IN THE COURT OF COMMON PLEAS
OF STARK COUNTY, OHIO

STEVEN FRANK, et al.,
Plaintiffs,
vs. Case No. 1997 CV 0047
JOHN VARGO, III, et al., Judge Reinbold, Jr.
Defendants.

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VIDEOTAPE DEPOSITION OF ROBERT K. DeVIES, Ph.D.
Tuesday, June 27, 2000

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Videotape deposition of ROBERT K. DeVIES, Ph.D., called for direct examination under the statute, taken before me, Elaine S. FitzGerald, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the office of Robert K. DeVies, Ph.D., 4572 Dressler Road, Canton, Ohio, on Tuesday, June 27, 2000, at 6:35 o'clock p.m.

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APPEARANCES:

On behalf of the Plaintiffs:

Becker & Mishkind Co., L.P.A., by
HOWARD D. MISHKIND, ESQ.
Skylight Office Tower
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(216) 241-2600

On behalf of the Defendants:

Berlon & Timmel, by
PATRICK S. CORRIGAN, ESQ.
76 South Main Street
Suite 1604
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ALSO PRESENT:

Barry D. Hersch, Videographer

MR. HERSCH: We're on the record.

ROBERT K. DeVIES, Ph.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF ROBERT K. DeVIES, Ph.D.

BY MR. CORRIGAN:

Q. Good evening, Doctor. Patrick Corrigan here for Cincinnati Insurance Company.

Could you identify yourself to the Panel, please?

A. Dr. Robert K. DeVies.

Q. And what do you -- what do you do as a professional?

A. I have -- I work at the Altman Hospital in the internal medicine residency program as an associate professor in internal medicine and psychology at the Northeastern Ohio University College of Medicine and I'm the president and chief executive officer of Psychological and Family Consultants in Canton.

Q. I'm going to hand to you a copy of what I believe is your curriculum vitae. It looks a little old --

A. Yes.

Q. -- but would you please identify that for the Panel?

A. Yes. This certainly was the vitae that we were using at that time.

Q. Fair enough.

MR. MISHKIND: Could I see it, please?

Q. Doctor, would you please describe your practice specialty for the Panel?

A. My specialty is in rehabilitation psychology. It -- I'm particularly interested from a clinical and a research standpoint on adjustment to illness and particularly neurologic illness has been my biggest interest as well as systemic disease. But I see patients in rehabilitation units who have had strokes, who have had head injuries and so on and teach internal medicine residents on what are the psychological aspects of that and how to evaluate patients for these kinds of conditions from a psychological standpoint.

Q. What portion of your practice here involves testifying or serving as an expert witness for either plaintiffs or defendants?

A. A very small part. I would say on -- in any given week, probably none, but maybe 5 to -- 5 hours a month on the average, maybe 60 hours to -- 60 to 100 hours per year.

Q. Okay. There came a time when you were asked to review records and undertake an examination of Steven Frank in this case. Can you describe for the Panel the records that you reviewed?

A. I was actually asked to review the records on Steven Frank I believe by Attorney Greg Beck from Baker, Dublikar, Beck, Wiley & Matthews who represented I believe one of the insurance companies, and that, I'm not sure who Greg Beck represented, but he provided me with a fairly lengthy set of materials having to do with the police report and the different medical reports on Steve Frank.

Q. Okay. Is it safe to say you reviewed medical records from Dr. Afield and various other --

A. Our -- I think in our initial -- Dr. Afield wasn't involved I don't think with the initial materials that I had available, but later I got to see something from Dr. Afield, yes.

Q. Okay. Can you tell the Panel about your interview with Steve Frank and the time you spent, the evaluation you performed?

A. Well, in -- in fact, I had reviewed these records for Mr. Beck and had concluded that there was certainly reason to pursue an examination, you know, to do an independent evaluation, and that was scheduled and that to be conducted I believe on June 13th of 1998 and he was to be here for two days of testing.

The -- he came in for the examination. He had flown in from where he was living, somewhere in the south. I don't know if it was Florida or North Carolina or South Carolina. One of the Carolinas or Florida. And he -- we proceeded with an interview that lasted somewhere over an hour, probably under two, and based on what I had read of him, I wanted to do a fairly extensive battery of tests that included the House Rattan Neuropsychological Test Battery, the Wechsler Adult Intelligence Scale, the Minnesota Multiphasic Personality Inventory, the Memory Scales, and we weren't able to do that.

Q. Can you tell the Panel why you weren't able to do that?

A. The -- Mr. Frank indicated first of all to me the morning of the second day that his flight was scheduled to leave in the late morning or around close to noon, he wouldn't be able to stay, so instead of having two days, I had one -- the best part of one day and only about an hour or two on the second day.

The second reason was is that after we had spent a couple hours doing the interview, we set on out to do these tests, and the first test, the MMPI or the -- I guess we gave him the Wide Range Achievement Test and the Shipley Assertive Living Test, he took forever to do them, and so, you know, when I give him the MMPI and I went in and would do a check on him regularly, he just wasn't moving. He would do maybe 20 questions an hour or 20 questions a minute, you know -- or, I'm sorry, an hour. He took an excessively long time to do it. And in fact, at the end of the first day, he had in fact pretty much only completed the MMPI. A test that should take an hour, an hour and a half to take, he had taken six hours to do.

Q. Did that pour into the next morning, the MMPI?

A. He finished up that on the next morning and I had to scrap our planned examination and give a bunch of tests of far less credence, far less validity, just a weaker set of measures all together.

Q. So the basics of your time with Steve Frank have just been testified to, is that correct?

A. Yes.

Q. The tests administered, the interview?

Were you able to achieve any diagnosis based on your time with Steven Frank?

A. I didn't -- I was asked at one point if -- if he had a head injury and I certainly conceded that I, you know, I thought he did have a head injury, but that was not based on my testing. I couldn't get that from the testing. I conceded that from -- and I say concede because that was a word that was used in my deposition.

Q. What was it based on?

A. It was based on my observation and the wreck and the emergency room records that I had reviewed.

Q. Okay. Were you able to draw any other

conclusions about Steve Frank based on the time that you spent with him?

A. The -- **I** believe that while there were some -- there certainly was evidence of a head injury, **I** felt that also there was evidence of a very, very significant tendency for him to drag his feet, to have -- that he was not giving me his best effort. He certainly on -- **I** would not use the word malingerer, you know. **I** -- **I** don't believe that's the right term, and **I** don't know that it's a particularly clinical term, but **I** would use the term sandbag. **I** felt that he was sandbagging me.

Q. Based on what you have said there, is -- in this case there has been testimony that Steve Frank, testimony from his medical professionals, that he sustained a brain injury that prohibits him from working and basically has precluded him from being a salesman. **Is** it the case in a mild brain injury that typically there would be mild memory or cognitive changes that are not necessarily disabling and such an individual such as Steve Frank could return to work and succeed in his prior job?

MR. MISHKIND: Let me just object to

the form of the question. It's leading in nature as well, but certainly the Doctor, given that this is to the Panel of Arbitrators, I will leave it at that.

MR. CORRIGAN: Thank you, Howard. I appreciate that.

A. I suspect the term what we used head injury, I would use maybe a post concussion type syndrome that includes this family of behaviors and things, and it's in fact the case that most people who sustain a mild head injury that has residual or thought of as post concussion syndrome does return to work. They do return to work. Most return to the same job. Even if you're an NFL quarterback, you return to the same job. So yeah, I -- I -- I think it's very fair to say that most people who sustain mild head injury return back to the same job.

Q. If there was testimony presented in this case from co-workers of Steve Frank and other business associates that he returned to work and achieved some success in sales commensurate with or at least similar to his prior performance, would you agree that that would be an important evidence for a

neuropsychiatrist or a neuropsychologist to consider in forming opinions regarding the ability to perform?

A. Yes.

MR. MISHKIND: Let me -- objection again --

THE WITNESS: I'm sorry.

MR. MISHKIND: -- but you have already answered and the Panel's going to consider it anyway, but my objection is noted.

Q. Okay. Let's assume that there has been testimony in this case that Steve Frank independently negotiated with an individual for the opportunity to represent his company, in other words, this other person's company, as an independent sales rep and then proceeded to achieve two significant sales in two months. Would that be significant in determining the ability of Steve Frank to return to his former occupation?

MR. MISHKIND: Objection.

A. I believe it's a significant piece of information, yes.

Q. And in the course of your practice as an expert in this field -- apparently you're a

rehabilitation psychologist, is that correct?

A. Yes.

Q. Is it -- would I be correct in assuming that when an individual returns to work from some class of a minor concussion such as occurred in this case, would I be correct in assuming that post-accident performance indicates -- which is testified to is a good indicator of the ability to work?

MR. MISHKIND: Let me just object.

Again, this is an arbitration, but the nature of your questions are so leading to an expert witness that I would ask the Panel to consider the content of the questions that are being presented to the Doctor and give the Doctor's testimony the weight that it deserves.

MR. CORRIGAN: Howard, I'm trying to ask a hypothetical and I admit I'm rather inartful at that, but --

MR. MISHKIND: I'll stipulate to that.

MR. CORRIGAN: Okay.

A. I'm not sure that I -- I'm up on the question now, but it -- I believe, if I understood the question correctly, is that the

ability to conclude business that you were able to do before is in fact a reasonably good predictor of some degree of recovery.

Q. Okay. Just a minute, Doctor. I'm trying to dispose of some other questions that Mr. Mishkind might not like here and --

MR. MISHKIND: Don't dispose of them on my account.

Q. Dr. Afield was asked on direct examination by Mr. Kulwicki whether his opinion of Steve Frank's condition would change assuming that several witnesses that defense counsel presents will opine that they've had dealings with Mr. Frank both before and after his injury and that they haven't noticed any change in his cognitive function. Dr. Afield stated on page 38 of his transcript that it does not change his opinions in any way, and he then went on to testify that, quote, "That depends on the level of witness. If it's me and the receptionist, she's not going to notice a difference, if it's me and my wife, she's going to notice a difference, and if it's me and my business manager and I can't make legitimate decisions, it becomes very obvious to the people who are close

and involved in working with you that there's something wrong."

Given that testimony, wouldn't the converse situation also be significant from a psychological evaluation point of view? In other words, if five different co-workers, one of whom was a supervisor, another of whom was an independent businessman who had daily contact with Steve, testified that Steve Frank was the same sharp guy after his accident as he was before, would that be important information for a diagnostic purpose?

MR. MISHKIND: Objection.

A. Well, you know, I think the entire situation there is pretty convoluted. I would say this, that if in fact Dr. Afield believes that the detection of a head injury requires such subtle kinds of innuendoes from one level of relationship to another, we must be talking about a very subtle and mild head injury. You know, that is not -- a person who has a head injury of some significance doesn't disguise that from anyone. That's an omnipresent condition, and your wife, your receptionist, your business manager, the garbage man can see that there are

significant changes.

If, in fact, the differences are so subtle and so brief as Dr. Afield suggests, then in fact the head injury's so minimal that it's becomes essentially irrelevant with regard to degree of injury.

Q. Okay. Well, given the -- and there came a time when you interviewed Steve Frank and can you tell the Panel how he presented to you in the interview?

A. Steve Frank -- I have some notes here from that. Let me just -- he came on time. He was very casual. He had come from Florida. He was friendly to me. My -- that's what I was looking for. His overall appearance was mildly disheveled although clean and coordinated; that is, he wore pants and shirt that -- he was disheveled though as I recall. Half of his shirt tail was out and his hair was all amuss (sic), but he didn't have any particular odor about him. He had -- he had showered and he was -- he was disheveled but he wasn't dirty.

Q. Okay. What about his affect or his presentation otherwise in terms of cognitive ability, his ability to converse? Did you make

any observations regarding that?

A. He came across very -- somewhat quite dull. He -- we were in my partner's office for the examination and he was seated on the couch and he would dart his head back and forth and he, you know, had a hard time making eye contact with me. His mood, in other words, was very flat and his speech was very flat and there was almost a monotone in which he spoke, and I noticed that his speech was somewhat dysarthric which is a common speech characteristic noted by individuals who have had a head injury.

Q. Would you define dysarthric for the Panel, please?

A. Dysarthric is a term in aphasia studies that in fact is short for central dysarthria which suggests that there are problems in the speech producing sound -- speech producing areas of the brain that creates a flattening of the T-H sound particularly. So there is a tendency to hang on to the "th, th," T-H sound, and you'll get a rather extension on that.

Q. Okay. I want you to assume that there has been testimony by up to eight different individuals who dealt with Steve Frank after his

accident, many who dealt on a daily basis in either his sales contacts with various jobs or in building a home in North Carolina, and each of them testified that Steve Frank seemed sharp or quick-witted and that his eye contact, his ability to go in and make a presentation was the same as it had ever been. Assume further that many of these individuals testified that they observed no difficulty in his ability to speak, such as slurring or stuttering or difficulty finding words or ability to express himself.

Given the above assumptions, is it possible for an individual with a mild brain injury as described by Steve Frank and his doctors to essentially improve his speech or eye contact or apparent focus or sharp-wittedness, or should one be able to expect him -- in other words, would he be unable to do that?

MR. MISHKIND: Let me object to the question and I would ask the Arbitrators, even though this is an arbitration, that any answer given to this question should not be considered based upon the form of the question, based upon speculation, possibility, although assumes facts which are not in evidence in the case and

probably for other reasons, but, Doctor, you can go ahead and answer the question.

A. If I can recall what it was. I -- I believe, and correct me, Mr. Corrigan, if I'm wrong, because I need to see if I understand the question correctly --

Q. Maybe I can try to simplify the question.

A. -- it sounded to me like the question was, is a person who has had a head injury able to turn it up or turn it down.

Q. In other words, the question really is, can a person who has a head injury with the presentation that you described regarding dullness, a flat affect, a speech difficulty, are they able to turn that off and speak normally?

MR. MISHKIND: Objection.

A. My position is is that symptoms can be added, symptoms can't be taken away. That is, if a person has a head injury, they're at the mercy of that head injury to the limitations imposed by that head injury. If a person has a head injury and they want to in fact make more of rather than less of that head injury, they can in fact then add symptoms to it, but they can't really take

symptoms away from it.

MR. CORRIGAN: Okay. Doctor, I don't have anything further at this time. Thank you.

CROSS-EXAMINATION OF ROBERT K. DeVIES, Ph.D.

BY MR. MISHKIND:

Q. Good after -- good evening. Good evening. Doctor, I introduced myself before the deposition began. This is the first time that we have met. I will slide around so you don't have to get a stiff neck turning toward me. I am Howard Mishkind and you had met Dave Kulwicki from my office previously when your discovery deposition was taken, correct?

A. I believe that was over the telephone I think.

Q. Very possibly. Very possibly. There has been a lot that's gone on in this case, some of it less convenient than others. I do have some questions for you this evening.

I've had an opportunity to review your report and your notes that you provided at the time of your discovery deposition. You have not considered any further information since the time of your discovery deposition?

A. Not to my knowledge, no.

Q. Your discovery deposition was taken back in September of 1998?

A. Right.

Q. Okay. By the way, you indicated that you had been retained by Mr. Beck from Baker, Dublikar who is counsel for Erie Insurance Company. I just -- I noticed that Erie Insurance Company is directly across the street from your office. Do you do many examinations at the request of Erie Insurance Company?

A. No. Matter of fact, I -- I don't think I -- I wouldn't have known that it was Erie Insurance Company unless you told me. Mr. Beck has -- I have done several examinations for him.

Q. Okay. I want to determine and sort of clarify a few items. Number one, we can agree, can we not, that Steve Frank in your opinion is not malingering, correct?

A. I don't believe that he was malingering in terms of the presence or absence of a condition, no.

Q. And Steve is not a hypochondriac, correct?

A. No. I do not believe that Steve is a hypochondriac.

Q. Okay. And you don't believe that Steve Frank is lazy either, do you?

A. Well, I -- I would say I can't say. I don't have any reason to believe he's lazy.

Q. Okay. Doctor, the deposition will go a lot faster if you can, when I ask you whether we can agree that you don't think a particular way, if it calls for a yes or a no, if you could just say whether you -- whether that's a yes or no and let me give the question to you again.

Can we agree that you do not think that Steve Frank is lazy?

A. Let me just have one clarification so we can go faster. If I can't say yes or no, I need a -- my answer is I have no basis to know.

Q. Do you recall when your deposition was taken -- and again, you were sworn to tell the truth --

A. Yes.

Q. -- and at page 71 the following question, I'll read the question and answer to you --

A. Okay.

Q. -- the question began at line 4, "Are you impressed by the fact that he tried to go

find work down in Florida?". Answer, "Yes." Question, "Why?". Answer, "I don't believe that Steve Frank is a malingerer. I don't think that's true. I don't believe that Steve Frank is a person who is lazy."

A. I'll stand by that.

Q. Okay. Now, Steve sustained a traumatic brain injury, correct?

A. To my knowledge, yes. Yes.

Q. You have no basis to say otherwise, do you?

A. That's right.

Q. You believe the traumatic brain injury is mild, correct?

A. That's my opinion, yes.

Q. And for the benefit of the Panel, you would certainly agree with me that a mild brain injury can cause serious effects on a person's ability to perform at a higher level in a job, correct?

A. Correct.

Q. Let's review a couple things that you talked about with Mr. Corrigan. Number one, at the time of your exam, his speech demonstrated some production difficulties, correct?

A. Yes.

Q. And that is consistent with someone that has traumatic brain injury, correct?

A. Yes, yes.

Q. His affect was mildly dull and he had a hard time keeping eye contact, correct?

A. That's right.

Q. He demonstrated this dysarhythmic -- dysarthric slurring which we talked about before?

A. That's right.

Q. Which is all consistent with someone that has a traumatic brain injury, correct?

A. Correct.

Q. In fact, Doctor, I believe that you indicated that you felt that part of Steve's brain injury based upon the review of the facts of the case and the tremendous collision that occurred, the impact to the rear of the vehicle, that you felt that part of his brain injury was due to cervical difficulties involving the brain stem causing a temporary anoxia, correct?

A. I recall we discussed that during the deposition and I felt that that was a possible explanation. I'm not sure that I said that that's the reason, but I thought that that was

certainly possible.

Q. Doctor, again, at lines -- at page 69 line 9 of your deposition was the following question and was the following answer given. "The next paragraph -- and I'm going to skip over the part about whether he was concussed at all because I think we kind of covered that in a different way -- I suspect that there may be some relationship to his cervical difficulties and disorientation moreso than an actual post concussive event. Tell me what you mean there." And your answer was, "My sense was that at least from an exploratory standpoint, the things that I wanted to examine was whether or not as you were talking about axonal injuries, I felt that some of the behaviors were more reflective of temporary anoxia secondary to cervical injury than in fact actual brain concussion post-concussive syndrome."

A. That's right.

Q. Okay. Did I read that accurately?

A. The -- I think --

Q. Did I read that accurately?

A. Yes, you did.

Q. Okay. So certainly part of the injury

to the brain, certainly you considered and cannot rule out a temporary anoxic event contributing to some of his brain damage, correct?

A. I could not rule that out, no.

Q. And anoxia is a lack of oxygen which will enhance someone's injury when they've had a traumatic brain injury, correct?

A. Or be the source of the brain injury.

Q. Sure. Exactly. But in this particular case, you do not believe that the hyperextension, hyperflexion injury, the blow that he took that caused the jarring of his head was not contributory to the traumatic brain injury, do you?

A. No.

Q. He was cooperative and friendly as you said throughout the exam, correct?

A. Yes.

Q. And certainly you're more likely to get truthful and accurate information from someone such as a Steve Frank because he was being cooperative and friendly as opposed to hostile and noncooperative, correct?

A. That's right.

Q. It's always better to have someone

that's answering you and not trying to -- to dodge the questions, correct?

A. That's right.

Q. You're not a medical doctor, correct?

A. That's right.

Q. You are not a neuropsychiatrist, are you?

A. No, I'm not.

Q. And in fact, you are not a neuropsychologist either, correct?

A. No.

Q. My statement's accurate?

A. That's right.

Q. Okay. Dr. Afield, one of Plaintiff's treating doctors, is a neuropsychiatrist. You're aware of that, correct?

A. I -- I -- I don't know.

Q. Are you aware or has Mr. Corrigan advised you of some of the world class credentials that Dr. Afield maintains as a neuropsychiatrist?

MR. CORRIGAN: Objection.

A. No.

Q. You have a master's degree in rehabilitation counseling which is as I

understand it from the Department of Education at Bowling Green, correct?

A. That's right.

Q. Not the Department of Psychology?

A. That's right.

Q. And you have been retained as an expert in well over 100 cases to provide expert testimony, correct?

A. Yes, I have.

Q. Doctor, neuropsychology is a -- or a doctor that is a neuropsychologist is a specialist in brain behavior relationships, correct?

A. Yes.

Q. And you have never testified as a neuropsychologist, have you, because you are not one, correct?

A. There is -- may I explain?

Q. First answer my question.

A. I have never held myself out to be a neuropsychologist.

Q. Neuropsychology is a subspecialty within psychology, correct?

A. That's right.

Q. You are a rehabilitation psychologist,

correct?

A. That's right.

Q. You know Dr. Toth, correct?

A. Yes.

Q. You would agree that she has impressive credentials, correct?

A. Yes.

Q. You are aware, are you not, that Steve Frank was referred to Dr. Toth not by one of the lawyers but by one of his treating physicians?

A. I don't know how he got there.

Q. Well, certainly you took a history and were provided with a plethora of information so you would certainly know, would you not, how --

A. I'm sure it's available, yes.

Q. Okay. But as you sit here right now, you're not aware --

A. I don't recall it, no.

Q. Okay. Dr. Toth is a neuropsychologist?

A. I don't -- what I'm saying, I am not familiar with how he got to Dr. Toth.

Q. But it wouldn't surprise you if Dr. Toth -- that Steve Frank was referred to Dr. Toth by one of his treating doctors as

opposed to by Dave Kulwicki or by Howard Mishkind?

A. No, that would not surprise me.

Q. Okay. And certainly in Dr. Afield as well, the referral came not from one of the lawyers, it came from one of the treating doctors.

A. That wouldn't surprise me.

Q. And certainly Dr. Toth you would agree arrives at opinions in an ethical and legitimate format, correct?

MR. CORRIGAN: Objection.

A. I have no opinion.

Q. Well, you have been asked that question before, Doctor, and do you recall --

A. I recall being asked that question before and I believe that I answered that I have a great deal of respect for Dr. Toth. I know Dr. Toth. Her credentials are quite impressive, but she has a distinct plaintiff's bias from my experience.

Q. Doctor, let me ask you again the question that I just asked you. I asked you would you agree that she arrives at her opinions in an ethical and legitimate format and I think

you said you have no opinion on that. Is that --

A. That's true. That's true.

Q. Okay. Now, Doctor, do you remember the Trussel versus Edelman case?

A. No, I do not.

Q. Just in January of 1997. You were cross-examined by Richard Nickodemo.

A. Yes.

Q. And was this question and was this answer provided when you were asked about Dr. Toth? "You know Dr. Toth, don't you?". Dr. DeVies, you actually at that time said, "Over the telephone."

A. Yes.

Q. "You would agree that she has impressive credentials?". Answer, "Yes, she does." "You would agree that she is well -- a well-intentioned psychologist?". "Yes, I would. That she's well-trained?". "Yes, I would." "You're confident I'm sure that she arrives at her opinions in an ethical and legitimate format?". Answer, "Yes, I would."

A. Yes.

Q. Okay. And that certainly you would

agree with that?

A. I agree with that, yes.

Q. Okay. That's fine.

Now, the -- on your direct testimony you indicated, and maybe I heard you wrong but I marked it down at the time, you said that your exam was June 13 of 1998. According to --

A. My exam -- I have the notes right here. Oh, right here. February 12, 1998.

Q. Okay. I think you may have said --

A. I may have -- yeah, I may have said June 13, but it's February 12th. I'm sorry.

Q. Your exam was February 12th. Your report was generated approximately four months later, in June of 1998, correct?

A. That's right.

Q. And you did not have an opportunity to do all of the testing that you wanted to do because Steve Frank had to go back home, correct?

A. That's right.

Q. Did you ever request an opportunity to do any additional testing on Steve Frank?

A. Yes.

Q. You would certainly have liked to have done additional testing, correct?

A. That's right.

Q. Then or at any other time, correct?

A. That's right.

Q. Well, Steve Frank was back up in Ohio two months later to see Dr. Sokolov, and did you request of Mr. Corrigan at that time for an opportunity when Mr. Frank was up in Ohio for him to see you for any additional testing?

A. I don't believe that I knew Mr. Corrigan at that point other than maybe he sat in on the deposition that I had with Mr. Beck. I -- I don't recall. Maybe he was there, but until Mr. Corrigan contacted me regarding this current situation, so I would have had no reason to call Mr. Corrigan.

Q. But suffice it to say, you would have liked to have done additional testing, correct?

A. I complained about that, yes.

Q. You -- there is nothing in any writing that -- that indicates to any of the attorneys in this case that bring me back Steve Frank, I want to do additional testing, correct?

A. There is no writing to that effect, no.

Q. Okay. And you never told Steve Frank,

"Come on back and visit me again for additional testing," correct?

A. I -- I expressed to him my dissatisfaction.

Q. That he had to go back and that you weren't able to finish things?

A. That's right. That's right. I didn't feel it was my call. I had him for that period of time and I explained to the attorney that had hired me that I couldn't get the information he wanted.

Q. Okay. And for whatever reason, that attorney or subsequently Mr. Corrigan when you were contacted by him never made arrangements to resubmit Steve to you for any additional testing, correct?

A. No.

Q. And you didn't get the sense from any of the communication that Steve Frank was unwilling to cooperate with regard to any additional testing at a later point, did you?

A. I did get the impression, yes.

Q. Well --

A. I was told that he wouldn't -- didn't want to come back.

Q. Well, do you have any explanation for why he came back in to Ohio just two months later after you had submitted your report, was seen just maybe a mile -- an hour or *so* south of where you are by Dr. Sokolov, a well-regarded psychiatrist, and arrangements weren't made for you to see him at that point? Do you have any explanation for that?

A. I don't know -- I don't know why that was.

Q. Okay. By the way, the dysarthric slurring, that's indicative of a person with a head injury where the cranial nerves have been jarred, correct?

A. That's -- dysarthric speech occurs, you know, in a head injury if the cranial nerves are jarred, but it can also occur if there is, you know, cortical problems, not just cranial nerves.

Q. Is there a validity scale that is available in the MMPI to determine whether or not someone is providing biased or unbiased testimony?

A. Yes.

Q. And did you perform the validity

scale?

A. His testing was computer scored and on that, his -- his F score on the MMPI was 70 and the interpretation of that is that there is minimal denial of common, ordinary faults and imperfection, average overall defensive, and a very high level of uncommon responses. This pattern suggests an extreme tendency to overstate problems, a tendency to overemphasize problems, suggests the possibility of motivational distortion to portray emotional disturbance.

Q. What was his -- the K scale

A. The K scale was 45. The -- which is in the normal range.

Q. Are you aware of Dr. Toth's validity scale?

A. I have not seen Dr. Toth's report to my knowledge.

Q. Okay. That wasn't provided to you?

A. Not this, no.

Q. Well, certainly in arriving at opinions, you'd like to have as much information --

A. Well, oftentimes they do not provide us raw data.

Q. Okay. Are you aware of what Dr. Afield testified to concerning the validity scale?

A. No.

Q. Would you agree with me that a neuropsychologist is in a better position than a psychologist to discuss damage to a person's brain and how the injury to the brain has resulted in emotional problems or a change in the person's personality?

A. A plain old psychologist or a rehabilitation psychologist?

Q. I'm talking about the difference between a neuropsychologist and a psychologist.

A. The neuropsychologist would be superior.

Q. When someone sustains a traumatic brain injury, they typically experience some alteration in behavior or cognition, don't they?

A. Yes, they do.

Q. And when a patient sustains a closed head injury, there is damage to the brain structures that lie within the skull, correct?

A. Occasionally.

Q. You don't need to see evidence of

injury to brain matter on an MRI for a patient to have sustained a closed head injury, correct?

A. No, you don't.

Q. And when a closed head injury takes place, the brain is actually mobilized and the brain collides with the skull on the opposite side, correct?

A. Yes, it is.

Q. And this is typically -- typically called rotational acceleration, isn't it?

A. Yes.

Q. And you can have rotational acceleration of the brain in a rear end collision, correct?

A. Yes.

Q. Especially such a violent collision like the one that Steve Frank was involved in, correct?

A. Again, I had not -- I don't recall his -- I don't know how violent it was. If there was damage, certainly in that I would expect that it's possible certainly.

Q. Tell me what your understanding is in getting the history from him as to how much damage, how hard he was hit and the structural

damage to the back of the vehicle.

A. Well, I saw -- I think I saw a picture and the back end of his vehicle was pretty well destroyed. That would say to me that he probably took a big hit from behind. But as an accident scene investigator, I don't know these things.

Q. Sure. That's fine.

When a patient sustains a post concussive syndrome, would you agree that they routinely have cognitive deficits such as problems with attention, concentration, short-term memory and general declines in level of performance over short-term on their intellect and achievement?

A. Yes.

Q. You may also see depression, volatility, hostility and emotions that are uncharacteristic -- easy for me to say -- uncharacteristic of the patient before the closed head injury?

A. Yes.

Q. Would you also agree that sensory losses, hearing and vision loss is also seen in patients that have sustained a traumatic brain injury?

A. They -- they may have that without any reference to the brain because of the damage to the sensory organs themselves.

Q. As a consequence of the rotational acceleration?

A. Well, actually I'm talking about just damage to the organ itself, you know, from -- from pressure, you know, pushing out on the ear drums or internally it creates that.

Q. But associated with the traumatic event?

A. Yeah, and it would be difficult to distinguish from a neuropsychological test standpoint. Because the vision's bad or the hearing's bad, is it caused because of the brain or is it caused because of the organ? I think you need an eye specialist or an ear specialist who could tell that.

Q. That's something that you not being an M.D. you would defer to others?

A. That's right.

Q. You would agree, however, that fatigue, soreness, coordination difficulties, eye/hand coordination, as well as headaches are some of the physical complaints recognized in

mild brain injury resulting from a closed head injury?

A. Yes.

Q. And some of the symptoms that are associated with traumatic brain injury and a closed head injury include the decreased information processing, correct?

A. Yes.

Q. Impaired attention and concentration?

A. Yes.

Q. Memory loss, difficulties in problem solving?

A. Yes.

Q. Difficulties in reasoning or judgment?

A. Yes.

Q. Mental inflexibility?

A. Yes.

Q. Social inappropriateness?

A. Occasionally, yes.

Q. Depression?

A. Yes.

Q. Social withdrawal?

A. Occasionally.

Q. Disturbance of sleep or appetite?

A. Yes.

Q. And can we agree that an individual can sustain a post-concussive syndrome closed head injury without having a loss of consciousness?

A. The debate is open. I don't -- I'm open to that possibility and I believe that was asked in my deposition. I have heard it argued both ways and I think I have seen it won both ways, but it was discussed at length in my deposition and I had always taken the other position, but in fact I had been to a trial and lost because I took that -- that the neurologist felt that it could and I --

Q. So you would certainly recognize that a patient can sustain a brain injury without having a loss of consciousness?

A. At this point I would say I would concur on the basis of some light experience with that opinion.

Q. You know Dr. Howard Sokolov, don't you?

A. I don't know him. I have encountered him. I mean I -- again --

Q. Do you know him by reputation?

A. -- I know him by reputation and I have

made a referral to him through another committee, not related to this case at all.

Q. And you have considered him I believe from other testimony that I have to be a very competent and objective neuropsychologist, don't you?

A. Yes, I do.

Q. Were you aware at any time prior to the day that Dr. Sokolov had examined Steve and wrote a report in this case?

A. Yes.

Q. And you would have learned that from this gentleman seated to my left, Mr. Corrigan, right?

A. No, no. I believe Mr. Beck made that referral.

Q. You believe Mr. Beck made the referral to Dr. --

A. I believe he did, yeah. I believe he did.

Q. Fine. In any event, I have a report written to Mr. Corrigan dated November 15, 1998 that Dr. Sokolov wrote to Mr. Corrigan. Have you seen that report?

A. No, I haven't.

Q. Certainly you're not in a position to disagree with Dr. Sokolov where he says that Steve Frank in his professional opinion to a reasonable degree of medical certainty has a permanent cognitive disorder and has organic brain damage mild in severity -- severity, are you?

A. I think that's consistent with what I said.

Q. Okay. Now, Steve Frank took longer than you expected for him to have taken with the test, correct?

A. Yes.

Q. When patient -- when patients have mild traumatic brain injury and they have bouts of depression, do they function worse at that -- during those periods of time?

A. Yes.

Q. Are you aware of what Steve Frank's situation was with regard to his employment at or around the time that he came up from Florida to see you?

A. I think he had started to work for another company down there.

Q. Are you -- are you aware of whether or

not he had recently had a failure with regard to his employment down in Florida or whether he was succeeding with his employment?

A. The -- I don't know if he was succeeding or failing. I don't know.

Q. Okay. And certainly if he was failing, based upon the level of the cognitive deficits that he had experienced as a result of the collision, would you expect that a patient would have more difficulty handling changes in life such as depressive episodes associated with a failed employment situation?

A. Again, I -- it was a long question. I -- I -- I -- if -- if I understand your -- your question correct, do I understand him being depressed both because he has a history of these brain difficulties and he's having some social stressors at the same time? Is that essentially what you asked?

Q. Is someone less able to handle social stresses when they have a mild traumatic brain injury?

A. Yes, that's true.

Q. So that if someone has a failure in a particular employment situation, they're less

able to handle those kind of stresses, correct?

A. I believe.

Q. And also the mild traumatic brain injury and their cognitive abilities can also contribute to their inability to function at higher levels?

A. In all probability, yes.

Q. Okay. And certainly you would agree, and I just have a few more questions for you, Doctor, given the time that it is and I know the Arbitrators are probably getting tired of listening to my questioning, that a person that suffers traumatic brain injury that has permanent residuals from the injury, that person is at increased risk of being unable to maintain personal relationships, correct?

A. I believe that's true, yes.

Q. And would you also agree that it's common for someone with traumatic brain injury to have personality changes and emotional changes, including depression?

A. Yes.

Q. Finally, Dr. DeVies, if a person has traumatic brain injury such as Steve Frank and it's permanent, the emotional and personality

problems that are common in this type of an injury can have a very extreme effect in the person's ability to have a healthy and enjoyable life, correct?

A. Correct.

MR. MISHKIND: I have no further questions. Thank you.

REDIRECT EXAMINATION OF ROBERT K. DeVIES, Ph.D.

BY MR. CORRIGAN:

Q. Dr. DeVies, you administered a number of tests to Mr. Frank. How did he do on those tests, the other tests in terms of IQ and other results?

MR. MISHKIND: Let me just object because this is beyond the scope of cross-examination.

A. He -- he did -- he did very -- very well. He had an estimated IQ of 109 which falls very near the bright normal range. His visual motor coordination was certainly quite adequate, at least to -- up to the level of the test which was a 12-year old. We were well past that.

I believe, if I look in the file, that he was reading at the 93rd percentile, better than 93 out of every 100 people, in word

recognition. His arithmetic was at the sixth grade level or at the 10th percentile which is much lower, and certainly the performance on arithmetic was much lower, but reading -- reading was very high. Arithmetic was very low.

Q. Okay. Doctor, Mr. Mishkind asked about your not being a neuropsychologist. Was there such a thing as a neuropsychologist when you obtained your doctorate?

A. Well, there was, but they were predominantly research. There weren't clinical neuropsychologists. I -- rehabilitation psychology, rehabilitation psychologists are trained in neuropsychology. They don't limit their practice because they deal with other kinds of things.

Q. Do you have any memberships in societies or academies related to neuropsychology?

A. I'm in the Division of Neuropsychology as well as the Division of Rehabilitation Psychology of the American Psychological Association. I was elected to membership in the Ohio Academy of Neuropsychology.

MR. CORRIGAN: Thank you, Doctor. I

have nothing further at this time.

MR. MISHKIND: Nothing -- nothing further. Thanks.

MR. CORRIGAN: Thanks. I m trying to keep it brief.

Doctor, you have the right to review your transcript or --

THE WITNESS: I'll waive.

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(Videotape deposition was concluded a, 7:27 p.m.)

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CERTIFICATE

The State of Ohio,)
ss:
County of Cuyahoga.)

I, Elaine S. FitzGerald, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ROBERT K. DeVIES, Ph.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 28th day of June, 2000.

Elaine S. FitzGerald

Elaine S. FitzGerald, Notary Public
Within and for the State of Ohio.

My commission expires July 13, 2004

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