IN RE: INVESTIGATION, Lisa McPherson

STATEMENT OF: DAVID MINKOFF.

DATE: April 20, 1997, 9:15 a.m.

BEFORE: Donna M. Kanabay, RPR, RMR
Notary Public, Court Reporter.

PLACE: State Attorney's Office
Criminal Justice Center
Clearwater, Florida

APPEARANCES: MR. MARK McGARRY, JR.
Assistant State Attorney
Attorney for State of Florida.

Agent Lee Strope
FDLE.

Sergeant Wayne Andrews
Clearwater PD.

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MR. McGARRY: Jim, do you want to put anything on the record in reference to your client being here pursuant to subpoena, and then we'll get started? If not --

MR. FELMAN: Yeah.

Basically, my understanding is that we are here pursuant to a subpoena, and that that, therefore, confers use and derivative use and immunity upon Dr. Minkoff for what may be covered today.

MR. McGARRY: Fine.

DAVID MINKOFF,

the witness herein, being first duly sworn was examined and testified as follows:

BY MR. McGARRY:

Q. My name's Mark McGarry. I'm a prosecutor. And we'll be asking you some questions in reference to the death of Lisa McPherson and what you have -- what knowledge you have about that.

Before we start into that, maybe I should get some background as to what you do at the hospital. And if you would, give us your credentials and where you went to medical school and training. Can do you that for me, please?

(Whereupon a discussion was held off the record).

BY MR. McGARRY:

Q. Let's put your name on the record. Please state your name and occupation for the record.

A. David Minkoff, M I N K O F F. I'm a medical doctor. I went to college and medical school at the University of Wisconsin, graduated 1974. I did an internship and residency at the University of California in San Diego in Pediatrics. I was chief resident of the teaching program there for a year, and then I did two years of an infectious disease fellowship, which was both adult and pediatric infectious disease. And then I remained as an adjunct faculty member for three or four years, teaching infectious disease. I did research at the university in new drugs to treat viral disease.

I went into private practice in 1980, doing pediatrics and infectious disease. I worked in Escondito, California, which is a little town outside San Diego, for ten years. I did emergency room medicine at the same time, and worked as co-director of a neonatal intensive care unit during that time.

I moved here in February of 1990, began working in a walk-in clinic, part of Doctor's Walk-in Clinic. He had seven clinics around the county, and I worked at most of them for about a year and a half.

And then, in August of '91, I started working at

the emergency room at Columbia in New Port Richey, and I've worked there, since, as emergency room staff.

Q. All right. What brought you to Clearwater in 1990?

A. I took a sabbatical from my medical practice. There was a Hubbard school here that I wanted my children to be at, and we were coming for six months, and the school was going very well, and we liked the area, and we decided to stay.

MR. McGARRY: Jim, could I get you to back up a little bit? 'Cause I can't see him when we talk.

MR. FELMAN: Sure. I'm sorry.

BY MR. McGARRY:

Q. So you were involved with the Church in California?

A. Yes. Since 19, probably, '81.

Q. All right. So pretty much the sole reason for moving to Clearwater was because of the Church?

A. Yeah.

Q. How long was your sabbatical?

A. Six months.

Q. And what did you do during that six months?

A. I worked part time in the walk-in clinic, and then I took courses at the Church.

Q. Okay. Did your family move with you at the same

time?

A. Yeah.

Q. In '90?

Where did you-all first move to when you moved here to Clearwater?

A. They had public housing at Hacienda Gardens, so I rented an apartment there. I was there for about a year and a half. And then we moved out to a rented house on McKinly Street. And then, a year after that, we built a house, which is where we live now.

Q. Your wife's with the Church also, right; and your children?

A. Mm-hmm.

Q. Okay. Are you still with the Church right now?

A. Meaning --

Q. Are you still a member of the Church?

A. Yeah.

Q. Okay. You've never been -- you've never been a staff member for the Church. You've just been affiliated with the Church as a --

A. Parishioner.

Q. -- parishioner.

How about your wife? Is she a staff member?

A. No.

Q. If I could, can you tell me how far you are

along in your courses? Have you received -- received a certain level?

A. I've done courses in all the areas in the administrative area; I've done courses in the counseling area; I'm a classified auditor; and received counseling up to what's called OT8.

Q. Okay. That's what I was looking for.

So you -- you would say that, in the general populace of church members, you're pretty knowledgeable, as to the Church teachings?

A. Oh, yeah.

Q. So I take it, somewhere along in 1992, you started spending most of your time over there at the emergency room? That is how that worked? After your sabbatical, that's when you went full time there?

A. Well, I actually was at the walk-in clinic, probably, fifty hours a week, and then the emergency room job came up, and I transferred to that, so I was -- the sabbatical -- I probably took three months off, and then I started working. I had a family, and we just needed more money. And so it was sort of combined, study at night and work during the day, or study in the morning and work at night. Just depended on the schedule.

We got here in February, and I think I started working at the clinic in, probably, April or May, and it

was a full time job, but I just did both things.

Q. Okay. Through your association with the Church, did you become -- what's the word I'm looking for here -- did you -- did you treat parishioners? Did they come to you because -- because of who you were, a doctor, and you were associated with the Church? Did you get -- I mean, were you referred to by the Church on some occasions? You know what I'm saying? They went to you because of who you were?

A. Right.

Q. And that's a long trip.

And my question is -- is -- kind of where I'm going is, did that happen often with the Church?

A. It didn't actually happen very often. When I was in the walk-in clinic, it happened more frequently, because it was in Clearwater. I was accessible. It was not an emergency-room setting. Somebody without a doctor could walk in there, and, for forty bucks, get an exam and do that. So local Scientologists and some of the staff members would come up there. It wasn't super heavy, but maybe a half dozen a week would come up, and I'd do my regular doctor thing on them.

Once I moved up to New Port Richey, it was pretty rare for somebody to come all that way, pay an emergency room fee. And I just wasn't that accessible.

Q. Because of the distance and --

A. Distance.

Q. -- and your position there?

A. Yeah.

And it wasn't really a practice I was trying to cultivate.

Q. Just happened.

A. Just would happen.

Q. Right.

Does the Church -- I know the Church has a dentist in the Flag Building.

That is what you call that building, "Flag Building"?

A. Yeah. Ft. Harrison. Yeah.

Q. Do they have a doctor --

A. No.

Q. -- up there?

They don't have a doctor that's, "I'm the doctor for you people. I'm in the building for any needs you have"?

A. No.

Q. Okay. So if they were to have a staff member or parishioner or somebody that needed medical help, they're on their own, just go out and get a doctor, like anybody else, right, unless --

A. They have a person there called a Medical Liaison Officer, and that person's job is to see sick people; decide, you know, like, if they need a doctor, to send them to a doctor. If they need advice on nutrition or something like that, give them the advice. It's not -- the job's not really sort of advising medical care, it's just so someone there has someone that can interface with medical care and get them there. And for a staff member, that's the person that would do it.

Q. Mm-hmm.

A. Because the money lines go through, if you're a staff member and you work at the Church and you want to go to the doctor, if you go -- if you go through the MLO, she will then take you to the doctor. Then the Church will pay for the medical care.

Q. If you're staff?

A. If you're a staff member.

Q. That's a pretty big benefit, isn't it? Is that a benefit that everybody knows about?

A. A staff member benefit?

Q. Yeah.

A. I mean, it's not a benefit of a public person.

Q. I understand.

A. But, I mean, their employees.

Q. Staff gets free medical services.

A. Right.

Q. It's almost like a medical plan, but it's really not. They just pick up the tab.

A. They pick up the tab.

Q. Hmm.

Is that the same way with doctor -- do you know Dr. Houghton?

A. Yeah.

Q. David Houghton?

Same thing?

A. No. He's a staff member.

Q. Right. He's their dentist.

A. So now they have an in-house dentist.

Q. I assume he's a salaried guy at the place.

A. Yeah.

So as a staff member, he gets food, lodging, salary. And his job there is to be the dentist, so people who have teeth trouble, they just go to him and get their teeth fixed.

Q. And that's free, too?

A. Yeah.

Q. Wow.

Staff.

A. Staff. Yeah.

Q. Hmm.

MR. FELMAN: You getting ready to join, Mark?

MR. McGARRY: No.

BY MR. McGARRY:

Q. All right. So the MLO, at the time of Lisa -- December -- this is going back to December 5th of '95 --

A. Okay.

Q. -- the MLO, then, was who, to the best of your knowledge?

A. Janice.

Q. That would have been Janice Johnson?

A. Yeah.

Q. She's not MLO any more, right?

A. No.

Q. Do you know who it is now?

A. I think that her name is Louisa something.

Q. Well, here. Let me -- you can straighten me out, here. I've got some names you can fill me in on.

A. All right.

Q. Susan Green, married name Schnurrenburger.

A. No. She was, I think, a receptionist or the office manager for the MLO office.

Q. Okay. So she was in that office, but she wasn't the head --

A. No.

Q. -- manager?

Judy Colesberry Webber.

A. She was working as an MLO in that office. They had a couple of them at one time.

Q. Okay. All right. So you're not sure who replaced Janice Johnson?

A. No. Because since then, there's been a couple of them. And the one who's been there the longest is --

You got any more names there? Blanking on the lady's name.

MR. McGARRY: Detectives, you guys --

SGT. ANDREWS: A. J. Strecker. She's in an office --

THE WITNESS: She's the senior above that office, and a bunch of other ones. She didn't actually work in that office.

SGT. ANDREWS: Judy Colesberry Webber, Emma Schamehorn.

THE WITNESS: Emma. Emma's been there the longest. She's probably been there three or four years.

BY MR. McGARRY:

Q. She's --

A. And she's been an MLO for a long time.

Q. Okay.

A. And Emma's still doing it, as far as I know.

Judy, I don't think, is doing it any more.

Q. Okay. So during the course of your practice in New Port Richey, did -- did you ever receive, like, phone calls from an MLO saying, "Hey, Doc, you know, I've got a situation here. Can you give me a -- maybe what she should do here," adds up --

A. Maybe once a month, twice a month, sure.

Q. So it wouldn't be uncommon for an MLO to call you, because they know you're with the Church, and you're willing and able to assist in whatever problems they might have.

A. Right.

Q. Just out of curiosity, do you have -- I believe it's called a senior or --

Who is your spiritual advisor or the person that's -- that you go to? Do you have somebody that you look to for -- as your senior?

A. My senior?

MR. McGARRY: Help me out here, Detective.

SGT. ANDREWS: He wouldn't have one, because he's not staff. He's public. He wouldn't have a senior, since he doesn't work at the Church.

MR. McGARRY: I got you.

A. In that sense, a senior in the Church is someone

who's in the organization board.
BY MR. McGARRY:
Q. Right.
A. Is, you know, like their boss.
Q. I got you.
A. But no, I don't have any bosses there.
Q. Okay. We'll go to, more specifically, the -- November and December of '95.
Can you tell me when -- when the first time you ever --
Have you ever met Lisa McPherson prior to December 5th, personally, face-to-face?
A. No.
Q. Had you ever heard about her? Did you know who she was, through the organization or through meetings or any Church functions?
A. Prior to her being ill?
Q. Yes, sir.
A. No.
Q. Okay. When is the first time that you -- you ever heard her name?
A. I probably heard her name -- I may not have even heard her name, but the first issue of her coming up was a call I got from the -- I'm not sure if it was Janice or if it was Alain Karduzinski, that there was a girl that had

become psychotic.

Q. Going back just for a second to Mr. Karduzinski, how is he set up in this organization? How is he affiliated?

A. He's what's called a case supervisor.

Q. Okay. Obviously, he's somehow connected up with this MLO office, or not?

A. Well, he was in charge of, sort of, the spiritual program that a person would be on --

Q. Okay.

A. -- who was -- whether -- so -- she was a public person, so for a public person.

Q. So she (sic) would have been Lisa's senior -- or, not senior -- she (sic) would have been --

A. No. He -- the way it works is that, if you're a public parishioner, and you buy auditing hours at the Church --

Q. Mm-hmm.

A. -- okay, there's a person who's, like, the -- like, the auditor, who's the person who actually does the interviews, communication, and writes the information down, asks the questions and does the counseling.

Above that auditor is a person called a case supervisor, who looks at the information, and then, based on policy that he's got, writes what the steps that should

be -- the processes and things that should be used on that person. And then somebody else actually delivers it.

Q. Okay.

A. So he got -- he must have gotten involved with her, because here was a person who was a parishioner and now she was ill, and he needed -- he had questions and he needed help.

Q. So you're not sure who the call came from? It was either him or Johnson, in reference to her situation?

A. Right.

Q. Can you recall approximately when that was?

I've got a calendar here from '90 -- these guys might have a blank one.

SGT. ANDREWS: No, I didn't bring it today.

BY MR. McGARRY:

Q. I'll just give you, for reference points, and this'll help us for point of reference, if it's okay --

A. Mm-hmm.

Q. She checked into Flag on --

MR. McGARRY: Is that the 19th, fellows?

SGT. ANDREWS: 18th. Evening of November 18th.

BY MR. McGARRY:

Q. -- November 18th. And of course, you know she ended up at New Port Richey on December 5th.

A. Right.

Q. So that's the time frame that we're dealing with.

A. So it was probably within a couple days of that.

And the complaint was that she wasn't sleeping, and she felt that she needed to get some rest, but she was so wound up that she just wasn't sleeping.

Q. Had you been briefed, at that period of time, or had you known that she had that little episode with her car wreck and --

A. No.

Q. -- running around naked and all that business?

A. No.

Q. Okay. So you --

A. A lot of this was sort of off-the-cuff. It's, "I've got a problem. What do you think," or, "Can you help out?" It wasn't really -- they weren't really asking me for medical care or medical intervention at that point, so -- I mean, I had had calls from him before, and it's, you know, like, "What would you do," or, "She's not sleeping." I might say, "Well, go to the pharmacy and get some Benadryl over the counter, and it might help her sleep," or something like that, and that would be the end of the conversation.

Q. Okay. Specifically, this conversation, do you

recall what it is that he said that was the problem there?

A. Well --

Q. Sleep?

A. What I recall about it was sleep.

Q. Okay.

A. She could not sleep.

And they wanted to do some -- you know, have some communication with her, and she was -- she just hadn't slept in a couple of days. And that's what the concern was.

Q. Okay. Your advice was what?

A. I can't remember what I prescribed, but it was either chloral hydrate or Valium, as a mild sedative, to maybe help her sleep. And I maybe even suggested Benadryl first.

Q. Okay. So if there was a prescription, that was obviously something you had to call in --

A. Right.

Q. -- or do something?

Do you recall doing that?

A. Yeah. What, exactly -- which one, I'm not sure, and I haven't -- I don't have records on it.

Q. Okay.

A. But it was maybe a couple doses -- it was not a -- it was not a big amount. It was not for a long time.

Q. Okay. And do you recall --

So you're not even sure, at that phone conversation -- Lisa McPherson had never really meant anything for you. I mean --

A. No.

And I'm not even -- I probably got her name 'cause I called it in, but I'm not -- it didn't ring a bell. I didn't know who she was, and I didn't know what the story was.

Q. All right. And -- well, I've got that record, and I'll let you look at it. I just received it today, as a matter of fact.

And it is chloral hydrate.

So I'll let you look at this. This is from Eckerd's. That's a pretty simple slip, there. I guess they just write down -- your name's on there, and it's for the --

A. For the chloral hydrate. Okay.

Q. And I think the date -- is there a date on that?

MR. FELMAN: Looks like 11-29. Yeah.

That may be when they picked it up. I don't know. Looks like that's the date of the receipt, or maybe that's the date.

SGT. ANDREWS: That's the day it was called in, 11-29. If you flip the page, maybe that'll have a

date when it was picked up.

MR. FELMAN: Same date. So --

MR. McGARRY: That looks like Schnurrenburger or --

THE WITNESS: Yeah. Emma. That was the Emma --

No, no. That's Susan what's-her-name. That was the office manager.

SGT. ANDREWS: Susan Schnurrenburger. That's what it looks like.

BY MR. McGARRY:

Q. All right. So is this what we're talking about right here, right?

A. Yes.

Q. Is that what you're referring to?

A. (Nods head).

Q. Okay.

MR. FELMAN: Let me just take a look. Do you have a quantity on there?

THE WITNESS: I think it says thirty.

MR. FELMAN: Where do you see that?

THE WITNESS: There.

MR. FELMAN: Thirty. Okay.

BY MR. McGARRY:

Q. What is that, thirty tablets?

What kind of form -- what does that pill look like? Is that a -- is that a regular pill or is it a gelcap or --

A. I don't even know.

Q. Well, you didn't see it, so --

A. It's the sort of thing that you give two to four, and if, in an hour, you don't get any sleep, you take two to four more. It's a pretty innocuous sedative.

Q. Chloral hydrate?

A. Yeah.

Q. Is that what that is? It's a sedative?

A. Yes.

Q. You mentioned Valium. Is it similar to Valium?

A. No, it's more like a barbiturate. It's more like phenobarbital. It's used a lot in children. It's just about impossible to overdose on, and causes sleep, but it's not -- doesn't cause any kind of heavy drug delirium or anything like that.

Q. All right. So if that was November 29th, that was after she'd already been there a week and a half. Is that possible?

A. That's possible, yeah.

Q. Okay. And that phone conversation was either Johnson or Karduzinski.

Do you recall having any other phone

conversation with either of those two or anybody else from the MLO office?

A. I think there's one more. I think I called in one more. It may have been Valium the second time. That she wouldn't swallow this, or she wouldn't take it, or there was a problem with a pill because she just wouldn't take a pill.

And this also comes as a liquid, but apparently, the liquid wasn't available, so I think I called in one more. And it may have been a few days later.

But again, you may have those records, and I --

Q. I don't, to be honest with you, but they may exist, so we'll go looking around for them.

A. Okay. Now, I know we had one more conversation. Now, whether --

Q. Who is "we"?

A. Either me and Alain or me and Janice.

Q. Mm-hmm.

A. And I thought I called something else in, but it may just have been a discussion of, maybe, "Grind it up in a liquid and try and do it that way," or something like that.

I'm sorry, but I'm not --

Q. That's okay. We're just asking you to use your best recall here.

A. Yeah.

Q. So you could smash that up and stick it in something else and administer --

A. Mm-hmm. Jell-o, jelly, peanut butter or something like that.

Q. Okay. Now, back to some -- the substance of these conversations, did they indicate to you the -- the nature of her -- her stay at the hotel, there?

A. Well, what I got from it is that she was what they called Type 3, which means the person's psychotic. And Hubbard's prescriptions for the psychotic person are to put them in a destimulating environment. So keep it quiet, and let them rest, and give them adequate nutrition and let them just cool off.

So my understanding was that's what was going on.

Now, as an outsider, you know, as a nonstaff member, the details of what, actually -- the processes or that -- what was going on -- they don't tell me, and I don't ask. You know, I sort of just do my medical thing.

Q. Mm-hmm.

A. And I didn't get the -- usually, when somebody's sick and they want medical things, they would say, "We need a doctor," or, "Will you see the person," or whatever it is, and then I just -- whatever it is. But I didn't --

that didn't come up on this one, so I wasn't really -- it was like a five-minute conversation: "Not sleeping, still. Any suggestions?" "Well, try this."

Q. Okay. I mean, the general feelings of a member of the Church of Scientologists (sic), as far as the psychiatric profession, is well-documented, and I've read about it. It's not well-taken to them, in that respect. Would you agree with that statement?

A. Well, that's true, yeah.

Q. So I assume, then, you would agree that their remedy for those situations is Hubbard's teachings or their own procedures, as opposed to going out for outside psychiatric problem-solving.

A. Right.

There has also been a paranoia about medical doctors, too, because a lot prescribed psychiatric-oriented drugs.

Q. In general --

A. I'm the first medical doctor Scientologist that's ever been in this town, so there's sort of a trust factor with me.

Q. That's kind of what I was getting at earlier. I didn't know that there was a general mistrust, but there is a general -- I guess "apprehension" is the word -- towards the medical profession, in total, from --

A. Not as a Church doctrine, but there's enough people that are Church members that have that sort of --

Q. Perception?

A. That perception. That -- it's -- it's true.

Q. So that's why you -- I mean, that's why your name is probably even more -- comes up more, because of the trust factor.

A. Yeah. Because I'm a regular medical doctor. I do regular stuff. And I'm a Scientologist. And it's, you know, it's -- the Scientology teachings aren't in any way opposed to regular medical doctoring. I do it all the time. But the understanding --

I can usually bridge that with somebody.

Q. I got you.

Were there any -- was there any descriptive -- was there any description used of what Lisa was going through? You said Type 3. Other than saying, "Hey, she's Type 3. We're going to use a little isolation and some bedrest and some proper nutrition, and handle it," but were there any other communications between you and any of the other staff members or caretakers that might have been looking after Lisa that gave you some further insight as to what she was going through? Do you recall anything like that?

A. The only thing -- sort of the negative thing

that I recall is that I never -- I never got sort of an indication that, "Oh, this girl is sick," or, "Maybe she needs to be seen," or, "A light sedative isn't the answer."

And I'm pretty sensitive on that. But I never got that feeling.

In fact --

Q. It was all "up here" for her, mental.

A. That's what I got.

And just -- by the way, the isolation is not by yourself. It's always -- I mean, there's always people with her. But the idea is that she's not walking down, you know, Broadway, or the TV set on or, you know -- it's quiet. But not alone.

Q. Well, we've heard, from the caretakers, that there's a no-talk policy.

A. Yeah.

Q. Is that your understanding --

A. Yeah.

Q. -- also?

A. Yeah.

Q. No communication?

A. Or minimum.

Q. Minimum.

A. If the person would ask them a question, they

would answer the question, but it's -- don't originate conversation. You know, they wouldn't be asking, like, "How's the weather today?" If the person says, "I need this," or, "What do you think about that," then the person who was there would talk to them, but they wouldn't be, like, trying to make conversation.

Q. I got you.

The procedure that was to follow, I've been told, was something called an "intraspective rundown." Are you familiar with that term?

A. The details of it, no. I -- I know -- you -- probably told you the basic purpose of it is to get the person back to where they're actually in communication with their environment.

Q. It's more of a Type 3 procedure?

A. Exactly. So here's a psychotic person. If you just give them rest, quiet environment, whatever it is in the environment that got them going in the first place will settle down to the point where someone can talk to that person. And then, through whatever the process is -- and I'm not up on what the particular details of the process are -- that she would then be able to actually be in communication again and not -- Type 3 means that she's not really in communication. So then she could function on her own.

Q. So other than, possibly, two phone calls up until December 5th, that was just about it, for the communication you had for --

A. As far as I remember, yeah.

Because when the call came on December 5th, they had to remind me who she was. That was sort of how out-of-mind it was, that, "Oh, remember the girl, you called in the prescription for?" It was sort of like, "Oh, yeah."

Q. So who -- let's go to December 5th, now.

Who made that -- that call?

A. Janice.

Q. Okay. And do you recall approximately what time that was, on December 5th?

A. It was probably right around seven. May have been a little earlier than that.

Q. p.m.?

A. Yeah.

Q. And what was the substance of her conversation with you?

A. She said that she had a girl that she had seen about six-thirty, who was sick; that she thought she had strep throat; she had a lot of diarrhea during the day -- in my earlier one, I said "twelve-pound weight loss," and I think that's what she told me -- and that what she

actually requested was, would I write a prescription or call in a prescription so that this girl could get an injection of penicillin because she thought the girl had a strep throat.

And what I said to her was, I wouldn't do that. If she's sick, to the point where she needs to get an injection, she needs to be seen. And I wouldn't do that.

So I said, "If she's really sick, you better take her to Morton Plant. If she's --"

She said, "No, she's not that sick. She can be -- can I bring her up to you?"

And I said, "That's fine. I'll see her."

But I emphasized to her, "If she's really ill, don't bring her up to me. It's too far."

And I -- the other concern -- I was off-shift at ten. Sometimes I've gotten a call and it's taken four hours to get there. And I said, "I've got to leave at ten. And if you're coming, come right away, because I don't want to see you at nine-thirty and then have to do blood tests and X-rays and be sitting with this person in the emergency room for three more hours, because my partner's not going to want to deal with it."

So she said, "Fine. We'll come right up."

Now, it was -- I don't have the record here, but whatever time they got there, nine-thirty --

MR. McGARRY: You guys know?

SGT. ANDREWS: Yeah. I have medical records that say about twenty-one-thirty hours.

THE WITNESS: Yeah.

MR. FELMAN: That is the time of death or --

THE WITNESS: No, because I think we coded her for twenty minutes. I think ten to ten was the time of death.

SGT. ANDREWS: It's a little vague. I'm not sure.

I have them here if you want him to look at them.

MR. McGARRY: Sure. That would probably be real helpful.

A. I saw her at about nine-thirty, so it must have been a couple hours. You know, maybe it was seven or -- the guy I was with says he remembers the call, so it must have been after seven.

So somewhere after seven, she calls. And by nine-thirty I was sort of trying to pack up and get ready to move out of there, and then, "boom," they come walking through the door. And I'd actually forgotten they were coming. I figured maybe something else happened, they went someplace else. Sort of out of mind at the time.

BY MR. McGARRY:

Q. Mm-hmm.

A. I think you have the scenario of what -- you know, there was a call to the nurse's station that they needed help at the intake area. And one of the orderlies went out there. And I -- as soon as he opened up -- "They need help getting somebody out of the car." He went out there. And then as soon as he got to the doors -- he went out there with a wheelchair.

When they wheeled her through the doors, he started yelling, and then I got up from the nurse's station and I walked over and saw her coming through the thing.

Q. Who was that guy, do you remember?

A. Yeah. That was Willy Burdette.

Q. He's a --

A. They call him PCT, patient care technician.

Q. And can you describe Lisa when -- when --

Was she carried in or was she wheeled in with a wheelchair?

A. She was draped over a wheelchair. You know, instead of sitting in the wheelchair like this, she was draped over the wheelchair like this.

And he was pushing the wheelchair into our trauma room, and that's when I saw her the first time.

And it didn't even dawn on me, then, who she was.

Then we got her in the room, we started the CPR procedures, and then they said -- somebody said -- you know, "Where did she come from?" "She was in a car." And then, "Her name is Lisa McPherson." And then I thought, "Oh, God, that's her."

Q. So chronologically going here, for -- now we're trying some CPR procedures at that point?

A. Yeah.

Q. What exactly did that entail?

A. We put a tube in their throat to breath them, put an IV line in to give them medicines. Somebody starts the actual CPR. And so all that stuff was done.

Q. When you first saw her, did you find any signs of life in her, or was she dead when she got there?

A. She had no vital signs when we saw her.

Q. All these things here I got, I'm -- excuse me. I'm no doctor, certainly, but these things here, these EKG deals here --

A. Once someone gets -- once CPR is called, they get hooked up to an EKG monitor --

Q. And that's what, all these?

A. -- and that records it if somebody's doing CPR.

Q. Those blips --

A. -- show up there --

Q. -- when they're doing CPR?

A. Yeah.

Q. I was wondering about that.

A. All those squiggly lines, that's during CPR. They leave it connected.

Q. So these things here would indicate somebody's giving a compression to the chest?

A. Exactly.

This first hook-up here that you see at twenty-one-thirty-two, which was "start," that was the underlying rhythm, and that's a rhythm that's pretty much ventricular fibrillation. So the heart was wiggling. It wasn't beating. Which, in most people, is a terminal event. Sometimes you can bring them around.

But that's what we got when she got there. So her heart wasn't -- not beating, but it was fibrillating.

Q. During -- during your observations, does that -- I assume that there's no lung workage here, there's no breathing going on. It's all -- the heart -- you described there, the heart situation?

A. I mean, most people with ventricular fibrillation will lose consciousness within a few minutes.

Q. Okay. There wasn't any gasping of air or any kind of breathing at all that you could tell.

A. No.

Q. And I assume the eyes are all fixed and --

A. Yeah. I've got "pupils unreactive" here.

Q. Is that -- what you're reading --

A. Yeah.

Q. -- that's your handwriting?

A. Yeah, that's me.

Q. You've got something else written on here, too. What does this mean: "Septic," something, "return, extreme," something?

A. "Septic --"

Q. Right.

A. "Petechiae, P E T C H, extremities," which were her arms and legs.

Q. Can you explain that? What does that mean?

A. They look like superficial bruises, but they also look like if the person has a bacteria that's circulating around their blood, and the bacterias -- and if there's a lot of them, they form clumps. And when they go to the real small little -- little capillaries that are in the skin, they block the capillary, 'cause there's a glob of them. If it was one bacteria, they would go through the little capillary, but if it's a glob of them, they get stuck and they block it. And since the area behind the capillary is not getting any blood, now, it

will begin to leak the blood that's already there, and it leaks it into the skin, and it looks like a superficial bruise.

And that's what it looked like.

Q. So you've had conversations about some of these things with our medical examiner, Dr. Wood, right? I mean --

A. I never talked to Dr. Wood.

Q. You haven't?

A. No. Never met the lady.

Q. You have a correspondence here, but that was probably just a letter, I guess, right?

A. Yes. I talked to the guy who did the autopsy.

Q. Oh, I see.

A. It wasn't --

Q. Okay.

A. But I wasn't aware even, at that time, that Dr. Wood had anything to do with it.

Q. Well, she took over, I guess, because that fellow left.

A. Yeah. It was, like, some months later, I think.

Q. Yeah.

You talked to him?

A. Yeah. I talked to him the next day. I think I talked to him twice, actually.

Q. What was the substance of that conversation?

A. Well, the first time I talked to him was the next day, and I said -- I just wanted to let him know that this girl looked to me like she was what we call "septic"; that she had an overwhelming infection; and that he make sure, when he do (sic) the autopsy, to look for that.

And his comment at the time -- 'cause I -- I practiced infectious disease for ten years. This looked like a septic shock.

Q. He said that?

A. No. I -- I -- that's what it looked like to me. I've seen this before.

So --

Q. You followed this up with this letter, right?

A. Yeah. That letter's way later.

Q. Oh. 16th. You're correct.

A. So I said, "Just be sure, when you do the autopsy, that you take the appropriate tissues, so if that's what happened, we can make the right diagnosis.

Q. This is a year later, this letter.

A. Right. Because -- I wrote this letter because of what came out in the newspaper. I was quoted in the newspaper. And at the time I talked to him, the next day, I said, "Be sure you do the pathology for this, because I don't know -- we may have a diagnosis here."

And he was not interested at all. He said, "I got a diagnosis. This doesn't have anything to do with it."

"Okay."

So then, that evening, which was --

Q. Did he tell you what his diagnosis was?

A. Yeah. He said she had pulmonary emboli and a thrombophlebitis in her -- whichever leg.

So then that evening, I think, around six o'clock, which was the next day, the 6th, the lab called me and said they had a positive blood culture.

Q. And that's this next page, on -- I think you've got that here, too -- I think --

Yeah. There it is.

A. Yeah.

But there was a prelim -- here is the preliminary report.

Q. Right.

A. So they called me -- yeah. "Phone to Dr. Minkoff at eighteen-fifteen on 12-6."

So the blood culture had been done around ten o'clock the night before --

Q. That was done December --

A. -- 5th.

Q. That night?

A. And I did that blood culture.

Q. You're the one that drew the blood?

A. I drew the blood culture.

Because when we finished this thing, and here she was, dead; she looked septic; we'd had four or five people in very close contact with her --

The thing that usually causes this disease is called meningococcus, and it can cause epidemics of death, and I was worried that -- I had had, you know, two inches from her mouth, trying to put a tube in her throat. The other doctor had done the same thing. I couldn't get the tube in, so he did it. And --

Q. Why is that?

A. 'Cause my --

Q. Why wouldn't the tube go in?

A. Well, sometimes you can't get it in.

Q. All right. I thought she had some specific problem that --

A. Oh, no. No.

Q. Okay.

A. No, no. I think I was in shock, myself, after realizing what this was going on. I just said, "Oh, my God." And he was there with me, so I just said, "You do it."

Q. Okay.

A. So I was concerned that the staff might -- 'cause if this is one of these bacteria that's communicable, you know, that you can get -- you can get the infection from the person who's dying, then we put everybody on antibiotics for a couple days to prevent them getting sick. That's what I was thinking. I might have to take antibiotics. The nurses -- we maybe should go on antibiotics.

Q. Because you were that close with her.

A. Because we were that close with her.

So that's why I drew the blood culture.

And so then, the next day, on the 7th, I was back at the hospital. They -- I got the report that it wasn't this meningococcus; it was a staph.

And I called the pathologist back and said, "Look, I've got a positive blood culture."

Now, blood cultures sometimes take three to seven days to grow out. If there aren't many germs in the blood, it takes a long time. If there's lots of germs in the blood, it usually grows pretty quick. And this is pretty quick, to put it in at ten or twelve at night and then, twelve hours later, have a positive. It means there was a lot of them in there.

So I called him and said, "There's a lot of germs in this blood. I mean, this girl's got a positive

blood culture in twelve hours. It's a staph. You ought to know about it."

But -- okay -- five months later, when the autopsy report came out, he didn't mention anything of that in the autopsy report or the pathology findings. And I remember thinking, at the time, "I'm not going to bother him with it now." I thought the thing was all over and resolved, and I hadn't heard anything in five months.

But then, in December, when he talked to the newspaper and everybody else started talking to the newspaper, and they were throwing my name around, that -- and this wasn't even mentioned as a possibility of what had gone on. That's why I wrote him the letter and I said, "Hey, this is --"

Q. Well, how does that work -- how does dehydration fit into this staph infection situation --

A. Well, if --

Q. -- as far as you can tell? I mean --

A. I don't know what the -- I actually don't know what the -- what the twelve- or twenty-four-hour events preceding her coming to me were. I haven't talked to Dr. Johnson about it, other than the superficial thing on the phone. And then I had conversation with her after the -- after we pronounced her dead. But most of that conversation was me yelling. It wasn't -- you know, it

was just like --

Q. You had a conversation with Dr. Johnson --

A. Yeah.

Q. -- that night?

A. That night.

Q. After Lisa had been pronounced?

A. Yeah.

Q. What was that conversation about?

A. It was like, "What did you do? How --" you know, "What is this?" I was flabbergasted. I was --

So she said that she had seen her at six-thirty, and there had been diarrhea and weight loss, and da, da, da.

And I -- I was just -- I was distraught.

And I don't know what her -- what her contact -- you know, I don't really know what her contact with Lisa was, preceding, or who was there. I don't know that stuff. I haven't actually asked the Church about it, and I haven't seen any of the records about it, so I don't know.

Q. Well, then, this investigation got started, and you understand why this is all going on here, is because there's a concern that something -- that she showed signs of being very medically ill, and it wasn't disposed of or she wasn't taken care of properly or in a timely fashion.

That's why these questions are being asked.

A. Totally understandable.

Q. How does one of these staph infections get started?

A. Sometimes -- this first got recognized in the -- in the late '70's, when women who had tampons that were left in too long -- the tampons would get colonized, which means they would get the staph growing on them, and then this staph would put out a poison in the system, which was a certain kind of protein it would put out, which would cause, in a very quick manner -- it might be in, like, maybe, four to eight hours, ten hours -- the toxin would actually make the blood vessels leak, give the person diarrhea, and they would go from maybe having what looked like the flu to being unconscious and in shock, which is no blood pressure.

And so the particular staph was identified, and then there were papers that came out on it.

Since that time --

And that was called "toxic shock syndrome."

Q. Right.

A. That entity has been seen in people without tampons. Sometimes -- sometimes it's a wound; sometimes the staph can be in a person's -- just -- just colonized in a person's nose. And if it's got that particular

protein that it's making, it can make them sick.

In this case, she had this -- this clot in her leg.

I was not -- I was not aware of that when I saw her, because I -- sometimes you can -- you can tell when someone's got a clot in their leg, and they come to the emergency room and complain about pain, and the leg hurts and all that stuff. But women can get clots in their leg and not have symptoms. And presumably, that could be colonized with the staph -- if she had the staph in her blood, it would grow on that clot and you could get it from that.

Q. How quickly does that clot form, or do you know? Is there a timetable on that?

A. It really depends on how it was caused. We see some people who don't have a prior history of having a clot, and they just get a clot. And then sometimes, if the clot is making symptoms in their leg, they'll come in, and then we'll do something with it.

Sometimes you'll see people who don't have symptoms of it. They'll come in, in breathing distress, because they've already thrown an embolus, a piece of that clot, into their lung, and it's blocking off part of their lung, and then they're sick. It happens in normal, healthy girls. It's not common. It's more common in

people with cancer and people on birth control pills, you know, all that sort of stuff.

But it was -- it was a -- it was sort of the way I thought about this thing, without having no prior, advance -- but trying to hook this blood culture into the series of events, as part of the terminal event, for my own understanding. I mean, that's the way I -- when I tried to put this thing together.

Q. Okay. How about from a nutritional aspect of all this? Did you see how that may have played a role in any of this series of events that occurred within her body? I mean, is that -- how does that factor in, or does it?

A. Well, in terms of a person's immune system, if their nutrition's not adequate, then their response to an infection wouldn't be adequate either, or certainly would be delayed.

Whatever this dehydration factor was, whether it was long-term or whether it was acute, just based on, like, an acute illness --

Let's say she was marginally dehydrated, and then, the last day, it was like "whoosh," that she got this staph, and the toxin, and blah, blah, blah, and then she got, you know, overwhelming dehydration, then that could have occurred fast.

Q. Could have played a role in it?
A. Yeah.
Q. Did this chloral hydrate stuff -- is that what used to be called a Mickey Finn? Remember that expression, slip somebody a Mickey Fin? Remember that?
A. I remember it, but I don't know if it's that.
Q. I --
A. It's not a very good --
Q. That's what a Mickey Finn used to be, is a chloral hydrate. Do you remember that?
A. Is it?
Q. I think so. Just thought I'd throw that out.
AGENT STROPE: Mixed with alcohol.
A. It's like a real old drug, probably, from the '40's.
BY MR. McGARRY:
Q. Right. People would drop it in your shot glass or your drink glass.
A. And you'd go to sleep.
Q. Yeah. Well --
A. I don't know.
Q. What -- this other drug that's come up through our interviews, magnesium chloride -- that's different from chloral hydrate, right? That's something --
A. Yes. That's just magnesium. That's just a

mineral.

Q. That's not a prescription --

A. No.

Q. -- anything?

What does that do to the body?

A. In high doses, it would be a muscle relaxant.

Q. So there is a medical need for that?

A. Yeah. I mean, it's -- also could -- I mean, sometimes it's used for real high blood pressure, like the most frequent time it's used in medicine is in pregnant women that have what's called toxemia, where the blood pressure is super high, and they give it intravenous.

Q. How is that administered?

A. In general, it could be in intravenous, could be IV, as a shot, by mouth, intermuscular.

But you can't get the intermuscular form without a prescription.

Q. That takes a prescription?

A. Yeah.

Q. Did you prescribe that?

A. No.

Q. But it's not a prescription drug?

A. No. You can go to Eckerd's or Nature's Food Patch and buy magnesium chloride tablets over the counter.

Q. But to get it in the IM fashion, that's

different?

A. Yes.

Q. It's the same -- it's the same drug --

A. Same drug.

Q. Needs a prescription to come in that fashion, though.

A. (Nods head).

Q. Now, you saw her and made observations of her, obviously, when she was in the emergency room that day.

Did --

You described these patches -- I've seen these pictures of the patches, the red patches on her arms, and you've also heard Dr. Wood describe them as being the result of bug bites.

Do you disagree with that assessment or do have you an opinion?

A. There were really two kinds of markings.

And I don't know if you have pictures here, but the petechiae, the purpura, the bruising, is probably distinguished from whatever -- if there was some insect bites --

And I don't -- I don't recall them. I have never heard -- where Dr. Wood got this from, I have no idea. I mean, I've never heard this, ever. I've been doing medicine for a long time. I have never heard

anybody look at a skin lesion and say, "This is a roach bite, a cockroach bite."

Q. I'm -- I knew you'd heard that, and I was going to ask your opinion --

A. I thought -- I don't know where she's getting this.

Q. That wasn't your observation at the time?

A. No.

Q. There's a -- if you'll look at that blood culture sheet, there, there's something I picked up on.

Do you see her birth date up there -- you probably don't know what her birth date is, but they've got, up here, a birth date of --

A. 7-20-50.

Q. Yeah. Forty-five-year-old female.

A. Yeah.

Q. That's wrong. Do you know why that could have been fouled up?

A. No.

Q. Her birth date is, in fact --

MR. McGARRY: Guys, you know what her birth date is?

SGT. ANDREWS: She was only thirty-six when she died, so it's ten years off.

Does she look forty-five? That would be my

question.

MR. McGARRY: Well --

SGT. ANDREWS: I mean, the doctor verifying that she was forty-five or -- yeah. That's correct -- forty-five.

My question would be, he's treating this patient. Does she look forty-five?

MR. McGARRY: Let's see if there's another birthday in here.

THE WITNESS: I think I was told she was thirty-two, because I wrote "thirty-two" on my actual --

SGT. ANDREWS: Okay.

THE WITNESS: -- written report, and the --

MR. McGARRY: Yeah.

THE WITNESS: -- people who do this stuff, I don't have anything to do with them, you know. Sort of the administrative hospital intake people. I don't know where they got that.

BY MR. McGARRY:

Q. So that's just a clerical screw-up? You've got "thirty-two year old white female" on your admitting sheet here.

A. Yeah.

Q. So we don't know --

My question is, there's no --

A. Could there be another Lisa McPherson?

Q. Or they get this record screwed up with somebody else?

That concerns me. If that's inaccurate, does that mean everything's screwed up, or what?

A. I think it's just a clerical screw-up.

Q. Okay. Or yeah, another Lisa McPherson --

A. Not the same day, with the -- no, I don't think so. I think it's just a clerical screw-up.

Q. Who does that? Do you happen to know who types that in there? Who's responsible for that?

A. There's people in the front of the emergency room, not in the treatment area, who do all the paperwork and type the stuff in the computer.

So where they got it or who they talked to or -- I don't know. I mean, it may have been -- there was a couple people that came up with her. It may have been one of those people that gave her birthday or --

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

Q. So the purpose for you, in drawing this blood, was what? What?

A. Personal safety.

Q. Why did you draw this blood?

A. Personal safety. Me and the group, there.

Q. Right. 'Cause you thought, "Wow, this could

be --"

A. I thought she had meningococcemia. It was an acute event, her death, caused by this. And I wanted to make sure that, if that's what it was, that I didn't die, and those other people in there didn't die of it, too.

Q. When you say -- can we -- if we could, let's narrow down "acute."

How much time are you saying, when you say "acute"? How much time do you think transpired for that death?

A. I -- I could suppose a lot of things, but I can't tell you.

Q. Okay. Well, when you say "acute" --

A. There are forms of meningococcemia which go on for a couple days and then, all of the sudden, overwhelms the person, and they die. Then there's forms of meningococcemia which occur -- I have seen a child in the office, when I was in office practice, where the child would come in the office at four o'clock, and have a high fever, and look sick, and I maybe saw one little petechiae on the knee or something, and I said, "Yes, sir, we better get this kid to the hospital," and I would give him a dose of antibiotics in the office, and they would go to the hospital, which was two blocks away. And by the time I got to the hospital two hours later, the kid might be just

about unconscious, with, now, showers of these things, all over. And that can happen in a matter of hours.

So it's -- there's -- sort of reaches a critical mass. And then, once the critical mass is reached, where the person may not look all that ill, then its over, because the mortality of it's high.

Now, the -- there is a form of meningococcemia where the people tend to live, and that form is, they get meningitis first, so the person has survived the germ long enough, with it in their blood, for it to get in their brain, and they come in with meningitis. Stiff neck, terrible headache. Those guys have a better chance of living because they've survived this first phase of where all the bacteria go in their blood.

But there was no evidence of meningitis in here. Which, if this is the scenario, this makes it seem like, you know, it wasn't in there that long.

This is not meningococcus. This is staph. It's a different germ.

But the literature has reports like this.

Q. And, in fact, I think that's what I read that you sent to the medical examiner.

A. Yeah. I just went on the Internet and did "staph, sepsis, pulmonary embolism." It showed three or four things. I just Xeroxed them off, and I said, "Be

aware of this thing" because --

Q. Right.

A. -- I -- I really wanted to ensure that the pathology was done so that a diagnosis could be made -- that was my intention -- so that if this was actually true, and the reason, it would be clear.

Q. I don't have the -- I -- I have it in my office, but I don't have the autopsy --

MR. McGARRY: Do you have a copy of that?

SGT. ANDREWS: Not here.

AGENT STROPE: Not here, no.

MR. FELMAN: I've got one.

MR. McGARRY: Well, pull that out, if you would.

Maybe I should get some photos, too. I've got the photos.

MR. FELMAN: That's fine.

MR. McGARRY: Yeah. Why don't -- I'd like to get the photos. I should have brought those in here.

You mind taking a break, and get a cup of coffee?

(Whereupon a recess was taken).

BY MR. McGARRY:

Q. I've got some pictures here, and you can use them to give a description of what you observed, if

they're consistent with your observations on December 5th, '95.

MR. FELMAN: Do you have these numbered or labeled somehow, Mark, or --

MR. McGARRY: Actually, I don't.

MR. FELMAN: Might be good, just for purposes of our record, if we can put a letter on them or number the back of each one, so it'll be clear what he's talking about, or --

MR. McGARRY: Yeah.

Here, I'll number these up for you.

MR. FELMAN: Doctor, if you're going to testify about any particular picture, make sure you identify what the number is on the back of it.

A. You know, what strikes me about these, is that -- I don't know what the time frame was between when we saw her and these were taken, but the amount of this blue blush of -- you see, here -- I do not recall -- I mean, this -- first this --

MR. FELMAN: That's what I was saying, if you're going to make a reference --

A. Number 2. When I said that there were -- there was purpura on the extremities, that would be a good example of it.

This would also be a good example, number 8.

BY MR. McGARRY:

Q. Mm-hmm.

A. This, I think, is post-mortem change. That's what it looks to me like. Because when she came in, she was very pale. But this amount of bruising around the face and around the flank, I do not recall at all. And I think that this is post-mortem change.

I think this process, whatever was going on, or what could have been going on -- and again, this -- I'm -- I'm -- what I'm giving you is sort of my conjecture on the thing. But this doesn't look like what I saw. It looks, if anything, worse. If you looked at this and you hadn't seen her -- she was very pale, but this --

And on Number -- I don't know what that is -- 7?

Q. Yeah.

A. And number M (sic) --

Q. 3 --

A. -- 3, it didn't look like that. My recollection is it didn't look like that.

Q. So did you -- these observations you made, though, observations of the hand, it looks like some type of raised lesion, almost, but is that what you described earlier as --

A. Yes. Septic petechiae.

Again, this -- the -- on Figure 1, what looks

like bruising on the legs, and especially that right knee, I did not -- I do not recall. I -- I think it's --

Q. How about the abrasion on the nose and chin?

A. Don't recall.

Now, this was -- I don't recall. I don't know whether this is actually cut, or it's blood.

Because the intubation was traumatic. I mean, it was -- it was -- it's a metal instrument, it's jammed into the mouth -- I mean, it was -- this is not a -- this is a --

Q. You're saying -- so this could have occurred --

A. We might have done this during the code.

A mask is put on them right away. There's -- you know, while --

Q. This looks like a scab-over, so that wouldn't be -- of course, I'm no doctor, but --

A. Yeah, I'm not sure if this is a scab or it's blood. It could be either one, you know, like just fresh blood wiped on there, or whether it's actually cut. Don't recall.

But I can tell you that the codes are not -- are -- this is a -- this is a -- it's not sort of a gentle operating room type, make-sure-you-don't-break-any-teeth thing. It's sort of a -- tends to be kind of chaotic.

I remember superficial bruising on one of the

anterior hips, but if you looked at this, I would have the same concerns you guys got. But I don't -- I don't recall that at all.

Q. So those pictures don't accurately portray what you were observing on --

A. When I observed her when she came in, no, they don't.

This does, on the -- again, the same things I said before.

See, on this one, too, Number 4, the part of the body that you see here -- I think that's post-mortem change. You know, whatever was causing these blood vessels to leak -- and again, I don't know if my conjecture on this thing is right, or there could be a totally different explanation for it -- but if you go with that, this process may continue even after a person died. Bacteria are still there, and it still leaks and so on.

Q. What is your conjecture on this? What is your theory on this? You have a better grip on it than, obviously, anybody but, maybe, the medical examiner, as far as being a doctor and having observed her in her last stages of life. What -- what is your opinion?

A. The opinion I could give you is only a scenario from seven or seven-thirty that night on, 'cause I really don't have any knowledge of what exactly occurred before,

except the week before, with the no-sleep and all that stuff.

Q. Mm-hmm.

A. I think that you've -- that there's been -- I don't know how she got the -- the -- I don't know what the ideology of the leg clot was, whether her nutrition was borderline and her hydration was borderline but not critical, and she got a leg clot, she got the infection.

And between the two -- and I'm not sure, and maybe the pathologist has got the tissues, because I don't know what happened there, either -- but that, between the two of them, she had a rapid terminal event which caused her to die.

Now, whether that was going on all day or whether it was in a few hours before, I can't tell you, because I think either one is compatible with this.

Q. You've probably -- you're probably aware of Dr. Wood's statements that she made publicly to the media, that, based on some numbers that she has in reference to some tests that were performed, that the numbers were so high that she was so severely dehydrated; it's her opinion she wasn't conscious for twenty-four to forty-eight hours. Have you heard that statement?

A. Yeah.

Q. Do you have any opinion as to that statement, as

far as your observations on December 5th?

A. Based on her appearance, I can't give you an opinion. I don't know -- I mean, the -- the things that she used -- the laboratory data that she used to test, I don't know if that's actually true, if a person has an acute dehydration -- you know, who's borderline dehydration, and then has an acute dehydration over one day -- what that does to the numbers. I don't know. I don't know.

The fact that she was unconscious for two days before, just based on my dealings with the people at the Church that I've had contact with, it would seem impossible that that occurred.

Q. Is that --

A. That's just personal knowledge of the -- like the people we spoke of here, you know, having had contact with them before, that they would be --

Q. They would --

A. -- so out of it, or so -- that they wouldn't have called somebody, they wouldn't have taken her in, or they wouldn't have maybe called me back or something, if she had been unconscious for two days. I just -- it doesn't seem possible.

Again, that's only my opinion. And I don't know, and I didn't talk to them.

Q. Mm-hmm.

A. But my contact with these people has been that they are pretty -- you know, they're not -- they're fairly aware, and they're -- care about their job and care about their parishioners and -- you know, I mean, my own experience with anybody there has been nothing which would make me think that anything like this would ever happen. That's my personal experience, you know, my family's experiences.

I don't consider myself, you know, sort of an offbeat or a kook or anything like that. I'm a regular guy; regular job; married twenty-eight years; three children. You know, just regular. And you know, this -- so -- and it just doesn't -- doesn't add up for me, that -- Dr. Wood's statements.

Q. Right.

Going back to her last few days, would any of these -- you have a heightened medical knowledge in infectious diseases -- would any of these things that she'd been given accelerate or cause a problem or complicate her medical problem, with reference to chloral hydrate and magnesium and Cal\Mag that's been brought up many times -- as well as --

SGT. ANDREWS: Valerian root.

BY MR. McGARRY:

Q. -- Valerian root -- a lot of these minerals and chemicals were provided for her, nutrition supplements, almost exclusively, toward the end, because she wouldn't eat. She refused to eat.

Do you have any input as far as -- do you have --

A. In terms of immune suppression or anything like that?

Q. Well, anything. Is (sic) any of these things incompatible with whatever infection you think was stirring around in her body?

A. That they contributed some way to it?

Q. Sure.

A. I don't think so. These were over-the-counter things. I don't --

In my experience, no.

Q. When was it you first had the opinion or thought that this was a staph infection? That is what your finding was; it was a staph infection in her body?

A. Based on the blood culture report, yeah.

Q. Was that your first inkling of that, when you got that report back?

A. The first inkling I had -- that I thought she had infection was the first look. Then, when the positive

blood culture was called, and they didn't know what it was, I thought, "Okay." And they said they'd have it identified by the next day. And then, when he told me it was staph, then I had the diagnosis of what it was.

When I saw her, I wasn't thinking "staph," because that isn't -- she didn't look like the other thing.

Q. And that was the --

A. Meningococcus.

Q. -- meningococcus.

Going back to your conversation with Janice Johnson about this, did you -- did you -- did you quiz her about her last couple days, as -- you know, obviously, that must have been an area that you were concerned with, because here they brought in, basically, a dead person. Would you agree with that?

A. Mm-hmm.

Q. I mean, she was "out" by the time she got to the hospital.

Did you quiz her about any of that?

A. I really wasn't in the mode of finding out what happened. I was more in the mode of, "How could you bring this person up to me like this?" I mean, that was really what was --

Q. Well, my follow-up question is -- when you say

that, that strikes me as an observation made by an emergency room doctor that's appalled with the condition that somebody's brought in at. It makes me think that somebody neglected to -- to handle a medical situation timely. That's what -- that's the impression you give me by that statement.

A. Mm-hmm.

Q. Would you agree with that?

A. Yeah.

Q. Okay. So my follow-up question from that is, when you talked to Dr. Johnson -- I mean, wasn't that the an area of inquiry you would have: "Hey, what's going on here?"

A. If I had been rational at the time, and sat down with her and said, "What happened today? How did this go on?"

And what I recall, she said she saw her at six-thirty. You know, same thing. Diarrhea all day, complained about her throat in the morning, I think she said; and then, when she saw her, that she felt she needed medicine and medical care.

Q. Okay. Did she say they had seen her anytime before that, or what her schedule was for looking after her?

A. No, not that I recall.

Q. Could the fact that -- I mean, it sounds to me like that -- the sole mission of -- we've interviewed a lot of people. I don't know if you know this or not. We've interviewed ten or more women that had been by her bedside for the period of two weeks that she was there.

A. Mm-hmm.

Q. And does it --

My question is, does the fact that they -- their sole mission was to get her to sleep and calm down and be -- and be still -- and apparently they did a lot of things to facilitate that; chloral hydrate, Benadryl, bed, quiet, no talking -- everything -- everything was designed to put her in the bed and to make her quiet and to make her sleep --

A. Mm-hmm.

Q. -- and some of it may have been successful, to some degree, or not.

Could that have -- could that have played a role in some of this situation that was going on, medically, within her body?

A. In terms of the hydration status or --

Q. Yeah. Hydration and staph infection.

A. Well, the staff, I'm -- I mean, the staph is either -- seems like it's because just her -- her immune system just wasn't up to par. Now, whether that was

because of dehydration or nutritional status, those certainly could have contributed to it.

Q. Okay. Because Dr. -- Dr. Davis' report -- I guess it was later signed off on by Dr. Wood -- but their immediate cause of death is thromboembolism, left pulmonary artery.

Now, what does that mean?

A. Well, thromboembolism is a blood clot, and it's a blood clot that came from someplace else. "Embolus" means it was like, you know, like, sent from someplace else. Thrombus is a clot.

The presumed thing is that the clot in her leg broke a piece off. You know, the vein in the leg was damaged somehow, or a clot formed in the leg, and a piece of that clot broke off went up through her body, into the right side of her heart and then into her lung, and blocked off a big chunk of her -- of the pulmonary artery, of the blood vessel that's going to her lung.

Q. So that would have been the final kicker, right there, when that occurred?

A. Yeah. Eighty percent fatal, with the size of the ones she had.

So that the heart can not pump blood to the lung, so the lung can't get oxygen to the blood, and then that is it.

Q. She has, "due to bedrest and severe dehydration."

A. Right.

Q. You would add to that, "staph infection"?

A. I would have put -- I'd definitely put on the thing -- on there to what degree, 'cause I don't know -- and I think the pathologist could have and maybe did, but there's no report in the autopsy -- to what extent the staph infection contributed to the thrombus formation or to the -- or to the thing in her leg.

But I certainly would have put it down as a secondary diagnosis, staph septicemia or staph sepsis. I mean, I don't think you can look at this case and try to say "cause of death," and have a finding like this, and completely ignore it.

Like, if somebody sent me this case to analyze, sort of outside, you know, a consultant --

Q. Mm-hmm.

A. -- if you just pretend that the staph wasn't there, you're not -- you're not looking at the case. So I think somebody has to take into consideration that this lady had that, as well as overwhelming infection.

And it's conjecture as to the --

Q. Well, you equated it, to some degree, of, like, toxic shock syndrome. You're not saying that's what the

cause of death was?

A. No, 'cause I don't know.

I mean, she did have a pulmonary embolus. That definitely can cause death. Was a pulmonary embolus involved with the staph infection? Did she have two things going on at the same time? I don't know.

I think that a -- a very interested pathologist, at the time, could have gone a long way to find out to what extent this staph infection was involved in this whole thing, if at all.

And actually, my purpose in contacting them, the two days after, was that he do that. I was -- I taught at university. At university, this stuff goes on. The pathologists are interested in what happened. "Why did this guy die?" They look at these tissues, do special stains to see, was there bacteria in there?

And that was my purpose in calling the guy.

And he couldn't have been less interested it in. He just --

Q. Dr. Davis?

A. The impression I got was, he was busy. It was Christmas. He just wasn't interested.

So I was uncomfortable with that.

Q. Have you had any conversation with Janice Johnson since all this occurred?

A. None.

Q. How about any of these other people we've mentioned, in reference to the MLO office?

A. On this case?

Q. Yeah.

A. Susan -- I don't know if she's even here. I haven't seen her.

Emma, I probably talked to her maybe once every two to four weeks, about something else. And I've never discussed it with her.

Q. Are you aware of any changes that have been made in the Church's procedures because of this disastrous result?

A. Well, definitely, there's been changes with regard to my procedure.

Q. Dealing with the Church?

A. Yeah.

And I told them that.

Q. What's that?

A. That anybody that they contact me on gets a complete medical work-up.

Q. This is to protect yourself?

A. Well, and protect the people, too.

Q. Right.

So if you're going to give advice on somebody,

you're not going to do it over the phone any more?

A. No. They're going to come to the office. They're going to get a full physical exam. If nursing care is needed, part of the treatment will be nursing care, if that's what's needed. You know, if it's -- you know, whatever the thing is.

Q. Who was that communicated to, if you remember?

A. Actually, I think it was communicated to Mr. Weinberg. On an interview I had with them, he asked me the same question you did.

Q. Sandy Weinberg?

A. So this was sort of personal policy.

I don't think the Church had to be -- had to be talked into anything like that, either, from their end. I mean, I --

Q. Well, I'm sure -- well, they are looking at civil liability and a lawsuit --

A. Yeah. It's a disaster for everybody. This is the last thing they want, too. I'm talking for them but, you know, it's obvious.

Q. Where, in all this, did the Weinberg conversation take place? Would that have been Lee Fugate and Sandy Weinberg?

A. Yeah.

Q. Do you know when --

A. Oh, when?
Q. Yeah.
A. Probably -- probably January.
Q. Of --
A. Of this year.
Q. Okay.
A. Yeah.
Q. When all this --
A. When all the newspaper things started up.
Q. Right.
A. Allegations going back and forth.
Q. Is it unusual that you were the one that drew the blood? Wouldn't that normally be a technician? Or is that something that you decided to do because of the grave situation that you encountered?
A. No. I mean the code was done. Everybody was just sort of packing up. And then I thought, "Oh, I better do that," so --
Q. What -- how does that work? How do you do that? I know --
A. Take a syringe and needle. And there's a big vein where the big artery comes down the middle of the body. Then there's a big branch that goes to each leg.
Q. So which vein was that that you used?
A. Femoral vein. Could have been the femoral

artery or vein. But there's two big blood vessels in the groin. And with no pulse, it's pretty to easy to hit. You just wipe off the skin, stick the thing in, pull the blood out, and then inject it into a bottle, which is to grow stuff from blood, and send it in.

Q. So there's some type of substance that is mixed with the blood that causes the cultures to multiply?

A. It's like a broth, and it grows in the broth.

Q. And I assume, from your training, you've got a little more expertise than most in that particular area, with infectious diseases?

A. Oh, yeah. I mean, it -- I mean, a technician could have done it. I was there. And rather than calling somebody from the laboratory to come draw blood on this thing, I just did it.

Q. Now, do you mark that with what you suspect the situation -- the problem is? Would that -- how do you write that up and send it up, "test this for," what? How do you do that?

A. Just "routine blood culture."

Q. Okay. Not -- you don't look for a specific thing? You just write down "routine blood culture" and they test it for all of those things on this list, here?

A. Right.

Actually, that list is a list of antibiotics

that the thing is sensitive to. So once they get a germ growing in the blood, they take some of that and put it on another plate, with antibiotic in the plate, to see which antibiotic would kill it, so that you know what to treat the person with once the diagnosis is made. Some of these things would be resistant to one antibiotic or another, and this gives you some guideline as to which to use.

Q. Going back to this chart here, this thing you filled out, which is the -- I guess, probably, the first thing you wrote down, "thirty-two year old white female --" can you decipher some of that?

A. Yeah.

"To ER," to emergency room. "By PC," private vehicle. "Absent VS," which is vital signs. "Noted had sore throat, today and tonight. Lethargy. To ER for evaluation. In car on way, stopped breathing, just as they arrived to ER."

I remember Janice Johnson told me that she was still breathing when they were in Palm Harbor, which is about halfway; that she knows that she was breathing then.

Q. So she said that to you?

A. Mm-hmm.

Q. And all this information, --

A. So then, "Unresponsive. Pupils unreactive. Neck is supple." That means her neck wasn't stiff --

Q. What does that --

A. A person with meningitis, their neck gets stiff, and they tend to cock their head back. And if you try to move their neck forward, it won't go, 'cause it's held in extension.

Q. The information above there, that top paragraph, that is obtained from -- I gather, from Dr. -- Janice Johnson and/or --

A. Right.

Q. -- whoever she was with?

A. Right.

That person that she was with, I didn't see.

Q. So the only contact --

My investigation reveals there's three people that carried her up there. Did you have any contact with --

A. No. Just Janice.

Q. Just Janice? And this information came from her?

A. Right.

Q. The diagnosis ordered, BCXI-2, what is that?

A. "BC" is blood culture, and it -- "X" is times, and then there's a Roman numeral "1," which means there was one blood culture done. And then that initial is the person -- the laboratory secretary signs it off when the

order is put down, to show that it was done.

Q. All right. And then, up here at the top, you've got, under Lisa's name, "to" something -- "full" something --

A. That was written by the nurse.

Q. Is that her name, "Gardner" or something?

A. Barbara Schmidt.

Q. Barbara Schmidt. Okay.

A. And it says, "To ER, full code. See CPR records."

And then there's -- that other sheet is -- this sheet is the CPR report, so it shows what medicines were given and what was done.

Q. Mm-hmm.

So this is all the stuff that she was --

A. Yeah. She got epinephrine three times, atropine twice, bicarbonate twice.

Q. That's all emergency heart-starting stuff, right?

A. Right.

Q. She signs that, and you sign that?

A. Yeah. Because I order all the medicines, so you sign off on all those things.

Q. This other sheet looks like it's also filled out by the same woman.

A. Yeah. That's a nurse's note sheet.

So she says, "Medical examiner office notified. Spoke with Debbie. Body not released --"

Q. How do they know to do that? I mean, what is the --

A. Well, the procedure on every dead person is to call the medical examiner if --

Q. Every dead person?

A. If the family doctor is called and says that he'll sign the death certificate, if it isn't funny circumstances -- you know, if it's an eighty-year-old who comes in. If it's a young person, gunshot, something weird, the medical examiner's always called.

In this case, the medical examiner would be called.

If it's something where it's -- any baby -- anything suspicious, then they're called.

Now, if the body's not released, then nothing's done. It's left that way. So when the medical examiner comes, they can see the tubes and all that stuff.

Q. Well, the main area that seems to be generating so much concern is the test that Dr. Wood performed or got back later from the lab that indicates such high numbers.

Do you know what test that was? Were you informed of that which test it was, that came up with such

high numbers, which is indicative of such high dehydration?

A. No. It came from reading the newspaper.

Q. That's fine. Whatever knowledge you gained. What test is that?

A. Well, they take the fluid that's in the eye and measure the concentration of sodium -- some other things in there -- and they have, I presume, controls that are normal, different values under certain circumstances, and these are high.

Q. Are you familiar with that particular test?

A. No.

Q. Is that something you ever did during your infectious disease period?

A. No. It's a forensic tool. I have no familiarity with it.

Q. Okay.

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

Q. So the values and the numbers don't really mean a whole lot to you?

A. No.

Q. How about -- well, just given the basic premise of severe dehydration -- I mean, if that is, in fact, true, that those numbers mean severe, severe dehydration, is there anything else -- other than somebody that hasn't

been given any fluids or food for a long period of time, is there any other medical situation that you can think of, based on your experience and education, that would lend itself to accelerate to such a high level?

A. Well, if she had high body losses, whether it was vomiting or diarrhea -- if you go to Africa or even here where people get cholera, where they have massive amounts of diarrhea, they can turn into prunes in a number of hours. I mean, you know, become severely dehydrated.

Now, what the eye numbers do in that sort of circumstances, where a person might lose, you know, ten, twenty pounds of body weight, over a couple of hours, I don't know.

Q. Looking at the pictures that we showed you earlier -- I think there were ten of them -- is there any -- is there anything you observed from those pictures that would give you that kind of indication of those numbers?

A. No.

I mean, she was definitely dehydrated. I mean, I think the pictures, to some extent, show that. She was dehydrated.

Q. All right, Doctor. I always neglect to ask questions that the detectives always want to follow up on. So if you can bear with us -- I think you know these guys,

Detective Strope -- Agent Strope and Detective Anderson. And they'd like to follow up with some questions, if it's not too much trouble.

Unless you want another break --

A. No, let's do it.

MR. FELMAN: Are you with FDLE?

AGENT STROPE: Yeah.

EXAMINATION

BY SGT. ANDREWS:

Q. Dr. Minkoff, could you explain your relationship with Janice Johnson? I know -- I don't want you to go over what you wrote in the previous statement.

I know you met her for lunch at the Ft. Harrison. Could you please just quickly explain to us how that relationship comes about, and your understanding of her medical expertise?

A. Okay. I had that lunch encounter with her. I'd had some people had needed physical examinations, which I did. The Church had a medical area. And prior to this Lisa McPherson thing, I had done examinations on some public people and some staff people, just physical exams, routine physical exams. And she worked in that office, and so I had -- you know, I had bumped into her in that office. And basically, the contact was casual.

What I understood -- most of her background, I

actually learned of in the time that we had lunch together. I did not know -- I knew that she had not been practicing medicine, and that she was not licensed in Florida. But other than that, I learned more about her from the newspaper and that article they wrote about her than I did -- about her license being taken away and the allegations of drugs and all that stuff. I didn't know any of that stuff before that.

Q. Okay. So basically, it would be safe to say that you knew she had background as an anesthesiologist MD, and that was your understanding, but not licensed to practice here?

A. Right.

Actually, I thought her background was pain management.

Q. Okay. Okay. Now, back to the Church --

A. She had physical deformity, she'd been in a parachute accident.

Q. Okay. I had gotten some of --

A. I mean, she walked funny, so I didn't -- she had told me about that.

Q. Okay. Now, the Church's policy on dealing with a Type 3 person, the psychotic break, you understand it -- and being on the other side of this thing, as the medical doctor -- do you agree with that, Hubbard's policy of what

he does?

A. I have to couch it in saying that, if proper conditions are there for the person's safety -- nutrition, physical safety, the rest of it -- that I have no first-hand knowledge, but second-hand knowledge that it's effective.

We do a lot of psychiatric work at the hospital I'm at, and I can tell you -- and I don't think most emergency room doctors will even disagree with this -- that the handling of psychotic people by the psychiatric system is very poor, in terms of the outcomes of these people, how they do. Do they ever get back on their feet?

Our basic experience is that all of the suicides and overdoses that we see -- and at the particular hospital I'm at, we see a lot. We have a psych unit there. So I mean, we see a lot, every day, probably -- four or five people wouldn't be an exaggeration -- the drugs that they commit suicide with are always drugs that are prescribed by psychiatrists. So that my --

I mean, when I'm in the emergency room and I see a psychotic person, I do the normal thing, which is, I write up Baker Act, and he gets thrown in the psych ward and they get the usual treatment.

But I can tell you it's not a good -- it doesn't work. For most people, it doesn't work.

I haven't worked closely with the Church on Type 3 people, ideal setting, nursing care and all this stuff, where they're not given drugs and they're around to do this thing. I haven't got first-hand experience with this. But most of the stuff that I have first-hand experience with that's -- that Hubbard researched, turns out to work. So that's all I can tell you about it.

Q. Okay. Magnesium chloride. Have you ever used it?

A. Yeah.

Q. Okay. How -- and -- how -- I don't want a lengthy one, but how did you use it? What was -- can you explain that?

A. Actually, what I'm using it for lately is for migraine headaches. It tends to work. And we do it in the emergency room. Also, for heart arrhythmias.

Q. So you have magnesium chloride up at HCA?

A. Mm-hmm.

Q. Okay.

A. It's usually magnesium sulfate, actually, but magnesium chloride's available.

Q. Now, I did do some research and found that magnesium sulfate is available in most emergency room hospitals, but the ones I talked to, like Bayfront, said magnesium chloride's not there.

My specific question to you is, do you have magnesium chloride, IM, okay, liquid, at HCA hospital?

A. Can't tell you.

Q. Have you used it there?

A. Used it IM?

Never.

Q. Okay.

A. No.

Q. All right. With your knowledge of using it IM, do you know what the side effects of it may be?

A. In real high -- in a normal dose, couple-gram dose, some people feel kind of a tingling all over, a body warmth. It's potential -- you could cause them a heart arhythmia. Maybe a little bit of sleepiness. It may lower blood pressure.

Q. Okay. I kind of did some research on it, and I saw a warning for possible kidney failure. Are you aware of that? I mean, does that sound not-way-out-of-whack, that a side effect could be kidney failure?

A. If you gave too much. No experience with that.

SGT. ANDREWS: Mark, could I see that report -- not that one. The one from Dr. Johnson.

Did you bring that with you?

MR. McGARRY: Oh, yeah. I stuck it up here.

BY SGT. ANDERSON:

Q. I want to show you a copy of a report we received. And I don't know if you've already seen it -- Have you seen this MLO report, a copy?

A. No.

Q. Okay. We received this under our subpoenas.

A. Okay.

Q. And I wanted to direct your attention to that first statement, "Given two grams MGCL 2 IM."

Could you explain that, if you read it as a doctor?

A. Yeah. Give a shot of two grams of magnesium chloride in the muscle.

Q. Okay. Now, on the first of December of '95, which would be two days after you wrote the prescription for chloral hydrate --

A. Okay.

Q. -- to Lisa McPherson, Janice Johnson writes a report that she gave this shot.

A. Okay.

Q. Now, do you remember any conversations with Janice Johnson authorizing this shot, or providing this medication to her?

A. No.

Q. Okay.

A. Didn't -- definitely didn't provide it and didn't authorize it.

Q. Okay. Now, if you wanted to get this --

It's been described in our interviews as being a blue liquid -- would that be consistent?

A. The magnesium chloride?

Q. Yeah.

A. Don't know.

Q. Okay. If you wanted to get that IM, you'd need a prescription for that.

A. As far as I know, yeah.

Q. All right. Thank you.

Just quickly, on the medical care, my understanding of research on the Church is that, as a staff member, they do attempt to provide the medical care. Do you know who gives the okay for that? My understanding is that it's not really like a medical insurance program, someone -- the Church is paying for it, to send you to get medical treatment.

A. Right.

Q. Are you -- are you aware -- you may not be, but are you aware, if I go in there and I'm staff and I've busted my toe up pretty good, who gives me the okay that the Church is going to pay for me to go to Morton Plant or to a doctor to get fixed up?

A. MLO, probably.

Q. That would be your understanding? MLO?

A. Yeah.

Q. Now, Alain Karduzinski was referred to in a bunch of these reports not only as this case supervisor but a senior case supervisor.

A. Right.

Q. Can you explain the difference between the two?

A. He's the case super -- there's a -- so --

Let's say there's a hundred people getting auditing --

Q. Okay.

A. -- and there might be twenty-five auditors that are doing that. And above each of those auditors -- let's say each five or ten auditors would have one case supervisor, so that there's a hundred people, twenty auditors, twenty-five five case supervisors, and then there's a senior case supervisor who's above all of those guys. And so final okay for programs and things would -- would go to him.

Q. Okay. Would it be unusual for the senior case supervisor of Flag Land Base to also be Lisa McPherson's auditor?

A. Can't tell you that.

Q. Not enough knowledge on the inner workings?

A. No.

Q. Okay. Earlier, you talked about Karduzinski possibly calling and asking to get some of this chloral hydrate, which I understood was a mild sedative to make them sleep, so that the people who are PT3, in a psychotic break, could be, say, softened up a little bit, to be able to recommunicate.

Now, that recommunicating -- is that really just auditing?

A. Mm-hmm.

Q. Okay.

A. As far as I know.

Q. Now, would that be a reason that they would give this mild wear-off drug, other than something very strong in a drug?

My understanding -- what I'm trying to get at is, your knowledge is, a mild sedative, like chloral hydrate, would be given, so that that person wouldn't have the drug defect, so that auditing could possibly work, or they could be audited?

A. I think the main intention is give them something mild so they could sleep, and then you wouldn't have a lingering drug effect. They would be more conscious, more alert, to have auditing, if they could.

Q. Okay.

A. Yeah.

Q. Your conversations with Janice Johnson about Lisa McPherson, as far as, like, writing the prescriptions and stuff, was it your understanding Janice Johnson was taking care of her?

A. At the times I talked to her, yeah. Or she was, at least, in contact, or consulted about it.

Q. Okay. The reason I -- I find it strange -- and I don't mean this as condemning -- but if I called you up and said, you know, "I want to -- I want a prescription of chloral hydrate for Lee Strode," okay, would you have written a prescription?

A. If you called me? No.

Q. Yeah.

Now, what I'm getting at is, there must have been some understanding between you and Janice Johnson or Alain Karduzinski in order to write a prescription for a patient you've never seen and knew nothing about history --

A. Right.

Q. -- for a drug, you know --

What would that relationship be?

A. Well, I knew she was a medical doctor. She was -- she had been in practice. I mean, she was a professional. She, I thought, could examine a patient and

had an understanding of the process that was going on, so that I thought that it would be safe to do that with her there.

Q. Okay. Would it be fair to ask you -- and I know this is a tough question, but would it be fair to ask you that you felt, by writing this prescription and sending it to Dr. Johnson, that she was actually taking care of this patient, and you were only helping her out because she couldn't get prescriptions in this state?

A. Would that be fair?

Yeah, that would be fair.

Q. Okay. Now, you're not sure -- you said there might be another prescription.

If you wrote that prescription, would it still be under your DEA number, you know --

A. If I wrote it, yeah.

Q. And it would have been for Lisa McPherson? It wouldn't have been to, like, Janice Johnson or to Alain Karduzinski? You would have wrote it specifically for Lisa McPherson?

A. No. It may have been -- it may have been in the name of the person who picked it up.

Q. Okay.

A. So if you're checking, you should check that.

Q. Okay. So probably I'll have to pull all of the

prescriptions you wrote for -- under the DEA things, to look at the names.

Would it be somebody at the Church you would remember, that --

A. Well, it might have been -- it probably is one of the people you talked to.

Q. Schnurrenburger or --

A. Yeah.

Q. How about -- you wouldn't have wrote it for Debbie Cook.

A. Debbie Cook, no.

Q. Okay. As far as Lisa arriving at the hospital -- and again this is an opinion, but I'm going to ask you to give it as an MD -- Janice Johnson says she stopped breathing about halfway up, which would have been, maybe, about twenty minutes ago. Everybody we interviewed from the hospital says they looked at this person and she looked dead.

There comes a point when -- I've been to emergency rooms with -- at Morton Plant and other places, where the doctor or the paramedics don't do the CPR, and they don't do all of these things.

In your opinion, was it viable to do all of these things, even though she hadn't been breathing for twenty minutes?

A. If she'd have been eighty, no. But pretty much as a rule for children, young people, we give it a go.

Q. Okay. What would be the prognosis of somebody thirty-six, a female like this, not breathing for at least twenty minutes, with no life support -- if she did come around, what would be the prognosis for survival?

A. Terrible.

Q. We're talking vegetable or severe brain damage or --

A. Yeah.

Actually, when the CPR was done, I didn't know she hadn't been breathing for twenty minutes.

Q. Okay.

A. That was after.

Q. Okay. Now --

A. Because I didn't see Janice before I saw Lisa.

Q. Okay. They rolled her in --

A. They rolled her in, we did it. Then afterwards, I talked to her.

So we didn't actually know, at the time --

Q. All right.

A. -- what -- how long she'd been down, what happened and all that stuff.

Q. Okay. I did some research, and I found not specific records, but in interviews, that the majority, on

almost all of the people at Flag Land Base, have gone to Morton Plant for treatment. We're talking heart attacks and broken arms and broken legs. I've talked to Dr. Lovette, who's been there since 1974, and he's treated thousands of patients from Scientology.

My concern, over that investigative twenty-five years of being a cop, okay, upsets me about the time frame -- and let me run the time frame for you because I know you probably aren't familiar with it -- but our time frame so far is that someone finally, on the 5th of December, at eighteen hundred hours, kind of blows the whistle and says, "Hey, something's wrong with this girl." About an hour later, another person -- I don't know if you're familiar with her -- Laura Arrunnada -- are you familiar with Laura?

A. She worked in this office also.

Q. Laura Arrunnada goes and physically finds Janice Johnson at nineteen hundred hours, and says, "I think there's something wrong with Lisa."

Janice Johnson arrives someplace between nineteen hundred and twenty hundred hours and examines Lisa, and says, "Yeah, there's something wrong."

Paul Greenwood is called to help transport this person, at twenty hundred hours.

And lo and behold, at twenty-one thirty hours,

okay, you're looking at this person in the emergency room.

My concerns here are not only from your testimony previously about this acute -- very acute critical incident, my concerns are that here we have a person who someone says is very, very sick, okay, we mess around -- and I'll say that -- we fool around for three and a half hours, maybe even a little longer, five o'clock, almost four and a half hours before we seek this medical attention that you can provide in the trauma center --

A. Laura saw her at what time?

Q. Laura said that she told -- no, Heather Petzold tells Laura Arrunnada, at eighteen hundred hours, that, "There's something wrong with Lisa McPherson --"

A. Six o'clock?

Q. Six o'clock. Yeah.

So then, at seven p.m. Laura Arrunnada finally goes and finds Janice Johnson and tells her, "Something's wrong with Lisa."

And then, about eight o'clock, they're saddling up and getting Paul Greenwood involved to help load her into Johnson's van to drive up to you, and finally arrive, and you're examining and doing CPR at twenty-one thirty hours, which is four and a half hours -- three and a half hours later.

A. Yeah.

Q. This acute -- I forget what you called it -- acute event -- this -- can this acute event occur between six p.m. and nine-thirty or had it already occurred and the people were just reacting to that event?

A. Can't tell you.

Q. Okay. Don't know.

A. Don't know.

Q. Okay. Does it seem like a long time for you to get emergency medical care?

A. Well, if she looked at five -- six o'clock, like she did, at maybe nine o'clock --

Q. Okay. When you saw her?

A. I saw her nine-thirty, but let's say half an hour before -- let's say quarter after nine, she was alive yet; if she looked like that at six o'clock, and it took till nine-fifteen to get her up there, that's not okay.

Q. All right. The blood clot in the leg -- I know we've done a lot of similar investigations to this in nursing homes -- it appears to me some of the people in the nursing homes, who are elderly and don't get moved around a lot, end up with similar symptoms of having a blood clot somewhere in the extremity and shooting that into their heart or their lung and dying.

A. Right.

Q. We have the paramedics, and everybody who testified that there was no injury, and Dr. Lovette, that there was no injury from the minor accident that she had.

A. Right.

Q. I'm a little confused on the blood clot versus the staph and your opinion on what may have affected the two.

Can you explain --

You know, I'm looking at it, like Dr. Wood says, you know, that this girl may be laying around for a couple of days, which contributes to this blood clot, and we finally move her and it moves --

A. Right.

Q. -- maybe, at seventeen hundred hours.

A. Right.

Q. I'm confused about the staph effect on that blood clot in that leg that you were testifying to.

A. Don't know.

Q. Okay.

A. We don't know.

Q. We don't know what kind of effect?

A. I don't know if the blood clot was -- whether there was staph inside the blood clot, whether the blood clot was cultured. Don't know. So what the cause of events, sequence here, these various things, blood clot,

embolus, staph, don't know.

Q. Okay. Now, the petechia that we see on her in the pictures here, by looking at that picture of the petechia that we showed -- hang on. I'll get to a number -- the petechia that is shown here in Number 8 --

A. Yeah.

Q. -- now, could that petechiae -- does that have to be signs of a severe blood infection or a staph infection, or could that be a minor staph infection, like a surface infection?

A. No, like that, it wouldn't be minor.

Q. Wouldn't be minor.

A. Huh-uh. If you -- you could put this in a textbook of infectious disease for an overwhelming infection, as an example of septic emboli in an overwhelming infection.

Q. Okay. Now, in any of these pictures you looked at that we had, is there any indications in these pictures of toxic shock syndrome? Is there similarities?

A. People with toxic shock don't -- there's two -- there's two diseases that could have occurred, either together, or only one. With classic toxic shock, you may not get any skin hemorrhages. It may be just the toxin, diarrhea and shock, without having the hemorrhages.

Q. Okay.

A. But with staph sepsis and toxic shock, you could get both.

Q. But it could look like this?

A. Sure. Could look like that.

Q. Now, is it possible or -- I read this someplace -- that everyone has some type of staph infection or the staph germs in their system or on their skin, at one time or another? Is that consistent?

A. That people can commonly be colonized with staph --

Q. Yeah.

A. Yeah.

Q. Now, is it possible to take a blood sample from that -- in her leg, where you did the vein -- femoral vein or the femoral artery, and pick up that staph from the outside of the skin?

A. It's -- it would be unusual. The skin staph is usually different kind of -- it's a staph epidermidis. It's not a staph aureus.

Q. So it would not be normal to take that blood sample and then develop the culture of a staph infection in her blood, picking it off of her skin.

A. No.

Q. Okay. In some of our descriptions of our interviews, I found it unusual -- and I want to ask a

medical person -- but I've had some of the people testify to us that, since she wasn't eating or drinking, in order to get fluids into her, that they would attempt to take what's been described as a turkey baster -- do you know what I'm talking about? I know they have them in the medical field that looks similar to a turkey baster --

A. Mm-hmm.

Q. Basically, they were taking this stuff and squirting protein shakes into Lisa's mouth, attempting her to get fluids.

A. Okay.

Q. Would that be something that we would do in the hospital at HCA, or we'd do an IV?

A. We'd do an IV.

Q. Okay.

A. Or we'd put a tube in the stomach and put the stuff through the tube.

Q. You don't recommend any care of that type --

A. No.

Q. -- turkey baster protein shakes?

A. No.

Q. Okay. Sorry.

Did you write any reports to the Church at all on your involvement with Lisa McPherson?

A. I wrote up -- actually --

MR. FELMAN: There is a report, but it is the subject of a work product claim that's been made by the Church, as I understand it.

SGT. ANDREWS: Okay. I'm not going to ask any questions about the report.

MR. FELMAN: We didn't assert the privilege. I think we're obligated to. I --

SGT. ANDREWS: I won't ask the content of the report, which would be the claim to the privilege, right?

MR. McGARRY: Well, I don't think they're claiming it. I think he can probably discuss it. I think that privilege is going to be as to obtaining the report. So feel free to ask him.

SGT. ANDREWS: Okay. I just wanted to know --

MR. FELMAN: Well, I --

MR. McGARRY: Well, the content -- he can -- pursuant to our investigation, just the conversation that he had with anybody wouldn't have been privileged. Just the report, itself, they're claiming, was a privilege.

MR. FELMAN: Let me hear the question and I'll try to sort it through.

BY SGT. ANDREWS:

Q. Who asked you to write a report about your incident with Lisa McPherson?

A. The actual incident with Lisa McPherson, I didn't write a direct report on.

Q. Okay.

A. The report I wrote was basically just my -- the interview I had with you guys, in April, of just what happened.

Q. Okay. Okay. So --

A. Just a --

Q. After we interviewed you in April, then you wrote a report to the Church?

Who asked you to write that report?

A. Probably Brian Anderson.

Q. And who did you turn that in to?

A. Him.

Q. Okay. Staph infection -- would it be contagious, in Lisa's -- if you knew, when Lisa came in, and everybody that took care of her, that she had a staph infection, would you be concerned about it being contagious?

A. Under normal circumstances, no.

Q. Okay. And it would have to be transferred like blood or fluids in order for it to be --

A. Usually.

Q. Okay.

A. There's some kinds of staph infections that we see in the hospital which are resistant to almost every antibiotic, and so -- and people who come into the hospital or who are in the hospital who have that particular infection, we take extra precautions with those people; wear gowns and masks and gloves.

Q. Okay. Back in January, there, when this thing went into the paper and all the accusations were flying and I was a bad guy and you were a bad guy -- and I'm still a bad guy, I guess -- there appear to be a time when the Church made a statement that they were told by you that she had a staph infection.

Now, I know that I had to get subpoenas, and I know I had to go through a lot of rigamarole to release her records to anybody.

How did the Church -- what I'm actually asking you is, did you give the Church the results of the staph infection of Lisa McPherson?

A. Yeah. Back in, probably, December, when they wanted to know what happened, I told -- I'm sure I told them then.

Q. Okay.

MR. FELMAN: You're talking about an oral

report to them, as opposed to giving them medical records?

A. I didn't give them the medical records. I've never given them the medical records.

BY SGT. ANDERSON:

Q. Okay. Would you assert now, thinking back on that, that that probably was a privilege of Lisa McPherson, and really, as her doctor at the emergency room, should not have been released?

A. Yeah.

Q. I thought so, too, and I was wondering why it was done. I can understand --

A. I was so naive, at the time, that -- I didn't have an attorney or anything, and I just was -- I went and talked to you guys with no attorney. I basically have just been totally open on the thing.

Q. And I tell you, we appreciate that.

When you took the blood sample, are you positive that you wiped the skin with, like, your alcohol preps and stuff?

A. Mm-hmm.

Q. Okay.

SGT. ANDREWS: I don't have any more.

EXAMINATION

BY AGENT STROPE:

Q. I just have a couple of questions. I usually

agree to go last, so if I kind of skip around, it's because I take notes, and I don't really have any plan of asking questions in a particular order.

A. Okay.

Q. This report that you wrote concerning the general incident -- not necessarily concerning Lisa in particular -- hear my question, and then -- did you make recommendations concerning cases in the future, similar to Lisa's, what should be done and what shouldn't have been done?

A. In that report?

MR. FELMAN: Um -- I guess I'm a little uncomfortable having him testify about the contents of the report.

AGENT STROPE: I'll rephrase the question, then.

MR. FELMAN: Okay.

BY AGENT STROPE:

Q. What could have been done differently and what should be done in the future to keep this thing from happening?

A. Actually, it's Church policy that is already there. The policy says that any medically ill person, that -- first of all, the policy says that most -- this is a rough paraphrase, but here's the basic idea -- that

Hubbard's policy is written -- is that anybody with a mental disease needs a thorough physical examination to rule out any possible medical cause -- because just about all mental disease is due to some underlying physical disease -- and that a medical doctor needs to examine the patient and make sure that there isn't anything going on that would be the cause of the problem.

Q. So what you're saying to me is that Lisa, at some time, should have had a medical examination?

A. Absolutely.

Q. Was it your understanding that Dr. Johnson was capable of delivering that medical examination?

A. In my conversations with her, initially, yes, I determined that she was.

Q. Was it your understanding that she had?

A. I guess an assumed understanding that she had.

Q. Did she tell you, at any time, about vital statistics, blood pressure, temperature --

A. No.

Q. -- look --

A. No.

Q. If -- and this is just an opinion certainly, not a fact -- is it your opinion that if -- if Lisa might have been taken, say, to Morton Plant at five or six o'clock that evening, would there have been a chance for survival,

then, while she was still alive and still pumping and --

I guess my question is, these embolisms -- when you get somebody that comes in the hospital has an embolism in their leg or has moved to their heart and has just happened, do you save these people?

A. Usually not.

Q. Usually not? So I guess it depends?

A. A big one like that, usually not.

Q. And this was a big one?

Did the autopsy people tell you -- Dr. Davis tell you that?

A. No. But from the report -- I mean, it says blocking, I think, the whole right pulmonary artery outflow.

Q. So even if she had gone at five o'clock, you don't think it would have made a different?

A. I don't know what she looked like at five o'clock. It's very hard to tell.

Q. So you don't know.

A. I don't know.

Q. Okay. You had mentioned earlier that you wrote a prescription other than Valium. Do you know what that could have been? You said chloral hydrate, Valium and maybe some other prescription? Do you remember what that was?

A. If I did, it was -- I think it was Valium.
Q. Think it was Valium?
A. The drugs that I would have used would be either chloral hydrate, which I did do -- it's possible that there was Valium. The other one that I usually do for -- if somebody asks me, is Benadryl, which they can get over the counter.
Q. Valium is what, a tranquilizer?
A. Sedative, again.
Q. That is a drug psychiatrists use, or used to use?
A. Yeah. They still do, sometimes.
Q. Do you know a Dr. Houghton?
A. Yeah.
Q. H O U G H T O N?
Do you know that he was involved in any way with Lisa?
A. As a doctor, I don't know.
He's a dentist, actually.
Q. Yeah. Have you ever talked to him about Lisa?
A. No.
Q. Were you aware that --
Who was in charge of the watch of Lisa?
A. No.
Q. Are you familiar with Alain Karduzinski?

A. Yeah.

Q. Have you talked to him about Lisa?

A. Not since.

Q. Not since this happened?

A. No.

Q. Do you see him regularly?

A. No. I don't think I've seen him since then, either.

Q. Haven't talked to Janice about this, either, since then?

A. No. Haven't seen Janice.

Q. Is your wife a doctor?

A. Nurse.

Q. Nurse? I happened to see her picture in the "What is Scientology" book. She's identified there as a doctor.

A. I know there's a mistake.

Q. Okay. We have people who testified in the last day -- December 5th, early that morning, eight or nine o'clock, they gave Lisa a bath, and at that time, Lisa was out of it. She wasn't -- she was limp, not able to walk. They had to carry her to the bathtub. She was breathing laboredly, heavy breathing, eyes fixed, not blinking.

Is that something that is consistent with staph infection? Is that something that is consistent with her

condition that night?

A. Yeah.

Or the embolus.

Q. Okay. So that could have been going on that early in the morning?

A. Yeah. Or the dehydration. Or even the dehydration, by itself.

Q. And we also have people that say, the day before that, she was also like that.

Wouldn't that -- shouldn't that be cause for alarm?

A. Absolutely.

Q. I mean, it's -- it's -- it's hard to believe that this -- and the decline in her medical condition, as described to us by her caregivers, wasn't one of rapid declination; it was something that happened over a period of, probably, a week or more.

Wouldn't that be not consistent with a sudden onslaught of staph infection?

A. Yeah. If -- if the staph infection was sudden, yeah.

Q. I guess what I'm asking is -- is knowing what the caretakers told us, and knowing that this wasn't a one-day affair that had happened over a period of a week or more, where she wasn't eating --

A. Mm-hmm.
Q. -- wasn't drinking --
A. Mm-hmm.
Q. -- and got steadily more weak, to the point where she couldn't walk and couldn't talk, other than just sounds --
A. Mm-hmm.
Q. -- as a physician, how would you react to that? Would you have --
A. Put her in the hospital right away.
Q. Okay. Have you talked to anybody, other than your attorney, about your testimony here today?
A. Huh-uh.
Q. You haven't talked to anybody at the organization, since you talked to us the last time, other than your attorney?
A. About details of what's going on?
Q. Yeah.
A. About the testimony here today?
No.
MR. FELMAN: I think he testified he cleared it with Sandy Weinberg and Lee Fugate in January.
THE WITNESS: Yeah.
BY AGENT STROPE:
Q. Have you talked to anybody since then other than

your attorney? I don't want to get into that.

A. No.

Q. Okay. In -- your first conversation concerning Alain -- correct me if I'm wrong -- was some two days after she was taken to Flag. Have you talked to Alain Karduzinski since?

A. Actually, it was probably the day I wrote that prescription. That was wrong. It was probably the --

SGT. ANDREWS: 29th.

A. -- 29TH.

BY AGENT STROPE:

Q. Was that Janice or Alain you talked to at that time?

A. I think they were both on the phone.

Q. Conference call?

What did Alain have to say about this? What was his conversation, do you remember?

A. "She's Type 3. She hasn't slept. We need to get her something to help her sleep. What can you suggest, or what would you do?"

Q. And you wrote that prescription for chloral hydrate?

A. Right.

Q. So Lisa --

A. Right.

Q. And the prescription for Valium, you wrote --
A. You're going to have to check that, 'cause I -- I don't know if it ever got -- I -- sorry. I'm -- we may have had a conversation about it and I didn't do it, and we may have had a conversation and didn't do it.
Q. Would that have been at Eckerd's, same place?
A. Yes.
Q. And that would have been in your name, your DEA number?
A. Would have been mine, yeah.
Q. Now, that prescription Valium, was that a liquid or was that tablets?
A. It was probably tablets. I don't think it comes as liquid.
Q. I thought it came --
A. Oh, as an injectable?
Q. Yeah.
A. I don't think they have injectable Valium there, but I can't remember, so --
Q. And you don't usually, in cases, prescribe any medication without seeing patients? That's not a usual procedure for you?
A. (Shakes head).
Q. And the exception was made this time because --
A. I knew these people. And it was -- I thought I

was talking to a doctor.

Q. You thought you knew these people.

A. I thought I knew these people.

Q. And I get the impression, from talking to you today, that it probably wouldn't happen again?

A. No, it won't happen again. No, it won't happen again.

Q. And you've stated that, on the night that Janice and others brought Lisa to your hospital, that she wanted a prescription for penicillin?

A. Yes.

Q. And --

A. She wanted to know if she could get a prescription for an injectable penicillin, 'cause she thought she had a strep throat, I think is what she said.

Q. Did she describe her throat?

A. She told me that she had a sore throat in the morning, diarrhea during the day. Nothing about her condition, in terms of -- I mean, we went through the thing, "If she's too sick, don't take her up here. Take her to Morton Plant." We had the conversation.

Q. That would have been the logical thing to do.

A. Yeah. Because --

Did you talk to David Niles? I think he was sitting at the desk. And he may have even heard that part

of it, because he looked at me and he said -- he didn't want this person to come up there. And I think he may have heard me say, "If she's too ill or she's really sick, don't bring her up here. Take her the Morton Plant."

Q. Is it out of the ordinary for members of the organization to come all the way up to New Port Richey to see you?

A. Yeah.

Q. So this case, from the beginning, is just not the ordinary case?

A. No. It's not the ordinary case.

Q. Did that -- did that arouse some type of suspicion with you after the fact?

A. Yeah. Sure it did.

Q. I mean, given all the conditions, given the fact that it's not the everyday event, given the condition of Lisa McPherson, you had to have some suspicions --

A. Yeah.

Q. -- of mishandling of this case.

A. Yeah.

Q. Certainly, you wouldn't have carried on the way this case was carried on.

A. No.

Q. Bear with me. I'm almost through my notes, here.

A. Okay.

Q. You stated that you were in shock when you realized what was going on. Could you elaborate on that a little bit?

A. Well, it's a horrifying experience to see a young person in that condition, and then to know that that person -- I mean, I -- we probably see two, three dead people a day in the emergency room, but to know that this person is someone that I had been called on, you know, an hour before, and thinking one thing and then seeing another, and then, "Oh, my God" -- I was horrified, for sure.

Q. You never visited Lisa at the Ft. Harrison?

A. No.

Q. Were you ever asked to visit Lisa at the Ft. Harrison?

A. No.

Q. You said that you had -- I believe you said one time that you had lunch with Janice Johnson, two weeks before you saw Lisa at the hospital. That would have been around the time that Lisa was still at the Ft. Harrison.

Did Janice discuss Lisa with you that day?

A. No.

Q. Did Janice ever discuss other patients with you that were -- that she was caring for at the Ft. Harrison?

A. No.

Q. So that, too, was out of the ordinary? Even her conversation about Lisa would have been out of the ordinary.

A. Mm-hmm.

'Cause actually, it may be more that these sorts of things hardly ever happen, too. Or to my knowledge.

Q. You're familiar with Watches, right, in run-down? And apparently this is a practice of the organization.

A. Mm-hmm.

Q. Is this still going on, do you know?

A. Not to my knowledge. I mean, I don't really have any knowledge of it right now.

Q. Okay.

A. I'm not involved in any.

Q. I just want to touch on this one picture for a minute.

This -- and it looks to me like scabbing. I mean, it doesn't look like, as you explained earlier, just blood that came off the procedure of the intubation or anything. This actually looks like it's already been scabbed over.

Did you -- did you notice that at the time? Did you have any questions about that?

There's a better picture here. Here it is.

Now, if you look at this really closely, you can see that that's an old wound. That's not something that happened that day. We've all been around deceased people enough to tell that's a wound scabbed over, if you can see the striations.

A. If it's not a piece of dried blood.

Q. I think, if you look really close, you can actually see the opening in this skin, where it's scabbed out over. You can actually see a cut or an abrasion.

I guess my question is, did -- that had to be part of your overall curiosity about this whole thing and your being upset with Janice. Bad enough she's thirty-six years old, but she's got all these unidentifiable marks, and these are scabbed over, and this --

If you look -- if you blew this up, you would see that there is a break in the skin there.

A. Didn't hit me.

Q. Didn't hit you.

I mean, had to be a little fresher when you saw it than, obviously -- there are some post-mortem changes here.

A. Before this tube is put in, a mask is put on the face.

Q. So you may not even seen it --

A. May not have even seen it, or it may have abraded her when --

Q. Well, my point is, this is obviously -- looks to me, anyway, to be an older wound.

A. Yeah. I can't tell you from this, and I don't recall --

I don't have a -- haven't even thought about it.

Q. Is it a usual procedure for you to draw blood from patients who are coded?

A. In times when the nurses can't get it, yeah.

Q. So you've done that before and you do it all the time?

A. (Nods head).

Not all the time, because usually they can get it.

Q. Okay. I don't know if you're aware or not, but apparently, you know, the people that we've talked to and the caregivers who started taking care of her -- and I'm not sure I know what my question is here, so bear with me --

MR. FELMAN: Guy apologizes a lot for asking pretty good questions.

BY AGENT STROPE:

Q. -- that it was a period of a long time. It wasn't like she didn't eat the 5th or 4th. She wasn't

eating or drinking for a long period of time. And when they did try to give her something, she spit it out. I don't know if she spit it out because she didn't want it or she couldn't swallow.

I guess my question is, how far back, from the time that -- say there was -- there was no drastic infection. How far back, from the time of the 5th back, would someone not have to eat or drink to get in that condition? I guess that's my question. Is that something that -- I mean, if you don't drink, you don't eat for a matter of a week --

How long can you go without drink before you're severely dehydrated?

A. Probably a couple days.

Q. Just a couple of days?

A. No drink?

Q. No drink.

I understand, food, you can go weeks.

A. Right.

Q. But water, it's just a few days isn't, it?

A. Yeah. Probably a couple days. Maybe three, four days.

Q. Wasn't so tough --

A. That's off the top of my head.

Q. It's just a personal curiosity with me, because

I hear people telling us she wouldn't drink anything and didn't eat anything. And I've also -- I've always believed that two or three days without drinking, and you're in big trouble, is that true?

A. Well, you would have symptoms, anyway. I mean, you would -- you would --

Q. What would those symptoms be?

A. Well, I mean, you would -- you would be weak and lethargic and your mouth would be dry.

Q. And just consistently weak till you're dehydrated, till your kidneys shut down?

A. Sure. If you don't have any --

AGENT STROPE: I don't have anything else.

(Whereupon a discussion was held off the record).