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1. *HENDERSON v. AMTRAK, 13 Civ. 6792 (GHW), 2015 Trial Trans. LEXIS 231, EXPERT TRIAL TRANSCRIPT OF MEHRDAD GOLZAD*

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# *EXPERT TRIAL TRANSCRIPT OF MEHRDAD GOLZAD; 2015 Trial Trans. LEXIS 231*

United States District Court for the Southern District of New York

13 Civ. 6792 (GHW)

February 24, 2015

**Reporter**
2015 Trial Trans. LEXIS 231 *

NATHANIEL HENDERSON, Plaintiff, v. NATIONAL RAILROAD PASSENGER CORP., Defendant.

**Expert Name:** MICHAEL LAWRENCE LIPTON, M.D., Ph.D., F.A.C.R.MEHRDAD GOLZAD, M.D.JONATHAN DAVID LEWIN, M.D.

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## Counsel

**[*1]** FLYNN & WIETZKE PC, Attorneys for Plaintiff, BY: MARC WIETZKE.

LANDMAN CORSI BALLAINE & FORD PC, Attorneys for Defendant, BY: JAMES WOOLSEY III.

## Judges

Before HON. GREGORY H. WOODS, District Judge

## Proceedings

2

[1]MEHRDAD GOLZAD,

[2]called as a witness by the plaintiff,

[3]having been duly sworn, testified as follows:

[4]DEPUTY COURT CLERK: Please be seated. Please state

[5]your full name for the record, and spell your last name slowly.

[6]THE WITNESS: Mehrdad Golzad, G-O-L-Z-A-D.

[7]DEPUTY COURT CLERK: Can you spell your first name

[8]also.

[9]THE WITNESS: M-E-H-R-D-A-D.

[10]DIRECT EXAMINATION

[11]BY MR. WIETZKE:

[12]Q. Dr. Golzad, I would **[*2]** like to introduce you a little bit to

[13]the jury. If you could, please, give them the benefit of your

[14]background in terms of your education.

[15]A. I finished high school in Isfahan, in Iran. It's a third

[16]city in the country.

[17]Q. You are going to need to speak into the microphone.

[18]A. And then I went to Paris. I actually escaped the country

[19]at that time. I went to Paris in France, and I was accepted

[20]into medical school at the University of Paris, which was an

[21]eight year program of premedical and medical studies. I began

[22]that program in 1983 and completed that in December of 1991. I

[23]came to the United States in January of 1992, began my

[24]residency in internal medicine at the Graduate Hospital of

[25]University of Pennsylvania. I finished my first year of

[3]

[1]internship, and then I did a total of five years of

[2]neurological training at the New York Medical College, Mount

[3]Sinai Hospital and New Jersey Neuroscience Institute. So, I

[4]graduated in 1997, and since then I have been working as a

[5]neurologist.

[6]Q. Now, do you hold any hospital affiliations?

[7]A. Yes, I'm affiliated with Flushing Hospital in Queens. And

[8]I **[*3]** was the former chief of neurology of St. Vincent's Catholic

[9]Medical Centers of Brooklyn and Queens during tenures.

[10]Q. Have you ever held any teaching positions?

[11]A. At St. John's University, during the tenures of director of

[12]neurological services at Catholic Medical Centers, and I still

[13]have some minor teaching activities with their PA school.

[14]Q. Do you know what it means to be board certified in a

[15]specialty?

[16]A. The board certification, the bodies are private bodies, and

[17]they arrange for examinations. They have nothing to do with

[18]licensing bodies. Many physicians are not board certified and

[19]can practice. They describe their goal as providing the

[20]excellence and maintenance of level of medical expertise. So

[21]after completing my neurology residency, I took the examination

[22]of the American Board of Neurology and Psychiatry. Even though

[23]it says neurology and psychiatry, the examinations are

[24]different, so doctors are either certified in neurology or

[25]psychiatry, so I was certified in neurology.

[4]

[1]I also had additional training in an area called

[2]electrodiagnostic medicine, which is the usage of

[3]electrophysiological **[*4]** principles for neurological diagnosis, so

[4]I took a second board in electrodiagnostic medicine, and I

[5]became certified from the American Board of Electrodiagnostic

[6]Medicine. This is considered as a subspecialty board. And

[7]finally I got a certification from the American Board of

[8]Disability Analysts.

[9]Q. Have you been in private practice since essentially 1997?

[10]A. Yes.

[11]Q. What's the nature of your practice?

[12]A. The nature of my practice is a general neurology practice.

[13]Basically I have approximately 85 percent of regular general

[14]neurology practice. Most of my patients are referred to me by

[15]a primary care physician. And I have probably ten to 15

[16]percent of forensic neurological evaluations.

[17]Q. Can you just describe what is the difference between

[18]forensic and clinical?

[19]A. Forensic is medical legal evaluation that I do for both

[20]parties, both defendants and claimants. And usually I'm not

[21]the treating physician, but I do an evaluation and write a

[22]report.

[23]Q. Are you being compensated for your time away from your

[24]practice today?

[25]A. Yes, I am.

[5]

[1]Q. How much?

[2]A. $ 7,500.

[3]Q. Do you keep a **[*5]** chart with regard to each of your patients?

[4]A. Yes, I do.

[5]Q. And could you describe for me how do you keep that chart?

[6]A. In every patient encounter a report is prepared. The

[7]report is kept electronically in an electronic file.

[8]Q. And I see -- I shouldn't say I see -- everyone can see that

[9]you have a laptop there in front of you. Why did you bring

[10]that with you today?

[11]A. Well, I have a report of every encounter that we had with

[12]Mr. Henderson.

[13]Q. Doctor, while you're setting that up, I can ask you some

[14]additional questions that will allow you to --

[15]A. It came unplugged. I'm having a tough time with this

[16]today? They are supposed to make life easier.

[17]Q. Doctor, at some point -- well, actually, let me ask you a

[18]little bit about your practice first. Have you ever heard of

[19]the term TBI?

[20]A. TBI? It's an abbreviation which stands for traumatic brain

[21]injury. Yes, I have heard of it.

[22]Q. Is there more than one level of traumatic brain injury?

[23]A. Well, like any injury it could go from very mild to

[24]extremely severe, so…

[25]Q. What is a traumatic brain injury?

[6]

[1]A. My understanding is a brain injury **[*6]** secondary to physical

[2]force, physical impact against the brain tissue. So, traumatic

[3]injuries to the brain can occur in various circumstances, but

[4]the application of physical force against the brain tissue may

[5]result in damage to brain tissues in different degrees and loss

[6]of function.

[7]Q. In the course of your treatment with Mr. Henderson, have

[8]you reached any opinions to a reasonable degree of medical

[9]certainty as to whether or not the train strike of May 18, 2012

[10]caused in whole or in part any injuries to Mr. Henderson?

[11]MR. WOOLSEY: Objection. No foundation.

[12]THE COURT: Lay a foundation.

[13]MR. WIETZKE: Sure.

[14]Q. Did Mr. Henderson become a patient of -- well, I will come

[15]back. Did Mr. Henderson become a patient of yours at some

[16]point?

[17]A. Yes, he did.

[18]Q. Do you recall when for the first time?

[19]A. I believe in 2012. I'm so sorry, this is not functioning.

[20]THE COURT: Let me do this. I'm going to take a very

[21]short recess just to allow the members of the jury to stretch

[22]their legs while you are doing that, and we will see if we can

[23]work on our technological things. Let's take a **[*7]** short recess.

[24](Jury not present)

[25]THE COURT: Can I just ask, in line with our

[7]

[1]conversation last night about use of these records, what is it

[2]that we're going to be taking from this, the materials that are

[3]included in Dr. Golzad's laptop, assuming that it's a laptop

[4]and not a brick.

[5]MR. WIETZKE: The answer is it's nothing that I am

[6]intending to display to the jury at all; it's, therefore, his

[7]reference as he is going, no different than if I were to mark

[8]his chart for identification.

[9]THE COURT: It is to refresh his recollection as

[10]opposed to --

[11]MR. WIETZKE: Correct.

[12]THE COURT: And you will lay the correct foundation in

[13]order to ask him to refresh his recollection.

[14]MR. WIETZKE: Correct. We just didn't get there yet.

[15]THE COURT: OK, good. Thank you.

[16]MR. WIETZKE: Because I was trying to get into a

[17]discussion of how he maintains his chart and did you bring a

[18]copy with you.

[19]THE COURT: Thank you. Thank you. I don't want to

[20]leave the jury with the impression that he is just reading

[21]these notes. The theory is these notes are to refresh his

[22] **[*8]** recollection, if not, and he has no independent recollection, I

[23]think the rule is we need to mark it as an exhibit as past

[24]recollection recorded.

[25]MR. WIETZKE: Correct.

[8]

[1]MR. WOOLSEY: The only thing I foresee coming up is

[2]the same issue that came up with Dr. Lewin yesterday with

[3]regard to how far the testimony will go, but we will have to

[4]deal with that as it comes up.

[5]THE COURT: Thank you. I appreciate that.

[6]THE WITNESS: Your Honor, I tested this last night and

[7]this morning, but it's not working.

[8]THE COURT: I am going to step down. I will leave

[9]you to work on it, and my hope is we will be able to resume in

[10]five minutes.

[11](Recess)

[12]THE COURT: So, I understand that the technical issue

[13]has been resolved, and so I'd like to call in the jury.

[14]MR. WIETZKE: Yes, your Honor.

[15]THE COURT: Thank you. Mr. Daniels.

[16](Continued on next page)

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[9]

[1](Jury present)

[2]MEHRDAD GOLZAD, resumed.

[3]DIRECT EXAMINATION (Continued)

[4]BY MR. WIETZKE:

[5]Q. All right. Doctor, I think we have resolved our technical

[6]difficulties, **[*9]** and we can return to our program originally in

[7]progress. The first time you met with Mr. Henderson was when?

[8]A. That was on August 20, 2012.

[9]Q. Now, doctor, to address something that the judge brought

[10]up, you explained that you keep a chart with regard to each

[11]patient. How do you keep that chart?

[12]A. Following each encounter with the patient a report is made,

[13]and the report is made electronically for each patient in a

[14]separate folder.

[15]Q. Now, did you create a chart with regard to Mr. Henderson?

[16]A. Yes, I did.

[17]Q. And have you continued to keep that chart throughout the

[18]course of time that you have treated him?

[19]A. Yes, I have.

[20]Q. In fact, when was the last time you saw Mr. Henderson?

[21]A. I believe it was last week.

[22]Q. And did you bring a copy of that electronic chart with you

[23]today?

[24]A. Yes.

[25]Q. Now, doctor, as I ask you questions going forward, please

[10]

[1]answer from your memory. If you can't recall something, let us

[2]know that, and we will address it. OK?

[3]A. OK.

[4]Q. You said August 20, 2012 was your first visit. How is it

[5]that he came to see you?

[6]A. He was sent by his orthopedic surgeon, **[*10]** Dr. Lewin.

[7]Q. Now, we heard from Dr. Lewin yesterday. Had you spoken to

[8]Dr. Lewin prior to Mr. Henderson being referred to you?

[9]A. I have no recollection. We may have. We do talk about

[10]different patients. In this particular case, I do not have a

[11]recollection.

[12]Q. When Mr. Henderson came to your practice, what were his

[13]complaints?

[14]A. He complained of headaches, he had neck pain, back pain,

[15]and he had pain in his arms and legs.

[16]Q. Did he report any particular incident to you?

[17]A. He reported the accident, the train accident of May 18,

[18]2012.

[19]Q. Over the course of the time that you have treated him, have

[20]you come to any conclusions within a reasonable degree of

[21]medical certainty as to whether or not he suffers from any

[22]injury as a result of that train accident on May 18, 2012?

[23]MR. WOOLSEY: Objection. Leading.

[24]THE COURT: Thank you.

[25]You can answer the question.

[11]

[1]A. Well, to determine the cause we rely on the history, and

[2]Mr. Henderson indicated that a number of symptoms began

[3]following the accident. So, by correlating the results of the

[4]examination, the diagnostic studies, MRIs, **[*11]** various studies, and

[5]the onset of symptoms, we determine the causality, the cause of

[6]those symptoms or those conditions. So, based on the history

[7]provided, correlated with my clinical findings and the

[8]diagnostic findings, the determination was that his brain

[9]injuries, neck and back injuries were due to the accident on

[10]May 18, 2012.

[11]Q. I would like to ask you a little bit about -- a little

[12]more, I should say, about TBI generally. Because it talks

[13]about the brain, is it a purely psychological injury?

[14]A. Well, the brain has multiple functions; it controls our

[15]psychological functioning but also our cognitive functioning.

[16]So, traumatic brain injury can affect every single brain

[17]function, depending on what part of the brain is involved.

[18]Q. How is it diagnosed?

[19]A. Well, as I mentioned, there are different degrees of

[20]severity of traumatic brain injury. An extreme traumatic brain

[21]injury can be lethal. Then there are large categories that we

[22]call mild to moderate brain injury. There is an abundance of

[23]symptoms; there is an incredible number of presentations. So,

[24]the evaluation is centered on the symptoms presented **[*12]** by the

[25]patient. Based on the symptoms, we decide on the number of

[12]

[1]clinical and diagnostic tests, and then we determine the extent

[2]of the problem.

[3]Q. And did you follow that procedure, that process, with

[4]Mr. Henderson?

[5]A. Yes, I did.

[6]Q. Could you walk us through your initial assessment of

[7]Mr. Henderson and what you did to treat him.

[8]A. His symptoms that could be due to brain dysfunction or

[9]traumatic brain injury were headaches, he felt dizzy, and he

[10]had difficulty with cognitive tasks. He told me that he had

[11]difficulties. His memory was not as good as before, his

[12]attention span was not as good. So, based on these complaints,

[13]we decided to do a number of clinical tests in the office.

[14]Q. And what did you do? Would it assist you to refer to your

[15]chart to determine specifically what tests you performed?

[16]A. We did a number of tests that are called cognitive tests.

[17]Cognitive tests, the closest example are the IQ tests that we

[18]have all taken at some point. They measure different areas of

[19]cognition. Cognitive function is separated into two different

areas. Obviously memory, but there is also what **[*13]** we call information processing speed, and there are statistical standards and norms, so there is a median that we consider like average for population, and then there are extremes that on the negative side are considered abnormal for a given individual.

So, in cognitive testing Mr. Henderson did have

[13]

problems with memory and especially in his initial first test, information processing speed, and in a test of frontal lobe that measures the impulse control. Because the frontal lobe, one of the many functions of the frontal lobe is to monitor multiple flows of information and then act upon it at the same time. People call that sometimes multitasking. An example is I will tell you look at the light; if it's green, press an odd number; and if it's red press an even number. The frontal lobe looks at the flow of light and then makes a decision. So, there are tests that measure the accuracy of response, and he had problems with this. So, our conclusion was that there is some degree of cognitive deficit and that he would benefit from cognitive remediation therapy.

Q. Now, in addition to the clinical **[*14]** tests, did you request any diagnostic testing?

A. Yes, I sent him for a brain MRI.

Q. We have heard of MRIs. Is there anything different about a brain MRI?

A. Well, MRI machines are in reality measuring instruments; they give you a number of parameters. The computer uses those parameters to sometimes create images, and in some cases it gives you tables of numeric values. For those tables of numeric values again we have statistical data with an average

[24]standard deviation and what we usually call abnormal below two

[25]standard deviations.

[14]

[1]So, when it comes to brain imaging by MRI, magnetic

[2]resonance imaging, practically all of those modalities are

[3]used, and the reason is that the resolution of MRI is about one

[4]to two millimeters. Anything smaller than that, the MRI does

[5]not see that. The size of an axon is one micron, so you can

[6]house thousands, sometimes tens of thousands of axons -- which

[7]are the connections with the neurons -- in one millimeter,

[8]which is below the resolution of regular MRI. So, somebody can

[9]have serious brain injury, a variety of symptoms and deficits,

[10]and have a totally **[*15]** normal MRI if only the usual sequences are

[11]performed.

[12]So, for the brain, a newer test modality of MRI is

[13]used that's called diffusion studies. Diffusion studies use a

[14]formula that was initially published by Einstein in 1905 and

[15]calculates the diffusion of water molecules.

[16]What happens is that our bodies react a lot of times

[17]because of variation in diffusion of water molecules. If I hit

[18]my hand and there is a swelling, the swelling is a result of

[19]abnormal water diffusion. If there is a blister, the water

[20]diffusion is abnormal. The brain is the same, when there is a

[21]brain injury, the water diffusion is not the same.

[22]Diffusion MRIs not only can map abnormalities of water

[23]diffusion, they can show that almost immediately. So, these

[24]are the technologies that were used in the brain imaging

[25]performed for Mr. Henderson.

[15]

[1]Q. Now, the complaints that he came to you with, did you take

[2]a history with regard to what medical treatment if any he had

[3]already undergone prior to coming to see you?

[4]A. Well, for his neck and back injuries he was under the care

[5]of Dr. Lewin and I believe a pain management **[*16]** physician who is

[6]part of Dr. Lewin's practice. And for his brain and TBI

[7]problems, to my recollection, I don't think he received any

[8]care until he came to my office.

[9]Q. So, what did you do with him at that first visit?

[10]A. Well, I performed a clinical evaluation that I mentioned,

[11]and I sent him for a brain MRI.

[12]Q. All right. Now, you also mentioned that you are board

[13]certified in electrodiagnostic medicine, correct?

[14]A. Correct.

[15]Q. Did you perform any electrodiagnostic tests on him as well?

[16]A. Yes. Dr. Lewin had asked me to do a test called

[17]electromyography, whose purpose is to look for nerve root

[18]injuries, to see if nerve roots coming out of the spine have

[19]been injured. So, we did perform electromyography in two

[20]different sessions of his cervical spine and the lumbar spine.

[21]Q. And were the findings of the electro-- the EMG --

[22]consistent with the history that he presented with?

[23]A. Yes.

[24]Q. Now, at the end of that first session, did you have an

[25]impression?

[16]

[1]A. Well, my impression was that he was likely to have

[2]traumatic brain injury, and I sent him for MRI studies to

[3]verify this possibility. **[*17]** And he had injuries to the cervical

[4]spine and lumbar spine.

[5]Q. And did he actually have the brain MRI performed?

[6]A. Yes, he did.

[7]Q. And did you receive the results of that?

[8]A. Yes, I did.

[9]Q. Did you review them?

[10]A. Yes, I did.

[11]Q. Now, separate and apart from just the report, did you

[12]actually review the images as well?

[13]A. I did not review the high resolution images. I did review

[14]the images that the neuroradiologist had interpreted, printed

[15]on a paper and sent to me. So, I looked at that. Those

[16]pictures are a low resolution than what you can see on a

[17]monitor designed for interpretation.

[18]Q. Now, are those the type of diagnostic testing and images

[19]that you rely on regularly in your practice?

[20]A. Yes.

[21]Q. And what were the findings from that MRI, the initial?

[22]A. The finding based on the interpretation of the

[23]neuroradiologist were twofold. He saw areas that he -- there

[24]is a measure in MRI they call intensity. Intensity, so there

[25]are areas of hyper increased intensity and hypo decreased

[17]

[1]intensity. So there were four areas of increased intensity

[2]that the neuroradiologist, Dr. Hausman, **[*18]** indicated could be

[3]traumatic, and he indicated that it could be due to a number of

[4]other medical conditions.

[5]And on the second type of study that Dr. Hausman had

[6]done, which is called the diffusion tensor imaging, that's the

[7]portion of MRI that looks at the diffusion of water molecules

[8]and the direction of the diffusion. His conclusion was that in

[9]certain areas of the brain there was evidence of axonal loss at

[10]microscopic levels.

[11]Q. What did that mean to you in terms of Mr. Henderson's care?

[12]A. That is indicative of axonal tear injuries. That means

[13]that the axons, the connections between different neurons at

[14]some point have been ruptured. That would be the meaning of

[15]his interpretation.

[16]Q. Did you -- where did that actually -- where were those

[17]findings based? Meaning I understand the findings are on a

[18]piece of paper, but what part of the brain?

[19]A. I believe it was in the frontal and temporal areas of the

[20]brain.

[21]Q. Was that relevant to you?

[22]A. Yes. However, the brain is organized as networks, so when

[23]there is a lesion in one point --

[24]Q. What's a lesion?

[25]A. A lesion is an area of structural **[*19]** disintegration. That may

[18]

[1]cause dysfunction of multiple other areas simply because it's a

[2]node of a network. So, when one node is damaged, many other

[3]functions may be affected. There is a lot of redundancy, but

[4]sometimes there is a loss of function, or the function is not

[5]lost but it's not as easy for the person to perform.

[6]So, the localization is not only based on where the

[7]lesion is, it's based on what that type of lesion will cause

[8]terms of dysfunction of other brain areas.

[9]Q. And the location of the lesions -- well, first of all, were

[10]there lesions in the findings? Were they consistent with

[11]lesions in his brain?

[12]MR. WOOLSEY: Objection to the form.

[13]MR. WIETZKE: Horrible question. Let me withdraw

[14]that.

[15]THE COURT: Thank you.

[16]Q. What relevance, if any, does what you just explained about

[17]lesions and nodes have to do with the treatment that you have

[18]rendered for Mr. Henderson?

[19]A. Well, clinically he complained of difficulty with cognitive

[20]function, and psychologically he complained of anxiety,

[21]depressed mood.

[22]On cognitive testing we did find a number of deficits

[23] **[*20]** in the areas of attention, concentration, processing speed.

[24]And the interpretation of the brain MRI indicated brain

[25]lesions. So, different findings are corroborated, they came

[19]

[1]together, so the conclusion at that point was that there is

[2]some degree of brain dysfunction as a result of traumatic

[3]injuries.

[4]Q. I wanted to ask you something. You said you administered

[5]some testing. Have you ever heard the term malingering?

[6]A. Yes.

[7]Q. What does that refer to?

[8]MR. WOOLSEY: Objection. May we approach, your Honor?

[9]THE COURT: Please do.

[10](Continued on next page)

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[1](At the side bar)

[2]MR. WOOLSEY: Your Honor, there is nothing in any

[3]report that I have seen -- and I have the complete subpoenaed

[4]records of the doctor up until December of 2014 -- that

[5]indicates he ever addressed the issue of malingering anyplace,

[6]nor is there anything in the disclosure under Rule 26 that this

[7]is the subject matter of his expert opinions.

[8]THE COURT: Thank you.

[9]MR. WIETZKE: Well, what we will find out is that it's

[10]built **[*21]** into the cognitive testing, the initial assessment he

[11]does for every patient, and it's part and parcel of the

[12]testing. They don't comment on it unless there is a reason to

[13]comment on it. And the answer is it came back as completely

[14]negative because it's built into the panel of testing, and they

[15]don't tell the patient about it, and it doesn't come up unless

[16]there is an issue.

[17]MR. WOOLSEY: But the whole point is there is no

[18]commentary at all about this subject; I mean there is just

[19]nothing. My understanding it's negative.

[20]MR. WIETZKE: There is no commentary --

[21]MR. WOOLSEY: I apologize. It seems like a strawman

[22]is being set up to be knocked down, and it's not. I don't

[23]think there is anything that reflects an opinion he has

[24]actually expressed one way or another. Apparently it's quote

[25]unquote built into things but not actually reflected in any

[21]

[1]interpretation of the data that you could pick up from anything

[2]other than -- there is nothing obvious on the surface in the

[3]data that would suggest that that is something for the basis of

[4]the opinion that he is going to offer.

[5]THE COURT: Thank **[*22]** you. Mr. Wietzke, is there

[6]reference within the treatment records regarding the testimony

[7]that you are seeking to elicit from the doctor?

[8]MR. WIETZKE: Well, it's sort of like saying there

[9]no discussion that he is wearing a hat when he came into the

[10]office. It's completely irrelevant. And so I mean what I can

[11]do -- maybe if you want me to come at it from a different

[12]angle -- is over the course of the two and a half years you

[13]have treated him, have you had any concerns that he is

[14]misrepresenting any of his conditions? No. Why not?

[15]The fact of the matter is it's built into the test,

[16]and that's why it's not commented on.

[17]THE COURT: As I understand it, this is not within the

[18]scope of the treatment records that were provided. I

[19]understand what you are trying to do Mr. Wietzke, trying to

[20]demonstrate that the plaintiff was not malingering. I think

[21]that you can establish that he is suffering from the injuries

[22]that you are asserting, and that proves itself, as opposed to

[23]asking a doctor to prove or testify that in his opinion he is

[24]not malingering. I think that to the extent that you want to

[25]elicit **[*23]** the fact that it's implicit that his injuries were in

[22]

[1]fact the cause of this, that's different from saying that he is

[2]not malingering.

[3]MR. WIETZKE: I presume that will also transfer over

[4]to defense counsel in terms of cross-examination, that there is

[5]absolutely no belief or no records and no indication whatsoever

[6]that he is malingering.

[7]MR. WOOLSEY: Well, I mean that actually underscores

[8]why the question is inappropriate at this point. It's an

[9]attempt at pre-rebuttal of a position that hasn't been taken

[10]yet.

[11]THE COURT: I have ruled. Continue.

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[1](In open court)

[2]BY MR. WIETZKE:

[3]Q. Doctor, how long have you been treating Mr. Henderson?

[4]A. Since August of 2012.

[5]Q. So, two and a half years about?

[6]A. Yes.

[7]Q. Has he been a compliant patient?

[8]A. Yes.

[9]Q. Approximately how many times have you seen him over those

[10]years?

[11]A. I have seen him probably personally I would say 15 times,

[12]16 times, but he has been coming to my practice to see our

[13]neuropsychologist very frequently. **[*24]**

[14]Q. Let me ask you about -- and how many times has he seen the

[15]neuropsychiatrist within your practice as well?

[16]A. I would say on average twice a week, so that would make it

[17]in excess of 100 times.

[18]Q. During your personal interactions, has he ever exhibited

[19]any behavior which you found to be untruthful?

[20]MR. WOOLSEY: Objection.

[21]THE COURT: Sustained.

[22]Q. After performing the testing -- I should say after

[23]receiving the results of the initial brain MRI, what did you do

[24]next with regard to Mr. Henderson's treatment?

[25]A. Well, I referred him to our neuropsychologist for cognitive

[24]

[1]therapy.

[2]Q. And what is neurocognitive therapy?

[3]A. We perform neurocognitive therapy combined with a

[4]technology called neurofeedback. So, it consists of giving

[5]cognitive exercises to the patient that is adapted to both

[6]their educational level and also to the severity of brain

[7]lesion. We choose a level of exercise that they could handle,

[8]and gradually we increase the degree of difficulty.

[9]While they do these exercises, an electron

[10]encephalography electrode is on the head and it indicates to

[11]the computer **[*25]** the break frequency. It so happens that when they

[12]are distracted, the brain frequency drops, so the system knows

[13]if they are paying attention or not, and it gives them a

[14]feedback that they are getting distracted.

[15]So, Mr. Henderson had cognitive therapy a number of

[16]times assisted with neurofeedback, and he made a steady

[17]progress. One of the reasons he made the steady progress was

[18]that he did follow the treatment.

[19]Q. And when you say steady progress, how do you determine

[20]there is progress?

[21]A. On the initial set of cognitive testing he had extremely

[22]low scores in some areas. And when our neuropsychologist Dr.

[23]Schweiger repeated the test approximately one year after the

[24]beginning of his treatment, he had made significant improvement

[25]especially in verbal memory. However, in nonverbal memory he

[25]

[1]still had weakness.

[2]Q. What is nonverbal memory?

[3]A. Memory of shapes as opposed to verbal, word.

[4]Q. And so did you continue with the therapy?

[5]A. Yes. He had made significant progress in his attention

[6]span. The one area where he stayed weak was his processing

[7]speed. Processing speed needs intact brain **[*26]** connections. It's

[8]not easy to do. So, in that area he did make progress but he

[9]was still below normal.

[10]Q. Over the course of the time that you treated him, have you

[11]asked for any additional testing?

[12]A. One of the problems I had was the severe intractable
[13]headaches. And he would respond to a set of treatment, he
[14]would be fine for a few months, and then headaches would recur,
[15]and so I had to change medications. And at some point I
[16]decided to repeat his brain MRI simply out of the fear of
[17]missing something, because he did have headaches but what if
[18]something else was going on.
[19]And I also chose to do the repeat MRI at a different
[20]center which had a higher level of expertise, at the Albert
[21]Einstein College of Medicine, at the Montefiore Hospital. And
[22]there was a neuroradiologist there who has an international
[23]reputation for recognition and diagnosis of traumatic brain
[24]injuries, so I referred him for a second MRI.
[25]Q. And what were the findings from -- well, first, explain to
[26]
[1]me how, if at all, that test is different than the first one
[2]that Mr. Henderson underwent.
[3]A. Well, Dr. Lipton applies **[*27]** more strict criteria. To call
[4]something abnormal he must have at least two standard
[5]deviations from the mean. If the value obtained for the
[6]patient is less than two standard deviations -- the deviation
[7]from the mean should be more than two standard deviations --
[8]then and only then he calls it abnormal. So, he does apply
[9]stricter criteria. And on his regular MRI also he performs a
[10]larger number of sequences. So, he obtains more data, and when
[11]he interprets that, his conclusions are based on more solid
[12]information.
[13]Q. What were the findings of the second brain MRI?
[14]A. The second MRI had one fundamental difference that the
[15]first one in that Dr. Lipton actually indicated evidence of

[16]previous hemorrhagic, bleeding lesions in the brain, and his

[17]conclusion was that they were traumatic.

[18]Q. Was that consistent with what you had seen in your

[19]practice?

[20]MR. WOOLSEY: Observation to the form.

[21]THE COURT: You can answer the question.

[22]A. It was consistent with the history of brain trauma. There

[23]is a trauma, physical force against the brain, and there was

[24]blood. And he also did his own diffusion studies, **[*28]** applied much

[25]more strict criterias, and found actually a larger number of
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[1]areas of axonal and disconnection lesions.

[2]Q. What did that mean to you as the treating neurologist for

[3]Mr. Henderson?

[4]A. Well, it further confirmed evidence of traumatic brain

[5]injuries.

[6]Q. Has Mr. Henderson continued to receive cognitive therapy in

[7]your practice?

[8]A. Yes.

[9]Q. Have you recommended that he cease the cognitive therapy at

[10]this point?

[11]A. Well, the cognitive therapy is really under the supervision

[12]of the neuropsychologist, Dr. Schweiger, who has recommended

[13]not only continuation of cognitive therapy but also regular

[14]psychotherapy and family intervention. He has been meeting

[15]with him, his family and his wife -- because there were some

[16]issues at home -- and his recommendation was to continue both

[17]cognitive therapy, regular psychotherapy to address issues of

[18]anxiety and depression, and family intervention, to help him

[19]with his family problems.

[20]Q. Were those complaints of family problems and anxiety and

[21]depression consistent or inconsistent with a traumatic brain

[22]injury?

[23]MR. WOOLSEY: Objection. **[*29]**

[23]THE COURT: You can rephrase it.

[25]MR. WIETZKE: Sure.

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[1]Q. What you just discussed about the family problems -- I will

[2]focus on one at a time -- is that consistent with a traumatic

[3]brain injury?

[4]MR. WOOLSEY: Objection. May we approach, your Honor?

[5]THE COURT: Thank you. Please come on up.

[6](Continued on next page)

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[1](At the side bar)

[2]MR. WOOLSEY: In addition to the issues with the form

[3]of the questions, substantively there is a couple of things.

[4]There are no consortium claims under the FLA, nor is the wife

[5]or spouse a party to the action.

[6]MR. WIETZKE: Agreed.

[7]MR. WOOLSEY: So, there can't be any inferential

[8]spousal claim here through any testimony about interaction with

[9]the wife or anything pertaining to the remainder of the family.

[10]The other aspect of it is that this doctor has just

[11]indicated that he is not the one administering that therapy,

[12]that another practitioner in his office is involved with doing

[13]that.

[14]Now, I know because I share a practice there **[*30]** is a

[15]little latitude there, which is why I didn't object to it when

[16]he is talking generally. But getting into specifics about the

[17]future care, what would be recommended by another practitioner,

[18]that really is not I think -- I think that's going beyond the

[19]scope of what he should be allowed to testify about.

[20]THE COURT: Thank you.

[21]Mr. Wietzke?

[22]MR. WIETZKE: Twofold. One, it is -- and I will

[23]establish more foundation about the interaction between the two

[24]of them so it becomes more apparent -- in fact Dr. Golzad is

[25]the point person and, for example, that's why he is seeing Dr.
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[1]Schweiger is because Dr. Golzad directed that he go over there

[2]and see him, and that he monitors and keeps up with that and

[3]reviews the charts. It's a single chart, for example, within

[4]the practice, because that's how it's handled, and that's how

[5]Mr. Henderson is treated within the practice.

[6]And so to the extent that it has not been recommended

[7]that he stop, he is part and parcel of that discussion on a

[8]regular basis.

[9]If I could address the first issue as well, however,

[10]the issue of the consortium **[*31]** claim. While it is true -- and Mr.

[11]Woolsey and I agree on this -- there is no consortium claim,

[12]there cannot be under the FLA, however, the effect of the

[13]injury on plaintiff in his home life is 100 percent relevant

[14]because we are entitled to know how it affects him and his

[15]interactions in the world around him.

[16]THE COURT: Thank you. I haven't heard it be

[17]established that the family issues were related to the injury,

[18]just as a matter of foundation.

[19]MR. WIETZKE: Right.

[20]THE COURT: Second, with respect to the scope, I think

[21]that part of the issue here is a result of the fact that Dr.

[22]Schweiger -- who you intended to call as a witness, Mr.

[23]Wietzke, but is not available -- I can't allow you to get in

[24]Dr. Schweiger's testimony through this witness. If this is not

[25]within the scope of the treatment provided by this doctor, I

[31]

[1]have to exclude it.

[2]MR. WIETZKE: Well, to the extent that he reviews

[3]Mr. Henderson's progress with Mr. Henderson, I think it is fair

[4]game.

[5]THE COURT: A part of this doctor's treatment of

[6]Mr. Henderson is within the scope.

[7]MR. WIETZKE: Correct. **[*32]**

[8]THE COURT: However, if it is another doctor's

[9]treatment of Mr. Henderson, and this doctor is simply reporting

[10]on that conversation, then I have to exclude it. And you are

[11]suffering from the fact that your witness had to leave early to

[12]go to Israel.

[13]MR. WIETZKE: Well.

[14]MR. WOOLSEY: And the other issue is, your Honor, that

[15]the doctor opened with the fact that there is a distinction in

[16]the boards between neurology and psychiatry, and he only got

[17]his board in medical neurology. He has a clinical

[18]neuropsychologist in his practice because he can't engage in

[19]that practice.

[20]THE COURT: Thank you. So, do you understand?

[21]MR. WIETZKE: I do. Thank you, Judge.

[22](Continued on next page)

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[1](In open court)

[2]BY MR. WIETZKE:

[3]Q. Dr. Golzad, let me withdraw the last question and ask it a

[4]little differently. At each of your appointments, sessions

[5]with Mr. Henderson, do you review his progress with him?

[6]A. I reviewed -- in my practice Mr. Henderson saw two doctors,

[7]the neuropsychologist and myself the neurologist. So, the

[8]focus of our encounters were mainly his **[*33]** neurological symptoms,

[9]the headaches; and he also felt dizzy and off balance; and

[10]psychiatric symptoms, depression and anxiety. So this was my

[11]focus.

[12]Q. All right. And during the course of your treatment with

[13]him, did he make any reports to you personally of symptoms that

[14]you considered to be related to depression and anxiety?

[15]A. Yes.

[16]Q. Was that consistent or inconsistent with your determination

[17]of a traumatic brain injury?

[18]A. It's a common complication of traumatic brain injury, the

[19]anxiety and depression.

[20]Q. Is there a cure for traumatic brain injury?

[21]MR. WOOLSEY: Objection.

[22]THE COURT: You can answer the question.

[23]A. Well --

[24]THE COURT: Actually, I'm sorry. I sustain that

[25]objection.

33

[1]Q. Based on your training and experience, have you determined

[2]whether or not Mr. Henderson continues to suffer from a

[3]traumatic brain injury?

[4]A. Mr. Henderson has made some progress especially in

[5]cognitive areas, but he still has a significant psychological

[6]anxiety depression and some degree of cognitive problems, so he

[7]has not recovered.

[8]Q. Have you determined whether or not **[*34]** you expect him to be

[9]able to recover?

[10]MR. WOOLSEY: Objection.

[11]THE COURT: Objection sustained.

[12]Q. Have you had discussions with him about him continuing his

[13]therapy?

[14]MR. WOOLSEY: Objection.

[15]THE COURT: Thank you. Sustained.

[16]Q. Does he continue to be a patient in your practice?

[17]A. Yes.

[18]Q. Why?

[19]A. Because of persistence of his complaints and his symptoms.

[20]Q. In addition to the cognitive therapy, have you prescribed

[21]any medications to assist with his treatment?

[22]A. I prescribed medications for headaches and anxiety and

[23]depression, and also one for pain.

[24]Q. Does he continue to suffer from headaches?

[25]A. He does, and with various modifications of medications we

[34]

[1]managed to control the symptoms, however, he gets recurring

[2]symptoms and he has to keep taking medications.

[3]MR. WIETZKE: No further questions at this time, your

[4]Honor.

[5]THE COURT: Thank you very much. If you don't mind,

[6]I'd like to take our lunch break now.

[7]Dr. Golzad, please don't discuss this matter or your

[8]testimony with anyone during the break, particularly counsel

[9]for plaintiff. **[*35]** With that, let's take our lunch break.

[10]I'm going to bring everybody back here at noon, so

[11]thank you very much.

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[1](Jury not present)

[2]THE COURT: Dr. Golzad, you can step down if you like.

[3]So, let's take our break. I haven't had the chance to

[4]review your memorandum yet, Mr. Woolsey, in any detail. I will

[5]ask the question that I had that you were commenting on

[6]earlier, which is why the CPLR is relevant at all in this case,

[7]given that the case that we are litigating is not a state law

[8]claim that I'm trying in diversity but rather as a federal

[9]cause of action.

[10]MR. WOOLSEY: My understanding -- and certainly if I'm

[11]in error, I would certainly ask the court to correct me, but

[12]given the fact that it's a -- well, my understanding is that

[13]under 601, FRE 601, that the court could look at the issue with

[14]regard to the applicability of the state law dead man statute.

[15]There is no federal equivalent that I am aware of. I simply

[16]couldn't find any in the course of our research. So given that

[17]fact, given the **[*36]** venue in which the case is being tried, and

[18]given that the substantive law -- and this is an area of

[19]substantive law, not procedure -- my understanding under FRE

[20]601, that the court should consider the application of the

[21]state law on this subject in the venue in which the matter is

[22]pending.

[23]THE COURT: What's the basis for that and the rule?

[24]MR. WOOLSEY: I'm looking at my memorandum of law, and

[25]specifically at the citation to Wilton Reassurance of New York
36

[1]v. Smith.

[2]THE COURT: My understanding from my vicarious

[3]research on this is that that's a diversity case.

[4]MR. WOOLSEY: I think that's correct, your Honor. But

[5]given the fact that even though there is federal jurisdiction

[6]here -- and obviously it's not a diversity action; I'm not

[7]claiming it's a diversity action -- the circumstance we have is

[8]that there is no federal law directly -- there is no federal

[9]statute, nor am I aware of any federal decision or decisional

[10]law per se on how to address the issue of the circumstance you

[11]are confronted with at this point, which is testimony regarding

[12]an individual who has passed away, **[*37]** who is not a spokesperson

[13]for Amtrak, as it were. So, perhaps it's a little bit of

[14]asking the court to look at the application of the New York

[15]law, but by the same token the court would have to consider

[16]this under 801 with regard to a hearsay situation.

[17]THE COURT: Right.

[18]MR. WOOLSEY: You know, obviously the cases we are

[19]citing are diversity cases, and I am not trying to mislead the

[20]court in any way with regard to that, but given these sort of

[21]novel circumstances here, there is no decisional law or federal

[22]law that I can point to directly on point.

[23]THE COURT: Thank you. So, I will look at this during

[24]the break to the extent I can. I'm clearly governed, in my

[25]view, by Federal Rules of Evidence and federal law on this
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[1]issue.

[2]With respect to the hearsay question, I'd like to

[3]address when we come back whether or not this connective

[4]statement that I understand Mr. Wietzke wants to bring in is

[5]really being introduced for the truth of the matter as opposed

[6]to for the purpose of explaining why it is that Mr. Henderson

[7]then took the steps that he took by assigning a second

[8]watchman. **[*38]** So, for that limited purpose -- which I understand

[9]was the scope of that -- I would be interested in after the

[10]break in your views as to whether or not I should be thinking

[11]about this as hearsay at all or something that is not in fact

[12]being introduced for the truth of the matter. But we can

[13]address that when we come back. Let's take our lunch break,

[14]plan to come back and recommence promptly at noon.

[15](Luncheon recess)

[16](Continued on next page)

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[1]AFTERNOON SESSION

[2]2:10 p.m.

[3](Jury not present)

[4]THE COURT: I understand the jury is ready, so why

[5]don't we bring them in.

[6]Mr. Golzad, let me just remind you you are still under

[7]oath.

[8]Please go ahead, Mr. Woolsey.

[9]MEHRDAD GOLZAD, resumed.

[10]CROSS EXAMINATION

[11]BY MR. WOOLSEY:

[12]Q. Good afternoon, doctor.

[13]A. Good afternoon.

[14]Q. Now, doctor, I believe when you were testifying earlier

[15]when Mr. Wietzke was asking you questions you emphasized to him

[16]the importance of getting an accurate history from a patient.

[17]Isn't that correct?

[18]A. It is correct.

[19]Q. OK. And you would agree **[*39]** with me that getting a complete

[20]and accurate history is essential to an accurate diagnosis,

[21]isn't that true?

[22]A. It is correct.

[23]Q. We're both probably going to be a little soft spoken.

[24]Maybe you could sit a little closer. I just want to make sure

[25]we can hear each other. OK.

39

[1]So, at the time that Mr. Henderson came to you the

[2]first time, what was the date of that visit, doctor?

[3]A. I believe August 15, 2012.

[4]Q. And with regard to the history that you obtained from

[5]Mr. Henderson, am I correct that he talked with you about what

[6]his current issues were, correct?

[7]A. Correct.

[8]Q. OK. Now, in your history, you actually wrote a note dated

[9]August 20, 2012?

[10]A. The date of my first consult was August 20, 2012.

[11]Q. And at the time did Mr. Henderson fill out any type of a

[12]history form at your office?

[13]A. I believe so. He may have, yes.

[14]Q. Do you have it in your records?

[15]A. I do not, but whatever I had is reflected in the report.

[16]Q. OK. So let me just see if I've got this right. Do you

[17]have an actual handwritten form that was filled out by

[18]Mr. Henderson regarding what he was complaining about **[*40]** at that

[19]point in time?

[20]A. We usually do have a handwritten form that I use, and every

[21]piece of information in that form is reflected in the report.

[22]Q. Did you obtain from Mr. Henderson a prior medical history

[23]that extended into his past beyond the event of May the 18,

[24]2012?

[25]A. I believe so.

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[1]Q. Is it reflected in your August 20, 2012 treatment record?

[2]A. All the information obtained from him is reflected in this

[3]report.

[4]Q. Just listen to the question I'm asking, doctor. OK?

[5]The August 20, 2012 note, does it provide any medical

[6]history for Mr. Henderson other than him reporting the onset of

[7]complaints following a train accident in or about May 18, 2012?

[8]A. It does not.

[9]Q. OK, it does not. In fact, no place in your -- let me back

[10]up for a second. Are you aware of the fact that my office

[11]subpoenaed your records?

[12]A. I know that you got the reports, yes.

[13]Q. Would you agree with me that no place in your treatment

[14]records of the patient is there a complete medical history of

[15]all of the medical care, events in his life, and things that

[16]happened to him -- or did or did not happen to **[*41]** him -- before

[17]May 18, 2012?

[18]MR. WIETZKE: Objection, your Honor.

[19]THE COURT: He can answer the question.

[20]A. I would agree, yes.

[21]Q. OK. So, you would agree then that you do not have a

[22]complete prior medical history of this patient in your

[23]treatment records.

[24]A. I do, yes.

[25]Q. You do agree with that, OK. So even though you just told

[41]

[1]us after my very first question that getting a complete and

[2]full medical history is essential to a diagnosis and an

[3]accurate diagnosis, you don't have one. So, doctor, the

[4]question I've got for you is this: Did you ever see the

[5]Elmhurst Hospital records associated with this incident? The

[6]immediate aftermath and emergency medical care.

[7]A. I did but just recently, not at the time.

[8]Q. Oh, OK. Well, then let's talk about that for a minute.

[9]Did you see them in the context of getting ready to come in to

[10]testify, or did you see them in the context of treating Mr.

[11]Henderson?

[12]A. As I mentioned, recently just like two weeks ago in the

[13]context of the trial.

[14]Q. Did Mr. Wietzke come meet with you?

[15]A. We met last week on Friday.

[16]Q. Did Mr. Henderson bring **[*42]** the Elmhurst Hospital records to

[17]you?

[18]A. No.

[19]Q. How is it that you got a chance to look at them?

[20]A. I read Dr. Bender's report, and he had all the details in

[21]

[22]Q. Oh, I see. OK. So, you actually haven't ever seen -- let

[23]me go back and ask the question again. Just so we're clear,

[24]you have not yourself personally reviewed the emergency room

[25]records and subsequent records from the Elmhurst Hospital which

[42]

[1]was the facility that received and treated Mr. Henderson on May

[2]18, 2012, correct?

[3]A. Correct.

[4]Q. OK. So, you're not aware of the fact that there was a

[5]negative CAT scan for acute head injury on that date, correct?

[6]You're not aware of that.

[7]A. Well, I was not aware of it when I saw him then, but

[8]recently, yes.

[9]Q. OK. You didn't have that. You only found that out when

[10]you looked at Dr. Bender's report.

[11]A. Correct.

[12]Q. So, Dr. Bender had looked at the Elmhurst Hospital records,

[13]but you hadn't?

[14]A. Well, I never had access to them.

[15]Q. Well, did you ever ask Mr. Henderson to make them available

[16]for you?

[17]A. We usually ask for every previous medical records. I

[18]request them but **[*43]** we don't always get them, so…

[19]Q. OK, wait a second.

[20]I'm actually going to move to strike that answer as

[21]being nonresponsive to the question that I asked.

[22]THE COURT: Stricken.

[23]Q. Did you ask Mr. Henderson to provide the Elmhurst Hospital

[24]records of May 18 and thereafter to you?

[25]A. What I tried to tell you is that usually patients don't
43

[1]have hospital records; we ask hospitals directly.

[2]Q. OK. Rather than fencing over a yes or no answer to that

[3]question, I'll just ask you a different question, doctor. Do

[4]you have any record in your electronic records of the patient

[5]of you having sent an authorization on behalf of the patient to

[6]Elmhurst hospital requesting the chart? Do you have a --

[7]doctor, it's a yes or no answer to that question.

[8]A. The answer is I don't know.

[9]Q. You don't know.

[10]A. Can I explain why?

[11]Q. You said no, and I will accept that answer. If Mr. Wietzke

[12]wants to ask you questions with permission of the court, he

[13]will.

[14]MR. WIETZKE: Your Honor, I would ask that be he

[15]permitted --

[16]THE COURT: No, please, proceed. You can follow up.

[17]Q. So, other than **[*44]** what you might have gleaned from reading

[18]somebody else's report, you weren't aware of the fact that the

[19]patient had a Glasgow Coma Scale score of 15, correct?

[20]A. Correct.

[21]Q. OK. Now, let's talk a little bit about the Glasgow Coma

[22]Scale. That's a neurological scale that's used to assess

[23]neurological function in patients, frequently in the set of

[24]circumstances where there has been a traumatic event, after an

[25]accident, and it's frequently used by first responders and
44

[1]personnel in emergency room settings to assess patients. Isn't

[2]that correct?

[3]A. Correct.

[4]Q. And what it does is it looks at different levels of

[5]neurological function in terms of eye response, verbal response

[6]and motor response, correct?

[7]A. Correct.

[8]Q. And the modern scale has a total possible score -- the

[9]highest possible score a patient could be recorded on that

[10]scale is 15, isn't that correct?

[11]A. Correct.

[12]Q. So, you are not aware of the fact that when Mr. Henderson

[13]was examined and treated at the emergency room at Elmhurst

[14]Hospital he had a GCS score of 15. You didn't know that

[15]independent of anything you might have **[*45]** read recently, right?

[16]A. Correct.

[17]Q. OK. Have you ever read Mr. Henderson's deposition

[18]testimony?

[19]A. I did not.

[20]Q. OK. Were you aware of the fact that Mr. Henderson has

[21]testified that after the incident occurred he was standing,

[22]felt something, reached to the back of his head and said 'what

[23]happened,' after falling into the ditch, used his cell phone to

[24]make a phone call to a specific individual, Mr. Priestly, to

[25]report the incident? Were you aware of that?

[45]

[1]A. No.

[2]Q. Would you agree with me that that reflects a level of

[3]consciousness in the patient, to be able to appreciate the fact

[4]that something occurred, ask a question about it, and

[5]thereafter in a short time proximity to it take out your cell

[6]phone and make a telephone call to an individual and have a

[7]conversation with them?

[8]A. I would.

[9]Q. You weren't aware of that before me just mentioning that to

[10]you, correct?

[11]A. Correct.

[12]Q. OK. Now, doctor, head injuries that happen in the remote

[13]past can continue to cause problems for people as they age,

[14]isn't that true?

[15]A. True.

[16]Q. Were you aware of the fact that Mr. Henderson **[*46]** sustained a

[17]concussion when he was age six?

[18]A. No, I did not.

[19]Q. Were you aware of the fact he was hospitalized in

[20]association with a motor vehicle accident where he had a

[21]fractured leg and a concussion at age six? Did you know that?

[22]A. I did not, no.

[23]Q. Do you know anything at all about the details of that

[24]concussion or any of the treatment for it?

[25]A. No, I did not know.

46

[1]Q. Before me mentioning that to you, were you aware of that?

[2]A. Well, I mentioned to you I read Dr. Bender's report, and

[3]that's how I found out.

[4]Q. Is that something Mr. Wietzke sent you?

[5]A. I believe so.

[6]Q. OK. So, let's talk a little bit about this. Am I correct

[7]that concussions in children can have long-term effects?

[8]A. Yes, you are correct.

[9]Q. In fact concussions in children have been the topic of a

[10]great deal of medical investigation and research and commentary

[11]over the course of the last ten years in association with

[12]sports and other activities, isn't that correct?

[13]A. It is correct.

[14]Q. And isn't it true that the research shows that children

[15]that have concussions often have problems in later life as

[16] **[*47]** associated with trauma at the early ages? Isn't that true?

[17]A. It's true.

[18]Q. And isn't it true that the younger that you have a

[19]concussion, the more potentiality there is for you to have

[20]issues in later life?

[21]A. It is correct.

[22]Q. Now, it's also true that a concussion at age six could

[23]leave evidence on MRI as an adult of that traumatic event,

[24]isn't that true?

[25]A. It's possible.

47

[1]Q. Now, doctor, other types of activities -- withdrawn.

[2]In terms of gaining a full history of an individual

[3]when you are exploring the cause of a possible traumatic brain

[4]injury, one of the things that you might potentially look at is

[5]whether or not the person was in any other types of accidents

[6]besides one producing a concussion? Isn't that true?

[7]A. Correct.

[8]Q. OK. You look potentially at falls, isn't that true?

[9]A. Correct.

[10]Q. I mean just to see what the circumstances were associated

[11]with it, right?

[12]A. Right.

[13]Q. And motor vehicle accidents in particular, those typically

[14]could be high energy events, isn't that correct?

[15]A. It is correct.

[16]Q. And aren't high energy events ones that are potentially

[17] **[*48]** suspicious for head injury?

[18]A. I'm not sure I --

[19]Q. It's a badly phrased question. I will rephrase it. Let me

[20]rephrase it.

[21]Were you aware of the fact that Mr. Henderson was

[22]involved in a motor vehicle accident in North Carolina in 2002?

[23]A. No, I was not.

[24]Q. OK. Were you aware of the fact that it was serious enough

[25]for him to be taken to the emergency room and undergo an
48

[1]evaluation for a fractured clavicle and to be treated for a

[2]fractured clavicle? Are you aware of that?

[3]A. No, I was not, no.

[4]Q. Are you aware of the fact that he underwent any kind of

[5]head x-rays or CT scans at the University of the North Carolina

[6]in 2002?

[7]A. No, I was not.

[8]Q. Just yes or no, wouldn't you have liked to have known about

[9]the fact that Mr. Henderson had had a concussion when he was

[10]age six by his own count, and had been in a motor vehicle

[11]accident in 2002, and I'm also going to throw in he was

[12]involved in a fall at work in 2010 in which he asserted that he

[13]sustained injuries to his shoulders and his back and also

[14]reported having struck his head? Wouldn't you have liked to

[15]have known that?

[16]A. **[*49]** Yes.

[17]Q. But that's not something that was ever shared with you by

[18]Mr. Henderson, was it?

[19]A. Not to my knowledge.

[20]Q. The reason why you would like to know those things is

[21]because they could have impacted on your diagnosis of the

[22]patient potentially.

[23]A. Potentially, yes.

[24]Q. OK. I mean you would at least like to have been able to

[25]see all the information, review it, take a look at it in the
49

[1]context of everything else you were looking at, and making a

[2]decision in the past as to whether or not it mattered or not in

[3]your assessment of the patient, right?

[4]A. Correct.

[5]Q. OK. But given the fact that you were never given the

[6]information, you never had the hospital records, you didn't get

[7]a history reflecting the fact that Mr. Henderson had the

[8]concussion when he was six years old, didn't have the history

[9]of the 2010 fall at work, you were deprived of the opportunity

[10]to be able to do that, correct?

[11]A. Well, I did not have access to this.

[12]Q. Understood. Thank you. With regard to assessing a patient

[13]for a diagnosis of traumatic brain injury, do doctors doing

[14]that assessment from time to time **[*50]** attempt to gain information

[15]regarding school records of the individual, how their academic

[16]performance was?

[17]A. Sure, to establish the preinjury cognitive status,

[18]absolutely.

[19]Q. OK. And sometimes you would look at an individual's work

[20]performance, maybe their employment records, to see whether

[21]they had any issues at work, correct?

[22]A. Academic and professional performance, yeah.

[23]Q. OK. Did you ever receive Mr. Henderson's academic records?

[24]A. Other than what he told me, I never received any records,

[25]no.

50

[1]Q. OK. You just have the information from him, correct?

[2]A. Correct.

[3]Q. And did you ever look at any of his employment records?

[4]A. No.

[5]Q. One of the things that you mentioned in looking at I

[6]believe one of the MRIs of Mr. Henderson, and also assessing I

[7]believe it was one of the early cognitive evaluations that was

[8]performed, or neurological evaluations -- and please correct me

[9]if I misspeak about this -- I believe you indicated you had

[10]looked at or were looking at the issue of whether or not there

[11]was any -- I don't think you used this -- I may not use the

[12]right term -- but was it **[*51]** lability of behavior that you referred

[13]to? Or am I using the wrong terminology?

[14]A. Are you referring to the MRI or to cognitive testing?

[15]Q. Cognitive testing. It was impulse control. My mistake.

[16]One of the things I thought you indicated earlier is that in

[17]looking at various aspects of the brain or areas of the brain,

[18]that one of the things that you took note of was an area

[19]involved with impulse control. Am I correct, did you testify

[20]to that?

[21]A. I believe so, yes.

[22]Q. OK. Now, impulse control involves an individual's ability

[23]to essentially control what they say, control what they do,

[24]things of that nature. It's behavioral in the way it manifests

[25]itself, correct?

[51]

[1]A. Correct.

[2]Q. So, one of the things you look at in terms of whether or

[3]not an individual has impulse control issues is the things that

[4]they do, the choices they make and how they behave, correct?

[5]A. It is correct. However, the test I referred to was not the

[6]psychological aspect of it; it was more the cognitive aspect.

[7]Q. OK. I understand. You're just looking at it in terms of

[8]what the data shows you on the page as opposed to analyzing **[*52]** how

[9]the behavior in the world might reflect an organic condition.

[10]Right?

[11]A. Yeah.

[12]Q. Well, let's talk about the organic condition itself and how

[13]it would manifest itself potentially in the world. OK? So

[14]here is the question I've got for you: When it comes to

[15]impulse control, is one of the things that you would look at is

[16]an individual's behavior in society?

[17]A. Correct.

[18]Q. OK. Would you look at whether or not they had had any

[19]issues at work that were disciplinary in nature?

[20]A. Certainly, yes.

[21]Q. OK. That would be something that would be important to

[22]potentially look at. It might or might not inform an analysis

[23]and diagnosis, correct?

[24]A. It is a relevant piece of information, yeah.

[25]Q. It's something -- do you want a glass of water?

[52]

[1]A. Yeah, actually --

[2]Q. It might potentially be useful information; it might be

[3]totally irrelevant. Right? It would depend.

[4]A. Yeah.

[5]Q. So, if an individual had a history of disciplinary issues

[6]at work, that might be reflective of impulse control issues,

[7]correct?

[8]A. It could be, yes.

[9]Q. If an individual had issues with regard to how they dealt

[10] **[*53]** with authority, authority figures, public or private, that

[11]could be an issue reflecting impulse control issues, correct?

[12]A. Correct.

[13]Q. Authority such as the government, governmental entities and

[14]agencies and so forth, correct?

[15]A. Correct.

[16]Q. Now, when Mr. Henderson came in to see you -- and I'm just

[17]going to confine myself now to August of 2012. OK?

[18]A. Um-hum.

[19]Q. When he first came to see you, was he driving? I don't

[20]mean did he -- it's a horrible question. Let me rephrase it.

[21]Do you know whether or not at that point in time in

[22]his life whether Mr. Henderson was operating a motor vehicle or

[23]was licensed to operate a motor vehicle?

[24]A. I did not, no.

[25]Q. At that point in time did indicate to him that he should
53

[1]not be driving?

[2]A. No, I did not.

[3]Q. You didn't restrict him in terms of driving, correct?

[4]A. No, I did not.

[5]Q. Now, I wanted to talk with you a little bit about the DTI

[6]MRIs that you testified about. I believe Mr. Henderson has had

[7]two of those, correct?

[8]A. Correct.

[9]Q. And the first one was done on August 27, 2012, the Alpha 3T

[10]MRI?

[11]A. Correct.

[12]Q. And the **[*54]** second one was on November 7, 2014, and that was

[13]done by Dr. Lipton?

[14]A. Correct.

[15]Q. And what facility was it that Dr. Lipton did that at?

[16]A. Montefiore Hospital in the Bronx.

[17]Q. Now, DTI is short for diffusion tensor imaging, correct?

[18]A. Correct.

[19]Q. It's essentially a supplemental analysis of an MRI,

[20]correct?

[21]A. It's one of many sequences they do, yes.

[22]Q. But there is a standard MRI, and then there is this

[23]additional diffusion tensor imaging, correct?

[24]A. Correct.

[25]Q. Would you agree with me that DTI has been the subject of a
54

[1]great deal of controversy in the medical profession or the last

[2]15 years?

[3]A. I would say in the legal profession, not in -- the

[4]discussion over any technology, when it comes to the diagnostic

[5]studies, is very different when it's among health care

[6]professionals or legal professionals, so I don't think the

[7]controversies are of the same nature.

[8]Q. Let me see if I can follow up on this thing. Isn't it true

[9]that there have been instances where testimony regarding DTI,

[10]diffusion tensor imaging, and its reliability has been

[11]excluded? Aren't you aware of that?

[12] **[*55]** A. You see, this is a hundred percent in the legal arena. And

[13]I've heard of it, but it was never my topic or my point of

[14]interest, but I've heard about it, yes.

[15]Q. I'm correct about that, correct?

[16]A. I think so, yes.

[17]Q. Yes, OK. Do you know Dr. Chris Felippe?

[18]A. No, I don't.

[19]Q. Have you ever heard of him at Hofstra?

[20]A. Sorry?

[21]Q. He is at Hofstra. Have you heard of him?

[22]A. I have not.

[23]Q. Have you heard of Dr. Howle Wertzel?

[24]A. No, I have not.

[25]Q. Have you heard of Dr. John Sorris?
55

[1]A. No.

[2]Q. Have you read anything by them?

[3]A. No.

[4]Q. Would you agree with the statement that the manner in which

[5]DTA data are acquired produces findings that not only lack

[6]specificity but also continue to be highly variable across

[7]institutions and among researchers? First, would you agree

[8]with that, yes or no?

[9]A. It was more than one question.

[10]Q. Well, let me withdraw the question and I'll re-ask it. OK?

[11]A. The variability between institutions I have personally seen

[12]a lot. It's a technology that's very complex; it uses quantum

[13]physics.

[14]The MRI machine is used as a measuring instrument. **[*56]**

[15]So, if very detailed and good quality techniques are not used,

[16]then obviously if they get wrong data into the formula they

[17]also get wrong results. But if they use good quality controls,

[18]they do get consistent data. That's been proven.

[19]Q. So, would you also agree that the neuroradiology community

[20]has not arrived at a consensus view of the value of DTI in

[21]particularly mild head trauma? Would you agree with that

[22]statement?

[23]A. No, it's correct. In the last conference they had

[24]disagreements. I happened to be there, and they were

[25]discussing it, yes.

[56]

[1]Q. OK. Did you attend the Multi-disciplinary Consensus

[2]Conference?

[3]A. I did not attend this one, no.

[4]Q. You attended a more recent conference? Was it the American

[5]Academy of Neurology?

[6]A. Yes, that, and then one in Montreal they were talking about

[7]advances in neuroradiology.

[8]Q. OK. Isn't one of the concerns that's expressed is about

[9]the use of DTI findings in singular cases as opposed to case

[10]studies? Isn't that one of the concerns that was expressed?

[11]A. Yeah, it's a probabilistic and statistical type of data, so

[12]it is always compared to groups, **[*57]** yes, it is.

[13]Q. So the reliability of it has been shown to be -- it's been

[14]shown to be -- let me withdraw that.

[15]The data has been shown to be more reliable when used

[16]in analyzing groups rather than single individuals, true?

[17]A. My understanding is that they use groups to generate what

[18]is called normative normal data. So, when an individual

[19]patient goes for a test they compare the data obtained from

[20]that patient to their normal controllers. So one of the

[21]sources of possible errors is that the normal controls are not

[22]normal.

[23]Q. So, since you brought this up, I'm going to ask you, the

[24]only DTI MRIs that were available in this case with

[25]Mr. Henderson were those taken on August 27, 2012 and November
57

[1]7, 2014, right?

[2]A. Correct.

[3]Q. OK. We don't know one way or the other whether he ever had

[4]a brain MRI before, right?

[5]A. Not to my knowledge.

[6]Q. OK. So, there was no preexisting baseline to analyze what

[7]his brain looked like, as far as we know, prior to this August

[8]27, 2012 test, with the exception of whatever was shown on any

[9]prior CAT scans, correct?

[10]A. Not to my knowledge. No previous **[*58]** MRIs, correct.

[11]Q. OK. So there wasn't any baseline for comparison for the

[12]radiologist Dr. Hausman to use to see what Mr. Henderson's

[13]brain looked like before he came in on August the 27th, 2012.

[14]A. Correct.

[15]Q. OK. And as a consequence of that, and based upon the fact

[16]that you have said that old injuries like a concussion at age

[17]six can show up later in life, and still be present on studies,

[18]MRIs, CAT scans done decades later, it's possible that the

[19]finding that Dr. Hausman found on August 27, 2012 could have

[20]been a consequence of one of Mr. Henderson's prior head

[21]injuries? Isn't that true? Isn't it possible?

[22]A. To be perfectly honest, I personally cannot tell you with

[23]confidence an injury between age six and whenever this accident

[24]happened -- I think he was 40 something -- such a long lapse of

[25]time, I don't think anybody knows. We do know that if an
58

[1]accident occurs now, and then you get an MRI a few years from

[2]now. The technology was recent. I was actually a medical

[3]student in Paris, and Dr. Lubian discovered it, it was '84,

[4]'85. So the technology has not existed for such a long time,

[5]and the DTIs **[*59]** started five or ten years later. So, I don't

[6]think that we even have data to be able to say one way or

[7]another that an injury at age six would show on this type of

[8]MRI 40 years later.

[9]Q. So, we just don't know.

[10]A. We don't, absolutely.

[11]Q. Can't rule it out, can't rule it in, right?

[12]A. Yes.

[13]Q. OK. So, let's talk a little bit about the August 27, 2012

[14]MRI reports from Dr. Hausman. And I just want to make sure

[15]we're literally on the same page, because there is a couple of

[16]pages to look at. And I'm not going to ask you to read, nor am

[17]I going to quote from the document that I am asking you

[18]questions about. Doctor, I'm not going to ask you to read

[19]verbatim from it, and neither am I going to quote from it. I'm

[20]just going to ask you some questions. OK? So, if you need to

[21]look at the document in order to refresh your memory or answer

[22]my questions, please feel free to do so.

[23]With regard to the plain MRI that was done by Dr.

[24]Hausman on August 27, 2012, one of the things that it looked at

[25]was findings pertaining to white matter. Isn't that true?
59

[1]A. True.

[2]Q. OK. And isn't it true that individuals **[*60]** that walk around

[3]basically perfectly healthy with no neurological anomalies and

[4]no neurological health problems can sometimes have normal

[5]signal intensity in white matter in their brain? Isn't that

[6]true?

[7]A. It is true.

[8]Q. One of the things that Dr. Hausman did when he did his

[9]traditional MRI analysis was to suggest that other things

[10]should be considered as possible causes of the -- as far as the

[11]etiology or the cause of that condition, the abnormal signal

[12]intensity within the white matter of the cerebral hemispheres,

[13]correct?

[14]A. Correct.

[15]Q. Some of the things he suggested looking for and excluding

[16]would have been demyelination, correct?

[17]A. Correct.

[18]Q. Hypertension?

[19]A. Correct.

[20]Q. Correct? Migraine syndrome?

[21]A. Correct.

[22]Q. Or small vessel ischemia, correct?

[23]A. Correct.

[24]Q. And demyelination can be a consequence of disease, isn't

[25]that correct?

60

[1]A. It is correct.

[2]Q. Particularly associated with Lyme disease?

[3]A. Yes.

[4]Q. Or one of the things that can cause it. There are other

[5]diseases that can cause demyelination?

[6]A. Correct.

[7]Q. Hypertension, that's high **[*61]** blood pressure?

[8]A. Correct.

[9]Q. Migraine syndromes. Now migraines are headaches, correct?

[10]A. Correct.

[11]Q. And they're genetically passed, isn't that correct?

[12]A. Correct.

[13]Q. And they can be latent, or they can manifest themselves at

[14]different stages -- let me withdraw the question.

[15]Isn't it true that migraines can manifest themselves

[16]at different points in times in individuals' lives?

[17]A. It is correct.

[18]Q. Small vessel ischemia, that would be a stroke, or something

[19]else?

[20]A. Yeah, that would be small areas of stroke caused by

[21]obstruction.

[22]Q. Now, with regard to those conditions, did you ever have any

[23]communication with any of Mr. Henderson's general medical

[24]practitioners?

[25]A. No, I did not.

[61]

[1]Q. Do you know a Dr. Johnson?

[2]A. No, I don't.

[3]Q. Do you know whether or not he was ever diagnosed or treated

[4]for any of those conditions prior to August of 2012?

[5]A. Not to my knowledge, no.

[6]Q. You don't know, or he indicated he had not?

[7]A. No, I said not to my knowledge.

[8]Q. OK, you don't know one way or the other. So when Dr.

[9]Hausman indicated to you that -- well, withdrawn. **[*62]**

[10]The August 27, 2012 MRI report, that was sent directly

[11]to you, correct?

[12]A. I think so, that's correct.

[13]Q. It looks like it's addressed to you, isn't it?

[14]A. Sorry?

[15]Q. It was addressed to you.

[16]A. Yes. Well, I was the referring doctor, so they sent the

[17]result to me.

[18]Q. Right. Sorry, bad question. With regard to Dr. Hausman's

[19]comment of clinical correlation recommended, one of the things

[20]he was suggesting by that is the exclusion of those other

[21]medical conditions that could be possible causes as a way of

[22]eliminating the differential diagnosis, isn't that correct?

[23]A. Correct.

[24]Q. Now, by the way, am I correct that you did not -- with

[25]regard to the DTI analysis done on August 27, 2012, the doctor
62

[1]also recommended clinical correlation, right?

[2]A. Correct.

[3]Q. Now, I believe that you indicated that with regard to the

[4]November if 27, 2014DTI that was performed on Mr. Henderson,

[5]that you had ordered that, correct?

[6]A. The one at Montefiore, right?

[7]Q. Right.

[8]A. Yes, I ordered it.

[9]Q. And the reason you did that is because you wanted to have

[10]someone you had a little more confidence **[*63]** in? I don't mean to

[11]disrespect anybody in any way but --

[12]A. No, absolutely. I mean you eloquently explained why the

[13]previous MRI did not answer all the questions. That was very

[14]clear, and that was the reason. I didn't want to put it this

[15]way, but it did not answer all the questions, so I looked for a

[16]more accurate study.

[17]Q. So, when Dr. Lipton sent you a report on November 7,

[18]2014 -- and again I'm not going to quote from the report, and

[19]I'm not going to ask you to read it; I'm just going to ask you

[20]questions about it, and you can refer to the document if you

[21]have it available to answer my questions. OK? Do we

[22]understand each other?

[23]A. Yes.

[24]Q. With regard to that MRI, one of the things that Dr. Lipton

[25]indicated to you, that other than injury, other disorders
63

[1]affecting white matter that could be relevant could have been

[2]microvascular infarct and demyelinating disease. Correct?

[3]A. At the end of his report, yes.

[4]Q. OK. There is a number of different disorders that can

[5]cause that, correct?

[6]A. The comment is at the very end of the report you are

[7]alluding to, right?

[8]Q. I am. I'm trying **[*64]** my best not to read it verbatim.

[9]A. No, that's fine. I believe these comments are about the

[10]DTI portion of his analysis. And he has similar to the

[11]previous report an initial section of the Ti and T2 and the

[12]flair images. And then he has his DTI data. So, the comments

[13]that you just mentioned was actually the DTI analysis.

[14]Q. Right. I was just trying to limit us to talking about the

[15]DTI specifically. But in regard to the DTI, one of the things

[16]that he recommended was clinical correlation or evaluation as

[17]to whether other types of disorders like Lyme disease,

[18]migraines, MS, any of those things might potentially be the

[19]underlying cause of what he was seeing on the DTI MRI at the

[20]time. Correct?

[21]A. He indicated two of the conditions, yes.

[22]O. OK. As of December of 2014 had Mr. Henderson been worked

[23]up for any of those conditions at your office?

[24]A. For microvascular infarcts, he had none of the risk

[25]factors. And for demyelinating disease there was no clinical
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[1]sign or symptom that would lead you to think he had like

[2]multiple sclerosis or any other type of demyelinating disease.

[3]MR. WOOLSEY: Doctor. **[*65]** Thank you very much for your

[4]time. I appreciate it.

[5]THE COURT: Thank you, Mr. Woolsey.

[6]Mr. Wietzke?

[7]REDIRECT EXAMINATION

[8]BY MR. WIETZKE:

[9]Q. Doctor, you remember you were asked about records from

[10]University of North Carolina following a car accident in 2002?

[11]A. Yes, I do.

[12]Q. What does it mean to have a negative head CT?

[13]A. That means that the CAT scan is negative, that the CAT scan

[14]is normal, CAT scan of the brain.

[15]Q. So, would that have contributed to your ability to diagnose

[16]Mr. Henderson with a TBI if in fact the prior hospital records

[17]said he had a negative CT?

[18]A. The type of abnormalities indicated on each of the two MRIs

[19]would not show on any CAT scan even if they are done today.

[20]Those abnormalities are -- the CAT scan is not sensitive

[21]enough, powerful enough to show that type of problem. So as

[22]compared to this MRI, it would not have changed anything.

[23]Q. So let me ask you something, and then I will flip what you

[24]just said. We talked about the December 2014 MRI done by Dr.

[25]Lipton.

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[1]A. Correct.

[2]Q. If Mr. Henderson went to get a regular head CT on the exact

[3]same **[*66]** day that he went for the brain MRI that Dr. Lipton did,

[4]would you expect the head CT to be negative?

[5]A. Probably.

[6]Q. You were asked a number of questions by Mr. Woolsey about

[7]if he had a concussion at age six, could it leave evidence and

[8]was it possible to leave evidence. Do you have an opinion, to

[9]a reasonable degree of medical certainty, as to whether what

[10]you're seeing on Dr. Lipton's brain MRI results were the result

[11]of an injury at age six?

[12]MR. WOOLSEY: Excuse me. Objection, your Honor, based

[13]upon the answer on cross.

[14]THE COURT: Thank you.

[15]You can answer the question.

[16]A. There are two abnormalities described on the second MRI

[17]done at Montefiore. One indicates remote hemorrhagic

[18]contusion. Even though the word remote is used, I truly doubt

[19]that an injury 40 years prior, the blood in that injury would

[20]still show. The diffusion tensor imaging or DTI portion of

[21]that, as I explained, we really don't know, we don't have

[22]enough data to be able to say with certainty. But the one on

[23]the initial MRI, the regular sequences where he indicates

[24]remote hemorrhagic contusion, which is evidence **[*67]** of blood at

[25]some point in the brain, I personally doubt that 40 years later

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[1]the blood would still show. The blood disintegrates and

[2]reabsorbed.

[3]Q. The Glasgow Coma Scale was performed, as indicated by Mr.

[4]Woolsey, at the hospital, correct? I should say he was

[5]evaluated at the hospital and the scale was determined,

[6]correct?

[7]MR. WOOLSEY: Objection. No foundation.

[8]THE COURT: Thank you. Rephrase the question.

[9]Q. Based on Mr. Woolsey's representation that Mr. Henderson at

[10]Elmhurst Hospital had as Glasgow Coma Scale of 15, does that

[11]mean that he was not unconscious at the scene?

[12]MR. WOOLSEY: Objection.

[13]THE COURT: Sustained.

[14]Q. Does a Glasgow Coma Scale of 15 necessarily mean that there

[15]was no TBI?

[16]A. No.

[17]Q. Why not?

[18]A. What we call mild traumatic brain injury at times doesn't

[19]cause a loss of consciousness but there is mild brain injury.

[20]The Glasgow Coma Scale done probably half an hour, one hour

[21]later, and it's totally normal, it would exclude a serious

[22]brain injury, but it does not exclude a mild or moderate pain

[23]issue.

[24]MR. WIETZKE: No further questions, **[*68]** doctor. Thank

[25]you.

[67]

[1]THE COURT: Mr. Woolsey?

[2]MR. WOOLSEY: Nothing.

[3]THE COURT: Thank you, doctor. You can step down.

[4]Mr. Wietzke, who is your next witness?

[5]MR. WIETZKE: Yes, your Honor. I call Mr. Henderson

[6]to the stand, please.

[7]THE COURT: Thank you.

[8]Ladies and gentlemen of the jury, would you like to

[9]take a rest break, or are you ready to continue? Continue?

[10]OK, good. Please come on up, Mr. Henderson.

[11]MR. WOOLSEY: May we approach for a moment.

[12]THE COURT: Please do.

[13](Continued on next page)

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