certainly that might take a little bit longer, you know, those types of things, but it does vary from patient to patient.

Q And it certainly can vary, Doctor, but your estimate for Matthew's case was 30 minutes?

A Again, I don't know exactly the number but sounds about right give or take a few minutes.

Q And that's what you testified to at your deposition; correct?

A I believe so. Yeah.

Q And you were under oath when you gave that deposition just like you are today?

A Correct.

Q Now, at the time you spent this estimate of 30 minutes with Matthew and his father going over all this information, Matthew was calm, there wasn't any sort of emergency or he wasn't agitated. There was nothing particularly concerning at that point in time according to you; correct?

A To my recollection, no.

Q So in this time where there's nothing particularly concerning, he's not agitated, he's not acting out, he's not

accusing people of being things they're not, he's not throwing hospital equipment around or taking off his clothes, you decided that it was necessary to spend 30 minutes with him in that initial evaluation; is that right?

A Again, about that, correct, between talking to Matthew, father, getting a history, also reviewing some of the laboratory values, you know, because we typically go through those before we go in and evaluate the patient. Oftentimes, the workflow is, you know, we sit down at the computer. We're on the phone, and as we're talking about the patient we're kind of both going through the same things at the same time, at least we try to, then we scan through that and then we typically go and evaluate the patient, and a patient may be on the floor, too. Again, that doesn't always happen, but it just depends on where, where we were at the time and, and that sort of thing.

Q Now you had -- a, a psych -- an order had been placed for a psych consult; correct?

A That's correct.

Q And you, it was your expectation that Dr. Oduwole was going to come that evening and do an evaluation of Matthew?

A Right. As I had said earlier, that conversation had occurred between Dr. Battisti and Lighthouse and the providers at Lighthouse, and shortly after -- concluding that conversation, she called me, and as I said earlier, we

discussed all of these things, including all the other objective values and, and, and findings and conveyed that information over to me. Ergo, I place the consultation based on my expectation that that's the next -- that's part of the process that we're doing here, so.

Q So Dr. Battisti not only called you, she had previously contacted somebody at Lighthouse?

A Right. As --

Q That's your understanding?

A That, that's my understanding, and again, I have no independent recollection of my conversation with Dr. Battisti. I've spoken to her for dozens of admissions before, and again, the, the many times that I've admitted patients that's our usual practice, to go over these types of things and, and that's how she'd relay that to me.

Q Well, she not only did that, she also documented that she did that in her notes; didn't she?

A I believe she did.

Q Now, you never contacted Lighthouse or Dr. Oduwole or any of those folks to determine when he may be expected on this Friday night at the hospital sometime around 7 p.m. or after with a hurricane outside, you never contacted him to determine if a psych consult was going to happen that Friday night?

A Again, no, like I said earlier, Dr. Oduwole's usual habit is to pretty much round, you know, after six, somewhere

between six and nine. He typically makes his rounds for the patients that are on his list, and the way they get on his list is we put the order in and that shows up. The other method that we use is we have a social worker case manager and they're already aware of the patient, if he needs to be seen by Dr. Oduwole at the time. So they already have a running list as well, and she typically hands them that list or they -- they're in contact, and, you know, they let him know, "Okay. So we have a patient in 1295, 94, 91 and then this patient down still in the ED is a, is a hold patient," and everything of that sort. So she would let him know, and then that's still how we do it as to who needs to be seen that day.

Q So we're all in agreement you never spoke with Dr. Oduwole or Dr. Ash-Bernal who were the two physicians who were expected to be involved with his care that evening; is that correct?

A That's correct.

Q You knew Matthew had been prescribed and taking Keppra for a seizure disorder; correct?

A That's correct. Keppra was one of his home medications that, that -- per the history. He had not been taking for some days. So it was ordered to be resumed.

Q And you agree that his failure to take that seizure medication was putting Matthew, I believe that I quote, at risk, excuse me, significant risk for serious harm. That's

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

that medication. Now, if that medication is not given or not given at the right time or refused or that sort of thing then my expectation would be that we would be notified of a medication that is ordered as important as it may be that the patient is saying no or we can't give it because suppose the medication is IV only and the patient doesn't have an IV or, you know, if they're not able to swallow pills anymore, and they're not able to give an oral medication we need to find another route. In any case, if a medication is not, not administered when it's ordered we would expect that, you know, the physician, whether it be me or whoever is on call or available would be notified that the patient is not taking it or not able to take it or, you know, whatever the reason may be.

Q And you have no recollection of any conversations with the nurses to remind them of the importance of making sure that he got this medication; do you?

A Again, as I said, since the medication was in the computer and it was ordered at its appropriate time as with the hundreds of thousands of other medications that I've ordered my expectation is a medicine that I've ordered would be given at its appropriate time.

Q Let's talk about the orders for a second, Doctor. You've ordered the psychiatric consult with Dr. Oduwole; correct?

A Correct.

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

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

or he has to say is, "You know, this patient is a little bit agitated, a little bit anxious," or anything, "could we have this medication," or Ativan or Geodon or what have you. You know, it could also be the case for any number of things as I said earlier. If the patient exhibits these symptoms or these signs and something is indicated we're a phone call away. So knowing those things, you know, kind of my thought process at the time that I was thinking about giving the Ativan and why I didn't order the Ativan, those are some of my considerations.

Q Doctor, can we agree that the time that it would have taken you to order the Ativan, actually put it -- enter the order into the computer --

A Correct.

Q -- would have been less than the time it took to give that answer?

A I would say, I don't know, maybe about 30 seconds to type in Ativan and put it in.

Q You never ordered any psychotic or, excuse me, antipsychotic medication for Matthew; is that correct?

A At the time I evaluated him I did not feel that he needed any antipsychotic medications.

Q All right. So let's go over your plan for Matt, psych consult, we agree it never happened; right?

A Correct.

Q All right. There was Keppra, he needed to take it, we

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

He's removed his shirt. He's pacing the halls. He's removed his wristband from the hospital. He's becoming aggressive with the staff. He's yelling that the staff are devil worshipers, they cannot control him nor could the president at the time, Obama. Would you agree with me that that would be an agitated state?

A I would agree that certainly that's odd behavior and certainly not the condition that he was when I saw him, and he certainly appears to be, you know, in an agitated state at that point.

Q And no one at that point in time according to the records, with no order entered, gave any Ativan to Matthew; correct?

A The records don't reflect any Ativan given at that point.

Q Now, and instead the nurses at that time they, they, without an order to give any Ativan or other anti-agitation medication, they contacted Dr. Ash-Bernal; correct?

A I believe at the time one of the nurses contacted Dr. Ash-Bernal as she was -- I think she was walking onto the floor at the time to see another patient, I believe.

Q Let's talk a little bit about some of the permissible, I can't say the words, permissible disclosures healthcare information. Do you believe, is it your belief that HIPAA or the other privacy laws would permit a healthcare facility or provider from stating whether or not a person was present in a

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

and visions and so forth that were discussed and other things, there wasn't any problem with David knowing any of that information when you sat down with him; correct? That was entirely appropriate?

A That was entirely appropriate. Yes.

Q And if there was a change in Matthew's condition after he -- you left the hospital, that paperwork that was completed we all agree that would allow David Scheer to be provided that information?

A In terms of? Say that -- say -- I'm sorry. Say that again.

Q Certainly. You guys went through all that paperwork, he was listed as the emergency contact and all that. If there was a substantial change in Matthew's condition and David wasn't in the hospital, we all agree that he could have been contacted to learn of that substantial change?

A As long as the patient consents to that, yes, he can be contacted.

Q And that role of consent and you're trained to do mental status exams and so forth, and you've had plenty of times in your practice where a patient who is not suffering from mental illness cannot consent or not consent to certain things; isn't that true?

A Typically, yeah, we, we encounter those situations, you know, throughout our, our day.

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

I'm -- as far I know the, the number the patients that are probably, you know, committed that can sometimes we have none per day. Sometimes we may have, you know, a handful per day. It, it really varies on a day-to-day basis.

Q So on this floor you're on it has psych rooms; right?

A Doesn't have psych rooms per se. There's a couple of rooms segregated on the floor, you know, that are made a little bit safer in the sense that, you know, we try and remove any potentially, you know, dangerous obstacles that, that may be in a room. There's a bed. There's a sink. At that time there were -- some had TVs, some did not have TVs. They try and remove cords and cables and there's probably a number of other things. The doors are typically left open, you know, and they're, they're just these four rooms or four or five rooms there that, you know, can have easy access to, but they're not -- it's not a locked unit. It's, it's not a, a segregated unit or anything of that sort. We don't have that, per se, in this hospital.

Q Now, so you're on the floor and there are psych rooms there, and you're on the floor, you said that these involuntary commitments may happen a lot more frequently down in the emergency department; is that right?

A Yeah. Current -- at, at that time in, in 2015, yeah, they may happen, but currently we have, you know, facilities that the patient can go. So, you know, currently we don't

necessarily have as many because, you know, more recently we've had, you know, facilities in the area that have allowed us to send patients directly to those facilities as we're not a psychiatric facility. Back then if a patient, you know, needed involuntary commitment, they would, you know, have to be committed in the ED and then they would come up to the floor, and, and then we would progress.

Q Let's focus on 20 -- October 2015 when all this happened, Doctor. Times change. Hospitals change. So let's focus back on October 2015.

A Sure.

Q If, if involuntary commitments are happening down in the ER on a daily basis, potentially, I think is what you just said, if somebody had questions about what to do in those situations up on your floor, you simply could summon somebody from the emergency department, and say, "Hey, whoa, we're not familiar with involuntary commitments. Get somebody up here who has some more information about how these can be done"?

A Well, not --

Q That could be done; couldn't it?

A Not, not quite as easily as you're describing it. Emergency physicians are downstairs. I mean, we can have a phone call and just ask.

Q Come up here; right?

A Actually, no. They typically don't leave the emergency

room because they have patients in the ER that they can't just leave, but --

Q Can you ask them?

A Huh? As I just said, you know, you can ask them on the phone.

Q Ask them, "Hey, this is what's going on. I'm not familiar a with involuntary commitments. I need this information."

MS. SPEARS: Your Honor, can the witness finish his answer?

THE COURT: Yeah. Let him finish his answer.

MR. PADGET: Sure.

A Not, I believe like I said, you know, we could talk to them on the phone and ask them a question and that sort of thing or paperwork if it's present on the floor we can, we can do that on the floor as well.

Q But the information's a phone call away?

A It can be.

Q Now, you said -- now, those -- these involuntary commitments happen on a daily basis down there. It's not your testimony that these patients that are being involuntary committed that no one has any concern for their liberties. You're not here saying that; are you?

A Well, I mean, there's always a concern for that. Remember, you're -- when you're committing a patient that's not a decision that you take lightly. You know, you're,

you're basically saying that, you know, you can no longer, you know, have the things that we take for granted, you know, phone calls, TV, you know, those, you know, many other things. You're saying that they can't have visitors. You're saying that, you know, no one can, you know, they can't contact anybody unless they have explicit permission from the physician, among other things. You're saying that, you know, these are your four medications and you must take these four medications right now or, you know, we're going to force them upon you. So I mean, it's not a decision that you take lightly because those are some of the things that, you know, you're going to be subjecting your patient to.

Q And nobody is saying anybody should take those decisions lightly, Doctor. I'm just saying that there are situations that occur where the physicians determine it's in the best interest of the patient, for a variety of reasons, that they need to be involuntarily commitment -- committed and that happens on a fairly regular basis at Grand Strand Regional Medical Center?

A If they feel that it's appropriate, correct.

Q You've actually completed some of these -- the paperwork to do that process yourself?

A Involuntary commitment papers?

Q Yes.

A I have, not frequently, but I have personally.

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

they feel, what their evaluation indicates, they feel that the patient needs to stay then, you know, they need to start that process. If they feel that the patient doesn't need to stay and is able to make decisions for themselves, then, then they're -- they have to honor the wishes and, and not commit the patient, depending on what the, the wishes are at the time.

Q You described a little bit earlier, Doctor, the process by which you -- I think you said you still do some dictating?

A Sorry.

Q Others don't, they're typing, but you, you still do the dictation?

A Correct. I still dictate almost all of my history and physicals.

Q And I still do some dictation occasionally. I -- but when you do it you, you pick up a piece of equipment and you speak into it; right?

A Correct.

Q And you're, you're saying what you want to be transcribed into the medical record; correct?

A That's correct.

Q All right. And you -- when you do that, I mean, you have an obligation as a physician to do that truthfully and accurately; correct?

A That's correct.

Q Now, you also in this case, Doctor --

MR. PADGET: Your Honor, if I may approach.

THE COURT: Yes, sir.

MR. PADGET: May we approach?

(Whereupon, a bench conference is held in the presence, but out of the hearing of the jury.)

BY MR. PADGET:

Q And Doctor, you have Exhibit One as well we talked about earlier, that's the medical record?

A Correct.

Q And this is your, this is your discharge note that you dictated the following morning when you came back to work and we're talking October 3rd sometime around 8 a.m.

A Now, which page are you on? On, on --

Q I'm sorry, page 54?

A Okay.

Q Are you with me?

A Yep.

Q All right. This is your discharge summary for Matthew that you completed the following morning?

A That's correct.

Q Okay. And just like you testified to a moment ago, when you do a medical record you talk into a machine and you put what you believe is truthful and accurate information about his care into your record; isn't that true?

A That's correct.
Q All right. Now, you wrote down at the bottom there 54, you see, are you with me? I'm beginning with, "The patient," it's the second line from the bottom?
A "The patient", correct.
Q [As read], "The patient left against medical advice later that night"?
A Uh-huh.
Q Do you see that?
A I see that?
Q That's what you wrote, [as read], "And all questions were answered to the best of my ability"?
A Correct.
Q You see that?
A I see that.
Q Okay. And you went on to write, shortly thereafter, [as read], "The discharge planning took greater than 25 minutes." Do you see that?
A I see that.
Q All right. Now, in this note, you're -- excuse me, you're saying that you answered all of his questions at discharge to the best of your ability?
A That's not correct. The questions that I --
Q That's not correct.
A -- the questions that you are referring to are the

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

dictate a discharge summary anywhere from, I don't know, five to 10 minutes or so. So that, that generally depends on that. Just to kind of work backwards, the patient was, again, do you have more questions or should I -- do you want me to --

Q Sure. Let's direct the questions, keep it specific.

A All right.

Q You wrote in your note that discharge planning took greater than 25 minutes; correct?

A I see that. Correct.

Q That's not preparing the discharge summary, that's discharge planning. That's done by a doctor who sends them out the door; correct?

A It can be referred to that way, but typically we refer to discharge planning is everything that took place at the time, whether it may be, you know, whether you were present or not. Again, you may not be present at the time, but the discharge planning, again, involves looking over everything, talking to whoever was around, nurses, reviewing test results and all of those things, and again, it's a general summary about how long if you were present, estimate how long it would take or how long it may have taken if you were not present to plan a discharge. Again, a discharge may be a patient going home, going to another facility, you know, whatnot, but that's generally a statement of a rough estimate of how long it took.

Q But you certified in your record it took greater than 25

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

legal hierarchies of every, of the businesses entail, I, I don't know, but if that's the case that's the case.

Q You were working for -- all right. The -- earlier we went over your credentials and your training --

A Uh-huh.

Q -- about where you, where you trained and where you went to school and all those things; correct?

A Correct.

Q Now, you, you omitted that you went to medical school down in Grenada; is that correct?

A That's correct.

Q Down in the Caribbean?

A That's correct.

Q And the reason you went to medical school in the Caribbean was because you were not accepted to any medical schools in the United States?

A I was not accepted to a medical school in the United States.

Q Doctor, you have been a party to a number of different lawsuits; isn't that true?

MS. SPEARS: Objection. Objection.

THE COURT: I sustain the objection.

Q It's not your first time today testifying, is it, Doctor?

A In trial.

Q Testifying.

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

Q And Dr. Battisti spoke to two different physicians about Matthew's care on the phone and you spoke with nobody about his care downstream; correct?
A I did not speak to a physician when I left the hospital, before I left the hospital, no.
MR. PADGET: That's all the questions I have, Your Honor.
THE COURT: All right. Redirect.
MS. SPEARS: Briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. SPEARS:
Q Dr. Patel, did you see any documentation in the medical records for -- that the nurses asked for Ativan at 1:13 in the morning when the patient became agitated?
A No. I did not.
MR. PADGET: Objection, leading, Your Honor.
THE COURT: Yeah. Rephrase your question.
Q In your review of the medical records, was Ativan ever requested by the nursing staff?
A It was not.
Q Was it appropriate for the nurses to call a physician when the patient became agitated?
A If they felt that the patient exhibited signs that needed a medication of any kind as needed it's within their power to request that or request an evaluation by a physician to see if it's necessary.

Q Thank you, Dr. Patel.

MS. SPEARS: Nothing further.

THE COURT: You can, you can step down and have a seat. Members of the jury panel, we'll take about a 15-minute break. It's -- we've been at it about an hour and a half, a little over an hour and a half, close to an hour and a half. We'll be at ease till about ten after.

(Jury exits courtroom.)

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: All right. We can bring in the jury.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: Call your next witness.

MR. GRESH: Your Honor, at this point the Defense would call Dr. Rachel Ash-Bernal to the stand, please.

THE COURT: All right.

Whereupon, Rachel Ash-Bernal is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: Please say your first and last name and spell it for the record.

MR. GRESH: Okay.

MS. ASH-BERNAL: Sure. My name is Rachel Ash-Bernal, R-A-C-H-E-L, A-S-H, hyphen, B-E-R-N-A-L.

DIRECT EXAMINATION

BY MR. GRESH:

Q And good morning, Dr. Ash-Bernal.

A Good morning.

Q I know you've already endured two hours of cross-examination that we watched yesterday.

A Yes.

Q But I did want to call you up to the stand to kind of go through some things that may not have been asked in that. It's not my intention to re-plow any of the ground that was covered there, but really give you an opportunity if one is necessary to explain some things.

A Yes.

Q Okay. So why don't we start kind of in the beginning and tell us a little bit about yourself, where you grew up, that kind of thing.

A Sure. I was born and raised in the Boston area. My mother is from Colombia, South America. That's what the Bernal is from. I grew up in a bilingual household. My father grew up in Detroit. He did high school on a military base because my grandfather was in the Army, went to Lexington public school systems, went to public high school. Then I attended college at the Pennsylvania State University. I had a partial volleyball scholarship at Penn State. I did two degrees while I was in college. I did a bachelor of arts in

Spanish literature and bachelor of science in biology. After I graduated from Penn State, I worked as a laboratory technician and a research assistant for several years and then I applied to medical school. At that time I was really interested in doing a lot of research because I had been in a research lab for a few years, really loved it, and I was awarded an MD PhD, full scholarship to go to medical school. So that was doing basically two degrees concurrently.

While I was in medical school in my clinical years I did some volunteer work in Honduras and Peru with underserved people in those areas. Some of those places were pretty remote, too, and about halfway through medical school and halfway through my PhD program I decided that I loved clinical medicine, I loved taking care of patients and that's what I wanted to focus on, and so I dropped the research and just decided I couldn't be so good at so many things and stuck with that.

After I finished medical school, which I was in for five years because of my PhD program, too, I had the honor of going to internship and residency at Johns Hopkins in Baltimore, Maryland. This was definitely a very formative time in my life. I still look back at my attending physicians with great respect and love.

After Johns Hopkins I went and did a heart failure, cardiac transplant fellowship at Columbia Presbyterian

Hospital in New York City. I applied to cardiology fellowship in my third year of residency and was accepted at Washington University in St. Louis, actually outside of the match. They offered me the position without going through the match process, which was a great honor, and doing the heart failure transplant program was sort of a fill in year for me as I wasn't going to attend general cardiology fellowship until the following year. At that point, you know, I, I could have done something else but I, I chose to do something that I was interested in and that I would learn more. So I went to New York. I moved around a lot when I was in training. I really had the attitude that I wanted to go anywhere where I could get the best training possible to become the best doctor I could become.

After New York City, I moved to St. Louis and went to Washington University in St. Louis where I did four years of cardiology fellowship. The second half of my fellowship there was mostly research based on imaging studies. The first two years were clinical based.

Q Did you for a time practice in the role of a cardiologist?

A Yes. Absolutely. As happens in many people's lives, I had something very difficult happen to me in general cardiology fellowship. My father was diagnosed with leukemia, and I'm sorry, I told myself I would not do this on the stand

because I'm not trying to elicit sympathy, but he was diagnosed with leukemia, and I was the only doctor in the family, and I was very involved with his care. He lasted 21 months. There were many dramatic moments with that. He almost died several times, and I was actually at his deathbed. In fact, I pronounced my own father.

Q Did that experience kind of help you move away from the cardiology world and into the, the world of an internal medicine physician?

A Absolutely. I mean, I can honestly say I felt very selfish at his funeral because I thought to myself if I only thought I had 20 years to live like when my dad died would I be doing what I'm doing, and I was working a hundred hours a week, you know, really didn't have a personal life and I really decided at that moment I'm going to change this. So, you know, when, when things are going in a certain direction it can be really hard to turn them around. You know, it takes years. So that's what I did. It took a little while. I practiced in cardiology. I enjoyed it but, you know, that was definitely kind of an epiphany for me, going through the medical system with my own family.

Q Have you received any type of board certifications?

A Yes. I'm board certified in internal medicine. I did that right after I finished residency and then I recertified in 2014.

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

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

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

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

Q The training that you received from Southern Myrtle Inpatient Services was that any different, better, worse than the training that you got from the other places that you worked?

A When I started at Grand Strand I remember sitting down with a nurse for an entire day. It was me and another physician, and we went through a slideshow with her, and she read each slide. I, I remember it was quite cold in the physician room, and it was about seven hours long.

Q Dr. Ash-Bernal, for how long have you been practicing as a hospitalist?

A Approximately five years.

Q And you've had a medical license since when?

A I graduated from medical school in 2000.

MR. GRESH: Your Honor, at this point I would tender Dr. Rachel Ash-Bernal as an expert witness competent to opine as to what a hospitalist would do.

MR. HINSON: No objection.

THE COURT: I find she's qualified.

BY MR. GRESH:

Q Dr. Ash-Bernal, I'd like to move to the morning hours of October 3rd of 2015, and if I could, I want to put in front of you what is already into evidence, has been marked as Defendant's Exhibit One.

A Okay.

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

Q Would you also as a physician having all the licenses and all the training that you have, have you developed certain habits and routines and practices that you would employ in the care and treatment of certain patients under certain circumstances?

A Absolutely.

Q To the extent you need to rely on your habit, routine, the nurses' notes or your notes feel free to do that, but I want to walk through the care and treatment that was provided to Matthew Scheer. You understand that you were the nocturnist or the night hospitalist on that day?

A Yes.

Q Was -- what was your first encounter with Matthew Scheer?

A I was walking down the hallway because there was another patient I was going to see, and the, the nurses asked me for help with him.

Q All right, Dr. Ash-Bernal. Excuse me, you all, you're good. You're good. I have up on the screen here a nursing note which you can find at page 116 of the records in front of you. Just for everyone's benefit this is the nursing note from Nurse Freeman, and just let me know when you've got that time.

A Yeah. At 1:13 a.m. that it occurred till 1:44.

Q Now, there's two times there on Nurse Freeman's note?

A Yes.

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

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

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

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

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

I had a good working relationship with the nurses. I think one of the reasons they felt so comfortable coming and talking to me when they saw me walking down the hallway was that I was one of the helpful doctors.

Q In a situation like this where in the chart Bethany Bell does a lengthy initial assessment, but there's no nursing notes from her until the 1:15 timeframe, I guess there would be no nursing notes for you to have reviewed to kind of catch up on this?

A Probably not.

Q Is that when -- that why you would rely on the nursing staff to report to you?

A Absolutely.

Q But you would have had access to Dr. Patel's note and you would have read Dr. Patel's note?

A Yes.

Q Did reading Dr. Patel's, I think it's a three-page history and physical, did that give you sufficient information about Matthew Scheer in to whose room you're just about to enter?

A I'd say it was adequate. I mean, you always hope for more, you know, but in, in, in the moment, you know, just as you're sitting here in court and you're going to be making decisions, this is what you got.

Q But in addition to Dr. Patel's note, you also had Dr.

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

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

reading through all these notes again is often what's notable is what's absent, you know. Dr. Patel didn't give me signout because, you know, I trust that he was not concerned that this patient was going to be a real, a real problem overnight, you know.

Q And when you went into Matthew Scheer's room you had enough information at your disposal at that point to address the situation?

A I believe so, and if I didn't feel that it was complete I would continue asking about it.

Q I want to talk a little bit about -- oops, I'm sorry. For the record, a picture of a, a boat popped up on the screen, got nothing to do with the case. Talking a little bit about Ativan.

A Yes.

Q When the nursing staff came to get you at 1:13 in the morning with -- and we just read the concerns that they had observed with Matthew Scheer, did they ask you for an Ativan order?

A They did not.

Q Did they ask you to prescribe Ativan so that they could give it to the patient?

A No. And nurses can ask me for a verbal order. I don't even need to go and put it in the computer, take a verbal order from me and they can execute that order based on that.

Q Is that -- is, is an order like Ativan is that something that the nursing staff from time to time would just call and ask you for?

MR. HINSON: Objection. Leading, Your Honor.

THE COURT: I sustain the objection.

A The typical types of questions --

Q He sustained it.

THE COURT: He's going to rephrase the question.

A Okay.

Q Let me try it again.

A Sorry.

Q Doctor, in your experience in working at the hospitals for as long as you have, what are some examples of types of orders that a nursing staff might come to you and ask for?

A So overnight I might have many nurses calling me, cross cover for other patients. There were three of us physicians on that night. So these duties were divided up among us, and it really depends on the nurse. If the nurse is concerned about a patient being agitated or anxious, they might just call and say, "This patient is really agitated and anxious or they're having trouble sleeping can I -- can you prescribe something to help them sleep?" Some nurses are sort of much more assertive and say, "This patient is really anxious and can you give them some Ativan?" Most of the time when a nurse asks me that it is not an immediate yes. It is, "Well, tell

me about the patient a little bit," because I don't want to go and sedate people just because a nurse is telling me, "Hey, you know, we need some Ativan." These are medications that can have adverse reactions. You want to be careful who you give them to.

Q When the nursing staff observed what they observed at around 1:13 in the morning, did they appropriately get you involved to evaluate the patient?

A Yes.

Q After you talked with the nursing staff and reviewed Matthew Scheer's chart, what did you do next?

A Went in and talked to him.

Q What was your goal when you entered Matthew Scheer's room at or around 1:13 in the morning on October 3rd?

A Whenever I go to see a patient that I've never seen before, my goal is to ask open-ended questions and try and find out what the truth is. That's it.

Q In a situation like this where Matthew Scheer has presented to the nursing station demanding to leave against medical advice, kind of walk us through some of the questions -- well, first off, have you been trained, whether it's at Hopkins or Philly or New York or wherever it was, have you been trained on how to handle patients who desire to leave the hospital against medical advice?

A I would say in general this is something that's routinely

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

we covered this earlier, of exactly the questions you asked Matthew Scheer; correct?

A Only the questions that I would ask by routine and habit.

Q Okay. I know you said they were open-ended questions. Can you give us a couple of examples of the questions? You said, "What's up? Why, why are you here? Why do you want to leave?" Are there any other kind of open-ended type questions you would ask as a matter of habit, routine and practice?

A Sure. Introduce myself. Identify myself as a physician. I know that I had the nurse come in with me. I routinely would have that so that she could be there to fill in any information I needed, and as we walk down the hall, I do remember that she said that he didn't want his father called. So, you know, going in there and talking to him, the first thing I do is, I mean, it's a basic thing that they teach you in medical school, look, listen and feel. What does the patient look like? What are they acting like? Are they answering questions appropriately? Do they seem to know where they are? Can they tell me their name? Can they tell me what the date is, what the time is? Can they tell me what the general places that they are? This is a hospital. You know, why you're here, you know, and based on those types of things I gauge what further questions I would ask.

Q Do you have an independent recollection of exactly the answers that Matthew Scheer would have given you in this

circumstance?

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

You look around and you see, "Is this a regular room, psychiatric room," okay.

Q Are you also observing the patient and their behaviors?

A Absolutely.

Q Some -- is it, as a physician talking to a patient in this circumstance, you're asking questions but also observing the conduct?

MR. HINSON: Objection. Leading, Your Honor.

THE COURT: That's leading. Rephrase.

MR. GRESH: All right.

A Sure. So some of the things --

BY MR. GRESH:

Q No, no.

THE COURT: Well, he's going to --

A Sorry.

THE COURT: -- he's going to ask you another question.

A Okay.

Q I'm going to -- yeah. Let's go to your cross cover note that you just referenced. In the stack in front of you, Dr. Ash-Bernal, that is page 89.

A Yes.

Q We talked a little bit ago that you became involved with Matthew Scheer at about 1:13. When is this note dictated?

A It's signed at 1:40 in the morning. The time at the top is 1:29.

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

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

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

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

A Yeah. I'd, I'd say this, this note is kind of more like nuggets.

Q Okay.

A Yeah.

Q It then continues, [as read], "Patient seemed able to weigh the information, [he interrupted his religious rant to think about the question]." Let's kind of pause there for a second.

A Uh-huh.

Q First off, do you remember the religious rant? Can you tell us any of the specifics that Matthew Scheer offered up that you characterize as a religious rant that evening?

A I, I really don't remember. If it was something really unusual I think I would document it though.

Q As a, a hospitalist and trained as you are, what -- when a patient pauses a rant and thinks about a question and responds appropriately to that question, what does that mean to you?

A To me it means that they're really thinking about what I asked them and they're making choices.

Q Is that something that you would look for as a hospitalist in this situation?

A Absolutely.

Q Is that a bad sign or a good sign?

A No. It's a good sign.

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

morning." Things look different in the light of morning after some rest, you know. That's what I always tell patients. I feel that way myself, you know. "Why don't we just kind of wait and see what happens", try and meet their immediate needs. By the time I'm getting to saying something like this, I am more desperately trying to keep this patient in the hospital by saying, "You understand that if you leave the hospital that you could die, that you could have a seizure, that you could have an infection? We haven't finished the workup. Do you understand that?"

A Based on your communication with Matthew Scheer, did he still want to leave?

A Yes.

Q At that point are there any other tools that are available to you as a physician to encourage a patient to stay?

A Directly in front of him, probably at that point I've used up almost everything I've got. At that point you can hope that you can maybe bring in the family. However, in this particular situation he told us that he did not want his family called, did not want his father called. That starts to put me in a real bind. It's not something I'm happy about. It's not something I agree with, but I have to respect the patient's wishes, and I really think that signing a form like that against medical advice it's sort of like the last resort,

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

here. Does filling out a form sometimes, as silly as it sounds, filling out a form, does sometimes that help keep more folks?

A Absolutely.

Q Describe for us your experience about what happens sometimes after, the patient still wants to leave and it's just oral, and now you bring out the form?

A So I think this kind of speaks to when people are triaged in the emergency department, one of the things that the triage nurse asks is, "How do you learn best," and they document that. That's something that we're all attuned to. Some people learn best with auditory information. Some people learn best with visual information. Some people learn best by actually having like a graphic memory and writing things. For, for me it's writing.

Q Did you instruct Nurse Bell to go get the AMA form?

A I would have had to because I don't have the AMA form.

Q When she -- does she return to you with the AMA form?

A Yes.

Q Walk us through, and, I apologize, I don't know which one is easier to read. Kind of walk us through, if you can, what this paperwork says, and more importantly, what it's designed to do in a patient such as this with -- like Matthew Scheer, and if you need it for the, the note there in front of you, page 87, 88 are the page one and page two. It's front and

back of the AMA form.

A Sorry. Orient to where you are. Sorry. There seems like there's two sets here.

Q You see an 87 and 88?

A Yeah. I'm sorry. Maybe you can help me.

Q Yeah.

A Okay.

Q So you've got 87 in your hand right there, which I'll -- two different sets, 85 and this one is 87 right there.

A Yes. Yes.

Q And just so we're oriented there's two parts to this, and this is the bottom part, but talk to us a little bit about the partial refusal of care. We're not going to spend a lot of time on that, but were there some things that the medical staff and the nurses wanted to do for Matthew that he partially refused care?

A Yes.

Q What are some of the things that, that Matthew partially refused that October 2 into 3?

A Well, what I listed and I recognize my handwriting it says he, he refused an IV peripheral line, he refused taking Keppra that was prescribed for him.

Q And you say just above that, [as read], "I acknowledge the treatment option, the risk of refusal." Kind of read that for us.

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

saying to him, that would take me down a different clinical pathway.

Q Okay.

A Just as someone with Alzheimer's, you know, like your mother with memory problems, you're not just going to go and have them sign some form if they don't seem to understand what's going on.

Q Okay. Beyond partial refusal of care, this form indicates that Matthew Scheer desired to leave the hospital against medical advice?

A Yes.

Q You don't need to read the entirety of that there. Describe -- there's a section an A, B and a C?

A Yes.

Q Describe the examination or specific treatment modalities that you recommended that Matthew Scheer declined to have.

A Right. Well, right above that it says, [as read], "I do understand -- I also understand that I may return to this hospital at any time in the event that I change my mind or if my condition worsens." That's something that I go over with people that are leaving. They are -- I'm not mad at them. They should feel free to come back for treatment at any time or any moment. "Describe the -- describe examination or specific treatment modalities recommended by physician and refused by individual." Physical exam, to me that says, "I

tried to perform a physical exam and he would not allow me to." An IV line, his medications.

Q Were there certain risks that when Matthew declined those things that that put him in jeopardy for?

A Yes. And I -- they're listed below. You know, that he acknowledges and understands refusing recommended examination or treatment or "My refusal to consent to recommend, to the recommended examination or treatment by the emergency physician and/or specialist may result in injury to me including death or severe and permanent disability or deformity as otherwise specified below," and I listed seizures, psychosis, infection.

Q Turn to the next page, if you don't mind of the AMA form, do you as the physician, who's there at the bedside with the patient, make a certification. You see it there on 88?

A Uh-huh.

Q Read for us what you certify after talking to Matthew that, that morning.

A [As read], "The signature," it states, "The signature of the physician certifies that the patient or the individual acting on the patient's behalf has the mental capacity to understand the risks and benefits of a partial refusal of care and/or leaving against medical advice and that the patient or caregiver has had an opportunity to ask questions about the benefits and risks of refusal of care and/or leaving against

medical advice."

A Doctor, in your interactions with Matthew Scheer did you assess whether he was able to appreciate the nature and implications of his condition?

A I, I believe he did.

Q Did you also assess whether Matthew Scheer could make reasoned decisions with his healthcare?

A I believe he did.

Q And in talking to Matthew Scheer about his healthcare, was he able to talk to you in an unambiguous and clear manner?

A Yes. He was calm and was able to tell me what he was thinking, and I don't want anyone to misunderstand. That doesn't mean I agree with it.

Q It's still against medical advice?

A Yes.

Q All right. Would you have signed your name on this AMA form if you didn't think Matthew Scheer had the competency to understand what you all had been discussing?

A No.

Q Dr. Ash-Bernal, did you, did you hurry through your time with Matthew Scheer?

A Not that I recall.

Q Is that something that you've ever done in a patient trying to leave against medical advice?

A Jack, I'm sure as you know, dealing with me for several

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

They documented, and pulling that trigger, it just didn't happen. It didn't, didn't happen at Lighthouse, didn't happen with Dr. Patel, didn't happen with Dr. Battisti, and just to put some context in that, there's a lot of psychiatric patients that go to Grand Strand Hospital. Generally there's four rooms down in the emergency department that are around-the-clock, 24-seven have psychiatric patients awaiting disposition to a psychiatric hospital down there, and we have to sign, the hospitalists have to sign to continue keeping them involuntarily committed. Okay. So this is not something that the people at Grand Strand Hospital are completely unfamiliar with or at Lighthouse, for that matter.

Q But Doctor, do you concede that Matthew had at least by history delusional thinking?

A Yes. Although, I, I do not recall him doing any of this in front of me.

Q In your examination of Matthew there, was there any dangerous delusional thinking offered up by the patient?

A Not that I witnessed and not that was explained to me by the nurses, and I can give you some examples of the types of things that I would be looking for.

Q Okay. What are some of the things, what are some delusions that a patient might complain of that you would find dangerous?

A Well, like, "I can't be cut. I can't be hurt," you know.

I've seen patients break mirrors, cut themselves, hang themselves, taking things that you would never imagine they could do that with, you know, pull out their IVs and just be bleeding all over the place and act like they don't even notice that they're bleeding.

Q Did Matthew Scheer ever demonstrate or suggest any of those types of dangerous delusional behavior?

A He did not.

Q If he had, if he had, what would you have done?

A I would have involuntarily committed him.

Q Even if that means taking away his, his rights?

A That's exactly what involuntary commitment means. It is detention. It is like jailing someone.

Q They can never own a firearm again?

A They can't wear what they want. They can't walk in the hallways. They can't leave their room. They may not be able to get out of bed.

Q Doctor, was there any indication to you that Matthew Scheer had an intent or a plan to harm himself or others?

A No.

Q Was there any indication that Matthew Scheer, despite his religious talk, wasn't able to understand his healthcare needs and take care of those as an outpatient?

A No.

Q And if there had been, what would you have done?

A I would have involuntarily committed him.
Q Would you have allowed Matthew Scheer to leave and sign this AMA form?
A No. I can call a security officer to the bedside at any time, and I have many times at Grand Strand when it was necessary.
Q Doctor, looking back, from 1:13 in the morning when you first got involved, Bethany Bell signs the form at 1:29, you dictate your note at 1:40, so in that timeframe, looking back, was the care and treatment that you provided to Matthew Scheer consistent with or in excess of what would be required under the standard of care?
A Yes.
Q Nothing further, Your Honor.
THE COURT: All right. Cross.
MR. HINSON: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. HINSON:
Q Not as tall as Mr. Gresh, can't do this.
MR. HINSON: One moment, Your Honor. The perils of being vertically challenged. Let's just try it this way.
BY MR. HINSON:
Q Good afternoon, Dr. Ash-Bernal.
A Good afternoon.
Q Would you agree with me that you claim to remember a lot

more today in this courtroom than you did when I took your deposition in December of 2017?

A Not necessarily.

Q Okay. Well, let's get your deposition out.

A Uh-huh.

Q Do you remember giving a deposition in December of 2017?

A How could I forget it?

Q All right.

A Sure.

Q We played some of your video earlier?

A Uh-huh.

Q Here it is right here. Dr. Ash-Bernal --

A Yes.

Q -- let's, let's reread some of this testimony from December of 2017. So that was -- when I took your deposition we're just a little over two years after Matthew's death; right?

A Yes.

Q All right. If you would turn to page 18.

A Okay.

Q Let's read lines eight through 12. I'll read the question. You read the answer, please. I asked, [as read], "And do you have any independent recollection? I know we can read the note."

A Yeah.

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

Q I asked, [as read], "Okay, suffice to say, you don't have an independent recollection of that conversation with Matthew; correct?"
A [As read], "Not, the, not the specifics, no."
Q [As read], "Well, do you have any general recollection?"
A [As read], "It's difficult. It was a long time ago."
Q [As read], "Okay. Do you have any, I mean, this is my opportunity, Doctor, to find out what you remember, if anything, about this encounter, and as I understood you to say a minute ago you have no recollection, independent recollection of Matthew," and you answered?
A [As read], "No."
Q [As read], "So you", and then you said?
A [As read], "I don't remember."
Q [As read], "Okay. So you don't remember that conversation with him?"
A At that time?
Q What's your answer? I said --
A [As read], "No."
Q -- [as read], "So you don't remember that conversation with him," you said?
A [As read], "No."
Q Okay. And I asked you, [as read], "You have any general recollection," and your answer to those questions was?
A Can you tell me where?

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

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

A Yes.
Q Thank you.
A Well, I had education at Harvard, distinguish that.
Q You had -- you were -- part of your education and training came from Harvard?
A Yes. Those specific classes that I mentioned, yes.
Q Okay. And included in those classes at Harvard you said was medical ethics?
A Yes.
Q Is that right? Doctor, the -- there are medical ethics that a physician is supposed to follow; is that correct?
A Yes.
Q And who -- what boards or organizations promulgate those medical ethics?
A Well, as a physician, when you graduate -- well, when you get admitted to medical school you swear to uphold the ethics of the medical profession.
Q Okay.
A That's the beginning of it, but there are other times where medical ethics was a required course in medical school and it's something that, you know, is part of general teaching. Certainly at Johns Hopkins we could call a medical ethics consult if we needed to.
Q The AMA -- what's, what's the AMA?
A American Medical Association.

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

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

(Whereupon, a bench conference is held in the presence but out of the hearing of the jury.)

THE COURT: This is over objection I'll allow it.

BY MR. HINSON:

Q Dr. Ash-Bernal, can you identify that document?

A It says Exhibit 7(A). There's a bunch of boxes with arrows going from one box to another. On the left it says hospital. It says contract. Shows EmCare, Inc. An arrow going above it says Envision. It says remote parent. Another arrow which has two arrowheads goes from EmCare, Inc., to shows administrative services contract. Then it says Inpatient Services of South Carolina, P.A. That box has a double-headed arrow that says sole shareholder. That goes to another box that says South Carolina EM One. That goes to another double-headed arrow that says sole shareholder and that goes to physician owner box. Below Inpatient Services of South Carolina, P.A., there's another double-headed arrow that says sole member. There's another box that says South Myrtle Inpatient Services. There's a double-headed arrow before that that says employees. There's a box below that that says employed hospital medicine physicians, and at the bottom it says Exhibit 7(A) on 12-5-2018.

Q Doctor, I represent to you, this was a corporate structure chart that was provided by your employer Southern Myrtle Inpatient Services in the deposition I took of your

employer, Southern Myrtle Inpatient Services, and according to the chart of your employer, Southern Myrtle Inpatient Services, EmCare over here is not your employer; isn't that what this document would show?

A Well, I'm, I'm -- I wasn't involved in the, in the business of this company. I note as a physician they were very proud to say that we were EmCare physicians.

Q During -- Southern Myrtle Inpatient Services' involvement with you was so little that you didn't even realize that that was who your employer was when I took your deposition in 2017; did you, Dr. Ash-Bernal?

A Yeah. I don't think I could agree with that statement.

Q Okay. Let's look at your deposition again, please.

A Uh-huh.

Q Dr. Ash-Bernal, let's look at page 10 of your deposition that you gave under oath in 2017. Let's start on line two --

MR. GRESH: Your Honor, could we approach?

THE COURT: Well --

Q -- at the end of line 19.

MR. GRESH: Can we approach?

THE COURT: Yes.

(Whereupon, a bench conference is held in the presence, but how the hearing of the jury.)

Q Dr. Ash-Bernal --

A Yes.

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

A I understood my employer to be EmCare.
Q Okay. And sitting here today you still understand your employer to be EmCare?
A That was my understanding of who my employer was.
Q Okay. Sitting here today, you understand your employer to be EmCare, this, this one over here?
A Not now.
Q Okay.
A At that time in 2015.
Q Okay.
A It's much like someone who works for Walmart and there's some large corporation over it that they may not have even really ever heard of.
Q Doctor, my question is sitting here today in this courtroom --
A Yes.
Q -- who do you understand your employer to be today?
A EmCare.
Q So you disagree with this chart?
A I can't see what you're looking at.
Q I'm pointing at the chart that's in your hand?
A Yes. Can you specify where, please?
Q Well, Doctor, at the bottom of the chart --
A This is -- you mean --
Q -- it says employed by --

A -- my deposition? That's what you're referring to?
Q No.
A No.
Q Dr. Ash-Bernal --
A Okay.
Q -- I'm talking about the chart in front of you.
A This chart.
Q The one I just handed you, this, this, this graph or chart --
A Okay.
Q -- of employers --
A Yes.
Q -- and employees?
A Yes.
Q Sitting, sitting in this chair under oath today who do understand your employer to be?
A My understanding of who my employer was was EmCare. I have not seen this before, and I would not know how to interpret this.
Q Okay. So you do not believe your employer to have been Southern Myrtle Inpatient Services. Is that your testimony?
A As I recall my employer was EmCare.
Q Did Southern Myrtle Inpatient Services have any involvement with you in October of 2015?
A I don't recall that.

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

THE COURT: You can step down. Of course you can step down and don't, don't discuss your testimony with your -- with, with anybody, Doctor.

MR. GRESH: But she's a party to the litigation and she's my client. She's not just a witness.

THE COURT: That's right. You're not just a witness.

MR. HINSON: But Your Honor, wouldn't it be the same as during the deposition?

THE COURT: Well, well, subject -- she's subject to cross though. She's subject to cross. So I -- I'm going to restrict her from not talking to you because it's, it's, it's a -- it's subject to cross.

MR. HINSON: Thank you, Your Honor.

THE COURT: Okay. So don't, don't, don't -- Mr. Gresh is not going to try to talk to you, nor is Ms. Spears.

A Okay.

THE COURT: All right.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: I think we've got a couple of jurors still using the facilities and Mr. Ropp is going to let us know when they're ready. All right. We can bring in the jury.

MR. HINSON: Thank you.

THE COURT: And have the doctor take the stand. All

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

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

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

isn't it? They fall into any of these three categories they're unable to consent; isn't that correct?

A Actually, number one doesn't -- it just has a semicolon at the end of it.

Q They have to fall in -- if they fall into any of these three categories they're unable to consent; isn't that right, Dr. Ash-Bernal?

A Yes.

Q Okay. What is the chain of command? Generally speaking, what is a chain of command?

A It's who you go to, your superiors when confronted with a problem you're not sure what to do with.

Q Okay. And the chain of command at Grand Strand and any hospital in this country goes all the way up to the CEO if necessary; doesn't it?

A I suppose, yes.

Q And so if you have a question about permissible patient disclosures for patient safety, you're not sure about an answer you have a tool, you and all doctors have a tool available to you to get an answer; don't you?

A I can tell you at Grand Strand what I would do if I didn't have an answer to something that was procedural in the hospital, I could talk to the nurses, I could talk to the charge nurse on each of the units, I could talk to the nursing supervisor.

Q At Grand Strand you have a tool called the chain of command --

A Uh-huh.

Q -- by which you can get an answer to a question you might have if you -- about permissible disclosures of healthcare information for patient safety purposes? That tool is available to doctors 24-seven; isn't it?

A If I had that question, possibly, yes.

Q Okay. And the administration at Grand Strand will find an answer for you any time of day, any time of night if it deals with patient safety; correct?

A Exactly who are you referring to in the administration?

Q If you have a question --

A Uh-huh.

Q -- if you're unsure about what the law will allow for disclosures for the purpose of patient safety --

A Uh-huh.

Q -- you have a question about that, the administration, the chain of command somewhere in there will be that answer, the person who knows those type things?

A I'm sure there's multiple people that could help, including risk management, if necessary.

Q Okay. They're part of the chain of command; correct?

A Yes, uh-huh.

Q Dr. Ash-Bernal, you said earlier, as I understood on

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

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

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

approximately 1:15 in the morning was Matthew at any point in time pacing shirtless?

A From what I recall from what the nursing note is, the note said that, yes.

Q But my question is this, prior to 1:13 in the morning had Matthew ever been seen pacing shirtless?

A According to what I remember from one of the nursing notes, that's what it said.

Q It's -- Dr. Ash-Bernal --

A I, I would have to refer back to the notes that the nurse wrote.

Q Okay. We'll --

A Okay. Because I did not see him pacing shirtless.

Q Okay. This is my question, Doctor, listen to my question. Prior to this 1:15, 1:30 incident on October 3rd, 2015, there had never been an occasion that was recorded by any doctor or nurse where Matthew was taking off his shirt and pacing in the hallways; had there?

A Again, I can only go by what's in the notes.

Q Dr. Ash-Bernal, prior to 1:15 in the morning there had never been an occasion where Matthew was becoming aggressive with the staff; had there?

A Again, I can only go by what was documented in the notes.

Q Doctor, prior to 1:15 in the morning there had never been recorded an occasion where Matthew was becoming aggressive

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

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

note that is in process or has been started and has not been signed. Some of the information from the hardcopy paperwork from the emergency department it's possible.

Q So you think it's possible that you may not have had all the information available to you?

A I think I had sufficient information to go and talk to the patient and assess him.

Q Assessing the patient you need to know his prior hospital course during that, during that time; don't you?

A It's helpful.

Q It's important; isn't it?

A There are times when I'm called to emergencies in the hospital where I don't know anything about the patient until I'm at the bedside. For instance, a code patient can't talk to me.

Q Was this an emergency?

A Is what an emergency?

Q Was the incident with Matthew between 1:15 and 1:30 in the morning an emergency?

A Not the way it was presented to the -- to me by the nurses.

Q You had time -- but you would agree the record reflects that Matthew at some point calmed down at the time he -- and was calm at the time he was discharged? At the time he walked out of the hospital he had calmed down a little bit from what

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

and sometime before 1:27 because that's when we know you were signing this form was at 1:27, which is what, less than 15 minutes, at the time you walked into his room you knew that just moments earlier a patient who had come to the hospital with acute psychosis, had just moments earlier been yelling that everyone was Obama or, excuse me, everyone was with the devil and Obama could not control him and had been aggressive with the staff, you were aware of that at the time you walked into Matthew's room?

A Well, I'm aware of what I put in my note. Okay.

Q So you don't think you would have been aware of that at the time?

A I don't, I don't know what you mean.

Q My question is you don't think -- is it your testimony that you don't believe you would have been aware of Matthew's behavior just minutes earlier? Is that your testimony? You don't think the nurses would have told you?

A I would refer back to my note, what I wrote there. Okay.

Q Doctor, I don't, I don't know that, that you're answering my question. The nursing note reflects a patient outburst, can we agree with that?

A Could you please refer to the page again?

Q 116 on Defendant's One.

A Okay.

Q Would you agree with the general concept that this is a

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

very verbal with staff, becoming aggressive with staff stating that we are all with the devil. Security at bedside. Patient verbalizing that he is here voluntarily and we cannot keep him here. Staff tried to calm the patient and reinforce that we are here to help him. Staff offered to call patient's father for him to speak to. Patient refused. Dr. Ash-Bernal in to see the patient. Patient stated he wants to leave. AMA paper signed by Dr. Ash-Bernal, patient and this RN. Patient escorted off the unit by security." That's what's on page 116.

Q Okay. Doctor, my question was --

A Uh-huh.

Q -- do you agree that there was a patient outburst between 1:15 and 1:30 in the morning?

A I, I wouldn't characterize it as an outburst. I'd characterize it the way the nurse described it.

Q Okay.

A Because I did not witness the outburst as you're describing it.

Q Okay. Well you, you wrote it in your own note and you said, [as read], "I was called to the patient room" --

A Uh-huh.

Q -- "by nursing staff since patient was yelling at nursing staff stating they were all devil worshipers and Obama is Satan?"

A That is what the nurses told me and that is what I

documented. I cannot say that the patient did that in front of me.

Q Okay. But if that is what occurred, if that is what occurred, Dr. Ash-Bernal --

A Uh-huh.

Q -- would you agree that that was a patient outburst?

A I mean, you're, you're sort of using a, a layperson's term that I would not necessarily use. Okay. I mean, are you a doctor?

Q No. Dr. Ash-Bernal, I'm not.

A Okay. So, I mean, it's sort of semantics. That might be how you describe it. What I would describe it as is as I am reading it I trust the nurses of what they observed. That's all I can say.

Q All right. Thank you, Doctor. At the time you allowed, allowed Matthew Scheer to leave the hospital at 1:30 in the morning during a storm, you were aware that he had come to the hospital for treatment of psychosis; correct?

A That was one of the diagnoses. Yes.

Q Okay. And at the time you allowed Matthew Scheer to leave the hospital at 1:30 in the morning during a storm you knew that he was an epileptic who hadn't been taking his Keppra; correct?

A Yes.

Q At the time you allowed Matthew Scheer to leave the

hospital at 1:30 in the morning during a storm, you knew that he had been dehydrated at the time of his admission and had not received any IV fluids?

A Yeah. Dehydration is a diagnosis.

Q Okay. Did his labs reflect dehydration?

A Not severe dehydration. No. They did not.

Q Did, did they reflect dehydration of any level?

A The types of things that I would look for for dehydration is on physical exam skin tenting, which means that the skin sort of stays up because you're so dehydrated. I would look at the laboratory studies and look for an elevated BUN and creatinine, which he did not have. It was not outside of normal. Okay.

Q What would be normal for BUN and creatinine?

A Creatinine, someone in his age group would be one or less and creatinine -- BUN depends on muscle mass. Someone who is pretty muscular, I don't know, low 20s. So typically, if somebody is getting really dehydrated, their BUN and creatinine elevate. That's one of the things we look for. The other types of things on physical exam that I would look for is dry mucous membranes, somebody's mouth almost like sticking together. You know, these are all signs and symptoms that I would look for.

Q Seizures can be dangerous; correct?

A They can be.

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

discharge Matthew, did you have any idea of what types of seizures he would typically have if he didn't take his medication?

A I did not observe him having a seizure, and I did not notice anything in the medical record that described observing him having any seizures in the hospital.

Q That's different than my question, Dr. Ash-Bernal. My question is this, at the time you discharged him did you know anything about what types of seizures Matthew would have, had, had had in the past related to his epilepsy? Did you know that?

A Again, you're saying I discharged him. He left against medical advice. The process that I go through for a patient for discharge is very different than the process that he went through.

Q Okay.

A And --

Q I'll be happy to --

A -- I did not see a characterization say from like a neurological consult or any other prior records that would indicate the exact type of seizures that he had.

Q Okay. So I'll be happy to rephrase my question then. At the time you chose to allow Matthew to leave AMA, you were unaware what types of seizures he had had in the past related to his epilepsy?

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

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

Q I didn't ask you that, Doctor. My question is the three categories for which a physician can put a temporary hold on a patient, in the third category is patients with delusions of thought that are so great they can't care for themselves and may be a threat to others?

A I believe by South Carolina State law it says that the third party is -- involves self-neglect, severe self-neglect.

Q Is a patient who isn't taking his Keppra, is that a patient that's exhibiting self-neglect?

A Not necessarily.

Q Is a patient who isn't eating exhibiting self-neglect?

A I'd really have to qualify that with how long they haven't been eating and whether or not they had clinical signs and symptoms of say like malnutrition or kidney failure because they were so dehydrated.

Q Would a patient --

A That's what, that's what I would consider severe. I mean, people can go a day or two not eat much, not drink much and if they're young and healthy I would say this would not have a severe adverse effect on their health. Now, if a 90-year-old went two days without eating or drinking and became dehydrated and fell at home because they were dizzy and had a fractured hip or something like that, I'd say, wow, yes, very dangerous.

Q Dr. Ash-Bernal, what about a patient who hasn't eaten and

they're exhibiting anorexia due to hallucinations, is that patient exhibiting severe neglect?

A Anorexia is a general term in medicine to indicate that people are -- that the patient does not have much of an appetite.

Q No further questions at this time --

A Is not eating.

Q -- Dr. Ash-Bernal.

THE COURT: All right.

MR. GRESH: Briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. GRESH:

Q Dr. Ash-Bernal --

A Yes.

Q -- I tried to be very careful when I was asking you questions earlier --

A Yes.

Q -- about you don't have an independent recollection of Matthew Scheer; correct?

A That's correct.

Q You're not here to say exactly, "Here's the 40 questions I asked Matthew"; correct?

A Correct.

Q Or, "Here's the 30 responses that he gave back to me"?

A Correct.

MR. HINSON: Objection, leading, Your Honor.

THE COURT: I sustain the objection. Rephrase your question.

Q But you -- are you here to talk about your habit, routine and practice in taking care of patients like Matthew Scheer?

A Yes, and I have tried to share that with the jury.

Q And we all watched this TV yesterday?

A Yes.

Q Did you try to go through your habit, routine and practice on the TV yesterday like you did today?

A As best I could. Yes.

Q You told me you'd go in, you try not to let them leave. You ask everything you can. This is all stuff that you had talked about before.

MR. HINSON: Objection, leading, Your Honor.

THE COURT: Don't lead.

Q Dr. Ash-Bernal --

A Yes.

Q -- have you come up with new creative memories or are you trying to talk about the habit, routines and practices?

A No. I'm trying to --

MR. HINSON: Objection, Your Honor, leading.

THE COURT: I overrule your objection.

A I tried to share with the jury what my habits are, what my routine is.

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

Southern Myrtle or do you see right here that it's Southern Myrtle?

A Yeah. As I said before, I believe what I saw it on was the paycheck stubs.

Q Dr. Ash-Bernal, I appreciate your time. Thank you.

THE COURT: You can step down and have a seat at counsel table.

A Thank you.

THE COURT: Call your next witness.

MR. GRESH: Your Honor, at this time the Defense would call Dr. Oscar Lovelace to the stand, please.

Whereupon, Oscar Fred Lovelace, Jr., is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: Please state your name and spell your first and last name, please.

MR. LOVELACE: I'm Oscar Fred Lovelace, Jr., and my spelling of my first name is O-S-C-A-R, last name is L-O-V-E-L-A-C-E.

DIRECT EXAMINATION

BY MR. GRESH:

Q Dr. Lovelace, introduce yourself to the jury, please.

A I am Oscar Lovelace. I'm a family doctor in a small town, Prosperity, South Carolina, been there for, in August, it'll be 31 years.

Q And tell us a little bit about what kind of work you do

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

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

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

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

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

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

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

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

A I thought it was reasonable. The fact is is that HIPAA has been around for quite a while and, and doctors have had to get continuing education on this from a variety of different sources. Even people that work in our office part-time is something that they have to go through, people that aren't doctors.

Q And just to be clear, was the PowerPoint that Southern Myrtle by way of EmCare provided to its doctors, did it comply with the standard of care necessary for those who are educating folks on HIPAA, meet the requirements?

A I didn't, I didn't see any gross deficiencies in it.

Q And when you -- did you see any deficiencies that were below the standard of care for HIPAA education of other providers?

A Well, I don't want to hold myself out as an expert in HIPAA, but I'm, I'm just saying it was, it was consistent with the training I've had in the Healthcare Insurance Affordability Act.

Q Whether that's from MUSC, Virginia or anyplace else?

A Right.

Q All right. So, you're here today as an expert witness. You were not there actually taking care of Matthew Scheer at any time; correct?

A I was not there.

Q But you have reviewed a lot of the deposition transcripts

in this case?
A I have.
Q And the medical records, you reviewed stacks of medical records as well?
A I have.
Q At this point have you reviewed enough information whether it's from deposition -- before that, you've also been here in the courtroom all day today?
A I have.
Q And you got to hear the direct examination and the cross examination of Dr. Patel?
A I have.
Q Did you also hear the direct examination and cross examination of Dr. Ash-Bernal?
A I did.
Q Both of those were under oath just a like a deposition testimony. You understood that?
A Yes.
Q Based upon your review of the medical records in this case, plus the deposition testimony that you reviewed, plus the live in-court testimony that you reviewed today, have you formulated opinions as to the quality of care and treatment provided by both Drs. Ash-Bernal and Patel?
A I wouldn't be here today if I didn't feel that Dr. Ash-Bernal and Dr. Patel met the standard of care. It's my

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

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

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

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

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

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

some instrumentalities that we might use commonly in the hospital might be dangerous in a psychiatric unit. You understand that, IV tubing, EKG leads, those types of things?

A I wasn't familiar with the term instrumentalities.

Q I'm sorry.

A Yeah.

Q That's my word.

A Okay.

Q Talk to me about what Dr. Patel did. He's there for medical clearance. Did Dr. Patel appropriately evaluate Matthew Scheer? Did he appropriately formulate a plan? Kind of walk me through that.

A In my opinion when Dr. Patel received the report from Dr. Battisti it was that he had come back from Lighthouse and that they wanted further medical clearance, and so Dr. Patel said, "Okay, well, we'll, we'll do that." One thing that was pretty impressive is he responded immediately according to the record. There was an hour and a half delay, and he came and evaluated the patient and decided, okay, for the hyperbilirubinemia we'll get an ultrasound, abdominal ultrasound. Sometimes high bilirubin is caused by gallstones trapped in a common bile duct, but again, he had no complaint of right upper quadrant pain. He had no fever to suggest he had cholecystitis, but he said, "Okay. We'll, we'll evaluate that," and so he orders an abdominal ultrasound. The

abdominal ultrasound is done and it is unremarkable, and then the other, the other aspect was the elevated white blood cell count, and white blood cells are made by your bone marrow. If you're under a lot of stress, you get in a car accident, you have been upset, you get shocked by something, you fall, your white blood cell count can go up, especially if you're a healthy person, but obviously, we always get concerned when the blood white blood cell count is elevated, does someone have an infection, and in Matthew's case he didn't have a fever. His blood pressure was normal. We weren't really concerned that -- I should say they were not really concerned, I think, that he was septic. So he, again, I believe was considered to be medically stable. He's put on a general medical floor. He wasn't put in the intensive care unit, and you know, by virtue of that they didn't feel like he needed like one-on-one direct supervision.

Q Was Dr. Patel's physical examination of the patient and plan of the patient appropriate?

A It's consistent with standard medical practice.

Q The -- did Dr. Patel seek to appropriately medically clear Matthew Scheer?

A I think he did. I think one of the other things that's important to, to bring out here is that when Dr. Patel sees Matthew he's described as being calm, cooperative. He's not actively hallucinating, and so, he's trying to take care of a

patient based on the history that is being provided to him, but he certainly doesn't see Matthew as a threat to himself or others, and another point that, that I would just make is that, you know, Matthew came into the emergency room saying, "I've been born again. I've been cured. I don't think I need my medicine anymore," and so it doesn't really strike me as, you know, especially if you're talking to someone who is not actively hallucinating or combative or aggressive at you that that seems to be, you know, a, a person that you need to put in the ICU or on one-on-one supervision. So I think that Dr. Patel he, he provided the history of what had been provided and the appropriate referral based on the history given by his father and, and the findings in the ER, but it was not, it was not what he was seeing.

Q It was stuff he had heard by history?

A And right, and was in the medical record from what was in the emergency room.

Q Dr. Patel writes in his note PRN Ativan but doesn't actually order the PRN Ativan.

A Well, this weekend, I, I, I had to use PRN Ativan on the patient that I wound up putting in the intensive care unit who said he was going to get a gun and shoot everybody and he was cursing at the nurses and he was resisting all the care and very combative. So I had to use something to sedate him, but in this case, if someone's calm and cooperative, you may put

in your note may use PRN Ativan, but you don't just put the order in. It's just something that you're saying you may do.

Q Was there any requirement under the standard of care applicable to Dr. Patel in these circumstances that he had to actually go write an order for PRN Ativan?

A Absolutely not. When a doctor writes their admission history and physical they, they basically outline what they feel like is the plan, but if I admit someone with chest pain and I may think that I'm going to -- I, I, I might say I'll do a stress test. I may wait till the next day to write the order for the stress test because I want to make sure that I rule out myocardial infarction by enzyme and EKG criteria first. So just because you put something in your admit note of a medicine you might use or some intervention, it doesn't mean you -- it's a -- it's, it's not a deviation not to write the order for that, for that test or treatment.

Q When Matthew is calm and cooperative with Dr. Patel is there any indication to give Matthew Scheer Ativan at that point while Dr. Patel is there with him?

A No, and I mean, I think it would be inappropriate actually. One of the things that we do when we admit people to the hospital and it is difficult. It is more difficult because I function both as a hospitalist taking care of people I don't know and then taking care of people that I've taken care of for 30 years, and that is that you don't want to knock

someone out or just sedate them if you really don't, don't know how they're presenting. You, you just don't put someone under, and I, I think Dr. Ash-Bernal was saying that, you know, or it may have even been in her, in her -- I'm not sure if I read it in her deposition or if I -- or she said it today, honestly, but even when a, when a nurse calls us and says, "Hey, I want to give this person some, some IV Ativan," you, you don't just say, "Okay, fine," you know, because you, you don't want someone just to be knocked out. If they have sleep apnea they may, they may become hypoxic and have more problems.

Q In, in a situation like Matthew where you know you're going to have a psychiatric consult is that maybe one more reason not to give Ativan?

A Well, you know, Ativan is a benzodiazepine. It's, it's a Valium drug. It has a little bit shorter half-life than Valium. Valium has about an eight-hour half-life. Ativan has a four to six-hour half-life. So it's, it's --

Q What's half-life?

A Half-life is like essentially it's the, the time it takes that the medicine is going to get in the system and out the system. So, you know, if a medicine has a half-life of, of eight hours you're going to give it about every eight hours. If it has a half-life of four to six you're going to get it every four to six, but what, what I would, I would just say is

that he is saying this is a patient who apparently has psychosis, which the definition of psychosis would just be not being in touch with reality, and so if their behavior manifested itself before the psychiatrist gets here and becomes disruptive or whatever, then I could use PRN benzodiazepine or Ativan.

Q Is another option that would be available in that circumstance get the physician involved?

A That's the best, that's the best option because then you've got an evaluation of the patient.

Q Let's, before we jump to that real quick, the other allegation as I heard it against Dr. Patel is the, the handoff or signout that hospitalists do. Let's talk about that real quick. When Dr. Patel left that evening were there any critical outstanding labs or tests that had not yet been completed that the nighttime hospitalist would have to follow up on?

A No, and I think if you look at Bethany Bell's note from sometime right before 7:30 after Dr. Patel left, he was described as being calm, cooperative and not having any abnormal speech.

Q In a situation like that is a handoff physician-to-physician, hospitalist-to-hospitalist, is that required?

A You know, this term, excuse me, this term of, of handoff typically what, what we call that in medicine is a signout,

and we sign out the patients who are unstable or patients who are in the middle of an evaluation for something that would require some follow-up that night. Dr. Ash-Bernal gave a pretty decent example of that which would be someone that comes in short of breath and you're wanting to rule out a pulmonary embolism, and you may have done a chest x-ray, but you're waiting on a pulmonary angiogram to come back and that would be something you would sign out to, to the other person who's coming in to take call, but as far as in the hospital environment functioning as a hospitalist, frankly, there's more information available within that system. I mean, they've already mentioned there's 132 pages worth of information and there's no way you're going to go over 132 pages of information on 20 patients before you leave and so, have a good 12 hours.

Q Was there any requirement under the standard of care for Dr. Patel to give a handoff to Dr. Ash-Bernal?

A In my opinion he was clinically stable, and he's -- he was described by the nurse within 30 minutes of Dr. Patel leaving the hospital that he was calm, cooperative and, and that he had no abnormal speech.

Q We know that at around 1:13 in the morning or so there's a -- Matthew Scheer has a change in condition.

A Right.

Q And we, we heard earlier that before Dr. Ash-Bernal would

have went in and talked to Matthew Scheer that by way of her habit, routine and practice she would have read that which was available to her in the chart prior to going and visiting the patient. Did you see that in her deposition?

A Well, I don't think you ever want to walk into a room cold without having some information and especially, you know, one of the things that we -- I even teach -- taught my four children the last thing you want to do is when there's drama is elevate the drama. You want to try to assess the situation and before walking into that, and so what, what Dr. Ash-Bernal describes is, and believe me if you're a resident and you don't to listen to the nurses you'll, you'll, you'll learn fast not to do that. She, she went to speak with the nurses, and said, "All right, what's going on," gets a history from the nurse, and then says, "Okay, I'm going to look in the computer at these pages," and describes the pages that she's going to look at. She's not going to look at the pages and pages of labs that are already listed in the H and P note from Dr. Patel or in the ER note. She's going to look at the, the ER evaluation, the doctor's admission note and she's going to talk to the nurses, and so, that's what she did because there had been a change in status.

Q Is there anything that she would -- let's assume there had been a handoff between the two physicians. Is there anything that she would have learned from that handoff that

wouldn't have been available in Dr. Patel's three-page dictated history and physical?

A I think it would be unlikely that he would communicate everything that would be readily available to her in a signout. There's just no way that she -- that he would have communicated all that information, especially all the back-and-forth between Lighthouse and --

Q And she would learn more from reading a chart than she would from a signout?

A I, I, I think so.

Q Okay. Well, let's -- talk to us real quick -- let's kind of before we get there, looking back at everything Dr. Patel did from the moment he first saw Matthew Scheer until he left that, that evening, is there any action or inaction that he took that fell below the applicable standard of care?

A I would just reiterate he got the call. He responded within the same minute. He said, "I agree to take the patient. I understand you have talked to Dr. Oduwole." He dictates an H&P before he leaves. I mean, frankly, I don't know what was going on with him that, that night, but you know, I had five admissions on Sunday. I had to do one of the admissions the next morning. So before he leaves he's got a history and physical in the chart, and he basically, in my view, is describing what everyone else is saying is going on with this person, but he's not seeing.

Q Is there anything that Dr. Patel did or failed to do that you believe deviated from the applicable standard of care for a hospitalist in that circumstance?

A No. I don't think he deviated.

Q Okay. Then let's move on to Dr. Ash-Bernal. We've all seen it, the 1:13 note from Charge Nurse Freeman and the Bethany Bell note after that. We heard Dr. Ash-Bernal get up on the stand and talked about what her habit, routine and practice would have been in handling a patient like Matthew Scheer. Based on what you've read in her deposition testimony and what you saw here firsthand today, do you think anything that she did in the handling of Matthew Scheer in this change in condition at around 1:13 in the morning deviated from the standard of care applicable to hospitalists under the same or similar circumstances?

A No. I don't, and if you don't want me to explain it, I'll, I'll --

Q Yes. Please.

A Okay. So this is actually a pretty common scenario that someone says, "I'm not staying here. I'm getting out of here," especially if they don't have a relationship with their doctor in the hospital, and frankly, most of the time in my experience, there's not this thorough process. Most of the time a patient says, "I'm leaving," they get up and walk out. They say, "Wait, wait, wait, wait. I want you to sign this

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

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

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

been cured," that may not necessarily be in touch with reality, but what I will say is that we don't take -- when you, when you, when you talk -- when you're talking with someone just because they say something that you think may not be fully based in reality, you don't call and invoke the chain of -- the, the chain of command or, or, or involuntary commitment. I've, I've done that before, and involuntary commitment is a traumatic process. I've done it in the office. I've done in the hospital. You know, law enforcement comes in, puts patients in handcuffs and have an officer in the room with them. That's the way it works at our hospital. You know, if there -- if somebody is, is refusing treatment, and I say, "You're a threat to yourself or others," then my next call if I'm in my office is to the county sheriff. If I'm in the hospital emergency room it's to the, it's to the, to the chief of police because if I, if I've got to invoke chain of custody, that patient cannot, and especially, you know, I will, I will say, I will say this, most of the time those people are overtly acting out. They are threatening themselves or others.

Q Whether it's traumatic or not, if it's indicated you would involuntarily commit somebody?

A Exactly, but you have to understand when, when you say to someone, "You are not leaving," especially to a young healthy male, you know, that could turn into a traumatic experience.

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

shirt. They say, "We're calling the doctor." The doctor comes in and makes an assessment. The doctor says, "Are you sure you want to leave?" "Yes. I want to leave." "I want you to sign this form." "Okay. I'll stay and sign the form." Stays and signs the form. "Okay. Now we'd like for the police officer to escort you downstairs." He, he cooperates with that. He's escorted downstairs and he leaves.

Q Throughout that entire experience was there anything that was observed by the nursing staff or Dr. Ash-Bernal that would have precluded allowing him to leave against medical device?

A I'm sorry. Restate that.

Q That may not have been a good one. Is there anything that was observed by Dr. Ash-Bernal or the nursing staff at around 1:30 in the morning which would have precluded allowing Matthew Scheer to leave against medical advice, danger to himself or others, suicidal or so --

A Yeah. I, I -- sounds like there were a lot of double negatives in there, but the bottom line is, I, I, I feel that he did not manifest behavior that in 30 years of experience that I would have given the same set of information said, "I am putting you under involuntary commitment. You are not leaving this hospital."

Q And looking back at all of the care and treatment that Dr. Ash-Bernal provided to the patient, whether it was documented in the chart or testified to, taking it in its, in

its totality, do you believe Dr. Ash-Bernal in all respects complied with the standard of care applicable in that situation?

A I do.

Q Appreciate your time. Thank you. Please answer any questions that Mr. Hinson may have.

CROSS EXAMINATION

BY MR. HINSON:

Q Good afternoon, Dr. Lovelace.

A Good afternoon.

Q All right. You're not a member of the Society of Hospital Medicine; is that correct?

A That's correct.

Q And you're not a member of the American Board of Internal Medicine; are you?

A That's correct.

Q Dr. Lovelace, how much are you charging to come here today and testify on behalf of the Defendants?

A I think I get $5000 a day because I'm out of the office.

Q Okay. And you charged a $5000 retainer; correct?

A I don't think I was paid a $5000 retainer, but I might have been.

Q If, if you told --

A I mean, you could get my invoice. I don't know.

Q But you took a -- you gave a deposition in this case?

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

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

requested, and you said you had a commitment in the evening and I could just send it to you later, and unfortunately that was about three weeks ago, and I haven't had a chance to get around to it.

Q Now in a trial, Dr. Lovelace. So we had your deposition, you didn't comply with the subpoena, you didn't bring your billing, and I said if you would just get a copy to the court reporter so that she would make it an exhibit to your deposition then I'd know how much you had billed total, but you didn't do that either; did you?

A If, if the billing information has an impact on this matter I will stop right now and we can take a break and I'll try to get it for you.

Q You've, you've billed more than $20,000 in this case; haven't you, Doctor?

A That I believe, sir, is erroneous.

Q How would much would you estimate you've billed?

A I would imagine somewhere around 15, but I'm, I'm not positive. I think this case, I think I got this material I think I got it in 2018.

Q But you haven't provided me any way to know that because you didn't provide me your bills?

A I've already admitted that, sir.

Q And Dr. Lovelace, you've testified in court quite a bit; correct?

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

standard," I send it back to the attorney. Your, your statement about -- in one case I told you that just before my deposition I had been in North Carolina and given a, a, a deposition and court testimony in a wrongful death case about a young woman who died of a pulmonary embolism and that that was the case that I had been in court on.

Q You've testified in court and at deposition numerous times; correct?

A That's correct.

Q And of those numerous, numerous times you've testified every single time, save that for one, it's always been on behalf of the doctor; is that correct?

A State that question one more time.

Q Of all the times you've testified, all the times you've been -- you've come to trial and been willing to testify, all the times, every, every single time except for that, except for one has been on behalf of the doctor?

A And it's important for the jury to know that often the way that -- no --

Q If you'd answer my question first and then you can qualify it if you need to.

A I will say I think I'm -- I think you're correct in that, but what I want the jury to understand is that often when I see a case where there's been a deviation from the standard of care, the lawyer will go back to the hospital or whoever is

being sued and they'll lay out the plan and say, "I, I have had this reviewed by a doctor and I think, you know, you better, you better pay up or we're going to have to take this through the court system," and many times those cases are settled.

Q You said earlier that involuntary commitment is a traumatic process. Were those your words?

A It is.

Q It takes some, takes some work to do that; doesn't it?

A It, it actually is pretty quick to, to draw the trigger to do that. What I'm saying is it's traumatic for the patient and it's traumatic for everybody around because it's like turning a person into a nonperson. I mean, the, the last time I did it I had a, a patient who had become manic and he would not get off his bulldozer because he was digging a deeper and deeper crater, and we went out to the site where this was happening, talked him off the bulldozer, talked him into the ER and put him in handcuffs.

Q He was having some sort of delusional thinking, the fellow on the bulldozer?

A That was a threat.

Q All right. Thank you, Dr. Lovelace. No more questions.

MR. GRESH: Real briefly.

REDIRECT EXAMINATION

BY MR. GRESH:

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

THE COURT: All right. I'm going to say we'll take a short break. Just wait a minute, wait a minute, we've got one other thing, short break, and then maybe we can meet back in my office or a conference room back here. The reason I said wait a minute, we've got -- I've got this notice of motion to hold Defendant in contempt and charge the jury about the -- that the Defendant, Spartan [sic] Myrtle, I guess it is, can pay any judgment that's awarded.

MR. HINSON: Your Honor, I don't know that it's, it's ripe just yet. Since the time that motion was filed Defendants have, have moved to bifurcate the case, and I mean, as much as I'd, I'd like for you to hear it at this point, I, I do think if, if, if the jury doesn't come back finding that anybody was grossly negligent since we now have a bifurcated trial I don't know that it's, it's -- needs to be heard at this point.

MR. GRESH: Well, Your Honor, I'd just as soon hear it now. Here's what happened because I mean, I find this, this interesting, and I'm surprised we're even -- I'm surprised he filed it and I'm surprised we're still arguing it. There was an order from another --

THE COURT: I saw the order. I've, I've read it.

MR. GRESH: Yeah. And so I take over the case and didn't know about the order. Brink does the honorable thing. Emails me, says, "Hey, just in case you didn't see this, don't forget

to get me this stuff before trial," appreciated the, the heads up, professional courtesy. I expressed my thank you for that.

Immediately reached out to Southern Myrtle and to Dr. Patel and Dr. Ash-Bernal and told them, "Hey, I need tax returns and those types of things." Sent Brink an email back saying, "Here's this time and update. Just I'm working but here's what I've got. Here's Dr. Patel's stuff according to the order. I assume you've got everything that you need from Southern Myrtle because you took the 30(B)(6) deposition there, and I've just talked to Dr. Ash-Bernal who's going to get some, some documents for you. Appreciate your time."

The next day I sent over Dr. Ash-Bernal's stuff. So I'm under the assumption that everything is good. Then I get the motion, and I said, "Lord, have mercy." I get on the phone the same day, that morning. I'm on the phone by lunch. I've gotten the information that night and it's in Brink's hands the next morning.

Judge, there's been no intentional hiding of any sort of thing. I turned over 200 and something pages of documents within 24 hours when it was called to my attention that something was missing. He's had it for essentially a week at this point, and I think the motion was to hold us in contempt, and there just really isn't anything to it, and I appreciate Your Honor's time on that issue.

MR. HINSON: Well, Your Honor, and I, I'm glad Mr. Gresh

wanted to hear this now because I do think, I do think it needs to be heard in the event that the jury comes back with a, a verdict that finds recklessness or, or gross negligence and that then there they would be a bifurcated trial with, with punitives, and I don't remember the exact dates off the top of my head, but more than a year ago we asked the Defendants for their financial information because it's, Your Honor, I'm sure is aware, ability to pay is a relevant factor in punitive damages, and Judge -- I believe it was Judge Seals ordered that essentially just before trial in time adequate to prepare the Defendants were to produce this information. Obviously, that wasn't the ideal situation for me, but I said, "As long as we get it in time for trial that I can read it and, and process it, and if I need a, a financial analyst or some, some, some kind of accountant or financial advisor to come in and tell the jury what these numbers mean, that'll be fine."

Your Honor, the 30(B)(6) deposition was nothing about financials. It was all about corporate processes and things like that, and even if it had been about financials, which it wasn't, the order didn't say produce the -- produce these documents unless the 30(B)(6) deposition is sufficient. The order from Judge Seals said produce them, and Your Honor, now at this point in trial Mr. Padget and I, as I'm sure Mr. Gresh has been, have been up till two, three in the morning every

night, waking up at six. There is no possible way I could have analyzed these -- he tells you it's 300 pages of information. This is something I needed the opportunity to do last week or week before last, and Your Honor, I would suggest, and this is something that, that my friend Costa Pleicones had mentioned to me when we were having lunch the other day, not over this, just different issues, we were telling war stories, and he said that he had an occasion where someone refused to provide financial information and that his solution to the problem was that he would just charge the jury that they are to presume that the Defendant has the ability to pay whatever punitive judgment they may impose and that that was -- that was the way to, to resolve the problem, and that's the, the resolution we're asking because I don't know what else would be sufficient at this point. I don't have time to go -- I mean, literally my financial guy, Charlie Alford, out of Greenville, he's on vacation this week. If I had had it last week I could have given it to him, but now I don't know what to do with this, this 300 pages of information that should have been provided two weeks ago.

THE COURT: All right. Well, I'll consider it if we get there. Now, you still think we can finish tomorrow even with the --

MR. GRESH: Uh-huh.

MR. HINSON: Oh, yes, sir.

MR. GRESH: Yes, Your Honor.

MR. HINSON: Yes, Your Honor.

THE COURT: All right. Well, let's -- while it's on my mind and we'll -- I'm sure I'll go over it when we start the -- I made some notes, when we start looking at the charges. Do I need to charge the jury on -- I mean, do they have to make a finding of agency relationship? Is it, is it -- does the Defendant admit the agency relationship between -- I haven't read the answer.

MR. GRESH: I checked on that before trial. We admitted in our answer that Southern Myrtle was vicariously liable for the conduct of Ash-Bernal and Patel.

THE COURT: Well, I still have to charge them what an agency relationship means. I think that's in one of the charges.

MR. GRESH: I don't know why we need it but if it -- if the Plaintiff requests it.

THE COURT: Well, I think they need to know why that they can be -- that the principal can be responsible for the servant, for lack of a better way to put it.

MR. PADGET: Your Honor, I -- we agree and I think the, the complexities now with the new statute requiring with the differentiation of percentage of fault we've got two allegations here. We've got the direct corporate liability allegations, but also you've got the, the typical respondeat

superior issues and what we're, we're trying to do is give the jury as much information as we can about that. It's going to be confusing no matter what we do, but -- because -- it's confusing to me, but I think that that's the best way to do it is to charge that, that Southern Myrtle can be liable for the acts of, of the physicians and also has the potential allegation of independent direct liability.

THE COURT: All right. Let's take a break and then we can take a look at the jury charges and the verdict form. All right. You all can come out in about, say in about 10, 10 or so minutes. If you all would come down the hall you'll see my door open. It's a good ways down.

(Adjourned for the day.)

(On the record, May 24, 2019. The following takes place outside the presence of the jury.)

THE COURT: Does -- do we have a final draft on the charge? I mean, if we don't, I think mine's pretty well marked up, but it would be nice to --

MR. PADGET: Yes, Your Honor. I think there's only, I think, two issues remaining from the charge that we marked up yesterday.

THE COURT: All right.

MR. PADGET: There's one additional charge that's been sought by the Defense, which I'm happy to take up now or perhaps we can discuss. They're seeking a charge as to, as to habit, routine and custom.

THE COURT: All right. Why don't -- can you hand it up and I can be looking at it, at both of them and let's take them up later so we can get started with the jury.

MR. PADGET: Okay. Very well.

MR. GRESH: Yeah.

THE COURT: Because it -- because I'm going to have to look at them. You don't -- do you have them?

MR. GRESH: We're just going to hand -- Judge, they're really essentially Rule 406. I was just going to try and make it where they could understand it, but I'll hand write out something, just --

THE COURT: All right. Well, I'll look at the rule. I

know what habit means, but I, I've never given a charge on it, but I don't know -- what's the other one just generally?

MR. PADGET: The other one, lastly, Judge, is the competency instruction at the end of the comparative negligence section.

THE COURT: All right. I don't have my -- I've, I've read over the form.

MR. HINSON: Your Honor, I have a final verdict form. There was one errant comma in the one we handed you last night.

THE COURT: Okay. I hate an errant comma.

MR. HINSON: I, I -- people get hung up on things like that so.

THE COURT: Despise them. Well, I majored in English, and sometimes I pick out typos where -- be kind of finicky, but I didn't notice that one. All right. You ready?

MR. GRESH: We are, Your Honor. Thank you.

MR. HINSON: Yes, Your Honor.

THE COURT: All right. Bring in the jury, and we're still on tap to get it to the jury around lunchtime, you reckon?

MR. GRESH: Yes, Your Honor.

MR. HINSON: Yes, Your Honor.

THE COURT: Good.

(Whereupon, the following takes place in the presence of the jury.)

THE COURT: All right. Mr. Gresh.

MR. GRESH: Your Honor, we would call Dr. Jim Ballenger to the stand.

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

Whereupon, James C. Ballenger is called to the stand, duly sworn by the clerk and testified as follows:

THE CLERK: Please state and spell your first and last name, please.

MR. BALLENGER: I'm Dr. James C. Ballenger, B-A-L-L-E-N-G-E-R.

DIRECT EXAMINATION

BY MR. GRESH:

Q Good morning, Dr. Ballenger.

A Good morning, sir.

Q Just tell the ladies and gentlemen of the jury what your occupation is.

A I am a psychiatrist. I have for about 20 years ran the psychiatry department at the medical school and taught, did research, treated patients. I'm retired from that, and now I see patients in an office, adult psychiatric patients, and I also do this kind of work more now since I retired because I have the time to do it.

Q Let's kind of walk-through real quick your educational background. Where'd you go to college?

A I went to the University of North Carolina in Chapel

Hill, have a BA in psychology with minors in chemistry and philosophy and English.

Q And graduated from there in 1966?

A I did.

Q And did you pursue any additional education following graduation from UNC?

A I did. At the horror of my friends I went to Duke Medical School and graduated from Duke in 1970, and at that point I accepted their very rigorous internal medicine internship residency for a year because at that point I knew I was going into psychiatry, and I went to Boston and trained in psychiatry at Harvard at the Massachusetts General Hospital where I was chief resident.

Q And when did you finish your training at Harvard?

A 1974, I had a two-year commitment to the Navy at that point. They had deferred me through college and med school, and I went to the National Naval Medical Center, on the faculty there. It's the big one in Bethesda where the president goes for his healthcare, and then for three years after that I went to the National Institute of Mental Health, which is also in Bethesda, and was ward chief of the -- one of the groups that studied manic depressive illness, bipolar illness, depression.

Q Following your stint at the National Institutes of Health generally where did you go following there?

A I went to Charlottesville, Virginia. My wife joined the law school faculty, and I joined the med school faculty, and, and I was there for four years as -- in the Department of Psychiatry and Behavioral Medicine as director of research and director of inpatient psychiatry. I also was -- had the same titles and responsibilities at Western State Psychiatric Hospital, which was a big state hospital in the western part of Virginia that our department -- was part of our department.

Q And did you, thereafter, come to South Carolina?

A I did. In, in 1983 I was recruited to be the new chair of psychiatry at the Medical University of South Carolina in Charleston, and I was chief and there until 2000, stayed on for several years after that as a professor there. I also built and ran the Institute of Psychiatry sort of the best, we think, psychiatric hospital in the southeast, and, and then I also wrote another grant and got the money to build the Center for Drug and Alcohol Programs, which is the best because it's the only one in the southeast where we study and treat substance abuse, alcoholism and other substance abuse problems.

Q And for how many years did you train residents and fellows at MUSC?

A Well, at MUSC for 20 years.

Q Okay. Are you board-certified?

A I'm boarded in psychiatry and neurology. I am also

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

professional papers and journals. I've edited the Yearbook of Psychiatry, the clinical psychiatry and the psychopharmacology parts of it for 15 years.

Q Do you have an estimate of the number of presentations that you've given in the field of psychiatry?

A I stopped counting when it passed a thousand, but --

Q I read a statistic that you're one of the 12 most cited authors in all of medicine?

A Yes. I was told that, which means that people cite my papers a lot.

Q In your, in your lectures and in your presentations, are you always lecturing or educating psychiatrists on issues in psychiatric medicine?

A No. I, I enjoy and I've spent a lot of those thousand plus lectures talking to psychiatrists, but a subspecialty of mine has been to talk to non-psychiatric physicians, and it, it grew out of a study one of my fellow residents and a friend of mine did where he determined that 85 percent of the evaluation and treatment of psychiatric patients in America, 85 percent is done by non-psychiatric, non-mental health people, general practitioners, internists, surgeons, ministers, and it became very clear that if we were going to improve that situation that's the system. We, we -- the mental health system is just a small amount of mental health centers and a small number of psychiatrists relative to the

population and one out of five people in America, I called it the best kept secret in America. I, I did a -- formed a foundation to try to do something about this, but the best kept secret is what percentage of Americans have a major psychiatric condition in their lifetime, I mean a major one, schizophrenia, bipolar illness, addiction, alcoholism or drug addiction, the depression problems or dementia. Now, those are really serious illnesses. I'm not even counting personality disorders, ADHD, that you had cancer diagnosed last year. It's one out of every two people in America. So it's a huge number of people. If 85 percent of those people are evaluated and treated by non-psychiatric physicians and other people, nurses, ministers, then I should be talking to them about how to -- how they should do their job because they're doing it more often than I am.

Q In this setting, obviously, we have Dr. Ash-Bernal. She's seated next to Dr. Patel.

A Right.

Q Are Dr. Ash-Bernal and Patel as hospitalists --

A Yes.

Q -- are they part of that 85 percent of medical doctors or other treaters who are evaluating and treating mental health who aren't psychiatrists?

A Absolutely, all day long, every day in every hospital.

Q Are -- you know, when you're going out and lecturing,

would your audience be filled with people just like Drs. Patel and Ash-Bernal trying to help them understand mental health issue, evaluation, diagnosis and treatments?

MR. PADGET: Your Honor, it's a leading question.

THE COURT: Leading question. I sustain the objection.

A Yeah. I, I, I --

Q Let me ask it -- ask that a different way.

A Sure.

Q How many times have you, A, spoken to non-psychiatrists about the evaluation and treatment of mental health disorder?

A Since I also do consult psychiatry and it's very pertinent to some of the things that are in this case and that I'll say today, I have no idea, tens of thousands. What -- it's sort of -- the, the lectures start with saying to the primary care doctor, the family practice doctors, "When you walk out in the morning and you see a full waiting room know, know that one-third to two-thirds of the people sitting there have only a psychiatric problem. They don't have a medical problem, one to two-thirds, and, and, and sometimes that grabs them and they say, "Well, maybe I really should listen to what you're getting ready to say."

Q Do you have an estimate on the number of times you've talked to internal medicine doctors, family practice doctors, GP type people on the issues of evaluation of mental health, and particularly as it might be helping them determine who's a

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

what they did, every night evaluating people with serious or not serious psychiatric problems to help figure out what needed to be done with them. The kind of questions of whether people should be committed or not happened all the time, every night, many times a night.

MR. GRESH: Your Honor, at this time we would tender Dr. Ballenger as an expert in the field of psychiatry and mental health treatment and evaluation.

THE COURT: Voir dire?

MR. PADGET: None, Your Honor.

THE COURT: I find he's qualified.

MR. GRESH: Thank you, Your Honor.

BY MR. GRESH:

Q Dr. Ballenger, I have in front of you, this is the medical record. If you need it at any time, feel free to refer to that. We -- I'm going to ask you certain questions today about the thoughts and opinions that you have on the care provided. Will you please only tell the ladies and gentlemen of the jury those opinions that you hold to a reasonable degree of medical certainty or probability. Okay?

A Of course.

Q And you, obviously, were not involved as a treating physician with Matthew Scheer; correct?

A No. I never had the honor to meet him.

Q You, you are here today as an, as an expert witness at my

request, and I've sent you certain medical records to review and certain deposition testimony. Kind of give us a little flavor of what all you have reviewed in connection with this case that helped you formulate the opinions you're going to offer today.

A Well, I certainly studied and restudied all of the medical records that were pertinent to his encounter with Grand Strand Hospital and the other people that day, what his medical records were from the past. He had a long history of epilepsy from birth. I also reviewed a lot of depositions from people who were fact witnesses or, or opinion witnesses, other experts involved, police reports, things -- about everything I could get my hands on that seemed pertinent.

Q Having the opportunity to review all of those deposition, sworn deposition transcripts and the medical records, do you feel that you have an adequate basis upon which to offer the opinions that you're going to offer today?

A Yes. I do.

Q You're here as an expert witness. I assume you have done expert witness work in the past?

A Yes.

Q This is a civil case. I know you -- have you done civil expert witness work?

A Yes. About 75 percent of the forensic work like this that I do, 75 percent of it is civil cases like this.

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

kind of thing. Had a very recently the judge said, "Okay, you -- this side, pay for him. This side" --

MR. PADGET: Your Honor, I'd object to what the judge said.

THE COURT: Yeah. Don't go, don't go into that.

A Oh, I'm sorry.

THE COURT: That's okay.

Q And to be, to be clear, you're not here today --

A No.

Q -- at the request of any judge?

A No. No. I'm not.

Q You're my request today; correct?

A That's right, and the, and the other instance is when the judge says, "I need help with a case." My 15 minutes of fame was the judge in the Dylann Roof case called me, asked me to do the competency exams of Mr. Roof.

Q When you do this type of forensic work, whether it's in the criminal context, the civil context or at the request of judges, do you charge for your expert witness services at a rate that's commensurate with other peers in the field?

A Yes. I do. I charge per hour for the time involved whether it's reading records, testifying in court and that's how I pay my mortgage, but yes, I do that, and my rate is probably a little more than some, a little less than others.

Q In over your 50-year career, can you estimate the number

of times that you have been involved in or consulted in helping with a decision to involuntarily commit a patient?

A The actual yes, no of commitment?

Q Or just the picking up the phone and calling you as an expert in this field, "What do I do"?

A Hundreds, probably pushing and over a thousand times.

Q Have you over your 50 years had to actually involuntarily commit folks?

A I've personally committed people over that almost 50 years hundreds of times, but as I've said earlier, the -- I've supervised residents for 30 years, and that question they always kick upstairs for advice and confirmation because committing somebody's a very big deal.

Q In your career as a psychiatrist have you also been involved in the decision to medicate patients with mental health conditions, whether it's Ativan or other stronger types of antipsychotic drugs?

A Medicate people, just period?

Q Yeah.

A Yeah. I'm -- you go to the internet I'm an international expert on what -- on using medicines with psychiatric patients.

Q One of the, the issues that we've heard about all week is that Dr. Patel encountered Matthew Scheer, thought about administering Ativan but did not actually write an order for

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

answered my questions, denied hallucinations, any suicidal ideation," and so his diagnosis was possible psychosis because he didn't see it, but he heard about it from the emergency room eight hours earlier, and then Bethany Bell said the same thing that --

Q She's the night nurse?

A She's the night nurse who admitted him and supervised him from after Dr. Patel saw him at seven to -- until he left -- that he was appropriate. She asked all kind of psychiatric problems and he denied everything repeatedly, and, and essentially, Dr. Ash-Bernal said the same thing. This is an adamantly, fervently speaking young man, but was logical, "answered my questions appropriate". So when Dr. Patel saw him about 7:00 o'clock he said, "Possible psychosis, consider the use of Lorazepam, Ativan if he gets upset." He could have written Lorazepam PRN, but I tell you Lorazepam, Ativan is in the water in hospitals. You -- any doctor -- every doctor uses it if somebody's upset. Now, if somebody is psychotically upset, sometimes we use Ativan and something like Haldol, but the person really has to be very clearly psychotic. Now, Dr. Patel testified something I really liked hearing because it was really expert, he said, "I want Dr. Oduwole to see him tonight or tomorrow, and I don't want to have him be asleep or abnormally calmed down by medicine now. I want him to see what there is," because one of the things that's really clear about

this is that this young man was headed into some psychiatric thing in my opinion, probably, probably a manic psychotic kind of picture or some other psychotic kind of picture or at the very least a major religious experience, but probably something in the psychotic range, but he was in and out of it. I mean, when he talked to his mother all night he was not making sense, not himself, but he got better as they talked, the more they talked. Father had the same experience when he, when he came there, he was really odd, but got better over time. So when Dr. Patel saw him and he was in a good place. He didn't see anything to treat. So he didn't leave any -- he didn't start treatment for anything, wanted Dr. Oduwole to evaluate him and decide what treatment he wanted, and so he waited and that was entirely appropriate.

Q So Dr. Patel's decision, do you have an opinion whether Dr. Patel's decision to not actually write the order for PRN Ativan was in keeping with the standard of care for this situation?

A Absolutely. If the nurses wanted to use it they would call a doctor to see the patient because he's just into the hospital. I mean, if he had been in the hospital four weeks and they knew they might give it to him before they call the doctor, but the night of admission if, if he became upset they would call a doctor, and that's exactly what they did, and then that doctor could within milliseconds prescribe Ativan or

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

eyes, there was nothing going on that was abnormal. He asked for a Bible, said he was Catholic and he'd like to have a Bible and she said, "That's nice. Here's a Bible," and he read his Bible. From seven to midnight they had hourly checks. She and the clinical nurse assistant had hourly checks, didn't see anything abnormal. He didn't come out of the room, cause any problem, asked anything abnormal. So nothing happened other than they have a cooperative, polite young man. Now, he refused an IV. He's very intelligent. He didn't have any IV orders. Why in the world should he have an IV? He refused that politely. He refuses oral Keppra, the anticonvulsant he'd taken for many years when he took it. He was off and on about that, but he hadn't taken it for several days, but he refused it, and she didn't think it was a big deal. I mean, that's just something the doctor the next morning could, could deal with because it -- he had seizures once every year or two that were usually in bed at night. They, they would last a short period of time and they, they weren't harmful, harmful. So and he did that politely. So, essentially, nothing happened until 1:13 when he appeared at the nursing station.

Q And talk to us, yeah, and talk to us about what happened in and around 1:13 from your review of the records and the sworn testimony.

A What the, the records say is he ripped his -- he took his

shirt off. He ripped off his patient bracelets and threw them on the ground and appeared at the nursing saying -- station saying he wanted to go home, he wanted to leave the hospital now and that he was a voluntary patient. He also had a whole series of statements about people, nursing staff being devil worshipers, that Obama had -- said it, it was, was sort of back and forth but apparently Obama said the right thing to him that, "Your epilepsy is not cured. You should stay on your medicine," but anyway, that Obama was bad and a devil and Obama couldn't control him either, and continued this religious talk until they called Dr. Ash-Bernal and she came within minutes -- she was nearby actually -- to evaluate him.

Q From your review of the records and the deposition testimony, did Dr. Ash-Bernal respond quickly to the nurses' calls?

A Very quickly.

Q Dr. Ash-Bernal testified yesterday that after talking with the nursing staff her habit, routine and practice, just like she said in her deposition, would have been to review the pertinent medical records before going in to speak with the patient. Is that reasonable and appropriate, in compliance with the standard of care for folks like Dr. Ash-Bernal?

MR. PADGET: Your Honor, he --

THE COURT: That's a leading question.

MR. PADGET: Object to leading.

Q What would a reasonably prudent hospitalist do when confronted with this situation at 1:13 in the morning before going in to see the patient?

A Would talk to the staff who'd interacted with him and look at the records to see what it was, look at the med sheet to see what medicines the patient was on and then after having read the record talk to the staff, go in to evaluate the person.

Q And in your review of the deposition testimony, is that what Dr. Ash-Bernal did?

A Yes.

Q Is that reasonable, appropriate and in compliance with the standard of care for the evaluation and treatment of folks that have these types of situations at 1:13 in the morning?

A It's absolutely standard. It's what every good doctor should do.

Q All right. So when she goes -- Dr. Ash-Bernal testified yesterday that when she goes in she asked a series of questions but doesn't recall exactly what questions she asked or exactly the information she received. Talk to us about how you train other non-psychiatrists to go in and handle situations like this.

A Well, these -- people who go to med school tend to be good students and smart and want to do the right thing, and they -- if they have experience, they already know many of the

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

was he was a -- he was fervent about his religious talk, even used word like a rant. He was really adamant about that, but when she talked to him it was appropriate. He listened to her. He stopped talking about his religious ideas and he listened to her. He considered what she had to say and then answered appropriately, and we have not only her observation of that but Bethany Belly who, in reading the record, seems like a competent person. I haven't met her either, but she said that's exactly what happened. Mr. Scheer's responses were appropriate. He listened to Dr. Ash-Bernal and responded appropriately, answered her questions. Now, he had his ideas. He wanted to leave. He was voluntary and he wanted to leave and he had religious ideas. Interestingly, to me, part of what Ash-Bernal must have been seeing is the reactions of the nurses who'd been there with him through the 1:13 to 1:30 something when she arrived, that the nurses thought what he said was sort water off a duck's back kind of an idea that they get insulted by patients and are irritated by, by the patients who are irritated at them and they say things to them. It seemed that kind of ballpark. It wasn't -- didn't seem crazy to them. I mean, Bethany Bell testified in her deposition that he didn't, he didn't seem psychotic to her.

Q And let's talk about that for a second. We know when we look at the chart that Matthew is pacing in the hallway. I think there's even a nursing note he's getting more aggressive

with staff. In your review of the nursing depositions from the nurses who were there, how did they describe that encounter?

A Well, the word aggressive was used, and there was some attempt to clarify what that meant. I mean, it did not mean anybody felt they were in danger. So they -- security was not there to make him go back to the room or to protect anybody. Nobody felt the need of protection from security and security didn't see any need for muscle either. The, the nurses -- the charge nurse and Bethany Bell sensed that this was not a psychotic, this was not dangerous and that he could calm down. Now, they, they did also explain that he was adamant about what he was talking about. He really strongly felt. Now, what that tells me as a psychiatrist, I mean, he's either really believes his religious stuff or is -- he's headed into some psychiatric thing that has religiosity as part of it, but it's really not clear at that point.

Q Would the standard of care have allowed Dr. Ash-Bernal to involuntarily commit Matthew Scheer at 1:13 to 1:30 that morning?

A Answer it two ways, absolutely not -- to -- not if she were going to practice ethical medicine or even legal medicine. To retain him at this point there was no grounds because the grounds that have evolved in psychiatry in general in South Carolina and, and specifics are you can't hold

somebody against their will unless they are imminently dangerous to themself or others and what imminently has been defined, much to our difficulty, these are hard rules, legal rules, ethical rules to live with for people who want to -- went to med school to help people, imminent means today or maybe tomorrow. It's been defined in case law in various ways. It usually means they're suicidal or homicidal and we have reason to think they're going to do it right away. Now, if we think somebody's going to do this in six months, we can't commit them, can't hold them in the hospital for six months.

Q Even if you think they're going to kill somebody in six months?

A No. Now, what we would do is notify the police we have a dangerous person, they need to be watched, need to be evaluated. We would have to handle it that way because their freedoms don't allow us in America to hold people before they do something or before they are, and this is one exception, if they're imminently dangerous to themself or others in the opinion of a doctor. Now, you can be picked up, if anybody in the jury said, "Pick up Uncle Fred and take him to the emergency room for evaluation by a doctor," and if a doctor says, "Yeah, I think this person needs to be held because they are imminently dangerous to themself or others," that will happen in South Carolina.

Q Was Dr. Ash-Bernal's decision to talk to the nurses, review the medical records and talk to the patient and ultimately allow him to leave against medical advice all done in compliance with the applicable standard of care?

A Yes. To do anything else would be to practice unethical medicine, actually illegal hold to somebody against their will without proper grounds. The only way we can prevent a patient or anybody else from leaving this room would be if a doctor, initially anybody and a policeman, but ultimately a doctor says this person is imminently dangerous, imminently dangerous to self or others and so they have to be held against their will.

Q Could Dr. Ash-Bernal picked up the phone and called David Scheer, the father?

A No. And this is a difficult issue perhaps for people in a jury to understand. All of this, when I said earlier, me personally, my problems with there's a -- what we call parens patriae. There's that view of those things, standing in for parents. I want to stand in for the parents and say, "Look, son, you need to stay here, you really do," and if the man is of legal age and understands what I'm saying and is not imminently dangerous to himself or others, I have to let him go. People refuse medical treatment all day long in America. There's an AMA form on every ward in America. There's a stack of them because it happens all day long every day, and what

the AMA form just says it's against medical advice. So what -- when you sign it what it says is, "I'm leaving but you have, in fact, told me the pros and cons of staying or leaving. So here it is. Thank you very much. I'm out of here." It's really sort of irrelevant to whether or not Dr. Ash-Bernal says to the policeman, "Don't let him go because I'm going to put him on pink papers and I'm going to send him to a place that accepts committed patients," and I don't know, and I don't know if there is a place in Myrtle Beach. Many times it means Columbia. They go in a police car there to be held until a judge, some and it varies, but seven days, four days, later says -- hears from doctors who say, "Yes. This person really is imminently dangerous. Still is. Please keep him here, judge," and the judge says, "I agree with you."

Q And to be clear, was Dr. Ash-Bernal's decision not to call David Scheer at around 1:30 in the morning --

A I'm sorry.

Q -- in keeping with the standard of care applicable in this situation?

A Yes. I'm sorry.

MR. PADGET: Your Honor, we object to leading.

THE COURT: All right. Just rephrase your question.

Q How would you characterize Dr. Ash-Bernal's decision not to call the father around 1:30 that morning?

A Painful, but appropriate. In that situation, I'm sure

you guys have learned about HIPAA, but HIPAA rules the world in hospitals and in outpatient now, and, and many, many good things have happened from HIPAA protecting people's privacy of their medical records, and this kind of case is the painful end of HIPAA, which is HIPAA protects people who are saying, "You know, I don't get along with my parents. Don't call them," and in people with psychotic problems that's actually a frequent situation. Now, that doesn't seem to have been the case here. The Scheers, from what I see, seem to be really good people and had a great relationship with their son, but it, it was Matthew Scheer's right to say, "Don't call him. I don't want to talk to him, and I don't want you to talk to him." They can only overrule this for the same reason that they can tell him he could not leave because he was also saying from the very beginning very clearly, "I'm a voluntary patient. You cannot keep me here." So the -- for the doctor to say, "Oh, yes, I can," the doctor has to be able to say, in this case Dr. Ash-Bernal, "You cannot leave because you are, in my opinion, imminently dangerous to yourself or others," and she did not reach that judgment. So she couldn't do it ethically, legally and meet the standard of care.

Q There's been an assertion that even if Dr. Ash-Bernal couldn't pick up the phone and call David Scheer, that she could have picked up the phone and said, "I can't tell you why, David, but come to the hospital." Would that be -- do

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

their ideas are good or bad or indifferent or actually psychotic unless they are imminently dangerous."

Q When you looked through Matthew Scheer's records from the time that David Scheer gets to Myrtle Beach to be with his son until Dr. Ash-Bernal allows him to leave against medical advice, did you see any indication in the chart from anybody that Matthew Scheer was in imminent danger to himself or to others?

A I saw no evidence. In fact, I saw a lot of evidence to the contrary.

Q Dr. Ballenger, with your almost 50 years of experience, looking back at all of the care and treatment provided by Drs. Patel and Dr. Ash-Bernal, do you have an opinion to a reasonable degree of medical certainty as to whether their care complied with or deviated from the applicable standard of care?

A I think it met the standard of care and didn't even get close to being not standard of care.

Q Thank you very much.

THE COURT: All right. Cross?

MR. PADGET: If I may I approach, Your Honor?

CROSS EXAMINATION

BY MR. PADGET:

Q Dr. Ballenger, this is just a copy of your deposition if we need it.

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

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

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

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

old will die without chemotherapy, he says, "Give the boy chemotherapy. Now, mother and father, you can decide not to have chemotherapy, but your son can't. You can't decide for your son." That's, again, the very special circumstances where we overrule people's rights.

Q Well, if, Doctor, unable to consent to informed healthcare means unable to appreciate the nature and implications of a patient's condition and proposed healthcare, to make a reasoned decision concerning the proposed healthcare or to communicate that decision in an unambiguous manner, if that's the definition of giving informed consent, to refuse healthcare, if that's the decision you have to -- a patient like Matthew has to be able to make a reasoned decision regarding that healthcare?

A What's the question?

Q My question is if that's the standard that this jury is going to be asked to apply in this case your opinion is that Matthew Scheer, in light of all these circumstances, was able to make reasoned decisions concerning that proposed healthcare?

A Dr. Ash-Bernal's assessment at the time was that he was hearing, thinking about and making appropriate responses to the pros and cons of refusing the medical care and to stay in the hospital that she proposed. She made a judgment that he understood well enough the consequences from a medical and

psychiatric point of view that could happen if he left and believed he understood that well enough. Now, if -- it could be even more extreme. I mean, he could have said, "I'm not going to take it because the rays from Mars in my head tell me not to do it," if she didn't think he was in imminent danger she still couldn't hold him.

Q You said, Doctor, there's -- was -- you described, I believe, some of those earlier descriptions as smoke. Is that right?

A That's a way of describing the uncertainty of what was going on with Matthew Scheer.

Q Well, at some point smoke -- let's talk about fire for a second. The patient who's, who's got this reported history, every doctor who's seen him has written the word psychosis, father has driven down from New Jersey, which was reported to the physicians because he was concerned about his son, brings the child, brings the 26-year-old to the hospital, makes those reports about fighting demons in the woods and others, and now that same patient comes out of his room, takes off his shirt, rips, doesn't just remove, rips off his medical bracelet, throws it, begins yelling at the staff, accusing them of being devil worshipers, accusing -- bringing up the president as we talked about, isn't that a psychiatric sign, as you've indicated, that there's something more serious going on with Matthew Scheer?

A Yes. I think there's -- I'll say two things about that. First, every doctor who has seen it has used the word -- has not used the word psychosis. After Dr. Battisti, Dr. Patel said possible psychosis, didn't see any evidence of it except the history from the emergency room and Mr. Scheer. Dr. Ash-Bernal didn't see it, any psychosis and Bethany Bell didn't see any evidence of psychosis.

Q Why order a psych consult?

A Because he needed evaluation. That's why he was in the hospital.

Q Why contact a psychiatrist if you're not concerned about psychosis?

A He was concerned whether it was there or not. To hold somebody against their will --

Q I'm not talking about that.

A -- unless you're going to -- let me finish my answer.

Q Certainly.

A To hold somebody against their will you are making a very specific statement that they are imminently dangerous now, not maybe they might be, maybe, maybe, maybe, maybe because -- maybe he's psychotic. It's a very specific thing. Now, as I've said, there's a lot of evidence -- I'm sorry, there's a lot of what I call smoke. There's a lot of suggestion that something was going on with Matthew Scheer, but he would clear up and do better, and he was in the right pace of getting

treatment for evaluation, evaluation of what was wrong with him. I mean, you know, I've spent however now 50 years. I'm not sure what's -- was wrong with Matthew Scheer. I have some suggestions. I can do a differential diagnosis that includes possibly a manic psychosis, possibly an early schizophrenic type psychosis, that he was taking hallucinogens, although his drug screen was, was negative for his, his age, and where he -- the kind of work he did, that's -- has to be in the differential or he was having a genuine religious experience, wanted to live a purer life. We don't know what was wrong with him, but we wanted Dr. Oduwole to see him that night or the next morning to help find out. Now, my guess what Dr. Oduwole would have done would be to put him in the hospital for a day or two and talk to him and decide.

MR. PADGET: Your Honor, I would object to a guess.

THE COURT: Yeah. You can't speculate to what the other doctor, another doctor would do.

BY MR. PADGET:

Q Doctor, let me, let me go back just to be clear. Matthew Scheer by Dr. Battisti was ordered and transferred to a psychiatric care facility, Lighthouse; is that true?

A Yes.

Q Okay. Doctor, you, you also have opined that the HIPAA laws would have prevented any contact of Matthew's father that morning, painfully, I believe as you described. HIPAA allows

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

Q And let's --

MR. PADGET: If I could approach, Your Honor?

THE COURT: Yes.

BY MR. PADGET:

Q I just want to hand you, if I could, Doctor, Plaintiff's Exhibit Five and show you and you're welcome to look at the whole thing. This is the hospital's privacy practices --

A Uh-huh.

Q -- that they give to every patient and that's, that's common; right?

A Something like this because HIPAA's so complicated, everybody needs to be explained.

Q And what this is is this is a simplification of a long law put into words that patients and everyday folks that we can all understand about when they can disclose certain health information. Is that fair?

A Well, yes.

Q In part, but there's a lot of it.

A Yes.

Q And I'm only referencing the one section here over on this page, Doctor, after the as permitted by law right here. Are you with me?

A I'm at that section.

Q All right. And the policy reads, [as read], "As permitted by law we may also use and disclose health

information for the following types of entities, including but not limited to," and there's a long list, and you're welcome to read them out loud if you want, but there's a long list. The jury has seen this big form already, but the very last thing there that it says is that, [as read], "We may disclose to a person or persons able to prevent or lessen a serious threat to health or safety." Is that what the policy says?

A That's what this piece of paper says.

Q Okay.

A It's not my understanding of what HIPAA rules say about when you can do it over a person's objections.

Q You believe that Grand Strand and, and their lawyers have drafted a poor privacy policy?

A I wasn't asked to come to such an opinion.

Q And you're a doctor, not a lawyer. I understand that. Now, let's talk a little bit about -- I think we've got some agreements too, Doctor. Let's talk about --

A About what?

Q Some agreements?

A Oh, okay.

Q A particular set of opinions. You have -- you, you say that Matthew could have probably been helped with psychiatric treatment. That correct?

A Absolutely, but I also say that about almost everybody, but he needed evaluation. Yes.

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

Q And the purpose of those checking outs, I believe as you call them, is so that you can give the best care to the next patient, the next doctor can be informed and give the best care; isn't that right?

A Yes. Whether I said that or not that's the right answer.

Q All right. And we -- it is undisputed here in this case that there was no handoff between Dr. Patel and Dr. Ash-Bernal on the evening of the 2nd. We agree on that; right?

A My answer, the answer is, no, not in the old-fashioned way that I used to do it where a doctor talked to another. The standard of care has shifted where the medical record does that. Doctors generally, unless there's some specific reason, hospitalists, in particular, leave the hospital and someone takes over, somebody comes at 7:00 o'clock. Somebody leaves at 6:59 somebody at 7:00 o'clock has complete and total responsibility for that patient, and that's the standard of care, which we're here to talk about the standard of care. That's what's done in, in hospitals with hospitalists all over South Carolina and the United States.

Q And you're not a hospitalist and you've never been a hospitalist; correct?

A The easy answer to that is no.

Q And you're not board certified in internal medicine?

A No.

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

wanted us to contact -- to speak," excuse me. Let me get it, let me get it right, "to speak with his father," and he said no?

A Correct.

Q And that language is Matthew wanted to speak to his father and he said no. We agree on that?

A I, I agree that that's what it says in at least one place that he said, "I don't want to," which certainly implies that he has strong feelings, but the other half of what we can't agree on because the records aren't clear on this point that he also didn't want -- he didn't want to talk to him but he'd be fine if the nurses or the doctor called his father and told him to come in because it'd be real clear what -- that's what they would want to say, that that's not clear. We're not agreeing about that.

Q And we agree that, that David's phone number and contact information as the emergency contact was readily available and in the chart?

A Yeah. That's all the more frustrating because I would have wanted to call his father because maybe his father could have talked him into staying there long enough to see Dr. Oduwole, which is what I would have been really concerned about. So that was sort of the issue. That was the issue that was there. There was no sense that he was imminently dangerous or even dangerous. It's he needs to see a

psychiatrist, and if he -- if he's leaving here, you know, he needed to get there the next morning or the next day or something.

Q If you're a doctor like that and you're, you're -- you believe you're painfully hamstrung by the law in light of the current situation, but you believe he -- it would really be better for him to get some care, you're in that situation and you're not certain, wouldn't it have been prudent and reasonable to contact somebody who knows more about the privacy laws to make sure you're right before you let that patient walk out the door?

A I don't have uncertainty. I don't hear any evidence -- I haven't seen any evidence that Dr. Ash-Bernal had any uncertainty about that.

Q None, no evidence, no evidence of that?

A I'm not aware that she was confused about that.

Q She also wrote in her note that, "The patient says he's here voluntary and that we cannot keep him." Do you see that?

A Yes.

Q That's just wrong. If a patient comes in the door voluntarily but manifests the need that they are a substantial danger to themselves or others, a doctor can absolutely place a temporary hold on them at that time?

A Is if he think -- he or she thinks he's imminently dangerous. So the rest of the sentence is, "He's here

voluntary and we can't keep him unless I make a new determination that he's imminently dangerous to self or others," and she didn't think that.

Q If the people on that floor did not believe Matthew to be dangerous why were two security guards up there?

A Because it's hospital policy to involve security when, when something like this happens. Otherwise security's just sitting on a chair somewhere not doing anything. Also they knew they'd need him -- well, they ultimately did need him to show him how to, to leave the hospital.

Q Somebody called security.

A Isn't there a security -- I think -- I don't know, maybe this is a misunderstanding, but there's a security guard just hanging around any unit that has psychiatric patients or beds. I don't know that for sure.

Q But the note says security was at bedside, Matthew's bedside?

A He was called --

Q That had he --

A -- and he walked into the room where everything was happening, yes.

Q So somebody called security?

A But they didn't say stand at the bedside. They did comment that they did not use him to make Matthew go back to his room. Matthew put his shirt on and went back to his room

on his own politely, and of course security is going to come and stand at least in the door. It's his job.

Q And not only was security called, Dr. Ash-Bernal was called?

A Of course. They needed a doctor for evaluation.

Q All right. And one of the reasons I think you said you can call a doctor if you're a nurse in that situation is to give Ativan; right, to calm the patient down? Is that one reason a nurse can call?

A Of many, yes, absolutely.

Q Sure. Well, in this case Dr. Patel thought it, it, it might be appropriate later; fair?

A Yes.

Q And the nurses, but though they didn't have an order to give any Ativan, and so they contact Dr. Ash-Bernal. Do we agree on that sequence of events?

A I think so.

Q Okay. And you said --

A Didn't realize you were testifying, but go ahead.

Q You said a moment ago when Mr. Gresh was asking you questions that Ativan was like water in hospitals. I think that's what I heard?

A I was joking, not testifying, that Ativan is easily available in every hospital on every floor.

Q Sure. And that's the point of it.

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

Doctor, of a drug you give and have given I'm sure thousands of times.

A Yes.

Q Would it have likely calmed down Matthew?

A As it would have calmed down anybody and everybody.

Q All right.

A Probably, if it were enough.

Q Doctor, you made a lot of -- I'm sorry. That's your CV. You made a good many notes about your review of this case; is that right?

A Yes. It's my custom. I always do that.

MR. PADGET: If I may approach, Your Honor?

THE COURT: You may.

BY MR. PADGET:

Q Give you the entirety, Doctor, but I've just got one question about this page. I've highlighted a little section there. Would you just read your handwriting for me so I can understand what it says?

MR. GRESH: What, what page are you looking at?

MR. PADGET: I'm sorry. Page five.

BY MR. PADGET:

Q You just decipher for me your handwritten notes there, Doctor?

A It's -- it was talking about Dr. Malone's testimony and the preceding sentence where parens, it says Dr. Malone had

previously declined a case from Attorney Hinson and then the part you've highlighted said, [as read], "Malone didn't take any notes of the records." That's where it stops, but the rest of the sentence is [as read], "as he read them like I do."

Q Yeah. And --

A And then it said, [as read], "Dr. Malone has been an expert in two cases and he did not know how much he charges for that work."

Q Okay. Thank you. So according to his deposition testimony Dr. Malone wasn't, wasn't even sure what he charged for his work; correct?

A Correct.

Q Did you ever consider whether -- because you wrote that in your notes -- did you ever consider whether or not Dr. Malone was testifying for reasons other than money?

A That statement is about his general practice, at least that's the way I understood it, he doesn't know what he charges in any cases. Now, if you're bringing new information that he decided not to charge in this case because of some other reason, that's total news to me.

Q Well, let's just talk about your charges, Doctor. You, you charge $680 per hour for your services?

A In South Carolina, yes.

Q In South Carolina. Yeah. You get a -- I think it was a

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

MR. GRESH: Just real briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. GRESH:

Q Can patients listen carefully to a physician, understand what the physician is saying and make reasoned decisions about their healthcare that aren't reasonable decisions?

MR. GRESH: Objection, Your Honor, leading.

THE COURT: Leading question.

Q When you look through the medical records and the sworn deposition testimony in this case, you saw that Dr. Ash-Bernal went over the against medical advice form. You remember that?

A Yes. I'm sorry.

Q And that within that form she certifies, and we've all seen this, certifies that Matthew Scheer had the mental capacity; correct?

A Yes.

Q To make the decision?

A Yes.

Q Can we -- describe for us having this mental capacity to make a healthcare decision, does that mean all medical decisions that person makes are reasonable?

A Where it's --

Q Or are they two different things?

A Totally different and were it so practicing medicine would be a whole lot easier. People have all kinds of ideas

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

that's all against the doctor's advice, and that's the main thing -- that's two-thirds of people.

THE COURT: Doctor, I think, I think you kind of strayed from the question.

A Oh, I'm sorry.

THE COURT: I'm going to ask you to be more specific in your answers, please.

A I'm sorry, sir.

Q And, and this'll be just a real, a real easy one. When Matthew Scheer was evaluated by Dr. Ash-Bernal does he have his shirt back on?

A Yes.

Q Is he calm at that point?

A Yes. He's still -- I think still strongly believing his religious beliefs.

Q Is there any indication for Dr. Ash-Bernal to give Matthew Scheer Ativan under those circumstances?

A No.

Q And looking back at the entirety of the care provided by Dr. Ash-Bernal and Dr. Patel, at any time did you feel that their actions or inactions deviated from the applicable standard of care?

A No.

Q Thank you.

THE COURT: All right. You can step down and be

excused. We appreciate your time, Doctor.

A Thank you.

THE COURT: Members of the jury panel we're going to take our morning break. I'm going to try to keep it around 10 to 12 minutes and so we can stay on track, along the track. The next part of the trial will be the closing arguments of the attorneys. I think that's the last -- your last witness?

MR. GRESH: Yes. The Defense rests.

THE COURT: Yeah. I'm sorry. Any reply?

MR. HINSON: No reply, Your Honor.

THE COURT: Maybe I'm off track, but we have a few matters to take up outside your presence. I don't think they'll take long, so 12 to 15 minutes. When you come back you'll hear the arguments of the attorneys, then my charge on the law. We probably won't have lunch until after we do those three things, depends on how long it takes. We don't have any particular time limit set on either of those three things, but we hope to have this in your hands by, by mid-afternoon. So I'm going let you go to the jury room at this time. Don't, don't start discussing the case yet.

(Whereupon, the following takes place outside the presence of the jury.)

THE COURT: All right. Anything from the Plaintiff?

MR. HINSON: Nothing, Your Honor.

THE COURT: Defense motions?

MR. GRESH: Yes, Your Honor. For the, for time sake if Your Honor would allow me, I would like to adopt and reincorporate all of the previous motions in limine that were made at the close of the Plaintiff's case, and if Your Honor would like me to reargue any of those?

THE COURT: No. Not motions in limine, directed verdict.

MR. GRESH: Thank you, Your Honor, directed verdict motions that I made at the close of the Plaintiff's case. I'm happy to reargue any of those.

THE COURT: I, I think I, you know, I'm, I'm, I'm flexible but I'm not going to change my mind on any of those. So I want to -- you -- you're on record as renewing all those DV, directed verdict motions, and I'm going to put myself on record as incorporating my earlier rulings and denying each and every one for the reasons set forth earlier. So let's take a break, and I, I said let's try to keep our arguments to about an hour. Is that -- an hour?

MR. HINSON: I would not anticipate that being a problem, Your Honor, not at all.

THE COURT: Because we -- and I've got the, the -- just told the clerk that we're shooting for around -- oh, I -- around 2:00 o'clock maybe for lunch. We might be a little later than that. Do you -- do you all -- do you have my -- the charge ready?

MR. GRESH: Yeah. Let me show it to Plaintiff's counsel.

THE COURT: I'm talking about the whole charge.

MR. GRESH: Oh, the whole charge. Yeah.

THE COURT: We'll -- also we need to go ahead and deal with --

MR. GRESH: Your Honor, may I approach? This is a supplemental charge that we requested.

THE COURT: The one on habit?

MR. GRESH: Yes, Your Honor. There's been ample testimony and lots of witnesses that didn't remember something but were able to talk about -- the jury needs to know that under the eyes of the law one does not have to remember everything, one can rely on their habit, routine and practice, and that either of those scenarios are admissible.

THE COURT: Well, that's not the way I rule - read Rule 406. It's an evidence rule, and it's where somebody else could testify, a third party could basically testify as to your habit or my habit. I don't see it as a, a shield sort of a -- with a -- for a party to where it's saying, "Here's my habit. That's, that's why I did X, Y and Z because that's my habit, the way I do it." I think it's -- under the -- as I read 406 it's an evidence rule giving a third party the right to say, "Jack Gresh eats breakfast at 8:00 o'clock every morning because I see him because we eat at the same place."

MR. GRESH: Okay. I, I just am, Your Honor --

THE COURT: I know. We'll make it part of the record.

MR. GRESH: Thank you, Your Honor.

MR. HINSON: Thank you, Your Honor.

THE COURT: And, and the charge? Well, if we can just get that so I can have it in a couple of hours. All right. We'll be at ease till -- let's say 20 after, about 20 after. That's about 10 minutes.

MR. PADGET: Thank you, Your Honor.

MS. SPEARS: Thank you, Your Honor.

OFF THE RECORD

(On the record. The following takes place outside the presence of the jury.)

THE COURT: In the old dogs new tricks category, I don't know why I just happened to think about this, would either side object to me giving a -- when I get to the verdict form giving a copy to the foreman so he can have it in his hands to look at as I go over what's on there? I've never done that before but it just made sense to me that the foreman's the one who's got to understand it. Anybody object I won't do it.

MR. HINSON: No objection from the Plaintiff, Your Honor.

MR. GRESH: None.

THE COURT: All right. Well, I'll -- can, can I -- I need, need a copy. All right. Plaintiff ready?

MR. HINSON: Yes, Your Honor.

THE COURT: Defense ready?

MR. GRESH: We are, Your Honor.

THE COURT: All right. Bring in -- well, we don't -- still don't have a bailiff. Okay. And have I got the, the final draft of the charge?

MS. SPEARS: I believe we're going to print it. Mr. Padget was working on adding some language.

THE COURT: Okay. Well, you can just -- I'll get, I'll get it. We'll, we'll take a break probably between arguments and charge. Thank you.

(The following takes place in the presence of the jury.)

THE COURT: All right. Members of the jury panel, you'll now hear the closing arguments of the attorneys. Keep in mind they're not witnesses. They're not giving you testimony. They're giving you their position on and, and summing up the case and the facts and the -- they'll tell you some things about the law, I feel sure, keeping in mind that I'm going to charge you the law and you take the law as I give it. An attorney would not misrepresent the law intentionally. If you hear something from the attorney and you don't hear it from me, just disregard what the attorney said, and if an attorney does that I'm sure it'd be inadvertent and they would not, obviously, try to mislead anybody. Counsel.

MR. HINSON: May it please the Court?

THE COURT: Yes, sir.

MR. HINSON: Ladies and gentlemen of the jury, on Monday morning you came here, parked in the Conway or, excuse me, the

Horry County courthouse parking lot. You walked by the American flag to come do your duty as jurors. You weren't alone. There were several hundred people in that jury pool. There's other juries that have done other things this week, and even the collective of you was not alone. All across America people came and served as jurors and did their duty. It is an imperfect system, but it's the best one there is, and I'm sorry that we had to have you -- keep you here all week, but sometimes to do something right takes time, and after a week we've now reached that crucial day. No longer will the 12 of you consider this case as individuals, but you will come together and you will decide the case as one jury. You sit as representatives of this community given the duty, given the task of reaching a verdict that speaks the truth and speaks for the safety of the people of Horry County, and through this voice you will speak about what the standards this county will accept, the way of living in our system of determining what is the acceptable way to treat a patient who's suffering from mental illness.

When you entered this courtroom you already had all the tools you needed. You didn't need fancy arguments from lawyers. You didn't need statements from the witness. You had your 581 years of collective experience. That's what you have, added up your, your ages, 581 years right here of living on this earth, many of which, most of which are living in this

community, and you have learned and you've gained common sense and logic and reason, and you know what's right and what's wrong and you know when somebody is telling you the truth and when someone is putting up a show, when someone's making excuses.

On Monday morning I mentioned a few safety rules to you. A physician should never be hasty and should take time to make a safe decision for her patient. I want to talk about this a little bit more, but when people are hasty they forget to do things. When people choose haste over their duty to properly do their job, bad things happen. When people choose to speed on the highway, bad things happen, and you may be able to get away with it for a while, but if you choose to speed every day you not only might get a ticket, it's foreseeable that you'll be in a wreck.

Doctors should communicate with other doctors. We've had a lot of talk about this, and I believe almost everyone that's taken the stand in this case has told you that signoffs or handoffs or passing the baton, signouts, whatever you want to call them, that that's what happens in medicine. It's for patient safety.

Dr. Ash-Bernal took the stand, and after more than two years of litigation, the case been filed more than two years ago, this day certain for this trial, we've known, we've known this trial would start on May 20th for more than five months,

and she didn't know the record. She couldn't answer the questions of wasn't this a dramatic change in Matthew at 1:14 in the morning. She couldn't answer that question. You can decide what that means, whether she really knew the answer or not or whether she just didn't want to answer it, but regardless, it shows the importance of a handoff because if the conversation had happened between Dr. Patel and Dr. Ash-Bernal, had he chosen to do his duty and just spend a few minutes to talk with the next physician on staff, she would have had all of this to look through, didn't have to be long. "Got Matthew Scheer here has been with his dad. I've talked with his dad, seems like it's a very supportive family. They're very concerned with him. His dad drove all the way down from New Jersey. He's been having some really, really serious delusions. He's hearing voices. I think they're command hallucinations. He's, he's had this episode in the woods fighting demons. He's been pretty calm and cooperative with me, but if he changes we need to really put him on some antipsychotics quick for his safety and for the safety of everybody around him." How long did that take? Less than 30 seconds?

The testimony you heard was, "We only do that if there's a concern." Think there was a concern about Matthew. Everybody else was concerned about Matthew. The ER doctor was concerned about Matthew. The ER doctor said take him

immediately to Lighthouse, immediately, not let's make an appointment, not you need to see the doctor real soon, see them today if they can get you in, go immediately, and you know what else she did? Excuse me. She picked up the phone. She called Lighthouse. She communicated with Lighthouse. She gave a handoff. Dr. Battisti gave a handoff to Lighthouse because that's the standard of care and that is what physicians who are not being hasty who are looking out for the safety of their patients do.

Lighthouse couldn't see him. We know that. There were problems with his blood work. He had chemical problems likely related to his extreme anxiety. It had raised his white blood cell count, likely related to not eating and drinking for several days. It was beginning to infect -- impact his organs. The record shows he was anorexic. That's a concern, and what did Lighthouse do? They arranged for a transfer back, and there was the confusion between Conway and, and Grand Strand, but Lighthouse still made effort to contact people because there's nothing better than just having a conversation. That's why I'm giving you a closing statement right now. You know, I could have written something down and the Judge could have handed it back to you, but that's not the way we do it because it's not as effective and it doesn't communicate well.

Matthew comes back to Grand Strand. Dr. Battisti sees

him again, and guess what she does? When she admits him to the hospital she talks to Dr. Patel. She gives a handoff. She passes the baton. She does a signout. Everybody else in this case did a handoff except for Patel to Ash-Bernal. Nobody else failed to do that, and now the Defense wants you to believe that, oh, that's not really done, although they can't quite admit that it's not really done. They just say, "Well, we don't do them unless there's a concern," and then now they won't admit there's a concern? Ask yourself if that makes sense. Was there not a concern about Matthew?

Doctors should communicate with their patients. You don't go to the doctor and just fill out the form, sit there in the waiting room, and then have an answer come back about what the doctor's going to do. The doctor sits down and he or she talks with you, and they ask you lots of questions, and depending on what your problem is then they ask you a lot of questions and depending on how important it is they may do a lot of tests.

It was 1:30 in the morning during Hurricane Joaquin. It's coming. It's battering the East Coast, and Dr. Ash-Bernal doesn't ask those questions of Matthew. She doesn't sit down with Matthew. She doesn't say, "Matthew, you really got me in a bind here. You know, I, I want to respect your privacy, of course, but I also care about you. You're my patient and I'm going to put your safety above everything.

Your safety is very important to me. So let's talk." Since Dr. Patel didn't give her the benefit of the signout because he didn't take the time to do that, Dr. Ash-Bernal would have had to taken the time to really look through the record, and if she'd done that, she would have seen that she had a patient who had a lot of problems.

Dr. Ballenger just said he sees a lot of smoke. Where there's smoke there's fire. Sure Matthew hadn't done -- hadn't harmed anyone yet. He hadn't taken his own life yet, but it's foreseeable that's coming. A man who is out in the woods fighting demons can do something very irrational. It might not just hurt himself. It might hurt others, and you have to sit down with that patient and talk with him, and Dr. Malone came and talked to you about that. He talked to you about the types of things that he -- that a physician should ask in a situation like this. This isn't a patient wanting to leave the hospital with a gallstone or a patient wanting to leave the hospital with an appendicitis. This is a patient with psychosis. If the -- a patient with appendicitis who has all of his wits about him wants to make a horrible decision, that's entirely a different picture than the psychotic patient not based in reality who wants to make a bad decision.

Doctors must protect patients who do not have the mental capacity to protect themselves. That's their duty. The Hippocratic Oath we often just hear that says do no harm.

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

be something that a physician would do if they were working to the best of their ability, and if that had really occurred wouldn't this note say, "I asked him was there anybody else he could call, I could call for him then." It doesn't mention anything about that. In fact, the only thing that you will find in this medical record is simply the nurses asking, "Would you like to speak to your dad?" That's it. HIPAA did not stop -- was not even in anyone's thought that night, that -- in anyone's mind that night.

The Judge is going to charge you when closing statements are done and he's going to talk to you about the preponderance of the evidence, the greater weight of the evidence, and what he's going to tell you is that all Plaintiff has to prove, all the Plaintiff has to do is move the scale slightly, that when we started off this case, the Plaintiff and the Defense, you were to consider us at an equal standing, and as the case went on, if we've tipped the scales ever so slightly then you should find for the Plaintiff, and so if you find yourself in the jury room saying things like, "I'm not convinced," or, "I'm just not certain," then you're not applying the greater weight of the evidence standard. All we have to do as the Plaintiff is convince you that it's more likely than not. Another analogy we might use is a football analogy. Plaintiff does not have to score a touchdown to win this case. We don't have to score a field goal. We don't even have to get a first

down. If we were on the 50-yard line, that's where we started in this case, and if we have moved the ball one inch forward you should find for the Plaintiff. If we haven't moved it at all or if we've gone backwards and lost yardage, you should find for the Defense, but if we have moved the ball even an inch, the greater preponderance of the evidence standard would say you should find for the Plaintiff.

There's been some discussion in this case about Southern Myrtle Inpatient Services, SMIS. They're a Defendant in this case. They are the employer of Drs. Ash-Bernal and Patel, and I will remind you and if you recall, we had a witness come and they played the part of the 30(B)(6) deponent, which is the corporate representative who comes and stands in the shoes of the corporation and speaks for the corporation. Their words bind the corporation, and I took the deposition of the corporation in this case, and I asked, "Does Southern Myrtle Inpatient Services have any specific knowledge of the training provided, and by that I mean, would they," speaking of Drs. Rachel Ash-Bernal and Patel, "would they have, have received," excuse me, "and by that I mean would they have received notice such as that on December 2nd, 2015, Dr. Patel attended such and such a seminar provided by X, Y, Z entity," and the corporation said, "I'm not certain," and I asked, "Do doctors report -- does Dr. Patel and Ash-Bernal when they worked for Southern Myrtle Inpatient Services did they report any ongoing

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

This lawsuit has been going on for more than two years.

This trial has been scheduled for more than five months, and she still doesn't know who her employer is. She said that she thought she might have seen the name on her paycheck, and when it came to money it kind of reminded her. Does that sound like an employer who's properly involved in their physicians?

And I kind of talked about this earlier. I got a little ahead of myself, I guess, but all the way through as David Scheer does to the best of his ability what he can do for his son, David's not a doctor, doesn't have any training in the medical profession, taking his son to Grand Strand, to Lighthouse, back to Grand Strand, everybody all the while is doing signouts and handoffs, but where did the ball get dropped? It got dropped from Drs. Patel and Ash-Bernal.

Let me jump back to the concern idea. Dr. Ash-Bernal said she would only, would only be necessary if there was a concern. Well, setting aside all the psychiatric issues, there's concerning labs. See the H here, you can see this in the record, the H stands for high, high, high. You have high white blood cell count, a high total bilirubin and a high BUN, creatinine level and remember she talked about BUN and creatinine and talked about how it would mean dehydration, that that's what -- those are the, the measures you look for for dehydration was BUN and creatinine. This is a dehydrated patient.

The Judge is going to charge you that you may consider

the way the witness acts on the witness stand, and that's another tool that you came into this courtroom with with your 581 years of experience watching how people react, the way they -- their body language, the way they, the way they react to questions, and I want you to take that into great consideration when you think about the different testimony you've heard, who was changing their testimony from their depositions. Did Dr. Robinson ever change his testimony? Did you ever see an occasion where Defense counsel came up to Mr. -- Dr. Robinson and said, "I took your deposition. You said something different there; didn't you?" Did you ever see them do that to Dr. Malone? "Changed your testimony; didn't you?" That never happened. Think about the other folks you've heard from in this case, how many times their testimony differed from what they said earlier.

Dr. Ash-Bernal, this is an exact quote when she took the stand. She said, "There were no red flags." When you go back and deliberate in this case I implore you to look at this medical record. Plaintiff embraces this medical record. Who showed you things from this medical record? Who wants to talk about the medical record in this case? Plaintiff, Plaintiff's, Plaintiff's doctors and who just wants to talk about, "Trust me, this isn't the way we do it and trust me this, trust me that." Who wants to talk about the evidence, the facts? There were no red flags? Anorexia due to

hallucinations isn't a red flag? Flight of ideas? That's not a red flag? Pressured tangential speech? He's all over the place. He can't, he can't have a linear thought. That's not a red flag? He has been having visions. That's not a red flag? Where there's smoke, there's fire. Visual hallucinations, auditory hallucinations, tactile hallucinations, what would she consider a red flag? Does he have to be holding a gun to his head for it to be a red flag? Does he have to be pointing it at others? And I want to make sure that it's clear, the need to treat a patient for psychosis doesn't -- they don't have to be homicidal or suicidal. It can just be based off of that they're a danger due to their misunderstanding of reality, and so all this -- one of the first things Defense counsel did with Dr. Robinson is he tried to get him to say that the only two ways you could, you could hold someone one, the only two ways were if they were suicidal or homicidal. That's not the truth. That's not the law, and that's not medicine. Someone can be a danger to others and never intend to be and don't understand what's going on around them and they're having paranoid thoughts, paranoid thoughts that others are against him. People who are having delusional paranoid thoughts that others are against them are not safe people.

As you go to deliberate, if you would just spend a minute more looking at this record than Dr. Ash-Bernal did, just a

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

When you go back in the jury room, when you have

questions about what does the law allow? "I've heard different things from different people." Dr. Ballenger basically said nobody ever gets to tell anybody anything. Read the letter from the United States Department of Health and Human Services. Please read this letter. It's addressed to our Nation's healthcare providers. It's addressed to the Defendants.

Had that phone call happened and we're talking about communication again, the decision to pick up the phone and find an answer. Had that phone call happened, what Dr. Ash-Bernal would have learned is, "Oh, yes, if you have a mental -- a patient with, with some mental problems and there's a, there's a family member that's able to or able to lessen this threat and you think he might be a danger?" Well, we know that he thinks he might -- she thinks he might be a danger. She -- we know this. He's at risk of death. "Oh, you think he's at, he's at serious risk of death?" He's got a seizure disorder. He's not taking his medication. The answer would have been yes. You can call the family member. Dr. Malone said, "I would never let some privacy law stand in the way of patient safety," and so even if you still somehow are misinformed, do what's right. Do your ethical duty. Do what you took a Hippocratic Oath to do and pick up the phone, call this dad who would have done anything for his son. He would have jumped out of bed, been down here in just a few minutes.

"Mr. Scheer, this is Dr. Ash-Bernal, and I'm -- just come down to the hospital," that's all she got to say. Nobody had any problem sharing Matthew's health information at any other time. Debbie calls the next morning and wants to speak to her son and they say, "He was discharged at 1:30." Debbie's not even listed as the emergency contact and they're willing to tell her that. Just saying come down here or even just saying he's about to be discharged, that's not patient health information. Patient health information is the details. He's about to leave isn't patient health information.

Talked about weighing witness credibility and how you're armed with that tool from all of your experience, and when you go back and deliberate I want you to remember and when Dr. Ash-Bernal took the stand and I said, "Do you agree there's a sudden change in Matthew?" I was shocked and I would imagine you were, too, when she wouldn't agree that there was a change in Matthew at 1:15. She wouldn't agree there was an outburst at 1:15. Look at this record. Look at these nursing notes when you get back there. Now, this one right here, this one that you're seeing, this is in Defense One. It's -- it is in, in Plaintiff's One, but it looks a little different. I just wanted to point this out to you all. This right here when you get back and there's going to be Plaintiff's One and Defendant's One. They're both the medical record. They're just in different order. Plaintiff's version of this document

looks like this. It's just a different way the printer or the computer system printed the information, but you can find this on page 100 of the Plaintiff's record, of Plaintiff's One. It's got all the same words, all the same times. The same, it just looks a little different, but the easier copy, the easier one is Defendants 116 and it will show you here what time these events occurred and what times they were recorded and the nurses are recording this stuff contemporaneously. It's not like they went back and did it a day later or two days later. By 1:44 Matthew was long gone and they were sitting at the -- at their desk charting what happened, and Defendant Ash-Bernal won't admit that this was an outburst. 581 years of experience should say that's not true.

The record shows how quickly she made the decision to discharge Matthew AMA. She won't even admit it's a discharge. Look at this record. It calls it a discharge at every single turn, an AMA discharge. He didn't run out of the hospital. They let him go. They had him sign this is a discharge. It just happens to be an AMA discharge. She discharged him from the hospital, and the record will show that the most this was was this difference between 1:13 and 1:27. She is signing for him to leave by 1:27. How much review of this record could she have possibly done? She wasn't even there at 1:13. At 1:13 she's being called. Is that a hasty decision to let a psychotic patient out, and let's not forget the circumstances,

too, what's going on outside. In the hospital there's security. There's drugs that have -- hundreds of millions of dollars have gone into researching. There's all kinds of lifesaving equipment, MRIs, CTs, just a mountain of things able to help Matthew, literally millions and millions of dollars of medical equipment right there to help him, and outside there's a hurricane going. Where is her patient safest? What makes the most sense and what duty is owed in that type of situation? And when you weigh witness credibility, I want you to remember Greg Phaebus's testimony. Mr. Phaebus, again, was the security guard. He doesn't work for Grand Strand. He works for an independent security company. He doesn't even work for them anymore. He's moved to Maryland, and we went to Maryland and we took his deposition under oath, a man who has no dog in this fight whatsoever. Okay. If you -- and I wanted to remind you of what he said.

MR. GRESH: Can't play it. He can talk about it.

THE COURT: Yeah. I sustain the objection. You can talk about what he said but don't, don't, don't play it.

MR. HINSON: Play it. Yes, Your Honor.

Remember what he said. He said this took two to four minutes, the entire interaction between Dr. Ash-Bernal and Matthew was two to four minutes. I've been talking with you all already a tremendous amount longer than she spent, and

patient safety, the safety of the community was at issue. She spent two to four minutes. I asked him, "Did you ever see Dr. Ash-Bernal do any sort of psychiatric evaluation or questioning of Matthew," and he said no. I said, "Did you ever see Dr. Ash-Bernal talk to Matthew about why he was believing all the food in the world was poisoned?" He said no. I said, "Did you ever see Dr. Ash-Bernal ask Matthew why he had just accused the nurses of being devil worshipers," and he said no. And then I asked him, "So she just walked up, said, 'Do you want to stay or do you want to go,' and then let him leave," and he said, "That's what it boils down to. That's what it boils down to. "

Then after Matthew has been released into the hurricane, later Dr. Patel comes back. Talk about witness credibility. He writes a medical record, you'll see this in, see this in Plaintiff's One. He writes what's called a discharge summary, and his discharge summary states, this is at the end of his summary. This discharge, and this is in, you'll find the page number. I'd be happy -- well, the discharge summary you'll find it at the -- this -- let me back up for a second. Plaintiff's Exhibit One is divided and there may not be a blue page for you all, but it's divided into two sections essentially. The first is the first ER visit, and that's pages one through 42. That's the first ER visit, and then the second half, pages 43 through 132, is the rest of the hospital

stay. So as you look through it understand it's divided into two parts, one through 42 and then 43 through the rest, but anyway, the discharge summary that you'll find from this second hospital stay, again, page 54, page 54 you'll find this. At the end of the summary he writes, "All questions were answered to the best of my ability." How could that be true? He wasn't there, and then he tries to explain this to you all by saying, "Well, at the time I saw him all questions were answered to the best of my ability." Well, he wasn't doing a discharge summary at the time he saw Matthew. At the time he saw Matthew the plan was for Matthew to stay in the hospital. How could he have been doing discharge, answering discharge questions when he never saw Matthew in a discharge capacity? Ask -- read this note and ask yourself if that's truthful, and again, at the end he writes discharge planning took greater than 25 minutes. 1:13 and 1:27, I'm not all that great at math, actually, but that is not 25 minutes. This isn't true.

Remember we played the deposition testimony under oath of Defendant Ash-Bernal and asked her questions, "All food in the world poisoned?" She said, "Possibly. I don't know." Asked her questions like, "Were all the -- were all the nurses devil worshipers"? She said, "I -- possibly, I don't know," and I showed her the handwriting. Let's remember that the ER staff, the only time they could -- the only time Matthew was ever

discharged other than the one that Ash-Bernal did, the only time he was ever discharged was when Battisti discharged him to go to Lighthouse because Lighthouse never admits him. So there's no discharge to happen. The only time he's ever discharged other than Ash-Bernal Battisti has David sign because she knows that Matthew doesn't have the mental capacity to sign himself out. Signing yourself in is different. You're -- if a person comes to the hospital and they're in need of help, the hospital isn't going to say, "We're not going to sign you in because you don't have the mental capacity to sign in." They'll, of course, let you come in and get you treatment. They owe you that. That is, that is their duty.

But anyway, I asked Dr. Ash-Bernal in her deposition, "Do these look -- do these look like the same signatures to you?" And remember her response was, "I don't know. I'm not a handwriting expert." I'm also not a handwriting expert. I can state with great competency that these are not the same signature. Think about that when you're weighing credibility in this case, and there's certainly a lot of legal questions that you're going to have to -- well, the, the Judge is going to charge you on all kinds of different legal matters, but one thing he's going to speak with you about is a patient's ability to consent, and you're actually going to have all that information available to you through Plaintiff's Exhibit Six.

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

was a man that had mental illness that needed treatment who believed that demons, he needed to fight demons. This wasn't a religious discussion. A religious discussion is what I have at 10 a.m. at the Methodist Church. This was not a religious discussion. This is not Sunday school. This is a man raving and ranting. So who's being truthful to you about the evidence? Consider that.

The second prong, unable to make a reasonable decision concerning the proposed healthcare. When you get back into deliberation not only all the things we've already talked about from Plaintiff's One, take a look at Three, Two, Two and Three. So Two is the notes from Matthew's time at Lighthouse which had just been a few hours earlier, early in the day before because now we're on the third, it would be on the second. Look at these notes, and they're hard to read. Somehow or another I don't know how Lighthouse's printing is so off. Look at this note. Read this note. They don't say he's a little bit delusional, which is what the Defense wants you to think, he's just a little, just a little, just a little bit of smoke. That's not what this note says. This note says, the term they use is very delusional. They make the effort to include the word very and then they go on is very delusional and confused. He had very disorganized thinking, and then look at Three. Three is the transfer back to the hospital. He is actively psychotic is the way it reads. He

is actively psychotic with delusions and disorganized thought. Can an actively psychotic patient make a reasonable decision concerning the proposed healthcare?

Dr. Ballenger just took the stand and said that Dr. Patel wasn't real sure it was a psychosis. It might be a psychosis. Everything in this record says psychosis. Lighthouse says primary diagnosis psychosis.

So I want to talk about this HIPAA excuse again. This is a made up defense. It has come only after years of litigation that they -- "Maybe we can argue HIPAA wouldn't let us call Matthew's dad. That's it. We'll use, we'll use HIPAA. Everybody knows that term. They've heard of HIPAA." There's nothing in the record about HIPAA. They didn't say, "We wanted to but HIPAA wouldn't let us." Matthew's dad's name is right there in the record. It would have taken minimum amount of effort, just decide to go over to the computer, look it up, find his name and number. "The staff offered to call patient's father for him to speak to." That is totally different than, than a note that says, "He refuses to let us call anybody." When you're back there, again, I want to read this. I just can't, I can't emphasize this enough. What you've been told by the other side about HIPAA isn't true.

Plaintiff's Exhibit Seven, "HIPAA does not prevent" -- this is to the Nation's healthcare providers. "HIPAA does not prevent your ability to disclose necessary information about a

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

lessen the risk of harm." That's what it says. That's what our government says. When you get back there, you're going to have a copy of Grand Strand's notice of privacy. It's number, number five. It looks just like this. It's just a copy of this one. That's my -- I stopped by the hospital and got one before I came into court this week. They've been using this one for years. It hadn't changed in years. It's the same.

Matthew's -- and you'll see in the record that Matthew signed that he got one. Everybody gets this. Everybody is supposed to know this. The effective date, it hasn't changed. This was what was in place in 2015. The effective date is September 23rd, 2013, and Grand Strand's got it right. This thing perfectly mirrors what the Department of Health and Human Services has said that they may disclose health information to a person or persons able to prevent or lessen a serious threat to health or safety. I don't think there's been any argument in this case that Dave was not a person able to prevent or lessen a threat to Matthew's safety and the safety of other people. As tragic as this case is it could have been worse if he had hurt other people, and as you consider this case, and you consider the weight of different witnesses, think about Dr. Tim Malone. I don't know if you noticed, he had a big ring on his finger. It's the Women's National Basketball Championship the Gamecocks won a few years ago because he's the, the director of medicine for the -- for

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

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

incurable disease is a person unable to care for themselves. Gravely disabled means a person -- this is what the Judge will charge you, gravely disabled means a person who due to mental illness lacks sufficient insight or capacity to make a responsible -- to make responsible decisions with respect to his treatment and because of this condition is likely to cause harm to himself through neglect. He's anorexic. Inability to care for himself, personal injury or others. Is he reasonably likely? He's already there. We're not talking about something in the future. He's there on October 3rd, 2015. He's already exhibited that he's unable to care for himself.

This is the verdict form in the case. This is what's going to go back with you into the deliberation. It's got five questions. The first question, truly the most important question, "We, the jury, unanimously find in favor of the Plaintiff, and we, the jury, unanimously find in favor of all the Defendants." You check for the Defendants you're done, but if we have tipped the scales ever so slightly and you think what happened here wasn't right, you think that doctors -- if Dr. Patel should have actually entered the order that he said he was going to enter, could have entered an order for Ativan, that he didn't do it, if you think that should have occurred, if you think a signoff or a handoff should have occurred, if you think that Dr. Ash-Bernal owed something more

to Matthew than, "Do you want to stay or do you want to leave", then check the top box.

The Judge is going to charge you on what negligence means. This is Plaintiff's burden to prove that the Defendants were negligent. It's a long charge, but I want to read some of the highlights of it. [As read], "Negligence is the failure to do what an ordinary careful doctor in the Defendants' field of medicine would do under the same or similar circumstances. When medical authorities are divided with regard to a specific portion of treatment or care, then the doctor is bound only to exercise his or her best judgment in determining which course on the whole is best for the patient," best judgment, not just some judgment. She used some judgment. She had an obligation to use her best judgment, a lady with a pedigree education, as good as any doctor you've heard from in this case, her resume is just as good. Is this the best she could do? That's what she owed to Matthew. That's what she owes all her patients, the best she can do. Take your 581 years of experience and ask yourself is, "Do you stay, do you want to stay or do you want to go," is that the best she could do? The best she could do was something much more, much, much more.

Remember the guy from Newberry, the one who wouldn't answer the subpoena? Didn't answer at his deposition, and his deposition under oath he told me he'd provide it to me later,

his bills. He didn't do that either. Under oath he said he would, still didn't do it. He came here and told you that this was above the standard of care. That's what he says, this went above and beyond. Ask yourself, is that, is that believable? What part of this is above and beyond?

I want you to look through this medical record. You've been told by the Defense that there was care and treatment provided. Then when crossed about that, the next question was, "What is some care and treatment that was provided to Matthew," and the answer was, "We ran some labs." Labs doesn't -- don't provide any treatment. They don't, they don't do anything but tell you more information. They told more information that he's very sick, that his psychosis has now impacted his body physically, his organs. So they ran some labs, but that's not treatment and that's not care. He never got a psych consult. Nobody ever picked up the phone, said, "Dr. Battisti [sic], I know there's a hurricane coming. I mean, I understand some people are actually evacuating the area. Are you going to be able to come tonight? Okay. Well, what would you have me do in the meantime?" There was no care provided. Matthew refused an IV. Matthew refused medication. Nobody came and ensured that he did those things.

Again, what we have in this, this case, "Well, maybe it's kind of the nurses' fault. The nurse never" -- Dr. Patel said, "Well, the nurse never told me." Then it also came out

with this -- in the trial of this case that the nurse was unaware that Matthew was a psychotic patient because obviously it's different like he talked about. If the person's in there for a kidney stone or appendicitis wants to refuse an IV, "Hey, that's their decision, that's kind of a bad decision," but when the psychotic patient is refusing one it's a different story. You heard that the nurse didn't know. Well, who do you think was supposed to make sure the nurse knew? Who's in charge of nurses? The attending doctor. So if Nurse Bell didn't know whose, whose fault is that because Dr. Patel didn't take the time to make sure his nurses knew what was going on with his patients. He didn't take the time to make sure that that's documented, didn't take, take the time to make sure his nurses knew.

While we're on the topic of negligence, the last question on the, on the verdict form asks about gross negligence. Gross negligence is a little bit different than negligence as I mentioned. Negligence is just the failure to do what an ordinary careful doctor in the Defendants' field of medicine would have done under the same or similar circumstances, and let me pause for a second on that. The Defense never brought up anyone who is full-time hospital medicine, never brought up a single expert who is a member of the American Society of Hospitalists. They brought up somebody they've paid -- well, really we don't know how much they've paid them because he

wouldn't send me his -- a copy of his invoices. He refused to comply with a subpoena, but they brought up this guy who works at a clinic, a family practice clinic in Newberry who works at a hospital that's much smaller. Have they shown you what a careful doctor in the Defendants' field of medicine would do?

So now let's talk about gross negligence. The Judge is going to charge you that gross negligence is a relative term. It's a relative term. It means the absence of care that is necessary under the circumstances, the absence of care, and so when you're deliberating ask yourself what care was provided to Matthew? Gross negligence involves an intentional conscious failure to do something which one ought to do or the doing of something one ought not to do.

Now, I want to -- excuse me. I thought I had the next slide up. I want to make sure we understand that an intentional conscious failure to do something doesn't mean you have to intend the result. There was an intentional conscious failure by Southern Myrtle Inpatient Services to train its physicians. It wasn't just like an accident to happen. They made a conscious failure to train their physicians. Dr. Patel not entering the Ativan probably isn't gross negligence. That would be an example of something that's negligence but not gross negligence. Not entering the Ativan, that was simply -- it's still negligent because you need to do that, but it's not gross negligence, but he made a conscious

failure, he knew that he hadn't done a signoff when he left that hospital. He may have thought that he'd entered the Ativan order, but he knew he hadn't done it. That's a conscious failure, and Dr. Ash-Bernal knew that she had not done an adequate evaluation of this patient. She chose to just spend a few minutes with him, and you're going to hear the Judge charge you on proximate cause. Plaintiff must show that some injury from the Defendants' negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. No one is claiming that Dr. Ash-Bernal and Dr. Patel should have foreseen that Matthew would go to 68 Avenue and at exactly such and such a time jump in the ocean and drown. That, that's not what proximate cause is. We do not have to prove that the particular injury would have occurred, but was it foreseeable that something might? It is absolutely foreseeable that if you release a psychotic man with delusions during a hurricane at 1:30 in the morning some harm should or might come. You might not know what. It might be that he jumps out in front of traffic and causes a horrible car wreck. It might be that he grabs a gun and goes and, yeah. There's all kinds of possibilities, and it's certainly foreseeable that some injury would occur.

The second question on the jury form is number two, and it's the allocation of fault, and it has to add up to a hundred percent, can't have 101 percent fault. So you can

decide that Southern Myrtle's, whatever it's in, it's in your discretion, 25 percent at fault, 25 for Patel, 50 for Ash-Bernal. I would submit that there's none for Matthew because the Judge is also going to tell you that if you find Matthew to have been mentally incompetent at the time he left the hospital, then he cannot be assigned any fault for his death. A person isn't in his right mind, they're not at fault, but I want to be clear, you don't have to find Matthew to have been mentally incompetent to even find for the Plaintiff. You can still find for the Plaintiff by just saying more was owed to him. You could decide, it's in your purview to say, "Maybe Matthew had the mental competency to do that, but still more was owed to him to try to convince him to stay, and certainly it was owed to him to just pick up the phone and call his father." Dr. Malone said, "Bring on that lawsuit. If I get sued for" -- well, he was speaking there on, on, on an involuntary hold, but so what if you violate HIPAA? But you wouldn't. Which is more important, patient safety, patient safety or some, some little reg?

Now let's talk about damages. The third question on the jury form is Matthew's damages. So there's essentially two lawsuits, more or less. There's Matthew's case for what he suffered and there's his parents' case, and so for Matthew this is called the survival claim. It's for his injury during the time he survived after the Defendants' negligence. So in

this case it would be all that he endured from the time he left the hospital till his lungs filled with water and his brain finally shut off.

And number three gives you the elements of a survival claim. It's the mental anguish and emotional distress. That's one element. I, I, I want you to consider the mental anguish that this young man went through. Of course we don't know what path he took, but we know he got from here to here alone, somewhere between 1:30, two or so in the morning thinking that demons were after him.

You heard from Mr. Doherty, a man who did more for Matthew than Dr. Ash-Bernal ever did, a man who had no duty to Matthew at all, still did more for him, tried his best, but you heard Mr. Doherty say that he saw this young man, saw Matthew, as we now know, come down to the beach and take off all his clothes, pumping his fists in the air and carrying on. That's mental anguish and emotional distress. Matthew suffered agony, agony in his head because he thinks he's being called to cleanse himself in the ocean during a hurricane, and Matthew suffered pain. Dr. Robinson talked to you briefly about that. The way when we die or when we -- if we were to drown that, that our throat goes through a spasm trying to keep because you probably don't want to let water into your lungs, it's your natural reaction not to. There's a spasm until finally your lungs fill with water. Think about it, how

horrible it is just when you -- when a little liquid goes down the wrong pipe. Imagine your whole lungs filling with water. You don't die instantly. The brain has to eventually shut off, and Matthew suffered pain before he died.

The fourth question on the jury form is for the wrongful death damages. Wrongful death is different than a survival claim. The wrongful death under South Carolina law in this case it's for Dave and Debbie. They each have a claim. They each are claimants in this, in this action. You'll find a blank for Dave's damages and you'll find a blank for Debbie's damages and you can decide if they're different. I would submit to you that those two are so tight-knitted I don't how they could be, but that's up to your purview.

The Judge is going to tell you that one of the elements is shock, and let's talk about shock with Dave. Dave went home thinking he was doing, thinking what he was doing was best for his son. He thought his son was in a safe place, in a hospital with doctors and nurses and security guards and whatever he would need. Dave made sure to tell the nurses, "Hey, you got my number just in case something," "Yeah, yeah, I got, I got your number." He went home to do what he thought was best for Matthew, get Matthew some clothes. Debbie said he was getting him some deodorant and toothbrush and other things you might need. You're sitting in the hospital. You don't want your breath to stink and be smelly. Dave was doing

what he thought was best for his son, and he'd thought he maybe was going up here, take him back to New Jersey and he can't drive. He'd be up for almost two days, and let's think about the shock when Debbie calls him that next morning and says in that voice, "Matthew's not in the hospital," imagine that's your -- that's a compensable damage for Dave, and he would have another shock when the police called and say, "Dave, we need you to come down here, Mr. Scheer," and show him a picture of the clothes that Matthew was wearing, and they tell him what Mr. Doherty has seen.

I've got two daughters. Kids are sometimes hard to keep up with. If I lose my seven-year-old in the grocery store for a minute I freak out.

MR. GRESH: Your Honor.

THE COURT: Yeah. I, I sustain the objection.

MR. HINSON: Dave and Debbie, before they get the call from the police, can you imagine their grief driving around Myrtle Beach looking for their son and driving around in a terrible rainstorm? That's a compensable damage for Dave Scheer.

Grief and sorrow, grief is what you feel at a funeral. Grief is the immediate feeling of sadness. After somebody dies you grieve for them. Dave grieved in the days following Matthew's death and grieves today, but grieved at the memorial service, grieved driving back to New Jersey without his son.

Wounded feelings, the wounded feelings Dave has in the way the Defendants let him down, go with him all of his life.

The next bullet point, the loss of Matthew's companionship. Debbie talked about how Matthew wanted to be like dad. You heard how they were golfing buddies, how Dave watching Philadelphia sports teams because they liked the teams from the area, and when the Eagles or whoever does something great he wants to text Matt and realizes he can't text Matt anymore. He doesn't have Matt's companionship anymore.

And this last one, loss of Matthew's advice on family matters. 26-year-olds probably don't give a lot of advice to their, to their parents, maybe on technology and how to handle this computer problem or whatnot, but that changes later in life. It changes as parents get older, and children start to give their parents advice. Dave and Debbie will never get that with Matthew. One day they may need help with things. They won't be able to get that from their son, and they said -- I don't remember if it was Dave or Debbie, but one of them very selflessly said, "I worry how that's going to impact Erik," and that really struck me. Instead of saying, "I wonder how that's going to impact me," they said, "I wonder how it's going to impact Erik," that now he's all alone to do this, and they're now worried about Erik, that he's going to feel a bigger burden. They've lost Matthew's advice on family

matters. That's Dave, and Debbie's are similar, but she has a view different, different aspects of it. Debbie's shock in that phone call to the hospital where they told her Matthew's not here, he was released, he was discharged at 1:30 a.m., the shock that she had.

Her grief and sorrow, you heard how Matthew was a hugger. She misses his hugs. You heard about her dreams that she dreams that Matthew's still with her and then wakes up and realizes that's not true and loss of Matthew's companionship. She told you about how often they spoke on the phone, that they went to the movies together. She was -- he was her movie buddy. She's lost that companionship, and the last element, Matthew's advice later in life for her.

When you're in the deliberation room, when you consider each one of these, these are all elements, and the law of South Carolina doesn't let me demand or request a number. I don't get to say the Plaintiffs want $10 million. I don't get to say that in South Carolina. We don't get to ask for a specific demand. It's up to you in your wisdom, and some of you may decide that $3 million is a reasonable number to consider for all this and others may think it's five and others may think it's six, and you have to decide together what a reasonable figure would be, and when you think about that, compensate Matthew for his damages for the way he died and his pain and suffering and agony, the Scheers, the Judge

is going to tell you what Dave and Debbie's life expectancy is because the longer Dave and Debbie live the longer they have to go through these things, what we don't know, but the law has a formula we use what a person's age is and there's an estimate of how long they would live, and the Judge is going to tell you that for Dave it's 16 more years and for Debbie it's 23. So that'll be 23 more years the dreams about her son only to wake up and realize that he's not still with her, 23 more years of wounded feelings and sorrow, 23 more years of sadness.

In this case, you can choose to believe that doctors never do anything wrong, that we must just totally defer to their claims of what happened out of -- in every respect or you can choose to recognize that doctors can also choose to break some basic safety rules that should be followed, and you can choose to hold them accountable for Matthew Scheer's death. The Scheer family asks that you find justice for Matthew.

THE COURT: Members of the jury panel we'll take a short break before we hear from the Defendant. This will just be a refresher break. So as soon as everybody's used the facilities if the bailiff will let me know we'll bring you back in.

(The following takes place outside the presence of the jury.)

THE COURT: All right. Do we have a charge for me yet?

(Ms. Spears and Mr. Padget confer.)

THE COURT: Yeah. We're going to, we're going to take a break. Yeah. (Lodging discussed.)

THE COURT: Just in general, Mr. Gresh, do you know about how long you're going to take?

MR. GRESH: Less than Brink.

THE COURT: Well, I --

MR. GRESH: I promise that. It'll probably be 45 minutes is my, is my hope, Your Honor.

THE COURT: All right. Take a short break.

OFF THE RECORD

(The following takes place outside the presence the jury.)

MR. HINSON: Your Honor, I apologize. I did not realize it was as long as it was after I told you I didn't think I'd be in excess of an hour, and I, I apologize to the Court.

THE COURT: Well, if you get a recovery maybe you can buy a watch with it. I say that in all good humor. It's an important case. I'm going to let -- I didn't stop you.

MR. HINSON: Thank you, Your Honor.

THE COURT: If I'd, if I'd thought you had been -- crossed the line somewhere I would have stopped you, but it's an important case and, and you did a good job.

MR. HINSON: Thank you, Your Honor.

THE COURT: Somebody going to get me the charge or is it already -- no, it's not up here yet.