

1

IN THE COURT OF COMMON PLEAS
 CUYAHOGA COUNTY, OHIO
 FORREST GREGG STONE,
 a Minor, etc., et al.,
 Plaintiffs,

-vs- CASE NO. 396873
 JUDGE BOYLE

CORAZON O. GO, MD.,
 et al.

Defendants.

Deposition of KEITH OWEN YEATES, Ph.D., taken
 as if upon cross-examination before Sandra L.
 Mazzola, a Registered Professional Reporter and
 Notary Public within and for the State of Ohio,
 at Childrens Hospital, 700 Childrens Drive,
 Columbus, Columbus, Ohio, at 11:45 am. on
 Wednesday, June 19, 2002, pursuant to notice
 and/or stipulations of counsel, on behalf of the
 Plaintiffs in this cause.

BARBERIC & ASSOCIATES, INC.
 COURT REPORTERS
 14237 DETROIT AVENUE, SUITE THREE
 CLEVELAND, OHIO 44107
 (216) 221-1970
 FAX (216) 221-9171
 1-888-595-1970

2

APPEARANCES:

Joel L. Levin, Esq.
 Levin & Associates
 323 Lakeside Avenue, N.W.
 Suite 450 Lakeside Place
 Cleveland, Ohio 44113
 (216) 928-0600,

and
 Jeffrey R. Wahl, Esq.
 Jeffrey R. Wahl Co., L.P.A.
 232 Lakeside Avenue, Suite 450
 Cleveland, Ohio 44113-1058
 (216) 344-9007,

On behalf of the Plaintiffs;

Carol K. Metz, Esq. (Via Telephone)
 Weston, Hurd, Fallon, Paisley & Howley
 2500 Terminal Tower
 50 Public Square
 Cleveland, Ohio 44113-2241
 (216) 687-3368,

On behalf of the Defendant
 Corazon O. Go, MD;

John R. Scott, Esq.
 Reminger & Reminger Co., L.P.A.
 Seventh Floor
 The 113 St. Clair Building
 Cleveland, Ohio 44114
 (216) 687-1311,

On behalf of the Defendants
 PHS Deaconess Hospital and
 Paul A. Hudock, MD.

3

KEITH OWEN YEATES, Ph.D., of lawful age,
 called by the Plaintiffs for the purpose of
 cross-examination, as provided by the Rules of
 Civil Procedure, being by me first duly sworn, as
 hereinafter certified, deposed and said as
 follows:

CROSS-EXAMINATION OF KEITH OWEN YEATES, Ph.D.

BY MR. LEVIN:

Q. Could I have your name, please?

A. Keith Yeates.

Q. And that's Dr. Yeates or Mr. Yeates?

A. Yes, doctor.

Q. And you are not a medical doctor, you are a
 psychologist, is that correct?

A. Neuropsychologist, correct.

Q. And that is not a medical doctor, correct?

A. No.

Q. I was given this morning a copy of your
 curriculum vitae which is dated as of June 2002.

Is this your most current CV?

A. Yes. I printed it this morning.

Q. Okay. And you believe it to be reasonably
 truthful and accurate?

A. Yes.

Q. You know of no mistakes in it?

4

A. Not as far as I know.

Q. And you know of nothing significant that's not
 listed in here that would be relevant to one's CV
 as you understand it?

A. No.

Q. I've just been presented it and it's fairly
 long. I just want to see if I can go through a
 couple of things.

To get your Ph.D. you majored in clinical
 child psychology and minored in developmental
 psychology, is that right?

A. Yes.

Q. Okay. Is your practice today restricted to child
 psychology?

A. It's restricted to child neuropsychology. We
 occasionally see young adults that have childhood
 disorders.

Q. When you say it's restricted to neuropsychology,
 do you have a degree that specifically claims
 neuropsychology or is that something you learned
 in practice?

A. There are no degrees in neuropsychology. It's
 very new. Most neuropsychologists obtain their
 Ph.D.'s in clinical psychology and then
 specialize in neuropsychology. I have a Board

5

1 certification in neuropsychology.
 2 Q. When did you become Board-certified in
 3 neuropsychology?
 4 A. I don't remember the exact year. It's listed in
 5 there. I believe it's '93 or '94, but I don't
 6 remember specifically.
 7 Q. All right. It's '93. And you have been a
 8 licensed psychologist in Ohio since 1993, is that
 9 correct?
 10 A. Yes.
 11 Q. And you were licensed in Massachusetts, but you
 12 gave that up when you moved, is that true?
 13 A. Yes.
 14 Q. And we are here at Ohio State University
 15 Childrens Hospital, is that right?
 16 A. Childrens Hospital is not part of Ohio State
 17 University, but --
 18 Q. Oh, pardon me. We are here in Columbus at
 19 Childrens Hospital. You are associated with Ohio
 20 State University though?
 21 A. Yes, I am a tenured faculty member at Ohio State.
 22 Q. And that's the department of pediatrics?
 23 A. Correct.
 24 Q. And you give your address as Childrens Hospital?
 25 A. Childrens Hospital houses the department of

6

1 pediatrics for Ohio State.
 2 Q. So there is that connection?
 3 A. Yes.
 4 Q. You wrote a report on March 6, 2002. Do you have
 5 that in front of you?
 6 A. Yes, I do.
 7 Q. Is that the first and only report you wrote for
 8 Mr. Scott?
 9 A. Yes.
 10 Q. Was there a draft of this earlier?
 11 A. I mean there's always a draft, but I don't keep
 12 drafts. I work on a draft and the final product
 13 is what I have.
 14 Q. What did you review for writing this report?
 15 A. The medical records that are in these two volumes
 16 provided to me by Mr. Scott, as well as I believe
 17 there was a separate letter from Dr. Rothner that
 18 was not originally in those records because it
 19 came subsequent to that. And there was a copy of
 20 a letter from a Dr. Matula. There's two letters
 21 from Dr. Rothner, but I believe one of them was
 22 already in those other records.
 23 Q. Do you have the dates on those?
 24 A. They're all right here. That includes the
 25 correspondence with Mr. Scott.

7

1 Q. Okay. When you say they're all right here,
 2 everything you reviewed for this case consists
 3 of either the medical records which are in those
 4 binders set -- or they were on the floor,
 5 correct, which we can look at in a minute --
 6 A. Uh-huh.
 7 Q. -- and what you've just handed me. Is that fair,
 8 doctor?
 9 A. Yes.
 10 Q. And I'm going to read this into the record. If
 11 you were a little closer, you could check to make
 12 sure that I am reading it accurately, but there
 13 is a March 6 letter to Mr. Scott along with the
 14 bill at the end, correct?
 15 A. Correct.
 16 Q. There is a letter from Mr. Scott to you enclosing
 17 Dr. Rothner's report of January 31, 2002 and
 18 asking you to comment on IQ in general?
 19 A. Yes.
 20 Q. There is a report of Dr. Rothner dated
 21 January 31, 2002, correct?
 22 A. Yes.
 23 Q. There is a cover letter from Mr. Scott asking
 24 again about IQ and enclosing a report of
 25 Dr. Matula, a copy of a speech language

8

1 evaluation of October 29, 2001, and a copy of
 2 Dr. Rothner's report undated per the letter, and
 3 a reference to the fact that the underlying
 4 records and the records of Dr. Schauer have
 5 already been provided, correct?
 6 A. Yes.
 7 Q. And you recognize Dr. Schauer as the clinical
 8 psychologist at Cleveland Metro?
 9 A. I don't recognize the name. I do remember seeing
 10 a report.
 11 Q. Do you recognize that that's her position?
 12 A. Again, I couldn't tell you. I don't recognize
 13 her name.
 14 Q. Do you know Cleveland Metro as a hospital?
 15 A. Yes.
 16 Q. Have you ever practiced in your field in
 17 Cleveland?
 18 A. Practiced in what sense? I've been involved in
 19 one or two legal cases that originated in
 20 Cleveland.
 21 Q. We will get to that in a minute, but have you
 22 ever taken on patients or conducted studies of
 23 patients in the Cleveland area specifically?
 24 A. Yes.
 25 Q. Okay. We will get to that then in a minute.

9

1 Dr. Matula's report is here, correct?
 2 A. Yes.
 3 Q. Do you know Dr. Matula?
 4 A. No.
 5 Q. Have you ever heard of Dr. Matula before this?
 6 A. No.
 7 Q. And you have a speech language therapist's
 8 record, correct?
 9 A. Yes.
 10 Q. You have a letter or report of October 22, 2001
 11 from Dr. Rothner, correct?
 12 A. Yes.
 13 Q. You have yet another letter from Mr. Scott saying
 14 the speech language evaluation records are
 15 enclosed?
 16 A. Yes.
 17 Q. And I think that may be duplicative.
 18 A. Yes, they are identical.
 19 Q. They're identical to what is elsewhere. And you
 20 have a letter from Mr. Scott which --
 21 MR. LEVIN: Let's go off the record.
 22 -- . . .
 23 (Thereupon, a discussion was had
 24 off the record.)
 25

10

1 Q. And the last thing in this pile is a letter of
 2 December 7 from Mr. Scott which asks you to
 3 render an opinion, suggests a summary of the
 4 matter and tells you what's in the binders, the
 5 two binders that are in 1 and 2, which have the
 6 medical records, correct?
 7 A. Correct.
 8 Q. Have you reviewed anything else in conjunction
 9 with rendering opinions in this matter?
 10 A. I don't believe so.
 11 Q. Have you discussed this matter with anyone else
 12 other than Mr. Scott?
 13 A. No.
 14 Q. Okay. Are you aware that there are several
 15 experts associated with Ohio State who are also
 16 rendering opinions in this matter?
 17 A. No.
 18 Q. Do you know any of the experts, that is, are you
 19 personally acquainted with any of the experts and
 20 do you know who the experts and who are rendering
 21 opinions in this case?
 22 A. I'm familiar with Dr. Rothner by name and
 23 reputation, but I don't know him personally, and
 24 I'm not aware of any other experts necessarily
 25 that -- I'm not sure if Dr. Matula was being

11

1 called as an expert or not. I don't know of
 2 anyone else.
 3 Q. Okay. Well, let me just quickly go through
 4 this. Other than Dr. Rothner, there is no other
 5 expert that you're aware of that you know either
 6 by on a personal basis or by reputation, correct
 7 --
 8 A. I haven't been told the names of any other
 9 experts, so I can't by definition --
 10 Q. --that you know?
 11 A. No.
 12 Q. And Dr. Rothner, it's fair to say you know of his
 13 reputation, but you don't know him personally, is
 14 that correct?
 15 A. Yes.
 16 Q. And what is his reputation?
 17 A. I don't know that I can characterize his
 18 reputation. I know he's a pediatric neurologist
 19 and I've seen his name on a few cases that I have
 20 been involved in. But I don't know that I know
 21 his reputation among pediatric neurologists.
 22 Q. There is a distinction between opinions that are
 23 rendered in neuropsychology and ones that are --
 24 that -- I ~~be~~ rendered in neurology. Is that a
 25 distinction you would accept or not?

12

1 A. I don't even understand how to apply -- respond
 2 to the question because I'm not sure what you
 3 mean by distinction.
 4 Q. Do you believe you will be rendering any medical
 5 opinions in this matter?
 6 A. Again, I'm not sure what exactly you would mean
 7 by medical opinions. So I'm not sure I'm able to
 8 answer the question.
 9 Q. Just for the sake of the jury, could you tell the
 10 jury the distinction between a psychologist and a
 11 psychiatrist?
 12 A. A psychiatrist has a medical degree, completes
 13 medical school, completes residency training in
 14 psychiatry. A clinical psychologist obtains a
 15 doctorate degree in clinical psychology that
 16 includes internship training and usually
 17 postdoctoral training. They are both involved in
 18 the diagnosis and treatment of a variety of
 19 different types of behavioral and medical
 20 disorders. A psychiatrist is legally entitled to
 21 prescribe medications. That's not true for
 22 psychologists in most states.
 23 Q. Are you allowed to prescribe medication, doctor?
 24 A. No.
 25 Q. Do you know how Mr. Scott came across your name?

13

- 1 A. No.
- 2 Q. Have you ever worked with Reminger & Reminger
- 3 before?
- 4 A. I was trying to remember that today, and the name
- 5 of the firm rings a vague bell, but I don't
- 6 remember if it's because I did a case for them or
- 7 that they were on the opposite side of a case I
- 8 was involved in. Just don't remember.
- 9 Q. How many medicolegal matters have you been
- 10 involved as an expert in?
- 11 A. Over all the years I've been practicing?
- 12 Q. Yes, over all the years.
- 13 A. I couldn't give you an exact number. My guess
- 14 that is that it's somewhere between 25 and 50.
- 15 Q. And how many have been plaintiff and how many
- 16 have been defendant?
- 17 A. The majority have been plaintiff, in part because
- 18 the nature of the practice we have here is the
- 19 kids are seen for traumatic brain injuries very
- 20 often in our acute trauma program and our rehab
- 21 program.
- 22 Q. I'm sorry. You said are seen for --
- 23 A. Traumatic brain injuries.
- 24 Q. Traumatic brain injuries, okay.
- 25 A. In terms of direct referral from attorneys,

14

- 1 again, it's still the majority plaintiff, but a
- 2 higher percentage of defense.
- 3 Q. And what do you charge for your services?
- 4 A. \$250 an hour.
- 5 Q. Have you asked for any records that you haven't
- 6 yet received?
- 7 A. I had asked if we could get copies of the raw
- 8 data from the speech pathologist, and I think
- 9 that's the only thing that I asked for that I
- 10 have not actually seen.
- 11 Q. Do you anticipate looking at any other records
- 12 other than reviewing what you already have and
- 13 perhaps seeing the raw data from the speech
- 14 pathologist before trial?
- 15 A. It depends on if there are any pertinent records
- 16 that become available.
- 17 Q. Well, is there anything that you can think of
- 18 today that you are waiting to see or even
- 19 anticipate seeing?
- 20 A. No. I guess I mean I suppose if there were
- 21 depositions by Dr. Rothner or other pertinent
- 22 parties, certainly I would prefer to see those
- 23 prior to trial.
- 24 Q. Are you aware that Dr. Rothner's deposition has
- 25 been taken?

15

- 1 A. Yes, I just found that out today.
- 2 Q. So would you anticipate reviewing it at some
- 3 point?
- 4 A. Yes.
- 5 Q. But you haven't been shown it before today?
- 6 MR. SCOTT: I'm not aware it's
- 7 available. To my knowledge, it has not been
- 8 returned, certainly not to my knowledge.
- 9 MR. LEVIN: Well, John, my court
- 10 reporters give me my stuff the next day.
- 11 However you pick your reporters, I just know
- 12 that it's been more than one day since
- 13 Dr. Rothner's deposition.
- 14 Q. Do you anticipate reviewing Dr. Schauer's
- 15 deposition testimony?
- 16 A. Possibly, yes.
- 17 Q. What is your understanding of the source of the
- 18 injury to the patient here, Forrest Gregg Stone?
- 19 A. Do you mean the nature of the injury? I'm not
- 20 sure what you mean by source.
- 21 Q. The cause or the nature of the injury itself.
- 22 Let's start with the cause.
- 23 A. I don't have any opinion as to the cause of the
- 24 brain insult that he has sustained. I think
- 25 that's part of the issue here. It's not my area

16

- 1 of expertise.
- 2 Q. Does it make any difference to you in terms of
- 3 rendering any opinions you would have what the
- 4 cause is?
- 5 A. Aside from in a sense of that the nature of the
- 6 lesion may have some bearing on expectation about
- 7 prognosis or outcome, but the way the lesion got
- 8 there is not relevant to my opinions.
- 9 Q. Does when the lesion got there make any
- 10 difference to your opinions?
- 11 A. Within some reasonably -- back it up. Yes,
- 12 within certain boundaries. It's not a matter of
- 13 minutes or hours. It's more a matter of we know
- 14 certain things about the outcomes of stroke
- 15 prenatally or close to the postnatal as opposed
- 16 to later in life, so in that sense, yes, but not
- 17 as a matter of did it happen within a framework
- 18 or a time frame of several hours or days.
- 19 Q. Dr. Rothner commented on a different set of
- 20 prognoses that might follow depending on whether
- 21 the insult is prenatal or postnatal. Do you make
- 22 that distinction in terms of trying to understand
- 23 the pathology of an insult?
- 24 A. Understanding the pathology of the insult and
- 25 when it originated clearly there are

17

1 characteristic differences between prenatal and
 2 postnatal stroke.
 3 There is a somewhat different set of issues
 4 though in terms of prognosis of long-term outcome
 5 from those strokes, and I don't believe there is
 6 scientific literature yet that makes a strong
 7 distinction between prenatal, perinatal and
 8 postnatal stroke.
 9 Q. Do you know if there is any literature that
 10 suggests that the two are coincidental, or is it
 11 your opinion that the literature is yet to be
 12 written comparing the two?
 13 A. I don't believe that there's a clear literature
 14 that differentiates between the two.
 15 Q. Do you know if there has been studies on that?
 16 A. There have been a lot of studies on perinatal
 17 stroke. A lot is sort of a relative term, of
 18 course. There have been some very interesting
 19 studies on perinatal stroke.
 20 Q. What are you calling perinatal stroke?
 21 A. It would include prenatal and postnatal in a
 22 relatively soon after birth period.
 23 Q. Okay. What do you understand the nature of this
 24 injury to be? You say the cause -- there is a
 25 lesion and the cause is not relevant to your

18

1 opinions as you understand them to be, is that
 2 fair?
 3 A. Correct.
 4 Q. Okay. How would you characterize the lesion?
 5 A. It's a stroke on the right posterior region of
 6 the brain with some sort of neurological
 7 sequelae, according to Dr. Rothner, and some
 8 residual findings on CT scan.
 9 Q. Have you read the CT scans?
 10 A. I've read the report.
 11 Q. Are you able to read CT scans.
 12 A. In the sense reading the films themselves?
 13 Q. Yes.
 14 A. I can do it informally, but I wouldn't rely on my
 15 opinion. I would rely on the radiologist's
 16 opinion.
 17 Q. Have you seen the opinion of the
 18 neuroradiologist, Dr. Charles Lanzieri, in that
 19 matter?
 20 A. I don't remember the specific name. You need to
 21 show me a document to see whether or not I've
 22 seen it.
 23 Q. Do you know who Dr. Lanzieri is?
 24 A. I don't have a recognition of the name.
 25 Q. Is neuroradiology to your understanding a

19

1 specialized field within radiology?
 2 A. Yes.
 3 Q. And the CT scans that we are talking about here
 4 are ones that you from your practice understand
 5 to normally be within the gambit and expertise of
 6 neuroradiologists?
 7 A. Yes. I mean other physicians will certainly
 8 interpret CT scans, as will neurologists, but the
 9 real expertise in neuroradiology is with a
 10 neuroradiologist.
 11 Q. Now, there have been a number of other findings,
 12 diagnoses and prognoses concerning Forrest Gregg
 13 Stone other than the IQ issue. You are aware of
 14 that. There have been other comments about
 15 what's happened to him and what's likely to come
 16 of him?
 17 A. Yes.
 18 Q. Okay. For instance-- and I want to go through
 19 some of them. For instance, there's been in some
 20 of the medical records and in Dr. Rothner's
 21 records a discussion of hemiparesis. Have you
 22 seen that?
 23 A. Yes.
 24 Q. Okay. And what is hemiparesis?
 25 A. It's a partial paralysis of one side of the body.

20

1 Q. Okay. And is it sometimes a sequelae of a
 2 traumatic brain injury?
 3 A. It can be a sequelae of traumatic brain injury or
 4 stroke or any insult to the brain.
 5 Q. Are you rendering any opinions as to whether
 6 Forrest Gregg Stone has suffered any hemiparesis?
 7 A. No.
 8 Q. Okay. And to follow up then, you wouldn't make
 9 any comment or be expected to render any opinions
 10 about the severity or prognosis with regard to
 11 hemiparesis, if he does have it, is that fair?
 12 A. The severity to hemiparesis or its sequelae you
 13 said?
 14 Q. Right, or its sequelae.
 15 A. The only way I can think that I would have any
 16 comments of a hemiparesis is in trying to make an
 17 argument about the relationship between
 18 hemiparesis and cognitive and behavioral
 19 outcomes, in which case I might have something to
 20 say about whether it's predictive and to what
 21 extent, but if you are talking about physical
 22 outcomes of hemiparesis, no.
 23 Q. I'll use your pronunciation, hemiparesis. I've
 24 heard it the other way, but I may have heard
 25 wrong.

21

- 1 A. You can say it either way.
- 2 Q. So if there was a finding of hemiparesis, you
- 3 then might be willing, if asked to make a comment
- 4 on it, to what extent it's indicative or
- 5 correlative with other cognitive factors within
- 6 your field, is that fair?
- 7 A. Yes.
- 8 Q. You haven't been asked to do that yet?
- 9 A. No.
- 10 Q. Okay. There's been something called -- let me
- 11 see if I can get some of the terms that are
- 12 actually in here. Well, first of all, have you
- 13 read anywhere that there's microcephaly with
- 14 regard to Forrest Gregg Stone?
- 15 A. I don't remember reading that, no.
- 16 Q. Do you know what microcephaly is?
- 17 A. Yes.
- 18 Q. Okay. What is microcephaly?
- 19 A. It's an abnormally small head.
- 20 Q. And is microcephaly something that is within your
- 21 expertise that is something that you discuss or
- 22 write about or review?
- 23 A. It's within my expertise, yes.
- 24 Q. Do you treat patients with microcephaly?
- 25 A. I've seen patients with microcephaly. I don't

22

- 1 actually engage in the treatment. Most of my
- 2 work -- virtually all of my work is evaluation
- 3 and consultation. Define treatment. Do I have
- 4 patients that have microcephaly? Yes.
- 5 Q. So you evaluate patients who perhaps among other
- 6 problems have microcephaly?
- 7 A. Yes.
- 8 Q. Okay. And we can agree that microcephaly is
- 9 generally a problem as opposed -- is that fair?
- 10 A. It's an abnormality, yes.
- 11 Q. And could you tell me or tell the jury what
- 12 microcephaly is in terms of being an abnormality,
- 13 why it's bad? Is it a bad thing to have, doctor?
- 14 A. It increases the risk of developmental problems,
- 15 but it's not a guarantee. It's better not to
- 16 have it.
- 17 Q. Doctor, in that I read through some of the
- 18 literature at the shallowest end of
- 19 neuropsychology, is it fair to say that it is
- 20 difficult to predict the future course and
- 21 prognosis of young children into adulthood as a
- 22 neuropsychologist?
- 23 A. I don't think that's limited to neuropsychology.
- 24 Q. It may include economists and physicists and
- 25 everything else. I'm just asking you as a

23

- 1 neuropsychologist. Is it fair to say that
- 2 predicting the course of development of children
- 3 into adulthood is an activity that
- 4 neuropsychologists deal with on a daily basis?
- 5 A. Sure.
- 6 Q. And often what they do is they talk about one
- 7 factor increasing a risk or one factor being
- 8 irrelevant to a risk, would that be fair?
- 9 A. Yes.
- 10 Q. So one thing that they do is they try not to base
- 11 opinions on a single factor if they're able to
- 12 look at a variety of factors so that they can get
- 13 a better indication of prognosis, is that fair?
- 14 A. Yes.
- 15 Q. So one thing that they would consider, if it
- 16 presented itself in terms of future developmental
- 17 problems, would be microcephaly, correct?
- 18 A. Yes.
- 19 Q. Do you know how microcephaly is defined?
- 20 A. I don't know the exact cutoff. It's based on a
- 21 certain amount of head size being below normal
- 22 levels, but I'm not sure exactly what the cutoff
- 23 would be -- or if there is a standard cutoff.
- 24 Q. Do you know whether in fact it would be expressed
- 25 in numbers of standard deviation?

24

- 1 A. Based on head circumference, but I don't know
- 2 what the standard cutoff is.
- 3 Q. But often that is how people speak of varieties
- 4 from the norm in psychology? They speak of
- 5 degrees from standard deviation?
- 6 A. Standard deviation from normal, yes.
- 7 Q. Standard deviations from normal, okay. And all
- 8 other things being equal, the further from normal
- 9 -- strike that. All other things being equal,
- 10 the greater the deviation from normal, the
- 11 greater concern one would have, would that be
- 12 fair as a very general rule?
- 13 A. Not always in that the relationship between the
- 14 degree of abnormality in something like head
- 15 circumference is not necessarily related to
- 16 outcome. So that's an empirical question
- 17 research would need to address.
- 18 The presence of microcephaly is a risk
- 19 factor. Whether or not it's worse to have less
- 20 is, I think, a question you have to look at the
- 21 research to answer.
- 22 Q. Well, do you know whether, for instance, two
- 23 standard deviations is less of a risk factor than
- 24 three standard deviations from normal?
- 25 A. I don't know.

25

1 **MR. SCOTT:** Objection.
 2 A. I don't know.
 3 Q. Do you know what being in the bottom two
 4 percentile of cephalo would be indicative of in
 5 terms of microcephaly?
 6 A. Well, it would be about two standard deviations
 7 away from normal. The second percentile would be
 8 closer to two if you have a norm, which you
 9 probably do in head circumference.
 10 Q. So you didn't notice anywhere in, at least as you
 11 sit here today and try to remember all the
 12 medical records, in Dr. Rothner's reports where
 13 he mentioned microcephaly?
 14 A. I don't remember right now one way or the other.
 15 Q. Would it be fair to say that microcephaly may be
 16 something that would be important to you in
 17 judging cognition if it were put in with other
 18 risk factors?
 19 A. Yes.
 20 Q. Are you aware of how many neurosurgeries this
 21 child has had?
 22 A. I haven't counted them, no.
 23 Q. You are aware that he's had more than one, is
 24 that fair?
 25 A. I have to go back to the records. I know he's

26

1 had some.
 2 Q. And by neurosurgeries, these are actual brain
 3 surgeries as opposed to hand surgery, let's say?
 4 A. Right.
 5 Q. Does brain surgery in a child count as a risk
 6 factor for developmental problems later?
 7 A. It's usually the reasons for the brain surgery
 8 that counts as the risk factor. I don't know
 9 that there is really any good data to suggest
 10 that just having an episode of neurosurgery
 11 necessarily places you at risk. It really would
 12 depend on the nature of the surgery, if there
 13 were other complications that occurred.
 14 Q. Is that something that you could evaluate if you
 15 were shown the operative records?
 16 A. Evaluate what?
 17 Q. Whether the nature of the surgery itself, that
 18 is, the trauma of the surgery of cutting the head
 19 open and dealing with the brain itself during
 20 surgery, would be a particular risk factor for a
 21 particular child. Would that be something you
 22 would be able to assess if given the operative
 23 records?
 24 A. My guess is that I would tend to rely on the
 25 opinion of a neurosurgeon as to the nature of how

27

1 much trauma the brain might sustain during a
 2 surgery. It's possible you might be able to tell
 3 from operative records, but my experience is that
 4 that's not often the case.
 5 Q. That would generally be outside your field of
 6 expertise at any rate, is that fair?
 7 **MR. SCOTT:** Objection.
 8 A. Again, it would depend on the nature of the
 9 records and how well documented it was.
 10 Q. Now, you said that one of the things that would
 11 be a risk factor would be the underlying reason
 12 for the brain surgery, is that fair?
 13 A. Yes.
 14 Q. Okay. And the underlying reason for the brain
 15 surgery with Forrest Gregg Stone you understand
 16 to be what?
 17 A. Well, at least one of them was the stroke itself.
 18 Q. And that stroke itself is a risk factor?
 19 A. Yes.
 20 Q. And it's a risk factor for developmental
 21 problems?
 22 A. Broadly defined, yes.
 23 Q. And it's a risk factor for problems with
 24 developmental and cognition problems?
 25 A. Yes.

28

1 Q. Would you characterize that underlying condition
 2 as an infarct?
 3 A. I have to go back to the records. Off the top of
 4 my head, I'm not remembering. If you want to
 5 give me back my records there, I can tell you.
 6 Q. You can have the reports. I don't have your
 7 records. You can certainly have back your
 8 reports.
 9 A. No. I mean the stuff that I gave you. Because I
 10 can't off the top of my head actually remember if
 11 it was an infarct or it was a hemorrhagic
 12 stroke. It does involve an infarct even though
 13 the stroke itself was hemorrhagic in nature.
 14 Q. So is the infarct a factor that presents an
 15 increased risk for developmental and cognition
 16 problems?
 17 A. Again, the stroke is part of that. I mean just
 18 answering the same question as before, from my
 19 perspective.
 20 Q. And the answer from your perspective would be
 21 yes?
 22 A. Yes, it is a risk factor.
 23 Q. Dr. Rothner -- I'm sorry. If you want to look
 24 through this, I don't mean to cut you off.
 25 A. I can process. Go ahead.

29

- 4 Q. i certainly don't want to get afoul of your
2 counsel.
- 3 A. No. If i need you to **stop**, I'm not shy about
4 telling you to stop.
- 5 Q. That's fine. Dr. Rothner in his testimony or in
6 his reports gave the opinion that there was
7 clinical manifestations of cerebral palsy at
8 least episodically with this child. Do you
9 recall seeing that anywhere in the records?
- 10 A. Yes.
- 11 Q. Okay. Is cerebral palsy an increased risk factor
12 for developmental and cognition problems?
- 13 A. Yes.
- 14 Q. And again, are you going to be rendering any
15 opinions as to the accuracy of the diagnosis of
16 CP by Dr. Rothner?
- 17 MR. SCOTT: Objection. Now? When
18 are you talking about? At the time that the
19 patient presented to MetroHealth, or are you
20 saying that the patient had CP at the time?
- 21 MR. LEVIN: At any time.
- 22 MR. SCOTT: Well, Dr. Rothner hasn't
23 made any diagnosis of cerebral palsy at this
24 time.
- 25 Q. My only question to your expert is if Dr. Rothner

30

- 1 renders an opinion one way or another about the
2 occurrence or manifestations of CP at any time,
3 are you going to be rendering opinion as to the
4 accuracy of that judgment?
- 5 A. No, I don't believe so.
- 6 Q. Okay. You have heard of uncal herniation?
- 7 A. Yes.
- 8 Q. What's uncal herniation?
- 9 A. It's a herniation of the uncus as a result of
10 pressure, usually some mass lesion that creates a
11 space in the cranial vault and brain herniation.
- 12 Q. Do you know whether or no? Forrest Stone suffered
13 an uncal herniation?
- 14 A. I have a vague memory that he did but I'm not
15 certain.
- 16 Q. Is uncal herniation an increased risk factor for
17 developmental and cognition problems?
- 18 A. In and of itself, I don't know that it would be
19 because it would depend on how quickly and
20 effectively it was treated and what the
21 underlying condition was. I'm not aware of
22 research literature that specifically looks at
23 the association between the uncal herniation and
24 developmental outcome.
- 25 Q. You said taken in and of itself. What about

31

- 1 taken with other factors, can it be a risk
2 factor?
- 3 A. Again, I don't know that as a neuropsychologist I
4 would pay a lot of attention to uncal herniation
5 per se. I would look at what the reasons were
6 for it having occurred and how long the mass
7 effect was likely to have occurred and other
8 factors. So it's an indication that there's a
9 pathological process occurring in the brain. The
10 question is what's that pathological process.
- 11 Q. Are you aware that there is a some discussion in
12 the medical records that there was some seizure
13 activity in Forrest Gregg Stone?
- 14 A. I have some vague recall of that.
- 15 Q. Would seizure activity be an increased risk
16 factor for developmental and cognition problems?
- 17 MR. SCOTT: Again, do you want to
18 give the doctor timing? You're not
19 suggesting to the doctor that the child has
20 had any seizures in the last two and a half
21 years, are you?
- 22 MR. LEVIN: I'm not suggesting
23 anything at all. I'm just asking him a
24 question.
- 25 A. If a simple comparison is made between children

32

- 1 who have seizures and children who don't at the
2 time they still have a seizure disorder, there is
3 some association between ongoing seizures and
4 cognitive functioning. In some disorders the
5 presence of seizures as a neurological
6 complication during the course of an illness will
7 be associated with a heightened risk of cognitive
8 or developmental problems. I don't know offhand
9 whether or not that pertains for children with
10 perinatal stroke. So whether or not the
11 association between seizures as neurological
12 complications and negative outcomes that's been
13 shown, for example, in kids with meningitis is
14 true of children with perinatal seizures, I would
15 have to look literature to find out.
- 16 Q. Okay. So as of this moment when I'm taking your
17 deposition, my only opportunity to take your
18 deposition and understand your opinions, you
19 don't have an opinion on that right now. You
20 have would have to look it up, is that fair to
21 say?
- 22 A. Right. With reference to children with perinatal
23 stroke like Forrest.
- 24 Q. What about midline shift? Do you see any mention
25 of midline shift in the medical records?

33

- 1 A. Yes.
- 2 Q. What is midline shift?
- 3 A. Midline shift is a displacement of the midline of
- 4 the brain to the side as a result of a mass
- 5 lesion, usually as a result of a mass lesion.
- 6 Q. Is that also a matter of degree, that is, the
- 7 amount of the shift?
- 8 A. Yes.
- 9 Q. Do you know how severe this shift was?
- 10 A. I don't remember.
- 11 Q. Are you able to judge the severity of a midline
- 12 shift?
- 13 A. Well, it's easy to measure a midline shift. I'm
- 14 not aware off the top of my head of the standard
- 15 grading scheme in terms of that and I generally
- 16 wouldn't be the person who would make a judgment.
- 17 Q. That would be the neurologist, most likely?
- 18 A. Neurosurgeon, neurologist, typically a physician.
- 19 Q. Is the midline shift an increased risk factor for
- 20 developmental or cognitive problems?
- 21 A. I would think a midline shift in the same way
- 22 would be pretty much all the answers to the same
- 23 questioning you asked for uncal herniation. In
- 24 and of itself, I don't know of any literature
- 25 that looks at midline shift per se. It would be

34

- 1 a matter of what the underlying pathology was,
- 2 how long the midline shift lasted, how severe it
- 3 was and so forth.
- 4 Q. And these are areas that again are even further
- 5 outside your field?
- 6 MR. SCOTT: Objection.
- 7 Q. This is not something you look at?
- 8 A. No.
- 9 Q. is that fair?
- 10 A. I don't agree with that. In fact, many of the
- 11 kids we see have midline shift, uncal herniation
- 12 or complications associated with their
- 13 condition. What I said was that I don't believe
- 14 there's specific literature about those factors,
- 15 but there certainly would be literature relative
- 16 to the pathologies that cause those things.
- 17 Q. Well, aside from the literature, clinically, have
- 18 you noticed any increased developmental or
- 19 cognition problems due to your patients who have
- 20 suffered either a midline shift or uncal
- 21 herniation?
- 22 MR. SCOTT: Objection. Go ahead,
- 23 doctor.
- 24 A. I mean because both of those factors by
- 25 definition involve some sort of abnormal

35

- 1 condition of the brain, that they are abnormal
- 2 conditions of the brain, but are caused by other
- 3 pathology. They would be certainly factors that
- 4 would indirectly reflect other processes that are
- 5 likely to be associated with risks.
- 6 Q. So it would be fair to say they are correlative
- 7 with factors that are indicative of increased
- 8 risk, is that fair?
- 9 A. Yes, I believe so.
- 10 Q. Okay. Did you know there was a hematoma
- 11 associated with Forrest Gregg Stone when he went
- 12 into Metro?
- 13 A. I believe so.
- 14 Q. Okay. And a hematoma is what?
- 15 A. A collection of blood.
- 16 Q. Is a hematoma-- and that would be in the --
- 17 somewhere in a cranial cavity?
- 18 A. You can have a hematoma outside of the brain, but
- 19 yes, in this case it was inside the cranial wall.
- 20 Q. I meant in this case that's where it was.
- 21 A. Yes.
- 22 Q. Would such a hematoma in a cranial cavity be an
- 23 increased risk factor for developmental or
- 24 cognitive problems?
- 25 A. In most cases, yes.

36

- 1 Q. Okay.
- 2 A. I mean we have a group of kids with epidural
- 3 hematomas in one of our studies that seem to do
- 4 very well. So again, it depends on the larger
- 5 context, but it's certainly better not to have a
- 6 blood clot or blood on the brain than it is to
- 7 have it.
- 8 Q. Now, I've given you a number of factors that may
- 9 impact on prognosis, right?
- 10 A. Yes.
- 11 Q. Okay. And if I was quicker at my math, I could
- 12 figure how many permutations there are of that,
- 13 but without doing that, would you agree that the
- 14 more of these risk factors that are present for
- 15 any patient, the greater the risks in general of
- 16 the developmental or cognitive problems, that
- 17 when taken in the aggregate, the risk factors
- 18 present increased risk?
- 19 A. I think clinically my judgment would usually rely
- 20 on some overall picture of severity of insult to
- 21 the brain, so that it isn't necessarily
- 22 additive. You add them up and there they are,
- 23 but the more you have some of the indicators that
- 24 you mentioned, the more likely you are to have a
- 25 more severe brain insult. So in a very general

37

1 level what you said is probably true. Although I
 2 don't believe you simply can just add them up.
 3 Q. More complicated but still generally true, is
 4 that fair?
 5 MR. SCOTT: Objection. He answered,
 6 A. I've answered.
 7 Q. You said it would all depend on the -- strike
 8 that.
 9 A. I wouldn't say it would all depend.
 10 Q. You said that it was important to know the
 11 severity of the impact to the brain, correct?
 12 A. Well, not impact.
 13 Q. The insult?
 14 A. Make sure we are not talking about trauma, but
 15 yes, the insult to the brain.
 16 Q. Okay. Severity of the insult would be an
 17 important thing to know, correct?
 18 A. Yes.
 19 Q. And how would you measure that? Would that be on
 20 some kind of scale?
 21 A. It depends on the nature of the brain insult.
 22 There are scales that can be used for traumatic
 23 brain injury, for example, but in perinatal
 24 stroke I don't believe there's a really well
 25 accepted grading scheme. There are grading

38

1 schemes, for example, for stroke associated with
 2 intraventricular hemorrhage, but that's not what
 3 we are dealing with here. So that I think that
 4 would be an overall clinical judgment of the
 5 severity of the injury in this sort of instance.
 6 Q. Do you use a grading scale in your own practice,
 7 you know, one through five, standard of
 8 deviations?
 9 A. It really depends on the nature of the case.
 10 Q. Well, for a case like this.
 11 A. I don't know that I would have a specific scale
 12 that I would make reference to. I mean I would
 13 have some probably, perhaps, notion of the size
 14 of the lesion, the complications associated with
 15 it, but I don't know that I would try put it into
 16 any one to five rating scheme, no.
 17 Q. Well, do you speak of very severe, somewhat
 18 severe, I mean do you --
 19 A. Typically --
 20 Q. Let me ask. Do you write notes in that way to
 21 other physicians to try to give them some idea of
 22 what your clinical judgment is on severity?
 23 A. Typically will do that certainly with reference
 24 to my description of cognitive outcomes in
 25 neuropsychological function in terms of level of

39

1 impairment. I will sometimes do that with the
 2 pathology involved if I feel like there is a
 3 reasonably well agreed upon system. For example,
 4 there is a pretty well agreed upon system for
 5 judging the traumatic brain injury.
 6 Q. Is this a trauma?
 7 A. Not as I would define it, no, it doesn't involve
 8 blunt trauma.
 9 Q. So traumatic brain injury has to involve trauma?
 10 A. A traumatic brain injury has to involve some sort
 11 of force being caused to the head.
 12 Q. You wouldn't think that would be the case here?
 13 A. Not that I believe.
 14 Q. Let me go back really to my question. Could you
 15 give me some notion of how severe you think the
 16 insult was here? Or do you feel that you can't
 17 answer that as you sit here today?
 18 A. I could characterize the injury as involving a
 19 significant neurological insult. I'm not sure I
 20 would put it on a grading scheme because I don't
 21 have a -- I mean I can use an adjective, but I
 22 don't know that it would have any particular
 23 standard reference.
 24 Q. Are you familiar with the use of the term,
 25 orthopedic injury, with regard to brain injuries?

40

1 A. Orthopedic injury would not be a brain injury.
 2 Q. What would an orthopedic injury be?
 3 A. Orthopedic injury --
 4 Q. A broken bone, you mean?
 5 A. -- involves fracture.
 6 Q. And do you believe there is literature -- I'm
 7 trying to understand what you said, doctor.
 8 There is a literature about traumatic brain
 9 injury and that literature does not apply to
 10 cases or conditions like that which you have
 11 observed with Forrest Gregg Stone, is that fair?
 12 A. He doesn't have a traumatic brain injury. He had
 13 a brain insult. Some people might say he has a
 14 brain injury, but in the way that traumatic brain
 15 injury is generally defined in research
 16 literature, he doesn't have a traumatic brain
 17 injury.
 18 People -- maybe I can add that many people
 19 would equate closed head injury to traumatic
 20 brain injury in neurosurgical literature.
 21 Certainly, there is a trauma here in the sense of
 22 some insult to the brain, but it wasn't caused by
 23 blunt trauma to the head.
 24 Q. There are studies about what happens to traumatic
 25 brain injury children, correct?

41

- 1 A. Yes.
 2 Q. You've published some of those studies?
 3 A. Yes, I have.
 4 Q. And you're publishing them on an ongoing basis, I
 5 assume?
 6 A. Yes.
 7 Q. Is there a parallel literature to your knowledge
 8 on brain insults that are not traumatic brain
 9 injuries?
 10 A. There is literature specifically about perinatal
 11 stroke.
 12 Q. Have you published in that field?
 13 A. Not yet, no.
 14 Q. Are you doing any research as we sit here today
 15 on that?
 16 A. We have a grant pending.
 17 Q. In other words, you applied for the money, but it
 18 hasn't been awarded and when it is awarded, you
 19 will begin the research, is that fair?
 20 A. Yes.
 21 Q. Do you know -- is that NIH?
 22 A. No, it's N-A-R-A-S-E-A. I couldn't even tell you
 23 what it stands for.
 24 Q. And when would you expect to hear from them?
 25 A. I'm a subcontract on this grant. I'm trying to

42

- 1 remember when the PI told me it would be. I
 2 think he said August or September, if I remember.
 3 Q. So it's unlikely that any significant research
 4 would be done before the trial begins in this
 5 case if it begins on time on September 30?
 6 A. Research here, yes.
 7 Q. Okay. Now, I believe you said that others have
 8 done research in this area, is that correct?
 9 A. Yes.
 10 Q. Can you point as you sit here today as an expert
 11 to any researchers in that field that are
 12 prominent?
 13 A. Sure. Elizabeth Bates. Joan Stiles,
 14 S-T-I-L-E-S. Jeffrey Max.
 15 Q. M-A-X?
 16 A. Yes. Dorothy Aaram, A-A-R-A-M. Joan Gerring has
 17 done some work in that area. G-E-R-R-I-N-G.
 18 Q. Is there any journal or --
 19 A. I'm trying to remember if Joan's actually done
 20 stroke. It might just be TBI. I may be wrong.
 21 Q. Is there any journal or set of journals that
 22 these people tend to publish in?
 23 A. There are a lot of journals they would tend to
 24 publish in.
 25 Q. They -- that they would publish these kinds of

43

- 1 results in, is that correct?
 2 A. Yes.
 3 Q. A number of them, okay. Would you agree that
 4 children who sustain a perinatal stroke are at
 5 high risk for problems in behavior?
 6 MR. SCOTT: Objection. You can
 7 answer that if you can.
 8 A. I believe they're at risk. I think you used some
 9 other adjectives, but there is a risk factor for
 10 behavior problems.
 11 Q. High risk. What about children who suffer severe
 12 brain injury? Are they at risk for problems?
 13 MR. SCOTT: Objection.
 14 A. I don't know what you mean by severe brain
 15 injury.
 16 Q. I'm sorry. I'll try it again. Would you agree
 17 that children who suffer traumatic brain injury
 18 are at high risk for problems with behavior?
 19 A. Depending on the severity. The more severe the
 20 injury, in general the higher the risk.
 21 Q. When you write, do you ever write about severe
 22 traumatic brain injury?
 23 A. Yes.
 24 Q. And when you write about severe traumatic brain
 25 injury, what do you mean by that?

44

- 1 A. There are accepted definitions of severity
 2 generally based on factors like the Glasgow Coma
 3 Scale and other indicators of severity of
 4 injury.
 5 I think it's important to point out that the
 6 literature about outcomes in traumatic brain
 7 injury and those in perinatal stroke actually
 8 come to somewhat different conclusions because
 9 the pathology is quite different and the risks
 10 associated with those two disorders are somewhat
 11 distinct, both cognitive and potentially
 12 behavioral.
 13 But having said that, because you are asking
 14 about both and going back and forth and I
 15 wouldn't want them to get mixed up, they don't
 16 have the same outcomes. But in terms of severe
 17 traumatic brain injury, yes, it's a risk factor
 18 for behavioral disorders.
 19 Q. And it's a risk factor also, that is, perinatal
 20 stroke is also a risk factor, correct?
 21 A. Yes.
 22 Q. And is perinatal stroke also a risk factor for
 23 adaptive functioning?
 24 A. Yes.
 25 Q. Is perinatal stroke a risk factor for problems in

45

1 educaional performance?
 2 A. Yes. And again, I would put the same parameters
 3 to the severity and nature of the injury, nature
 4 of the stroke, but yes, all things being equal.
 5 Q. Doctor, when I gave you back your notes, I gave
 6 you back my copy of your report.
 7 A. Oh, I'm sorry.
 8 Q. No. That's my fault. You must have at least six
 9 copies. The hole-punched copy is my copy.
 10 A. Actually, I only have one.
 11 Q. I do want to address your report.
 12 - - -
 13 (Thereupon, a discussion was had
 14 off the record.)
 15 - - -
 16 Q. Doctor, you believe that all the opinions that
 17 you hold thus far in this case are contained in
 18 this report, is that fair?
 19 A. No. I have other opinions that I was asked -- I
 20 rendered opinions in response to Mr. Scott's
 21 questions in that report. Actually, you have
 22 already elicited some opinions from me today that
 23 are not in that report.
 24 Q. What is the Bayley Scale of infant Development?
 25 A. The Bayley scale is a standardized measure of

46

1 early motor and mental skills in early
 2 development for infants and children.
 3 Q. Can you keep your voice up just for the woman on
 4 the line?
 5 A. The Bayley Scale is a standardized measure of
 6 early motor and mental skills intended for
 7 infants and very young children.
 8 Q. When is it typically administered, what ages?
 9 A. I'm trying to remember. Anywhere from birth up
 10 to, I believe, if I remember correctly, it's 42
 11 months, but I'd have to double-check the scale.
 12 Q. In that age range is it the most common test
 13 given in this area?
 14 A. Certainly under the age of about two and a half
 15 there are a variety of other tests that are often
 16 given to two-year-olds. But the Bayley is one of
 17 the standards.
 18 Q. Have you administered it yourself?
 19 A. Not in many years, but I have.
 20 Q. So it would be fair to say that in the actual
 21 administration, that's something you did earlier
 22 in your career and now you have others do the
 23 actual administration, but you continue to use it
 24 as an interpretive stool, to interpret, is that
 25 correct?

47

1 A. That's correct. We don't actually see too many
 2 kids and do Bayleys because, again, we don't see
 3 lots of infants, but yes, we do use it that way.
 4 Q. When you say you don't see lots of infants, what
 5 age is typically in your practice or what is the
 6 range of your practice typically?
 7 A. Most of the children that we see will be between
 8 the ages of three and fifteen.
 9 Q. When you say we, common problem for witnesses, I
 10 mean as a whole, there is a hospital here and
 11 there is the Ohio State Medical School, both of
 12 which you're associated with.
 13 A. I run the neuropsychology program here at
 14 Childrens Hospital. I have two other staff
 15 neuropsychologists and two postgraduate fellows
 16 and some interns who work with us. I also have a
 17 graduate student that sees patients.
 18 Q. So when you say we --
 19 A. In the neuropsychology program at Childrens
 20 Hospital.
 21 Q. Okay. That's fine. I just want to know who the
 22 we is. And Childrens Hospital is a tertiary care
 23 center for children, is that fair?
 24 A. Childrens maintains and provides primary care,
 25 psychiatric care and tertiary depending on --

48

1 Q. Actually, I meant it to be inclusive. When you
 2 say you have patients that are typically between
 3 three and fifteen, after they're older than
 4 fifteen, they're sent to adult treaters who treat
 5 -- people who treat adults rather than children
 6 typically?
 7 A. No. We see older adolescents. I know what the
 8 age distribution tends to be. And we see children
 9 under age three or under two. It's just you
 10 asked me for the range that we commonly see.
 11 Some older children would be sent to
 12 neuropsychologists who typically see adults. It's
 13 a matter of referral sources.
 14 Q. How many patients do you see a year through this
 15 department?
 16 A. Our program sees about 350 a year.
 17 Q. And how many are below three typically a year?
 18 A. It wouldn't be many. I couldn't tell you an
 19 exact number. Probably less than 30 would be my
 20 guess. Maybe less than 20. Under age 2 and
 21 below, probably less than 30.
 22 Q. And that would be for all kinds of problems?
 23 A. Yes.
 24 Q. So it would be even more difficult for -- well,
 25 let me ask you. You don't know how many you

49

1 would see with perinatal stroke ~~or~~ with the kind
 2 of condition that Forrest Stone --
 3 A. Actually, we see a lot of those children.
 4 Actually, we tend to see them at slightly older
 5 ages.
 6 Q. But you don't see many that are under three?
 7 A. Generally not, because you are limited in the
 8 range of testing you can do and its predictive
 9 utility.
 10 Q. Why do you have give the Bayley test to children
 11 zero to four? What's its purpose?
 12 A. It's usually to get a -- broadly speaking, to get
 13 some sense of their developmental status at that
 14 time.
 15 Q. And would it be fair to say it's a tool to give
 16 you some understanding?
 17 A. Oh, yes.
 18 Q. And it's a tool to be used, if possible, along
 19 with other tools, including medical records,
 20 clinical examination, history?
 21 A. Again, used for what purpose, but yes, I mean in
 22 the context of a broader evaluation, all of that
 23 information would be relevant.
 24 Q. Well, for instance, in making a prognosis, those
 25 other areas would be useful in adding to a more

50

1 confident prognosis as a general rule?
 2 A. Yes.
 3 Q. Have you ever been asked to make a prognosis of a
 4 three-year old?
 5 A. Yes.
 6 Q. Okay. And what tools do you use? Do you ever
 7 use the Bayley as one of the tools?
 8 A. Usually wouldn't with a three-year old. There
 9 are other tests that can provide more reliable
 10 measures ~~of~~ overall cognitive ability, more
 11 specific cognitive skills. We would certainly
 12 have used it in a two-year-old.
 13 Q. How old was this patient when he had the test, do
 14 you recall?
 15 A. I believe he was -- my memory is that he was in
 16 the two-year-old range, but I need to check.
 17 Q. I believe he was two years and four months, and
 18 maybe John and I can agree on that.
 19 A. I'm thinking 28 to 35 months, but I don't know.
 20 Q. I can show you the Metro record where it says
 21 that.
 22 A. Yes. For the -- when he was given the Bayley,
 23 yes.
 24 Q. Yes. He's been seen by a variety -- you
 25 understand he's been seen by a variety of health

51

1 professionals for a variety of reasons, correct?
 2 A. Yes.
 3 Q. And you understand that he is being treated for
 4 his clotting disorder by a hematologist?
 5 A. I assume he is. I didn't pay attention to that.
 6 Q. Right. But you would assume that a child with
 7 the kind of medical course he has has seen a
 8 number of people, would that be fair?
 9 A. Yes.
 10 Q. And I understand there are a whole range of
 11 opinions you're not going to be venturing into
 12 including hematology?
 13 A. I wouldn't venture opinions about hematology
 14 other than its and cognitive outcome, but not
 15 about hematology itself.
 16 Q. If you were to do a prognosis of a child who is
 17 two years and four months old, would one of the
 18 tools that you would use be a Bayley test?
 19 A. I have to break that down into two parts. If
 20 he's two years and four months old, I probably
 21 would use the Bayley depending on what I know
 22 about the case in terms of the level of
 23 functioning. I would be, for the reasons I
 24 mentioned in my letter to Mr. Scott, extremely
 25 reluctant to rely on the Bayley for making any

52

1 determination of long-term prognosis.
 2 Q. Would it be fair to say that you would be willing
 3 to use the Bayley as one tool or one indicator
 4 along with other indicators for a child who is
 5 two years four months in making a prognosis?
 6 MR. SCOTT: A prognosis of what?
 7 Q. A progress -- a neuropsychological prognosis?
 8 MR. SCOTT: Objection. You're going
 9 --
 10 A. One of the things we know about the Bayley, the
 11 infant assessment, is that if children are
 12 extremely impaired, they tend to remain extremely
 13 impaired. And one of the reasons the Bayley is
 14 sometimes used is to try to get a sense of
 15 whether the child is severely impaired. So in
 16 some cases it has more prognostic value than
 17 others. But in the broadly defined normal range,
 18 depending on the clinical context we would use to
 19 get a sense of where a child's function is now,
 20 and depending on the results, it may or may not
 21 have prognostic significance.
 22 Q. Right. My question is would you use it in any
 23 case for a two-year and four-month old to make a
 24 prognosis with regard to cognition and
 25 development, along with other indicators,

53

1 including medical records, examinations, clinical
 2 assessments?
 3 A. I think I've answered question. I would use --
 4 in my own clinical work would incorporate all of
 5 that information.
 6 Q. Including the Bayley?
 7 A. Bayley would be considered. Whether or not it
 8 provided prognostic information or not.
 9 Q. Because you wouldn't give it to a two-year
 10 four-month old here at Childrens Hospital if you
 11 thought it would have no value, would that be
 12 fair?
 13 A. No value? No. I would prefer not to give my
 14 patients anything that has no value.
 15 Q. How much does it cost for the Bayley to be
 16 administered? How much do you charge for it?
 17 A. We don't charge per test. We have an hourly
 18 rate. It depends on how long it takes to give a
 19 child a test.
 20 Q. What's the normal range?
 21 A. Depending on the child's age. A two-year-old
 22 would usually need about an hour and he give most
 23 the motor and developmental skills.
 24 Q. And would you charge an hourly rate for that time
 25 to the patient?

54

1 A. The hospital charge is roughly \$150 an hour.
 2 Q. And then would you also evaluate that as a
 3 neuropsychologist?
 4 A. Well, yes. There is -- the total cost of
 5 evaluation would include test administration
 6 time, interview, report preparation, review of
 7 records.
 8 Q. And certainly, you wouldn't charge a patient for
 9 a test that you didn't think was valuable, is
 10 that fair?
 11 A. Valuable is defined a lot of different ways, but
 12 no, if I thought that a test was totally useless,
 13 I wouldn't give it in the first place. Now, if I
 14 have a test that is invalid because the child is
 15 uncooperative or whatever, we still would charge
 16 the patient for the time.
 17 Q. Do you find the tests with Forrest Stone to be
 18 invalid?
 19 A. I don't have any indication that it was, no.
 20 Q. Would you expect that if a test is invalid
 21 because, let's say the child is uncooperative,
 22 that the psychologist who was preparing the
 23 evaluation would note that?
 24 A. Actually, he actually did in terms of his
 25 interpretation that he felt it was perhaps under

55

1 reporting of function based on the final report.
 2 So I would expect a colleague to mention if they
 3 felt the results of testing may not be valid.
 4 Q. Who is he, by the way?
 5 A. She. It's a she.
 6 Q. Dr. Schauer?
 7 A. I assume that's a she. I've actually known Orels
 8 that are men, so I try not to make assumptions
 9 about those sorts of things,
 10 Q. Let me go back to your report, doctor. We can
 11 speak of mental development index, which is what
 12 the Bayley measures, is that fair?
 13 A. It's a name.
 14 Q. Purports to measure?
 15 A. Yes.
 16 Q. And how does that match up to IQ? Are those
 17 numbers supposed to be the same even if they
 18 often fail to correlate?
 19 A. IQ, when it's applied to a specific test is
 20 simply just another name for what's meant to
 21 measure ability, and in that sense the MDI is
 22 meant to measure something similar to that.
 23 Q. So one would expect to correlate in general in IQ
 24 with -- let me finish -- with all the caveats of
 25 the problems of administering tests to younger

56

1 children and any other testing problems involved?
 2 A. You would expect to correlate with IQ measurement
 3 being administered around the same time.
 4 Q. But that would be true of IQ tests, too, that
 5 sometimes change over time?
 6 A. Yes.
 7 Q. What is the normal IQ within one standard
 8 deviation?
 9 A. One standard deviation?
 10 Q. Yes, for all measures.
 11 A. For most tests, again, it all depends on what the
 12 actual norms are for the test. For most tests
 13 the one standard deviation would be anywhere
 14 between 85 and 115. 15 points of the standard
 15 deviation of most of these tests.
 16 Q. 15 points. And so the norm -- and that would
 17 mean for most of these tests 85 to 115?
 18 A. No, I don't think that anybody uses the word,
 19 normal, necessarily just on the psychometrics.
 20 Most people often use a cutoff of around --
 21 again, it depends who you speak to, but most
 22 neuropsychologists would use the cutoff of the
 23 ten percentile to describe a performance that as
 24 impaired or abnormal.
 25 Q. What's a ten percentile in IQ?

57

- 1 A. in IQ it would be roughly 80.
 2 G And on the Bayley scale --
 3 A. Yes.
 4 Q. I'm sorry?
 5 A. Yes.
 6 Q. You have to give me a word. And is there plus or
 7 minus for any point in terms of the way the tests
 8 are administered, a polling data where they now
 9 talk about four points. That is, in polling data
 10 they speak as 50 as meaning it's the same as 54
 11 to 46 being fairly indistinguishable because the
 12 polling data doesn't account for accuracy closer
 13 than that.
 14 A. There is a confidence interval associated with
 15 any score on psychological tests like the Bayley,
 16 but it's not really accurate to say it's -- it
 17 really ~~isn't~~ accurate to say the score is the
 18 same as something else, but you can confidently
 19 state that it is between a certain range or
 20 within a certain range.
 21 Q. You dropped your voice or maybe my hearing is
 22 going. I apologize. You called it confidence
 23 integral?
 24 A. Interval.
 25 Q. Oh, interval. I'm trying to think of what

58

- 1 integral would be. Confidence interval. What
 2 would be the confidence interval in the Bayley?
 3 A. It depends on how confident you want your
 4 interval to be. I don't want to be facetious.
 5 But you can use 90 percent or you could use 95
 6 percent confidence intervals, and off top of my
 7 head I couldn't tell you what the Bayley is. I
 8 know that, I think, Dr. Matula mentioned what it
 9 is or what it was with a particular confidence,
 10 but ~~off~~ the top of my head I don't know.
 11 Q. Well, you have done this. Do you think it's in
 12 the range of two, three points or seven or eight,
 13 or don't you know?
 14 A. I'd have to look. I don't think it's more than
 15 seven or eight points, but I don't know for
 16 certain.
 17 Q. Is 84 below average?
 18 A. No.
 19 Q. Didn't you tell me average was 85 to 115?
 20 A. No. I said that the first standard deviation is
 21 85 to 115.
 22 Q. Fair enough.
 23 A. Most tests in standard nomenclature would be to
 24 describe 90 to 110 as average. 80 to 90 it's a
 25 low average. Anything under 80 is below

59

- 1 average. Again, it's a matter of convention more
 2 than anything else.
 3 Q. Because obviously, there's a bigger difference
 4 between 80 and 89 than there is between 89 and
 5 90. It's just a matter of convention, each point
 6 would be a point?
 7 A. Yes.
 8 Q. So it would be -- it would be -- is this -- is
 9 this a straight scale grading or is this some
 10 kind of logarithmic scale? It's straight scale
 11 grading, isn't it?
 12 A. I'm not exactly sure what you mean, based on
 13 normal distribution?
 14 Q. No. What I mean is are there going to be the
 15 same population between 80 and 81 as between 90
 16 and 91 as between 100 and 101?
 17 A. In terms of percentage of population, no.
 18 Q. So it is not going to be logarithmic?
 19 A. It has nothing to do with logarithms. It has to
 20 do with normal distribution.
 21 Q. Dr. Rothner rendered an opinion as to why this
 22 child would have problems, developmental
 23 problems, later based on a number of factors. Do
 24 you recall that?
 25 A. You have to point to what you are specifically

60

- 1 referring to.
 2 Q. Okay. You don't recall it without looking?
 3 A. I remember he had opinions about certain outcomes
 4 and certain factors that are relevant to that.
 5 Q. Okay. Can you tell me what factors would to your
 6 mind indicate that a child ~~will~~ have
 7 developmental problems later in life?
 8 A. How many hours do you want to spend? I mean
 9 there are so many factors that could be related
 10 to developmental problems, I don't know how to
 11 begin.
 12 Q. Does this child have any of them?
 13 A. Yes. We have already talked about a number of
 14 them that are risk factors.
 15 Q. Are cognition problems different than
 16 developmental problems? I think we talked about
 17 that earlier and I think there was a distinction
 18 made, but I'm not sure.
 19 A. I think the word, developmental problems, is
 20 always a very loose and slippery term because it
 21 can mean a lot of different things to different
 22 people. You can have cognitive deficits, you can
 23 have behavioral problems, adaptive deficits, and
 24 those are all potential developmental problems.
 25 So I prefer to use more specific terms and talk

61

- 1 about what particular outcomes we are talking
 2 about.
 3 Q. What about -- there are children with behavior
 4 problems obviously, correct? There are children
 5 who have behavior problems?
 6 A. Yes.
 7 Q. Okay. And those may manifest themselves by
 8 observation as opposed to testing. One might be
 9 able to see some of them, correct?
 10 A. You don't generally test them. You either
 11 observe them directly, or more commonly, you
 12 would get information about them from people who
 13 observe the child regularly.
 14 Q. Do you know whether Forrest Stone has had
 15 behavioral problems?
 16 A. I don't remember one way or the other whether
 17 there is indication of significant behavior
 18 problems.
 19 Q. Have you been asked to render any opinions
 20 whether he will have behavioral problems, has
 21 them or will have them?
 22 A. Mr. Scott hasn't asked me to -- some of your
 23 questions indirectly asked me --
 24 Q. I'm asking if Mr. Scott asked you.
 25 A. No.

62

- 1 Q. Do you know whether Forrest Stone is having
 2 cognition problems?
 3 A. The only results -- well, I take that back. The
 4 only results that I'm aware of that would address
 5 that question have to do with the Bayley and the
 6 speech language evaluation that was done. The
 7 Bayley, I think, is equivocal as to whether or
 8 not there are overall cognitive ability deficits
 9 even at this point in time. Because 85 is not
 10 significantly impaired.
 11 The speech language evaluation is lower and
 12 certainly he is described as having -- at least
 13 in the past, and again, I don't know what his
 14 current status is, Forrest is having speech
 15 difficulties and language difficulties. And
 16 those are the pieces of evidence that I have
 17 available to me.
 18 Q. Would those be indicative of cognition problems?
 19 A. I think I've answered the question. I mean I
 20 don't think the Bayley necessarily is. I think
 21 the results of the language testing suggests that
 22 at least at the time that he was assessed that
 23 there were some significant deficits in language
 24 skills.
 25 Q. Right. And I'm just asking about those. Those

63

- 1 significant deficits in language skills would be
 2 indicative of underlying cognition problems?
 3 A. They're a type of cognitive problem, yes.
 4 Q. You don't discuss that in your report, is that
 5 fair?
 6 A. No.
 7 Q. I want to ask you about a statement you make on
 8 the second page of your report. It's in the
 9 first full paragraph, which is the second
 10 paragraph, the second to last sentence.
 11 Adolescents with IQ scores in the low
 12 average range are often capable of graduating
 13 from high school or obtaining GED. Do you see
 14 that?
 15 A. Yes.
 16 Q. Okay. I want to try to understand what you mean
 17 by often capable. Do you mean that some are
 18 capable and some are not?
 19 A. That more often than people with IQ's in that
 20 range graduate from high school than don't.
 21 Q. Do you have any numbers on that, 60 percent, 50
 22 percent?
 23 A. No.
 24 Q. Do you know how many graduate from high school
 25 compared to hard core median, let's say a hundred

64

- 1 -- first of all, we can agree that from the
 2 tests that he has an 84, is that right?
 3 A. Well, if you want to make a prediction based on
 4 the Bayley, I don't have any prediction
 5 whatsoever because I don't think it predicts high
 6 school graduation.
 7 Q. But I want to ask you about a sentence you have
 8 --
 9 A. But you then referred to the Bayley.
 10 Q. Only because I want to remind so that you're not
 11 embarrassed later.
 12 A. You mentioned both an 85 and 84 on the Bayley.
 13 Q. I just reminded you, doctor. If you don't want
 14 to be reminded, it's a courtesy.
 15 A. I don't believe I referenced the Bayley.
 16 Q. You said it a minute ago. I just want to be sure
 17 we are on the same page.
 18 I want to talk about low average range,
 19 people with IQ in the low average range, wherever
 20 that came from, whatever test was administered or
 21 set of tests, along with clinical, along with
 22 whatever, achievement scores, along with whatever
 23 would indicate to you that somebody was low
 24 average. What would be the graduation rate of
 25 those as opposed to people within the average

65

1 range.

2 MR. SCOTT: Objection.

3 A. I don't have a foundation for an answer right

4 now. I don't know.

5 Q. When you say that adolescents in the low average

6 range are often capable of graduating from high

7 school or obtaining a GED, do you know in general

8 how many get to high school as opposed to how

9 many get the GED?

10 A. I don't know.

11 Q. Have you read studies that indicate that GED

12 children or GED graduates do significantly worse

13 in the workplace in terms of income than high

14 school graduates?

15 A. I'm not an economist. I'm sorry.

16 Q. There is a woman on the phone who is struggling

17 to hear you.

18 Talking about going to college or let's say

19 graduating from college, is it typical for those

20 with low average IQ's to graduate from college?

21 A. I'd say it's harder for them.

22 Q. Do you have any number on what harder would be?

23 A. No.

24 Q. It would be harder for them to do everything that

25 requires cognition than someone with a higher IQ,

66

1 the more cognition, the easier it is to handle

2 cognitive skills?

3 A. I think it's always an empirical question whether

4 the relationship is that linear or what the

5 minimum cognitive is required for certain

6 activities. Some don't require more. You just

7 have to have minimum level and you can do it.

8 Depends on the particular outcome you are talking

9 about. I will sometimes tell people you may not

10 be better off having a high one.

11 Q. Have you ever done any studies of long-term

12 outcomes of patients with perinatal traumatic

13 brain injuries?

14 A. You just mixed two different forms of injury as

15 far as I'm concerned.

16 Q. Wait a second. Let me impact that. You can have

17 traumatic brain injury at any point perinatal or

18 later in life. You can be hit over the head when

19 you're one day old.

20 A. Traumatic injury, yes.

21 Q. Let me ask my question again. Have you done any

22 extensive study of long-term outcomes of patients

23 with perinatal traumatic brain injuries?

24 A. Okay. I misunderstood. Our research does not

25 involve children with traumatic brain injuries

67

1 sustained perinatally. Most of those injuries

2 are a result of abuse. Most traumatic brain

3 injuries that I see are inflicted intentionally,

4 so it's a very different population that I see.

5 Q. You said you have done work for the plaintiff's

6 side as well as work for the defense side?

7 A. I've been retained by both, yes.

8 Q. Can you give the names of any Ohio lawyers on the

9 plaintiff's side?

10 A. No.

11 Q. You can't name me any?

12 A. Names, no. I've got far too many things to

13 remember. I can give you a list of the cases

14 that I have either been deposed or testified in

15 but I don't remember attorneys' names.

16 Q. Can you recite the names of the cases?

17 A. I couldn't. I don't have it off the top of my

18 head.

19 Q. You can't?

20 A. I know Dale Purdue. I think may I have worked

21 for him.

22 Q. Doctor, if you give me a minute, I might be close

23 to done. Let me consult my colleague and see if

24 he has any other questions other than what he's

25 already handed me.

68

1 (Thereupon, a recess was had.)

2 Q. Doctor, do you have a prognosis with regard to

3 cognition for this patient?

4 A. Only in very general sense.

5 Q. What would that be?

6 A. Well, the studies on perinatal strokes suggest

7 that it is not likely to see large effects of

8 perinatal stroke. They tend to be somewhat more

9 subtle. And more specific cognitive outcomes

10 certainly affect visual, spatial skills or have a

11 subtle effect on language skills, and I'm talking

12 about long-term school age sorts of outcomes.

13 There are also an increased risk of certain

14 types of behavioral problems, particularly

15 attention problems. So that I do think there is

16 a decreased risk for this child, but I think that

17 it will be much easier to begin to get a sense of

18 what those actual manifestations would be as he

19 gets a bit older, and there are tests which

20 become more extensive in terms of what we can

21 measure or become more predictive, I should say,

22 of future outcomes.

23 Q. I don't want to mischaracterize what you have

24 just stated, so let me see if I have got this

25 right. You would agree that under your prognosis

69

1 for this child, he is at risk for behavioral
 2 problems, correct?
 3 A. Certain kinds of behavioral problems, yes.
 4 Q. And what would those be?
 5 A. I think that the list predominantly focuses on
 6 attention problems, inattentiveness seem to be
 7 associated with perinatal stroke.
 8 Q. And is he at risk for problems with linguistic
 9 skills or language skills?
 10 A. Of a certain sort, yes.
 11 Q. And what would those be?
 12 A. The research literature suggests that unlike
 13 adults when you have a perinatal stroke, you
 14 don't tend to have gross language disturbance and
 15 the language manifestations change over time. So
 16 that they tend to be more obvious and basic
 17 linguistic skills at a younger age. But at older
 18 ages if they are present, they tend to involve
 19 more subtle problems with using language
 20 conversationally, discourse, connecting language
 21 and meaning-- it's not that they don't have the
 22 basic building blocks of language, but when they
 23 do have problems, and not all kids with perinatal
 24 stroke do, but when they do, it tends to be
 25 higher level language skills.

70

1 Q. What about -- I read some of your articles. I
 2 found you interesting and I understood them.
 3 A. Put you to sleep probably.
 4 Q. Actually, they didn't. You speak in some of your
 5 articles about the difference between math skills
 6 and other skills. You set out math skills, and
 7 I'm not sure I used the term exactly right, but
 8 you talk about the ability to do math as a
 9 separate factor often from other skills. Would
 10 math skills be impacted by or would any
 11 deterioration or abnormality in math skills be
 12 evidenced because of this insult to your
 13 understanding given the prognosis you have?
 14 A. You know, the Statements I'm making about
 15 prognosis are not about -- the statements about
 16 outcomes of perinatal stroke that I just made
 17 were not so made. In reference specifically to
 18 Forrest, but in an attempt to give you a general
 19 description of what we know from research. I
 20 can't retrieve off the off top head what the
 21 studies have been showing about academic
 22 performance in any detail. So I would have to
 23 look back at them. Now, again, my research does
 24 not concern perinatal stroke, and I certainly
 25 would make the assumption that the outcomes of

71

1 traumatic brain injury or other disorders because
 2 I've looked at this particular question relating
 3 spinal bifida, are necessarily, you know, related
 4 to this particular child.
 5 Q. I'm not actually asking that. I understand, at
 6 least I understand from your testimony that you
 7 are separating out the articles you wrote in
 8 terms of traumatic brain injury from the insult
 9 here.
 10 All I'm asking you is that in that these
 11 studies that I have of yours you talk about math
 12 skills, and I can probably find -- what I am
 13 saying is, what I am asking you is do you have an
 14 opinion in terms of prognosis for patients like
 15 Forrest Gregg Stone whether his math ability will
 16 be harmed because of the perinatal insult that he
 17 had?
 18 MR. SCOTT: Will it be more likely
 19 than not or is he at risk?
 20 Q. At risk. And then more likely than not.
 21 Separate questions. I'll ask the two of them.
 22 A. I would actually probably not want to venture a
 23 guess -- or an answer. Not a guess. Venture an
 24 answer right now. I really would want to go back
 25 to those groups of studies with children with

72

1 perinatal stroke to be sure it's based on sound
 2 science.
 3 Q. And at the risk getting a vociferous objection,
 4 would you agree with me that you believe that
 5 given the insult that Forrest Gregg Stone had in
 6 terms of his prognosis, he is at risk for --
 7 generally, for cognition problems, but you don't
 8 believe that it's more probable than not that he
 9 will suffer a significant IQ drop?
 10 A. I think only -- two questions in that question.
 11 I wouldn't say that in general -- this is the way
 12 I phrased it. He is at risk for cognitive
 13 deficits. I don't believe that he's more likely
 14 than not going to show a significant decline in
 15 IQ.
 16 Q. Are you making a distinction between a small drop
 17 in IQ and significant drop? I'm just asking
 18 that.
 19 A. A drop that I would attribute to or be related to
 20 the neurological incident.
 21 Q. I mean as I'm looking at one of your articles,
 22 you are talking about math skills, and that's
 23 what I was referring to before. You are talking
 24 about how in traumatic brain injuries when there
 25 is more than one risk factor, math skills can be

73

- 1 involved.
- 2 A. I believe, yes, all those risk factors that we
- 3 are talking about there are include not the
- 4 injury, but the environment that the child is
- 5 raised in, because our research is more focused
- 6 on the interplay between the child's environment
- 7 and their brain injury.
- 8 Q. Do you have any knowledge as to whether there is
- 9 any literature about environment impacting on
- 10 children like Forrest with the injuries he has?
- 11 A. There is some, yes.
- 12 Q. And what does that literature conclude about
- 13 environment as a risk factor?
- 14 A. Plays a significant role.
- 15 Q. So if that child's home life is less than
- 16 optimal, less than Ozzie and Harriet, he's at
- 17 greater tendency towards things like abuse,
- 18 towards domestic --
- 19 A. I don't think that our research would suggest
- 20 that you need to have grossly abnormal family
- 21 environments to have an effect on children. In
- 22 fact, not just our research, but in much of the
- 23 research, the variation of normal quote-unquote
- 24 range in families has an impact on children.
- 25 Q. All children or these children?

74

- 1 A. I think that there is evidence to suggest that
- 2 variations in family and parents plays a role in
- 3 the outcomes of children with neurological
- 4 insult, including children with traumatic brain
- 5 injury, and I think there is a literature that's
- 6 relevant to children with stroke. Mostly with
- 7 children with prematurity, but there is some
- 8 specific evidence.
- 9 Q. Let me put it another way. I'm not sure if you
- 10 answered my question. Maybe you did. Are
- 11 children like Forrest Gregg Stone more at risk
- 12 than average children for environmental
- 13 difficulties in the home?
- 14 A. No. That's flipping it around the other
- 15 direction. I don't think that necessarily that
- 16 kids with perinatal stroke are more at risk for
- 17 adverse family environments, although having a
- 18 child with neurological insult does -- is
- 19 sometimes associated with more stress at home.
- 20 Q. So you flipped it a third way. That is, that
- 21 there may be more stress in the home life because
- 22 of an impaired child?
- 23 A. If the child is impaired, yes.
- 24 Q. Is that something that's part of your studies?
- 25 A. Yes.

75

- 1 Q. Impaired in the way that Forrest Gregg Stone is?
- 2 Would you expect that --
- 3 A. I haven't said that he is impaired other than --
- 4 Q. You don't --
- 5 A. Other than the language area based on old
- 6 testing. I don't know where he is right now.
- 7 Q. Well, you have certainly seen patients with
- 8 physical issues as well as psychological or
- 9 neurological issues, that is, in your practice
- 10 some patients who come here must be patients who
- 11 have all kinds of physical problems, correct?
- 12 A. Yes.
- 13 Q. And do those physical problems in your experience
- 14 put greater stress on environment?
- 15 A. One of the interesting things is that most data
- 16 would suggest that families find children with
- 17 physical handicaps not particularly distressing.
- 18 It tends to be behavioral, cognitive, academic
- 19 sorts of problems that families find most
- 20 difficult to cope with.
- 21 Off the record, I do need to stop by two.
- 22 Q. I think I'm done.
- 23 A. Great.
- 24 MR. LEVIN: I believe I'm done,
- 25 doctor. Carol, do you have any questions of

76

- 1 the expert?
- 2 MS. METZ: No, I have no questions.
- 3 MR. SCOTT: The doctor will read.
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25

KEITH OWEN YEATES, Ph.D.

CORAZON O .GO., M.D. et al.

77

CERTIFICATE

The State of Ohio) SS:
County of Cuyahoga.)

I, Sandra L. Mazzola, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named KEITH OWEN YEATES, Ph.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of stenotypy and was later transcribed into typewriting under my direction, that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties or a relative or employee of such attorney or financially interested in this action. I am not, nor is the court report firm with which I am affiliated, under a contract as defined in C.J.R. 21(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 2002.

Sandra L. Mazzola, Notary Public, State of Ohio
14237 Detroit Avenue, Cleveland, Ohio 44107
My commission expires February 19, 2007

78

WITNESS INDEX

PAGE

CROSS-EXAMINATION
KEITH OWEN YEATES, Ph.D.
BY MR. LEVIN 3

OBJECTION INDEX

| OBJECTION BY | PAGE NUMBER |
|--------------|-------------|
| MR. SCOTT: | 25 |
| MR. SCOTT: | 27 |
| MR. SCOTT: | 29 |
| MR. SCOTT: | 34 |
| MR. SCOTT: | 34 |
| MR. SCOTT: | 37 |
| MR. SCOTT: | 43 |
| MR. SCOTT: | 43 |
| MR. SCOTT: | 52 |
| MR. SCOTT: | 65 |

| | | | |
|--|---|---|---|
| \$ | | administering 55:25 administration 46:21,23; 54:5 adolescents 48:7; 63:11; 65:5 adult 48:4 adulthood 22:21; 23:3 adults 4:16; 48:5,12; 69:13 adverse 74:17 affect 68:10 affiliated 77:0 aforementioned 77:0 afoul 29:1 again 7:24; 8:12; 12:6; 14:1; 27:8; 28:17; 29:14; 31:3,17; 34:4; 36:4; 43:16; 45:2; 47:2; 49:21; 56:11,21; 59:1; 62:13; 66:21; 70:23 age 3:1; 46:12,14; 47:5; 48:8,9,20; 53:21; 68:12; 69:17 ages 46:8; 47:8; 49:5; 69:18 aggregate 36:17 agree 22:8; 34:10; 36:13; 43:3,16; 50:18; 64:1; 68:25; 72:4 agreed 39:3,4 ahead 28:25; 34:22 al. 1:0 allowed 12:23 along 7:13; 49:18; 52:4,25; 64:21,21,22 already 6:22; 8:5; 14:12; 45:22; 80:13; 67:25 Although 37:i; 74:17 always 6:11; 24:13; 60:20; 66:3 among 11:21; 22:5 amount 23:21; 33:7 and/or 1:18 answer 12:8; 24:21; 28:20; 39:17; 43:7; 65:3; 71:23,24 answered 37:5,6; 53:3; 62:19; 74:10 answering 28:18 answers 33:22 anticipate 14:11,19; 15:2,14 anybody 56:18 anyone 10:11; 11:2 anything 10:8; 14:17; 31:23; 53:14; 58:25; 59:2 anywhere 21:13; 25:10; 29:9; 46:9; 56:13 apologize 57:22 APPEARANCES 2:1 applied 41:17; 55:19 apply 12:1; 40:9 area 8:23; 15:25; 42:8,17; 46:13; 75:5 areas 34:4; 49:25 argument 20:17 around 56:3,20; 74:14 articles 70:1,5; 71:7; 72:21 Aside 16:5; 34:17 ask 38:20; 48:25; 63:7; 64:7; 66:21; 71:21 asked 14:5,7,9; 21:3,8; 33:23; 45:19; 48:10; 50:3; 61:19,22,23,24 asking 7:18,23; 22:25; 31:23; 44:13; 61:24; 62:25; 71:5,10,13; 72:17 asks 10:2 assess 26:22 assessed 62:22 assessment 52:11 assessments 53:2 associated 5:19; 10:15; 32:7; 34:12; 35:5,11; 38:1,14; 44:10; 47:12; 57:14; 69:7; 74:19 ASSOCIATES 1:2 association 30:23; 32:3,11 assume 41:5; 51:5,6; 55:7 assumption 70:25 assumptions 55:8 attempt 70:18 attention 31:4; 51:5; 68:15; 69:6 attorney 77:77 attorneys 13:25 attorneys' 67:15 attribute 72:19 August 42:2 authorized 77:8 available 14:16; 15:7; 62:17 AVENUE 1:2; 2:77 average 58:17,19,24,25; 59:1; 63:12; 64:18,19,24,25; 65:5,20; 74:12 awarded 41:18,18 aware 10:14,24; 11:5; 14:24; 15:6; 19:13; 25:20,23; 30:21; 31:11; 33:14; 62:4 away 25:7 | |
| \$158 54:1 \$250 14:4 , | 6 6:4; 7:13 60 63:21 65 78:13 687-1311 2:17 587-3368 2:12 | | B |
| '93 5:5,7 '94 5:5 | 7 7 10:2 700 1:15 | | |
| 1 | 8 80 57:1; 58:24,25; 59:4,15 81 59:15 84 58:17; 64:2,12 85 56:14,17; 58:19,21; 62:9; 64:12 89 59:4,4 | | |
| 1 10:5 1-888-595-1970 1:0 100 59:16 101 59:16 110 58:24 113 2:16 115 56:14,17; 58:19,21 11:45 1:16 14237 1:77 15 56:14,16 19 1:17; 77:0 1993 5:8 | 9 90 58:5,24,24; 59:5,15 91 59:16 928-0600 2:0 95 58:5 | | |
| 2 | A A-A-R-A-M 42:16 A.D 77:20 a.m 1:16 Aaram 42:16 ability 50:10; 55:21; 62:8; 70:8; 71:15 able 12:7; 18:11; 23:11; 26:22; 27:2; 33:11; 61:9 abnormal 34:25; 35:1; 56:24; 73:20 abnormality 22:10,12; 24:14; 70:11 abnormally 21:19 above-named 77:0 above-set 77:0 abuse 67:2; 73:17 academic 70:21; 75:18 accept 11:25 accepted 37:25; 44:1 according 18:7 account 57:12 accuracy 29:15; 30:4; 57:12 accurate 3:23; 57:16,17 accurately 7:12 achievement 64:22 acquainted 10:19 across 12:25 action 77:17 activities 66:6 activity 23:3; 31:13,15 actual 26:2; 46:20,23; 56:12; 68:18 actually 14:10; 21:12; 22:1; 28:10; 42:19; 44:7; 45:10,21; 47:1; 48:1; 49:3,4; 54:24,24; 55:7; 70:4; 71:5,22 acute 13:20 adaptive 44:23; 60:23 add 36:22; 37:2; 40:18 adding 49:25 additive 36:22 address 5:24; 24:17; 45:11; 62:4 adjective 39:21 adjectives 43:9 administer 77:0 administered 46:8,18; 53:16; 56:3; 57:8; 64:20 | | |
| 2 10:5; 48:20 20 48:20 2001 8:1; 9:10 2002 1:17; 3:19; 6:4; 7:17,21; 77:20 2007 77:0 216 1:1; 2:2,12,17 22 9:10 221-1970 1:0 221-9171 1:24 232 2:0 25 13:14; 78:0 2500 2:0 27 78:9 28 50:19 28(D) 77:18 29 8:1; 78:0 | | | |
| 3 | | | |
| 3 78:0 30 42:5; 48:19,21 31 7:17,21 323 2:3 34 78:10,0 344-9007 2:0 35 50:19 350 48:16 37 78:11 396873 1:0 | | | |
| 4 | | | |
| 42 46:10 43 78:78 44107 1:23; 77:23 441 13 2:4 44113-1058 2:7 441 13-2241 2:0 44114 2:0 450 2:2 46 57:11 | | | |
| 5 | | | |
| 50 2:11; 13:14; 57:10; 63:21 52 78:0 54 57:10 | | | |
| 6 | | | |

body 19:25
bone 40:4
bottom 25:3
boundaries 16:12
BOYLE 1:6
brain 13:19,23,24; 15:24; 18:6; 20:2,3,4; 26:2,5,7,19; 27:1,12,14; 30:11; 31:9; 33:4; 35:1,2,18; 36:6,21,25; 37:11,15,21,23; 39:5,9,10,25; 40:1,8,12,13,14,14,16,20,22,2,41:8,8; 43:12,14,17,22,24; 44:6,17; 66:13,17,23,25; 67:2; 71:1,8; 72:24; 73:7; 74:4
break 51:19
broader 49:22
Broadly 27:22; 49:12; 52:17
broken 40:4
Building 2:16; 69:22

C

called 3:2; 11:1; 21:10; 57:22
calling 17:20
can't 11:9; 28:10; 39:16; 67:11,19; 70:20
capable 63:12,17,18; 65:6
care 47:22,24,25
career 46:22
Carol 2:75
CASE 1:7; 10:21; 13:6,7; 20:19; 27:4; 35:19,20; 38:9,10; 39:12; 42:5; 45:17; 51:22; 52:23
cases 8:19; 11:19; 35:25; 40:10; 52:16; 67:13,16
cause 1:19; 15:21,22,23; 16:4; 17:24,25; 34:16
caused 35:2; 39:11; 40:22
caveats 55:24
cavity 35:17,22
center 47:23
cephaly 25:4
cerebral 29:7,11,23
certain 16:12,14; 23:21; 30:15; 57:19,20; 58:16; 60:3,4; 66:5; 68:13; 69:3,10
certainly 14:22; 15:8; 19:7; 28:7; 29:1; 34:15; 35:3; 36:5; 38:23; 40:21; 46:14; 50:11; 54:8; 62:12; 68:10; 70:24; 75:7
certification 5:1
certified 3:5
certify 77:77
change 56:5; 69:15
characteristic 17:1
characterize 11:19; 18:4; 28:1; 39:18
charge 14:3; 53:16,17,24; 54:1,8,15
Charles 18:18
check 7:11; 50:16
child 4:10,13,15; 25:21; 26:5,21; 29:8; 31:19; 51:6,16; 52:4,15; 53:19; 54:14,21; 59:22; 60:6,12; 61:13; 68:16; 69:1; 71:4; 73:4; 74:18,22,23
child's 52:19; 53:21; 73:6,15
childhood 4:16
children 22:21; 23:2; 31:25; 32:1,9,14,22; 40:25; 43:4,11,17; 46:2,7; 47:7,23; 48:5,8,11; 49:3,10; 52:11; 56:1; 61:3,4; 65:12; 66:25; 71:25; 73:10,21,24,25,25; 74:3,4,6,7,11,12; 75:16

Childrens 1:15,15; 5:15,16,19,24,25; 47:14,19,22,24; 53:10
circumference 24:1,15; 25:9
Civil 3:4; 77:18
claims 4:19
Clair 2:16
clear 17:13
clearly 16:25
CLEVELAND 1:23; 2:4,7,2; 8:8,14,17,20,23; 77:77
clinical 4:9,24; 8:7; 12:14,15; 29:7; 38:4,22; 49:20; 52:18; 53:1,4; 64:21
clinically 34:17; 36:19
close 16:15; 67:22
closed 40:19
closer 7:11; 25:8; 57:12
clot 36:6
clotting 51:4
Co. 2:6,15
cognition 25:17; 27:24; 28:15; 29:12; 30:17; 31:16; 34:19; 52:24; 60:15; 62:2,18; 63:2; 65:25; 66:1; 68:3; 72:7
cognitive 20:18; 21:5; 32:4,7; 33:20; 35:24; 36:16; 38:24; 44:11; 50:10,11; 51:14; 60:22; 62:8; 63:3; 66:2,5; 68:9; 72:12; 75:18
coincidental 17:10
colleague 55:2; 67:23
collection 35:15
college 65:18,19,20
Columbus 1:16,16; 5:18
Coma 44:2
comment 7:18; 20:9; 21:3
commented 16:19
comments 19:14; 20:16
commission 77:0
COMMON 1:1; 46:12; 47:9
commonly 48:10; 61:11
compared 63:25
comparing 17:12
comparison 31:25
completes 12:12,13
complicated 37:3
complication 32:6
complications 26:13; 32:12; 34:12; 38:14
concern 24:11; 70:24
concerned 66:15
concerning 19:12
conclude 73:12
conclusions 44:8
condition 28:1; 30:21; 34:13; 35:1; 49:2
conditions 35:2; 40:10
conducted 8:22
confidence 57:14,22; 58:1,2,6,9
confident 50:1; 58:3
confidently 57:18
conjunction 10:8
connecting 69:20
connection 6:2
consider 23:15
considered 53:7
consists 7:2
consult 67:23
consultation 22:3
sontained 45:17
context 36:5; 49:22; 52:18
continue 46:23
contract 77:0
convention 59:1,5
conversationally 69:20
cope 75:20
copies 14:7; 45:9

copy 3:18; 6:19; 7:25; 8:1; 45:6,9,9
CORAZON 1:7; 2:0
core 63:25
correct 3:14,15,16; 5:9,23; 7:5,14,15,21; 8:5; 9:1,8,11; 10:6,7; 11:6,14; 18:3; 23:17; 37:11,17; 40:25; 42:8; 43:1; 44:20; 46:25; 47:1; 51:1; 61:4,9; 69:2; 75:11
correctly 46:10
correlate 55:18,23; 56:2
correlative 21:5; 35:6
correspondence 6:25
cost 53:15; 54:4
couldn't 8:12; 13:13; 41:22; 48:18; 58:7; 67:17
counsel 1:18; 29:2; 77:15
count 26:5
counted 25:22
counts 26:8
COUNTY 1:2; 77:0
couple 4:8
course 17:18; 22:20; 23:2; 32:6; 51:7
COURT 1:1,22; 15:9; 77:17
courtesy 64:14
cower 7:23
CP 29:16,20; 30:2
cranial 30:11; 35:17,19,22
creates 30:10
cross-examination 1:12; 3:3,7; 78:0
CT 18:8,9,11; 19:3,8
current 3:20; 62:14
curriculum 3:19
cut 28:24
cutoff 23:20,22,23; 24:2; 56:20,22
cutting 26:18
CUYAHOGA 1:2; 77:0
CV 3:20; 4:3

D

daily 23:4
Dale 67:20
data 14:8,13; 26:9; 57:8,9,12; 75:15
date 77:0
dated 3:19; 7:20
dates 6:23
day 15:10,12; 66:19; 77:20
days 16:18
Deaconess 2:0
deal 23:4
dealing 26:19; 38:3
December 10:2
decline 72:14
decreased 68:16
Defendant 2:13; 13:16
Defendants 1:2
Defense 14:2; 67:6
Deficits 60:22,23; 62:8,23; 33:1; 72:13
Define 22:3; 39:7
defined 23:19; 27:22; 40:15; 52:17; 54:11; 77:18
Definition 11:9; 34:25
Definitions 44:1
Jegree 4:19; 12:12,15; 24:14; 33:6
Jegrees 4:22; 24:5
Jepartment 5:22,25; 48:15
Jepend 26:12; 27:8; 30:19; 37:7,9
Jepending 16:20; 43:19; 17:25; 51:21; 52:18,20; 3:21

depends 14:15; 36:4; 37:21; 38:9; 53:18; 56:11,21; 58:3; 66:8
deposed 3:5; 67:14
Deposition 1:11; 14:24; 15:13,15; 32:17,18; 77:10,11,14
depositions 14:21; 77:9
describe 56:23; 58:24
described 62:12
description 38:24; 70:19
detail 70:22
deterioration 70:11
determination 52:1
DETROIT 1:77
development 23:2; 45:24; 46:2; 52:25; 55:11
developmental 4:10; 22:14; 23:16; 26:6; 27:20,24; 28:15; 29:12; 30:17,24; 31:16; 32:8; 33:20; 34:18; 35:23; 36:16; 49:13; 53:23; 59:22; 60:7,10,16,19,24
deviation 23:25; 24:5,6,10; 56:8,9,13,15; 58:20
deviations 24:7,23,24; 25:6; 38:8
diagnoses 19:12
diagnosis 12:18; 29:15,23
didn't 25:10; 51:5; 54:9; 58:19; 70:4
difference 16:2,10; 59:3; 70:5
differences 17:1
different 12:19; 16:19; 17:3; 44:8,9; 54:11; 60:15,21,21; 56:14; 67:4
differentiates 17:14
difficult 22:20; 48:24; 75:20
difficulties 62:15,15; 74:13
direct 13:25
direction 74:15; 77:0
directly 61:11
discourse 69:20
discuss 21:21; 63:4
discussed 10:11
discussion 9:23; 19:21; 31:11; 45:13
disorder 32:2; 51:4
disorders 4:17; 12:20; 32:4; 44:10,18; 71:1
displacement 33:3
distinct 44:11
distinction 11:22,25; 12:3,10; 16:22; 17:7; 60:17; 72:16
distressing 75:17
distribution 48:8; 59:13,20
disturbance 69:14
factor 3:12,13,16; 7:8; 2:23; 22:13,17; 31:18,19; 4:23; 40:7; 45:5,16; 55:10; 4:13; 67:22; 68:2; 75:25; 76:3
doctorate 12:15
document 18:21
documented 27:9
Joos 16:2,9; 20:11; 26:5; 8:12; 40:9; 53:15; 55:16; 0:12; 66:24; 70:23; 73:12; 4:18
Joesn't 39:7; 40:12,16; 7:12
Joing 36:13; 41:14
Joestic 73:18
Joone 42:4,8,17,19; 58:11; 2:6; 66:11,21; 67:5,23; 5:22,24
Joothy 42:16

double-check 46:11
down 51:19
Dr 3:11; 6:17,20,21;
7:17,20,25; 8:2,4,7;
9:1,3,5,11; 10:22,25; 11:4,12;
14:21,24; 15:13,14; 16:19;
18:7,18,23; 19:20; 25:12;
28:23; 29:5,16,22,25; 55:6;
58:8; 59:21
draft 6:10,11,12
drafts 6:12
Drive 1:15
drop 72:9,16,17,19
dropped 57:21
due 34:19
duly 3:4; 77:10
duplicative 9:17
during 26:19; 27:1; 32:6

E

earlier 6:10; 46:21; 60:17
early 46:1,1,6
easier 66:1; 68:17
easy 33:13
economist 65:15
economists 22:24
educational 45:1
effect 31:7; 68:11; 73:21
effectively 30:20
effects 68:7
eight 58:12,15
either 7:3; 11:5; 21:1; 34:20;
61:10; 67:14
elicited 45:22
Elizabeth 42:13
else 10:8,11; 11:2; 22:25;
57:18; 59:2
elsewhere 9:19
embarrassed 64:11
empirical 24:16; 66:3
employee 77:77
enclosed 9:15
enclosing 7:16,24
end 7:14; 22:18
engage 22:1
enough 58:22
entitled 12:20
environment 73:4,6,9,13;
75:14
environmental 74:12
environments 73:21; 74:17
epidural 36:2
episode 26:10
episodically 29:8
equal 24:8,9; 45:4
equate 40:19
equivocal 62:7
Esq 2:2,2,0
etc. 1:0
evaluate 22:5; 26:14,16;
54:2
evaluation 8:1; 9:14; 22:2;
49:22; 54:5,23; 62:6,11
everything 7:2; 22:25; 65:24
evidence 62:16; 74:1,8
evidenced 70:12
exact 5:4; 13:13; 23:20;
48:19
exactly 12:6; 23:22; 59:12;
70:7
examination 49:20
examinations 53:1
example 32:13; 37:23; 38:1;
39:3
expect 41:24; 54:20;
55:2,23; 56:2; 75:2
expectation 16:6
expected 20:9

exoeience 27:3; 75:13
expert 11:1,5; 13:10; 29:25;
42:10; 76:1
expertise 16:1; 19:5,9;
21:21,23; 27:6
experts 10:15,18,19,20,24;
11:9
expires 77:0
expressed 23:24
extensive 66:22; 68:20
extent 20:21; 21:4
extremely 51:24; 52:12,12

F

facetious 58:4
fact 8:3; 23:24; 34:10; 73:22
factor 23:7,7,11; 24:19,23;
26:6,8,20; 27:1,1,18,20,23;
28:14,22; 29:11; 30:16;
31:2,16; 33:19; 35:23; 43:9;
44:17,19,20,22,25; 70:9;
72:25; 73:13
factors 21:5; 23:12; 25:18;
31:1,8; 34:14,24; 35:3,7;
36:8,14,17; 44:2; 59:23;
60:4,5,9,14; 73:2
faculty 5:21
fail 55:18
fair 7:7; 11:12; 18:2; 20:11;
21:6; 22:9,19; 23:1,8,13;
24:12; 25:15,24; 27:6,12;
32:20; 34:9; 35:6,8; 37:4;
40:11; 41:19; 45:18; 46:20;
47:23; 49:15; 51:8; 52:2;
53:12; 54:10; 55:12; 58:22;
53:5
fairly 4:6; 57:11
Fallon 2:10
familial 10:22; 39:24
families 73:24; 75:16,19
family 73:20; 74:2,17
far 4:1; 45:17; 66:15; 67:12
fault 45:8
FAX 1:24
February 77:0
eel 39:2,16
ellows 47:15
elt 54:25; 55:3
ew 11:19
ield 8:16; 19:1; 21:6; 27:5;
34:5; 41:12; 42:11
ifteen 47:8; 48:3,4
igure 36:12
ilms 18:12
inal 6:12; 55:1
inancially 77:0
ind 32:15; 54:17; 71:12;
5:16,19
inding 21:2
indings 18:8; 19:11
ine 29:5; 47:21
inish 55:24
irm 13:5; 77:0
irst 3:4; 6:7; 21:12; 54:13;
8:20; 63:9; 64:1; 77:10
ive 38:7,16
lipped 74:20
lipping 74:14
loor 2:7
ocused 73:5
ocuses 69:5
ollow 16:20; 20:8
ollows 3:6
orce 39:11
orms 66:14
ORREST 1:3; 15:18; 19:12;
0:6; 21:14; 27:15; 30:12;
1:13; 32:23; 35:11; 40:11;

49:2; 54:17; 61:14; 62:1,14;
70:18; 71:15; 72:5; 73:10;
74:11; 75:1
forth 34:3; 44:14; 77:0
found 15:1; 70:2
foundation 65:3
four 49:11; 50:17; 51:17,20;
52:5; 57:9
four-month 52:23; 53:10
fracture 40:5
frame 16:18
framework 16:17
front 6:5
full 63:9
function 38:25; 52:19; 55:1
functioning 32:4; 44:23;
51:23
further 24:8; 34:4
future 22:20; 23:16; 68:22

G

G-E-R-R-I-N-G 42:17
gambit 19:5
gave 5:12; 28:9; 29:6; 45:5,5
GED 63:13; 65:7,9,11,12
general 7:18; 24:12;
36:15,25; 43:20; 50:1; 55:23;
65:7; 68:4; 70:18; 72:11
generally 22:9; 27:5; 33:15;
7:3; 40:15; 44:2; 49:7;
61:10; 72:7
Gerring 42:16
gets 68:19
getting 72:3
giving 77:10
Glasgow 44:2
going 7:10; 29:14; 30:3;
44:14; 51:11; 52:8; 57:22;
59:14,18; 65:18; 72:14
good 26:9
grading 33:15; 37:25,25;
38:6; 39:20; 59:9,11
graduate 47:17; 63:20,24;
65:20
graduates 65:12,14
graduating 63:12; 65:6,19
graduation 64:6,24
grant 41:16,25
Great 75:23
greater 24:10,11; 36:15;
73:17; 75:14
GREGG 1:3; 15:18; 19:12;
20:6; 21:14; 27:15; 31:13;
35:11; 40:11; 71:15; 72:5;
74:11; 75:1
gross 69:14
grossly 73:20
group 36:2
groups 71:25
guarantee 22:15
guess 13:13; 14:20; 26:24;
48:20; 71:23,23

H

half 31:20; 46:14
hand 26:3; 77:0
handed 7:7; 67:25
handicaps 75:17
handle 66:1
happen 16:17
happened 19:15
happens 40:24
hard 63:25
harder 65:21,22,24
harm 71:16
harriet 73:16
hasn't 29:22; 41:18; 61:22

haven't 11:8; 14:5; 15:5;
21:8; 25:22; 75:3
head 21:19; 23:21; 24:1,14;
25:9; 26:18; 28:4,10; 33:14;
39:11; 40:19,23; 58:7,10;
66:18; 67:18; 70:20
health 50:25
hear 41:24; 65:17
heard 9:5; 20:24,24; 30:6
hearing 57:21
heightened 32:7
hematologist 51:4
hematology 51:12,13,15
hematoma
35:10,14,16,18,22
hematomas 36:3
hemiparesis 19:21,24;
20:6,11,12,16,18,22,23; 21:2
hemorrhage 38:2
hemorrhagic 28:11,13
hereby 77:9
hereinafter 3:5
hereunto 77:19
herniation
30:6,8,9,11,13,16,23; 31:4;
33:23; 34:11,21
high 43:5,11,18;
63:13,20,24; 64:5; 65:6,8,13;
66:10
higher 14:2; 43:20; 65:25;
69:25
history 49:20
hit 66:18
hold 45:17
hole-punched 45:9
home 73:15; 74:13,19,21
Hospital 1:15; 2:5;
5:16,19,24,25; 8:14;
47:10,14,20,22; 53:10; 54:1
hour 14:4; 53:22; 54:1
hourly 53:17,24
hours 16:13,18; 60:8
houses 5:25
However 15:11
Howley 2:10
Hudock 2:19
hundred 63:25
Hurd 2:10

I

I'll 20:23; 43:16; 71:21
I've 4:6; 8:18; 11:19; 13:11;
18:10,21; 20:23; 21:25; 36:8;
37:6; 53:3; 55:7; 62:19;
57:7,12; 71:2
idea 38:21
identical 9:18,19
Illness 32:6
impact 36:9; 37:11,12;
36:16; 73:24
impacted 70:10
impacting 73:9
impaired 52:12,13,15; 56:24;
32:10; 74:22,23; 75:1,3
Impairment 39:1
important 25:16; 37:10,17;
14:5
inattentiveness 69:6
NC 1:0
incident 72:20
include 17:21; 22:24; 54:5;
3:3
includes 6:24; 12:16
including 49:19; 51:12;
3:1,6; 74:4
inclusive 48:1
income 65:13
incorporate 53:4

| | | | |
|---|---|---|---|
| <p>increased 28:15; 29:11; 30:16; 31:15; 33:19; 34:18; 35:7,23; 36:18; 68:13</p> <p>increases 22:14</p> <p>increasing 23:7</p> <p>index 55:11</p> <p>indicate 60:6; 64:23; 65:11</p> <p>indication 23:13; 31:8; 54:19; 61:17</p> <p>indicative 21:4; 25:4; 35:7; 62:18; 63:2</p> <p>indicator 52:3</p> <p>indicators 36:23; 44:3; 52:4,25</p> <p>indirectly 35:4; 61:23</p> <p>indistinguishable 57:11</p> <p>infant 45:24; 52:11</p> <p>infants 46:2,7; 47:3,4</p> <p>infarct 28:2,11,12,14</p> <p>inflicted 67:3</p> <p>informally 18:14</p> <p>information 49:23; 53:5,8; 61:12</p> <p>injuries 13:19,23,24; 39:25; 41:9; 66:13,23,25; 67:1,3; 72:24; 73:10</p> <p>injury 15:18,19,21; 17:24; 20:2,3; 37:23; 38:5; 39:5,9,10,18,25; 40:1,1,2,3,9,12,14,15,17,19,24; 43:12,15,17,20,22,25; 44:4,7,17; 45:3; 66:14,17,20; 71:1,8; 73:4,7; 74:5</p> <p>inside 35:19</p> <p>instance 19:18,19; 24:22; 38:5; 49:24</p> <p>insult 15:24; 16:21,23,24; 20:4; 36:20,25; 37:13,15,16,21; 39:16,19; 40:13,22; 70:12; 71:8,16; 72:5; 74:4,18</p> <p>insults 41:8</p> <p>integral 57:23; 58:1</p> <p>intended 46:6</p> <p>intentionally 67:3</p> <p>interested 77:0</p> <p>interesting 17:18; 70:2; 75:15</p> <p>interns 47:16</p> <p>internship 12:16</p> <p>interplay 73:6</p> <p>interpret 19:8; 46:24</p> <p>interpretation 54:25</p> <p>interpretive 46:24</p> <p>interval 57:14,24,25; 58:1,2,4</p> <p>intervals 58:6</p> <p>interview 54:6</p> <p>intraventricular 38:2</p> <p>invalid 54:14,18,20</p> <p>involve 28:12; 34:25; 39:7,9,10; 66:25; 69:18</p> <p>involved 8:18; 11:20; 12:17; 13:8,10; 39:2; 56:1; 73:1</p> <p>involves 40:5</p> <p>involving 39:18</p> <p>IQ 7:18,24; 19:13; 55:16,19,23; 56:2,4,7,25; 57:1; 63:11; 64:19; 65:25; 68:7; 72:9,15,17</p> <p>IQ's 63:19; 65:20</p> <p>irrelevant 23:8</p> <p>isn't 36:21; 57:17; 59:11</p> <p>issue 15:25; 19:13</p> <p>issues 17:3; 75:8,9</p> <p>its 20:12,14; 49:8,11; 51:14</p> <p>itself 15:21; 23:16; 26:17,19; 27:17,18; 28:13; 30:18,25; 33:24; 51:15</p> | <p>J</p> <p>January 7:17,21</p> <p>Jeffrey 2:2; 42:14</p> <p>Joan 42:13,i6</p> <p>Joan's 42:19</p> <p>Joel 2:2</p> <p>John 2:15; 50:18</p> <p>journal 42:18,21</p> <p>journals 42:21,23</p> <p>JUDGE 1:6; 33:11</p> <p>judging 25:17; 39:5</p> <p>judgment 30:4; 33:16; 36:19; 38:4,22</p> <p>June 1:17; 3:19</p> <p>jury 12:9,10; 22:11</p> <p>K</p> <p>keep 6:11; 46:3</p> <p>KEITH 1:11; 3:1,7,10; 76:77; 78:4</p> <p>kids 13:19; 32:13; 34:11; 36:2; 47:2; 69:23; 74:16</p> <p>kind 37:20; 49:1; 51:7; 59:10</p> <p>kinds 42:25; 48:22; 69:3; 75:11</p> <p>knowledge 15:7,8; 41:7; 73:8</p> <p>known 55:7</p> <p>L</p> <p>L.P.A 2:6,15</p> <p>Lakeside 2:3,2</p> <p>language 7:25; 9:7,14; 62:6,11,15,21,23; 63:1; 68:11; 69:9,14,15,19,20,22,25; 75:5</p> <p>Lanzieri 18:18,23</p> <p>large 68:7</p> <p>larger 36:4</p> <p>last 10:1; 31:20; 63:10</p> <p>lasted 34:2</p> <p>later 16:16; 26:6; 59:23; 30:7; 64:11; 66:18; 77:12</p> <p>lawful 3:1</p> <p>lawyers 67:8</p> <p>earned 4:20</p> <p>least 25:10; 27:17; 29:8; 15:8; 62:12,22; 71:6</p> <p>egal 8:19</p> <p>egally 12:20</p> <p>esion 16:6,7,9; 17:25; 18:4; 30:10; 33:5,5; 38:14</p> <p>ess 24:19,23; 48:19,20,21; 3:15,16</p> <p>.et's 9:21; 15:22; 26:3; 4:21; 63:25; 65:18</p> <p>etter 6:17,20; 7:13,16,23; 1:2; 9:10,13,20; 10:1; 51:24</p> <p>etters 6:20</p> <p>avel 37:1; 38:25; 51:22; 6:7; 69:25</p> <p>avels 23:22</p> <p>evin 2:2,3; 9:21; 15:9; 9:21; 31:22; 75:24; 78:0</p> <p>licensed 5:8,11</p> <p>life 16:16; 60:7; 66:18; 73:15; 74:21</p> <p>ikely 19:15; 31:7; 33:17; 35:5; 36:24; 68:7; 71:18,20; 72:13</p> <p>imited 22:23; 49:7</p> <p>ine 46:4</p> <p>inear 66:4</p> <p>inguistic 69:8,17</p> | <p>list 67:13; 69:5</p> <p>listed 4:3; 5:4</p> <p>literature 17:6,9,11,13; 22:18; 30:22; 32:15; 33:24; 34:14,15,17; 40:6,8,9,16,20; 41:7,10; 44:6; 69:12; 73:9,174:5</p> <p>little 7:11</p> <p>logarithmic 59:10,18</p> <p>logarithms 59:19</p> <p>long 4:7; 31:6; 34:2; 53:18</p> <p>long-term 17:4; 52:1; 66:11,22; 68:12</p> <p>look 7:5; 23:12; 24:20; 28:23; 31:5; 32:15,20; 34:7; 58:14; 70:23</p> <p>looked 71:2</p> <p>looking 14:11; 60:2; 72:21</p> <p>looks 30:22; 33:25</p> <p>loose 60:20</p> <p>lot 17:16,17; 31:4; 42:23; 49:3; 54:11; 60:21</p> <p>lots 47:3,4</p> <p>low 58:25; 63:11; 64:18,19,23; 65:5,20</p> <p>lower 62:11</p> <p>M</p> <p>M-A-X 42:15</p> <p>M.D 2:19</p> <p>M.D. 1:7; 2:0</p> <p>maintains 47:24</p> <p>maored 4:9</p> <p>majority 13:17; 14:1</p> <p>make 7:11; 16:2,9,21; 20:8,16; 21:3; 33:16; 37:14; 38:12; 50:3; 52:23; 55:8; 63:7; 64:3; 70:25</p> <p>makes 17:6</p> <p>making 49:24; 51:25; 52:5; 70:14; 72:16</p> <p>manifest 61:7</p> <p>manifestations 29:7; 30:2; 38:18; 69:15</p> <p>March 6:4; 7:13</p> <p>nass 30:10; 31:6; 33:4,5</p> <p>Massachusetts 5:11</p> <p>natch 55:16</p> <p>nath 36:11; 70:5,6,8,10,11; 71:11,15; 72:22,25</p> <p>natter 10:4,9,11,16; 12:5; 16:12,13,17; 18:19; 33:6; 34:1; 48:13; 59:1,5</p> <p>natters 13:9</p> <p>atula 6:20; 7:25; 9:3,5; 0:25; 58:8</p> <p>atula's 9:1</p> <p>flax 42:14</p> <p>may 9:17; 16:6; 20:24; 12:24; 25:15; 36:8; 42:20; 2:20,20; 55:3; 61:7; 66:9; 7:20; 74:21</p> <p>maybe 40:18; 48:20; 50:18; 57:21; 74:10</p> <p>Mazzoia 1:13; 77:77</p> <p>MDI 55:21</p> <p>mean 6:11; 12:3,6; 14:20; 15:19,20; 19:7; 28:9,17,24; 34:24; 36:2; 38:12,18; 39:21; 40:4; 43:14,25; 47:10; 49:21; 56:17; 59:12,14; 60:8,21; 32:19; 63:16,17; 72:21</p> <p>neaning 57:10; 69:21</p> <p>neans 77:12</p> <p>neant 35:20; 48:1; 55:20,22</p> <p>measure 33:13; 37:19; 45:25; 46:5; 55:14,21,22; 58:21</p> | <p>measurement 56:2</p> <p>measures 50:10; 55:12; 56:10</p> <p>median 63:25</p> <p>medical 3:13,16; 6:15; 7:3; 10:6; 12:4,7,12,13,9; 19:20; 25:12; 31:12; 32:25; 47:11; 49:19; 51:7; 53:1</p> <p>medication 12:23</p> <p>medications 12:21</p> <p>medicolegal 13:9</p> <p>member 5:21</p> <p>memory 30:14; 50:15</p> <p>men 55:8</p> <p>meningitis 32:13</p> <p>mental 46:1,6; 55:11</p> <p>mention 32:24; 55:2</p> <p>mentioned 25:13; 36:24; 51:24; 58:8; 64:12</p> <p>Metro 8:8,14; 35:12; 50:20</p> <p>MetroHealth 29:19</p> <p>Metz 2:76</p> <p>microcephaly 21:13,16,18,20,24,25; 22:4,6,8,12; 23:17,19124:18; 25:5,13,15</p> <p>midline 32:24,25; 33:2,3,11,13,19,21,25; 34:2,11,20</p> <p>mind 60:6</p> <p>minimum 66:5,7</p> <p>Minor 1:0</p> <p>minored 4:10</p> <p>minus 57:7</p> <p>minute 7:5; 8:21,25; 64:16; 57:22</p> <p>minutes 16:13</p> <p>mischaracterize 68:23</p> <p>mistakes 3:25</p> <p>misunderstood 66:24</p> <p>nixed 44:15; 66:14</p> <p>noat 53:22</p> <p>noment 32:16</p> <p>noney 41:17</p> <p>nonths 46:11; 50:17,19; 51:17,20; 52:5</p> <p>norning 3:18,21</p> <p>Mostly 74:6</p> <p>notor 46:1,6; 53:23</p> <p>noved 5:12</p> <p>N</p> <p>N-A-R-A-S-E-A 41:22</p> <p>N.W 2:3</p> <p>tame 3:9; 8:9,13; 10:22; 1:19; 12:25; 13:4; 18:20,24; 15:13,20; 67:11</p> <p>ames 11:8; 67:8,12,15,16</p> <p>ature 13:18; 15:19,21; 6:5; 17:23; 26:12,17,25; 7:8; 28:13; 37:21; 38:9; 5:3,3</p> <p>ecessariiy 10:24; 24:15; 6:11; 36:21; 56:19; 62:20; 1:3; 74:15</p> <p>eed 18:20; 24:17; 29:3; 0:16; 53:22; 73:20; 75:21</p> <p>egative 32:12</p> <p>eurollogical 18:6; 32:5,11; 9:19; 72:20; 74:3,18; 75:9</p> <p>eurologist 11:18; 33:17,18</p> <p>eurolgists 11:21; 19:8</p> <p>eurology 11:24</p> <p>neuropsychological 38:25; 52:7</p> <p>Neuropsychologist 3:15; 22:22; 23:1; 31:3; 54:3</p> <p>neuropsychologists 4:23;</p> |
|---|---|---|---|

23:4; 47:15; 48:12; 56:22
neuropsychology
 4:15,18,20,22,25; 5:1,3;
 11:23; 22:19,23; 47:13,19
neuroradiologist 18:18;
 19:10
neuroradiologists 19:6
neuroradiology 18:25; 19:9
neurosurgeon 26:25; 33:18
neurosurgeries 25:20; 26:2
neurosurgery 26:10
neurosurgical 40:20
 new 4:23
next 15:10
NIH 41:21
nomenclature 58:23
norm 24:4; 25:8; 56:16
normal 23:21;
 24:6,7,8,10,24; 25:7; 52:17;
 53:20; 56:7,19; 59:13,20;
 73:23
normally 19:5
norms 56:12
Notary 1:14; 77:77
note 54:23
notes 38:20; 45:5
nothing 4:2; 59:19; 77:11
notice 1:17; 25:10; 77:15
noticed 34:18
notion 38:13; 39:15
number 13:13; 19:11; 36:8;
 43:3; 48:19; 51:8; 59:23;
 60:13; 65:22; 78:0
numbers 23:25; 55:17;
 63:21

O

oaths 77:0
Objection 25:1; 27:7; 29:17;
 34:6,22; 37:5; 43:6,13; 52:8;
 65:2; 72:3; 78:0
observation 61:8
observe 61:11,13
observed 40:11
obtain 4:23
obtaining 63:13; 65:7
obtains 12:14
obvious 69:16
obviously 59:3; 61:4
occasionally 4:16
occurred 26:13; 31:6,7
occurrence 30:2
occurring 31:9
October 8:1; 9:10
off 9:21,24; 28:3,10,24;
 33:14; 45:14; 58:6,10; 66:10;
 67:17; 70:20,20; 75:21
offhand 32:8
office 77:0
often 13:20; 23:6; 24:3;
 27:4; 46:15; 55:18; 56:20;
 63:12,17,19; 65:6; 70:9
Oh 5:18; 45:7; 49:17; 57:25
OHIO 1:2,14,16,23; 2:4,7,2;
 5:8,14,16,19,21; 6:1; 10:15;
 47:11; 67:8; 77:5,8,77,23
Okay 3:22; 4:13; 7:1; 8:25;
 10:14; 11:3; 13:24; 17:23;
 18:4; 19:18,24; 20:1,8;
 21:10,18; 22:8; 24:7; 27:14;
 29:11; 30:6; 32:16; 35:10,14;
 36:1,11; 37:16; 42:7; 43:3;
 47:21; 50:6; 60:2,5; 61:7;
 63:16; 66:24
old 50:4,8,13; 51:17,20;
 52:23; 53:10; 66:19; 75:5
older 48:3,7,11; 49:4; 68:19;
 69:17

one 6:21; 8:19; 15:12; 19:25;
 23:6,7,10,15; 24:11;
 25:14,23; 27:10,17; 30:1;
 36:3; 38:7,16; 45:10; 46:16;
 50:7; 51:17; 52:3,3,10,13;
 55:23; 56:7,9,13; 61:8,16;
 66:10,19; 72:21,25; 75:15
one's 4:3
ones 11:23; 19:4
ongoing 32:3; 41:4
open 26:19
operative 26:15,22; 27:3
opinion 10:3; 15:23; 17:11;
 18:15,16,17; 26:25; 29:6;
 30:1,3; 32:19; 59:21; 71:14
opinions 10:9,16,21; 11:22;
 12:5,7; 16:3,8,10; 18:1;
 20:5,9; 23:11; 29:15; 32:18;
 45:16,19,20,22; 51:11,13;
 60:3; 61:19
opportunity 32:17
opposed 16:15; 22:9; 26:3;
 61:8; 64:25; 65:8
opposite 13:7
optimal 73:16
Orels 55:7
originally 6:18
originated 8:19; 16:25
orthopedic 39:25; 40:1,2,3
others 42:7; 46:22; 52:17
outcome 16:7; 17:4; 24:16;
 30:24; 51:14; 66:8
outcomes 16:14; 20:19,22;
 32:12; 38:24; 44:6,16; 60:3;
 61:1; 66:12,22; 68:9,12,22;
 70:16,25; 74:3
outside 27:5; 34:5; 35:18
overall 36:20; 38:4; 50:10;
 62:8
OWEN 1:11; 3:1,7; 76:77;
 78:4
own 38:6; 53:4
Ozzie 73:16

P

page 63:8; 64:17; 78:78
Paisley 2:10
palsy 29:7,11,23
paragraph 63:9,10
parallel 41:7
paralysis 19:25
parameters 45:2
ardon 5:18
arents 74:2
art 5:16; 13:17; 15:25;
 28:17; 74:24
artial 19:25
articular 26:20,21; 39:22;
 58:9; 61:1; 66:8; 71:2,4
articularly 68:14; 75:17
arties 14:22; 77:16
arts 51:19
ast 62:13
athological 31:9,10
athologies 34:16
athologist 14:8,14
athology 16:23,24; 34:i;
 15:3; 39:2; 44:9
atient 15:18; 29:19,20;
 16:15; 50:13; 53:25; 54:8,16;
 18:3
atients 8:22,23; 21:24,25;
 2:4,5; 34:19; 47:17; 48:2,14;
 3:14; 66:12,22; 71:14;
 5:7,10,10
aul 2:19
ay 31:4; 51:5
ediatric 11:18,21

pediatrics 5:22; 6:1
pending 41:16
people 24:3; 40:13,18,18;
 42:22; 48:5; 51:8; 56:20;
 60:22; 61:12; 63:19;
 64:19,25; 66:9
per 8:2; 31:5; 33:25; 53:17
percent 58:5,6; 63:21,22
percentage 14:2; 59:17
percentile 25:4,7; 56:23,25
performance 45:1; 56:23;
 70:22
perhaps 14:13; 22:5; 38:13;
 54:25
perinatal 17:7,16,19,20;
 32:10,14,22; 37:23; 41:10;
 43:4; 44:7,19,22,25; 49:1;
 66:12,17,23; 68:6,8;
 69:7,13,23; 70:16,24; 71:16;
 72:1; 74:16
perinatally 67:1
period 17:22
permutations 36:12
parson 33:16
personal 11:6
personally 10:19,23; 11:13
perspective 28:19,20
pertains 32:9
pertinent 14:15,21
Ph.D 3:7; 4:9; 76:78
Ph.D. 1:11; 3:1; 77:0
Ph.D.'s 4:24
phone 65:16
phrased 72:12
PHS 2:0
physical 20:21;
 5:8,11,13,17
physician 33:18
physicians 19:7; 38:21
physicists 22:24
PI 42:1
pick 15:11
picture 36:20
pieces 62:16
pile 10:1
Place 2:54; 77:0
places 26:11
plaintiff 13:15,17; 14:1
plaintiff's 67:5,9
Plaintiffs 1:1; 2:3
Plays 73:14; 74:2
PLEAS 1:1
please 3:9
plus 57:6
point 15:3; 42:10; 44:5;
 57:7; 59:5,6,25; 62:9; 66:17
points 56:14,16; 57:9;
 58:12,15
polling 57:8,9,12
population 59:15,17; 67:4
position 8:11
possible 27:2; 49:18
Possibly 15:16
postdoctoral 12:17
posterior 18:5
postgraduate 47:15
postnatal 16:15,21;
 17:2,8,21
potential 60:24
potentially 44:11
practice 4:13,21; 13:18;
 19:4; 38:6; 47:5,6; 75:9
practiced 8:16,18
practicing 13:11
predict 22:20
predicting 23:2
prediction 64:3,4
predictive 20:20; 49:8;
 58:21

predicts 64:5
predominantly 69:5
prefer 14:22; 53:13; 60:25
prematurity 74:7
prenatal 16:21; 17:1,7,21
prenatally 16:15
preparation 54:6
preparing 54:22
prescribe 12:21,23
presence 24:18; 32:5; 77:14
present 36:14,18; 69:18
presented 4:6; 23:16; 29:19
presents 28:14
pressure 30:10
pretty 33:22; 39:4
primary 47:24
printed 3:21
prior 14:23
probable 72:8
probably 25:9; 37:1; 38:13;
 48:19,21; 51:20; 70:3;
 71:12,22
problem 22:9; 47:9; 63:3
problems 22:6,14; 23:17;
 26:6; 27:21,23,24; 28:16;
 29:12; 30:17; 31:16; 32:8;
 33:20; 34:19; 35:24; 36:16;
 43:5,10,12,18; 44:25; 48:22;
 55:25; 56:1; 59:22,23;
 60:7,10,15,16,19,23,24;
 61:4,5,15,18,20; 62:2,18;
 63:2; 68:14,15;
 69:2,3,6,8,19,23; 72:7;
 75:11,13,19
Procedure 3:4
process 28:25; 31:9,10
processes 35:4
product 6:12
Professional 1:13
professionals 51:1
prognoses 16:20; 19:12
prognosis 16:7; 17:4; 20:10;
 22:21; 23:13; 36:9; 49:24;
 50:1,3; 51:16; 52:1,5,6,7,24;
 68:2,25; 70:13,15; 71:14;
 72:6
prognostic 52:16,21; 53:8
program 13:20,21; 47:13,19;
 48:16
progress 52:7
prominent 42:12
pronunciation 20:23
provide 50:9
provided 3:3; 6:16; 8:5; 53:8
provides 47:24
psychiatric 47:25
psychiatrist 12:11,12,20
psychiatry 12:14
psychological 57:15; 75:8
psychologist 3:14; 5:8; 8:8;
 12:10,14; 54:22
psychologists 12:22
psychology 4:10,11,14,24;
 12:15; 24:4
psychometrics 56:19
Public 1:14; 2:11; 77:77
publish 42:22,24,25
published 41:2,12
publishing 41:4
Purdue 67:20
Purports 55:14
purpose 3:2; 49:11,21
Pursuant 1:17; 77:0
Put 25:17; 38:15; 39:20;
 15:2; 70:3; 74:9; 75:14

Q

question 12:2,8; 24:16,20;

| | | | |
|--|---|---|---|
| <p>28:18; 29:25; 31:10,24; 39:14; 52:22; 53:3; 62:5,19; 66:3,21; 71:2; 72:10; 74:10 questioning 33:23 questions 45:21; 61:23; 67:24; 71:21; 72:10; 75:25; 76:2 quicker 36:11 quickly 11:3; 30:19 quite 44:9 quote-unquote 73:23</p> <p>R</p> <p>radiologist's 18:15 radiology 19:1 raised 73:5 range 46:12; 47:6; 48:10; 49:8; 50:16; 51:10; 52:17; 53:20; 57:19,20; 58:12; 63:12,20; 64:18,19; 65:1,6; 73:24 rate 27:6; 53:18,24; 64:24 rather 48:5 rating 38:16 raw 14:7,13 read 7:10; 18:9,10,11; 21:13; 22:17; 65:11; 70:1; 76:3 reading 7:12; 18:12; 21:15 real 19:9 really 26:9,11; 37:24; 38:9; 39:14; 57:16,17; 71:24 reason 27:11,14 reasonably 3:22; 16:11; 39:3 reasons 26:7; 31:5; 51:1,23; 52:13 recall 29:9; 31:14; 50:14; 59:24; 60:2 received 14:6 recess 68:1 recite 67:16 recognition 18:24 recognize 8:7,9,11,12 record 7:10; 9:8,21,24; 45:14; 50:20; 75:21; 77:13 records 6:15,18,22; 7:3; 8:4,4; 9:14; 10:6; 14:5,11,15; 19:20,21; 25:12,25; 26:15,23; 27:3,9; 28:3,5,7; 29:9; 31:12; 32:25; 49:19; 53:1; 54:7 reduced 77:0 reference 8:3; 32:22; 38:12,23; 39:23; 70:17 referenced 64:15 referral 13:25; 48:13 referred 64:9 referring 60:1; 72:23 reflect 35:4 regard 20:10; 21:14; 39:25; 52:24; 68:2 region 18:5 Registered 1:13 regularly 61:13 rehab 13:20 related 24:15; 60:9; 71:3; 72:19 relating 71:2 relationship 20:17; 24:13; 66:4 relative 17:17; 34:15; 77:77 relatively 17:22 relevant 4:3; 16:8; 17:25; 49:23; 60:4; 74:6 reliable 50:9 reluctant 51:25 rely 18:14,15; 26:24; 36:19; 51:25 remain 52:12 remember 5:4,6; 8:9;</p> | <p>13:4,6,8; 18:20; 21:15; 25:11,14; 28:10; 33:10; 42:1,2,19; 46:9,10; 60:3; 61:16; 67:13,15 remembering 28:4 remind 64:10 reminded 64:13,14 Reminger 2:15,15; 13:2,2 render 10:3; 20:9; 61:19 rendered 11:23,24; 45:20; 59:21 rendering 10:9,16,20; 12:4; 16:3; 20:5; 29:14; 30:3 renders 30:1 report 6:4,7,14; 7:17,20,24; 8:2,10; 9:1,10; 18:10; 45:6,11,18,21,23; 54:6; 55:1,10; 63:4,8 Reporter 1:13 REPORTERS 1:22; 15:10,11 reporting 55:1; 77:17 reports 25:12; 28:6,8; 29:6 reputation 101:23; 11:6,13,16,18,21 require 66:6 required 66:5 requires 65:25 research 24:17,21; 30:22; 40:15; 41:14,19; 42:3,6,8; 66:24; 69:12; 70:19,23; 73:5,19,22,23 researchers 42:11 residency 12:13 residual 18:8 respond 12:1 response 45:20 restricted 4:13,15,18 result 30:9; 33:4,5; 67:2 results 43:1; 52:20; 55:3; 62:3,4,21 retained 67:7 retrieve 70:20 returned 15:8 review 6:14; 21:22; 54:6 reviewed 7:2; 10:8 reviewing 14:12; 15:2,14 right 4:11; 5:7,15; 6:24; 7:1; 18:5; 20:14; 25:14; 26:4; 32:19,22; 36:9; 51:6; 52:22; 62:25; 64:2; 65:3; 68:25; 70:7; 71:24; 75:6 rings 13:5 risk 22:14; 23:7,8; 24:18,23; 25:18; 26:5,8,11,20; 27:11,18,20,23; 28:15,22; 29:11; 30:16; 31:1,15; 32:7; 33:19; 35:8,23; 36:14,17,18; 43:5,8,9,11,12,18,20; 44:17,19,20,22,25; 60:14; 68:13,16; 69:1,8; 71:19,20; 72:3,6,12,25; 73:2,13; 74:11,16 risks 35:5; 36:15; 44:9 role 73:14; 74:2 Rothner 6:17,21; 7:20; 9:11; 10:22; 11:4,12; 14:21; 16:19; 18:7; 28:23; 29:5,16,22,25; 59:21 Rothner's 7:17; 8:2; 14:24; 15:13; 19:20; 25:12 roughly 54:1; 57:1 rule 24:12; 50:1; 77:18 Rules 3:3 run 47:13</p> <p>S</p> <p>S-T-I-L-E-S 42:14 sake 12:9</p> | <p>Sandra 1:12; 77:77 saying 9:13; 29:20; 71:13 says 50:20 scale 37:20; 38:6,11; 44:3; 45:24,25; 46:5,11; 57:2; 59:9,10,10 scales 37:22 scan 18:8 scans 18:9,11; 19:3,8 Schauer 8:4,7; 55:6 Schauer's 15:14 scheme 33:15; 37:25; 38:16; 39:20 schemes 38:1 school 12:13; 47:11; 63:13,20,24; 64:6; 65:7,8,14; 68:12 science 72:2 scientific 17:6 score 57:15,17 scores 63:11; 64:22 Scott 2:6; 6:16,25; 7:13,16,23; 9:13,20; 10:2,12; 12:25; 15:6; 25:1; 27:7; 29:17,22; 31:17; 34:6,22; 37:5; 43:6,13; 51:24; 52:6,8; 61:22,24; 65:2; 71:18; 76:3; 78:78,78,78,78 Scott's 45:20 se 31:5; 33:25 seal 77:0 second 25:7; 63:8,9,10; 66:16 seeing 8:9; 14:13,19; 29:9 seem 36:3; 69:6 seen 11:19; 13:19,22; 14:10; 18:17,22; 19:22; 21:25; 50:24,25; 51:7; 75:7 sees 47:17; 48:16 seizure 31:12,15; 32:2 seizures 31:20; 32:1,3,5,11,14 sense 8:18; 16:5,16; 18:12; 40:21; 49:13; 52:14,19; 55:21; 68:4,17 sent 48:4,11 sentence 63:10; 64:7 separate 6:17; 70:9; 71:21 separating 71:7 September 42:2,5 sequelae 18:7; 20:1,3,12,14 services 14:3 set 7:4; 16:19; 17:3; 42:21; 34:21; 70:6; 77:19 seven 58:12,15 Seventh 2:0 several 10:14; 16:18 severe 33:9; 34:2; 36:25; 38:17,18; 39:15; 43:11,14,19,21,24; 44:16 severely 52:15 severity 20:10,12; 33:11; 36:20; 37:11,16; 38:5,22; 43:19; 44:1,3; 45:3 shallowest 22:18 shift 32:24,25; 33:2,3,7,9,12,13,19,21,25; 34:2,11,20 show 18:21; 50:20; 72:14 showing 70:21 shown 15:5; 26:15; 32:13 shy 29:3 side 13:7; 19:25; 33:4; 37:6,6,9 significance 52:21 significant 4:2; 39:19; 42:3; 47:17; 62:23; 63:1; 72:9,14,17; 73:14 significantly 62:10; 65:12</p> | <p>similar 55:22 simple 31:25 simply 37:2; 55:20 single 23:11 sit 45:11; 39:17; 41:14; 42:10 six 45:8 size 23:21; 38:13 skills 46:1,6; 50:11; 53:23; 62:24; 63:1; 66:2; 68:10,11; 69:9,9,17,25; 70:5,6,6,9,10,11; 71:12; 72:22,25 sleep 70:3 slightly 49:4 slippery 60:20 small 21:19; 72:16 somebody 64:23 someone 65:25 something 4:20; 20:19; 21:10,20,21; 24:14; 25:16; 26:14,21; 34:7; 46:21; 55:22; 57:18; 74:24 sometimes 20:1; 39:1; 52:14; 56:5; 66:9; 74:19 somewhat 17:3; 38:17; 44:8,10; 68:8 somewhere 13:14; 35:17 soon 17:22 sorry 13:22; 28:23; 43:16; 45:7; 57:4; 65:15 sort 17:17; 18:6; 34:25; 38:5; 39:10; 69:10 sorts 55:9; 68:12; 75:19 sound 72:1 source 15:17,20 sources 48:13 space 30:11 spatial 68:10 speak 24:3,4; 38:17; 55:11; 56:21; 57:10; 70:4 speaking 49:12 specialize 4:25 specialized 19:1 specific 18:20; 34:14; 38:11; 50:11; 55:19; 60:25; 68:9; 74:8 specifically 4:19; 5:6; 8:23; 30:22; 41:10; 59:25; 70:17 speech 7:25; 9:7,14; 14:8,13; 62:6,11,14 spend 60:8 spinal 71:3 Square 2:11 SS 77:5 St 2:16 staff 47:14 standard 23:23,25; 24:2,5,6,7,23,24; 25:6; 33:14; 38:20,23,23; 56:7,9,13,14; 57:5,8,0 standardized 45:25; 46:5 standards 46:17 stands 41:23 start 15:22 State 1:14; 5:14,16,20,21; 3:1; 10:15; 47:11; 57:19; 77:5,8,0 stated 68:24 statement 63:7 statements 70:14,15 states 12:22 status 49:13; 62:14 stenotypy 77:12 Stiles 42:13 stipulations 1:18; 77:15 STONE 1:3; 15:18; 19:13; 20:6; 21:14; 27:15; 30:12; 31:13; 35:11; 40:11; 49:2;</p> |
|--|---|---|---|

| | | | |
|---|--|---|---|
| <p>54:17; 61:14; 62:1; 71:15; 72:5; 74:11; 75:1 stool 46:24 stop 29:3,4; 75:21 straight 59:9,10 stress 74:19,21; 75:14 strike 24:9; 37:7 stroke 16:14; 17:2,8,17,19,20; 18:5; 20:4; 27:11,18; 28:12,13,17; 32:10,23; 37:24; 38:1; 41:11; 42:20; 43:4; 44:7,20,22,25; 45:4; 49:1; 68:8; 69:7,13,24; 70:16,24; 72:1; 74:6,16 strokes 17:5; 68:6 strong 17:6 struggling 65:16 student 47:17 studies 8:22; 17:15,16,19; 36:3; 40:24; 41:2,65:11; 66:11; 68:6; 70:21; 71:11,25; 74:24 study 66:22 stuff 15:10; 28:9 subcontract 41:25 subscribed 77:0 subsequent 6:19 subtle 68:9,11; 69:19 suffer 43:11,17; 72:9 suffered 20:6; 30:12; 34:20 suggest 26:9; 68:6; 73:19; 74:1; 75:16 suggesting 31:19,22 suggests 10:3; 17:10; 62:21; 69:12 SUITE 1:2; 2:0 summary 10:3 suppose 14:20 supposed 55:17 surgeries 26:3 surgery 26:3,5,7,12,17,18,20; 27:2,12,15 sustain 27:1; 43:4 sustained 15:24; 67:1 sworn 3:4; 77:0 system 39:3,4</p> <p>T</p> <p>taken 1:11; 8:22; 14:25; 30:25; 31:1; 36:17; 77:14 takes 53:18 taking 32:16 talk 23:6; 57:9; 60:25; 64:18; 70:8; 71:11 talked 60:13,16 talking 19:3; 20:21; 29:18; 37:14; 61:1; 65:18; 66:8; 68:11; 72:22,23; 73:3 TBI 42:20 Telephone 2:0 tell 8:12; 12:9; 22:11,11; 27:2; 28:5; 41:22; 48:18; 58:7,19; 60:5; 66:9 telling 29:4 teils 10:4 ten 56:23,25 tend 26:24; 42:22,23; 49:4; 52:12; 68:8; 69:14,16,18 tendency 73:17 tends 48:8; 69:24; 75:18 tenured 5:21 term 17:17; 39:24; 60:20; 70:7 Terminal 2:0 terms 13:25; 16:2,22; 17:4; 21:11; 22:12; 23:16,25:5; 33:15; 38:25; 44:16; 51:22;</p> | <p>54:24; 57:7; 59:17; 60:25; 65:13; 68:20; 71:8,14; 72:6 tertiary 47:22,25 test 46:12; 49:10; 50:13; 51:18; 53:17,19; 54:5,9,12,14,20; 55:19; 56:12; 61:10; 64:20 testified 67:14 testify 77:0 testimony 15:15; 29:5; 71:6; 77:13 testing 49:8; 55:3; 56:1; El:8; 62:21; 75:6 tests 46:15; 50:9; 54:17; 55:25; 56:4,11,12,15,17; 57:7,15; 58:23; 64:2,21; 68:19 that's 3:11; 4:2; 5:22; 8:11; 12:21; 14:9; 15:25; 22:23; 24:16; 27:4; 29:5; 32:12; 35:20; 38:2; 45:8; 46:21; 47:1,21; 55:7; 72:22; 74:5,14,24 themselves 18:12; 61:7 therapist's 9:7 there's 6:11,20; 17:13; 19:19; 21:10,13; 31:8; 34:14; 37:24; 59:3 Thereupon 9:23; 45:13; 68:1 They're 6:24; 7:1; 9:19; 23:11; 43:8; 48:3,4; 63:3 thing 10:1; 14:9; 22:13; 23:10,15; 37:17 things 4:8; 16:14; 24:8,9; 27:10; 34:16; 45:4; 52:10; 55:9; 60:21; 67:12; 73:17; 75:15 think 9:17; 14:8,17; 15:24; 20:15; 22:23; 24:20; 33:21; 36:19; 38:3; 39:12,15; 42:2; 43:8; 44:5; 53:3; 54:9; 56:18; 57:25; 58:8,11,14; 60:16,17,19; 62:7,19,20,20; 64:5; 66:3; 67:20; 68:15,16; 69:5; 72:10; 73:19; 74:1,5,15; 75:22 thinking 50:9 third 74:20 thought 53:11; 54:12 THREE 1:24; 47:8; 48:3,9,17; 49:6; 58:12 three-year 50:4,8 thus 45:17 time 16:18; 29:18,20,21,24; 30:2; 32:2; 42:5; 49:14; 53:24; 54:6,16; 56:3,5; 62:9,22; 69:15; 77:0 timing 31:18 today 4:13; 13:4; 14:18; 15:1,5; 25:11; 39:17; 41:14; 42:10; 45:22 told 11:8,42:1 tool 49:15,18; 52:3 tools 49:19; 50:6,7; 51:18 top 28:3,10; 33:14; 58:6,10; 67:17; 70:20 total 54:4 totally 54:12 towards 73:17,18 Tower 2:0 training 12:13,16,17 transcribed 77:12 trauma 13:20; 26:18; 27:1; 37:14; 39:6,8,9; 40:21,23 traumatic 13:19,23,24; 20:2,3; 37:22; 39:5,9,10; 40:8,12,14,16,19,24; 41:8; 43:17,22,24; 44:6,17; 66:12,17,20,23,25; 67:2;</p> | <p>71:1,8; 72:24; 74:4 treat 21:24; 48:4,5 treated 30:20; 51:3 treaters 48:4 treatment 12:18; 22:1,3 trial 14:14,23; 42:4 true 5:12; 12:21; 32:14; 37:1,3; 56:4; 77:13 truth 77:7,11 truthful 3:23 try 23:10; 25:11; 38:15,21; 43:16; 52:14; 55:8; 63:16 trying 13:4; 16:22; 20:16; 40:7; 41:25; 42:19; 46:9; 57:25 two 6:15,20; 8:19; 10:5; 17:10,12,14; 24:22; 25:3,6,8; 31:20; 44:10; 46:14; 47:14,15; 48:9; 50:17; 51:17,19,20; 52:5; 58:12; 66:14; 71:21; 72:10; 75:21 two-year 52:23; 53:9 two-year-old 50:12,16; 53:21 two-year-olds 46:16 type 63:3 types 12:19; 68:14 typewriting 77:0 typical 65:19 typically 33:18; 38:19,23; 46:8; 47:5,6; 48:2,6,12,17</p> <p>U</p> <p>Uh-huh 7:6 uncal 30:6,8,13,16,23; 31:4; 33:23; 34:11,20 uncooperative 54:15,21 uncus 30:9 undated 8:2 underlying 8:3; 27:11,14; 28:1; 30:21; 34:1; 63:2 understand 4:4; 12:1; 16:22; 17:23; 18:1; 19:4; 27:15; 32:18; 40:7; 50:25; 51:3,10; 63:16; 71:5,6 understanding 15:17; 16:24; 18:25; 49:16; 70:13 understood 70:2 University 5:14,17,20 unlike 69:12 unlikely 42:3 upon 1:12; 39:3,4 use 20:23; 38:6; 39:21,24; 46:23; 47:3; 50:6,7; 51:18,21; 52:3,18,22; 53:3; 56:20,22; 58:5,5; 60:25 used 37:22; 43:8; 49:18,21; 50:12; 52:14; 70:7 useful 49:25 useless 54:12 uses 56:18 using 69:19 usually 12:16; 26:7; 30:10; 33:5; 36:19; 49:12; 50:8; 53:22 utility 49:9</p> <p>V</p> <p>vague 13:5; 30:14; 31:14 valid 55:3 valuable 54:9,11 value 52:16; 53:11,13,14 variation 73:23 variations 74:2 varieties 24:3 variety 12:18; 23:12; 46:15; 50:24,25; 51:1</p> | <p>vault 30:11 venture 51:13; 71:22,23 venturing 51:11 Via 2:0 virtually 22:2 visual 68:10 vitae 3:19 vociferous 72:3 voice 46:3; 57:21 volumes 6:15</p> <p>W</p> <p>Wahl 2:2 Wait 66:16 waiting 14:18 wall 35:19 want 4:7; 19:18; 28:4,23; 29:1; 31:17; 44:15; 45:11; 47:21; 58:3,4; 60:8; 63:7,16; 64:3,7,10,13,16,18; 68:23; 71:22,24 wasn't 40:22 ways 54:11 Wednesday 1:17 went 35:11 Weston 2:10 whatever 54:15; 64:20,22,22 whatsoever 64:5 WHEREOF 77:19 wherever 64:19 whether 16:20; 18:21; 20:5,20; 23:24; 24:19,22; 26:17; 30:12; 32:9,10; 52:15; 53:7; 61:14,16,20; 62:1,7; 66:3; 71:15; 73:8 whole 47:10; 51:10; 77:0 why 22:13; 49:10; 59:21 will 8:21,25; 11:24; 12:4; 19:7,8; 32:6; 38:23; 39:1; 41:19; 47:7; 60:6; 61:20,21; 66:9; 68:17; 71:15,18; 72:9; 76:3 willing 21:3; 52:2 within 1:14; 16:11,12,17; 19:1,5; 21:5,20,23; 56:7; 57:20; 64:25; 77:8 without 36:13; 60:2 witness 77:77,19 witnesses 47:9 woman 46:3; 65:16 word 56:18; 57:6; 60:19 words 41:17 work 6:12; 22:2,2; 42:17; 47:16; 53:4; 67:5,6 worked 13:2; 67:20 workplace 65:13 worse 24:19; 65:12 wouldn't 18:14; 20:8; 33:16; 37:9; 39:12; 44:15; 48:18; 50:8; 51:13; 53:9; 54:8,13; 72:11 write 21:22; 38:20; 43:21,21,24 writing 6:14; 77:0 written 17:12 wrong 20:25; 42:20 wrote 6:4,7; 71:7</p> <p>Y</p> <p>year 5:4; 48:14,16,17 years 13:11,12; 31:21; 46:19; 50:17; 51:17,20; 52:5 YEATES 1:11; 3:1,7,10,11,11; 76:77; 78:4 yet 9:13; 14:6; 17:6,11; 21:8; 41:13 you're 11:5; 31:18; 41:4;</p> |
|---|--|---|---|

47:12; 51:1 1; 52:8; 64:10;
66:19
you've 7:7; 41:2
young 4:16; 22:21; 46:7
younger 55:25; 69:17
yourself 46:18