IN RE: INVESTIGATION, Lisa McPherson

STATEMENT OF: DAVID MINKOFF.

DATE: May 19, 1998, 9:43 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.

Sergeant Wayne Andrew
Clearwater PD.

MR. JAMES E. FELMAN
KYNES, MARKMAN & FELMAN
P. O. Box 3396
Tampa, FL 33601-3396
Attorney for Dr. Minkoff.

KANABAY COURT REPORTERS
TAMPA AIRPORT MARRIOTT HOTEL (813) 224-9500
ST. PETERSBURG - CLEARWATER (813) 821-3320

ORIGINAL

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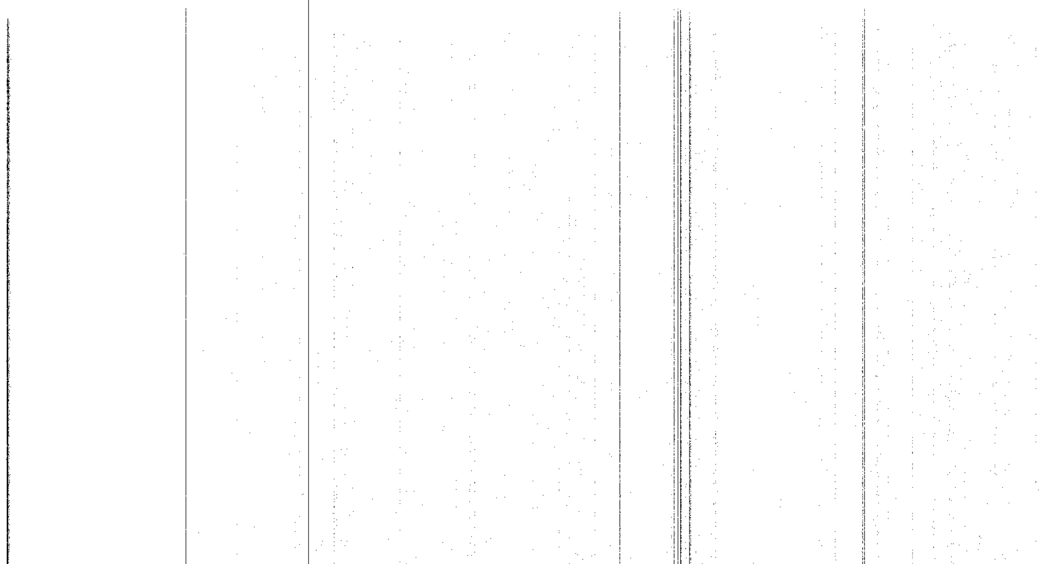

1 DAVID MINKOFF,
2 the deponent herein, being first duly sworn, was examined
3 and testified as follows:
4 DIRECT EXAMINATION
.5 BY MR. CROW:
6 Q. would you state your name, please, sir?
7 A. David Minkoff.
8 Q. Okay. And you're a physician?
9 A. Yes.
10 Q. You've been subpoenaed here today, and you're
11 represented by your attorney, Mr. Felman, who's present.
12 MR. CROW: Do you have anything you want to
13 put on the record now, about the subpoena?
14 MR. FELMAN: Yeah. I just want to make
15 sure it's clear on the record that we are appearing today
16 pursuant to a investigative subpoena, which my
17 understanding, under the law, would confer both use
18 immunity and derivative use immunity to Dr. Minkoff, to
19 what he has to say today, pursuant to Florida statute.
20 MR. CROW: And it's my understanding that
21 he was served with a subpoena, and he's not willing to
22 testify without one, is that correct, Dr. Minkoff?
23 MR. FELJ4AN: That's correct.
24 THE DEPONENT: Whatever he says.
25 MR. CROW: Well, obviously, we would prefer

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1 to have witnesses talk to us voluntarily, without the
2 grant of immunity, but I understand your attorney has
3 insisted on that, and he has that prerogative, and you're
4 going to abide by that --
5 THE DEPONENT: Yes.
6 MR. CROW: -- decision.
7 BY MR. CROW:
8 Q. Dr. Minkoff, I haven't spoken to you before. My
9 name's Doug Crow. I'm an assistant State Attorney, and
10 I'm one of the attorneys charged with investigating the
11 circumstances surrounding the death of Lisa McPherson on
12 December Sth, 1995. We've talked to you previously.
13 We've learned some things since we talked to you, so
14 there's some new areas we want to go in. And also,
15 there's some areas that we talked to you about, in more
16 general terms last time, and what I want to kind of
17 achieve today, I want to exhaust your knowledge in those
18 areas. In other words, I don't want to leave any stone
19 unturned.
20 And I realize that, over time, you may have
21 thought about it more and recall more, or there may be
22 things you don't recall, but I want to, at least at this
23 point in time, in the areas we discussed, make sure that I
24 have everything that you can recall, okay?
25 A. Sure.

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1 Q. Tell me, are you still with the hospital in New
2 Port Richey?
3 A. Yeah.
4 Q. Okay. In what capacity?
.5 A. I'm an ER physician there.
6 Q. And do you work directly for the hospital, or is
7 this a group that they contract out with, or explain the
a relationship.
9 A. I actually work for a big corporation called
10 MCare. It's on the New York Stock Exchange,'1 think.
11 It's about 3 or 4,000 doctors. They're run by a big
12 holding company in Toronto. It's a big -- they have
13 hundreds of ER contracts.
14 Q. Okay.
15 A. So when this thing occurred, it was with a local
16 group, which got bought out by a bigger group, which has
17 now been bought out by a bigger group.
ia Q. So it keeps getting bigger and bigger.
19 SO you essentially work for the corporation, and
20 the hospital contracts with the corporation to provide
21 trauma or emergency care for the hospital?
22 A. Correct.
23 Q. Are you also on staff there for any other
24 purpose other than the emergency room?
25 A. No.

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1 Q. Do you have a private practice at this time?
2 A. Yeah.
3 Q. Where is that located?
4 A. Garden and Drew in Clearwater.
5 Q. So that would be in downtown Clearwater?
6 A. Yes.
7 Q. How long have you had the private practice in
8 Clearwater?
9 A. About six months.
10 Q. About six months?
11 Back in 1995, did you have any practice other
12 than your duties for the hospital in New Port Richey?
13 A. I have a back clinic, which I was doing at the
14 time.
15 Q. Where was that physically located?
16 A. 131 Garden Avenue.
17 Q. So that was in Clearwater?
18 A. Yeah.
19 Q. Close to where your private practice is now?
20 A. Yeah. It's in the same building.
21 Q. Okay.
22 A. It's actually from a chiropractor's office.
23 Q. Okay. And tell me the nature of that practice
24 back in 1995. How long have you been doing that?
25 A. I've been doing that -- it'll be three years, so

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1 probably been doing that about six months --
2 Q. Okay.
3 A. -- at that point.
4 Q. I's that something you did --
5 Okay. Let me -- let me backtrack.
6 My recollection is that you came to Clearwater
7 about 1990.
8 A. February of '90.
9 Q Okay. So from '90 until --
10 Were you licensed in Florida at the time you
11 came here?
12 A. Yeah.
13 Q. Okay. From February of '90 up to beginning this
14 back clinic, tell me what you were doing in the medical
15 profession.
16 A. When I moved here, I started working at Doctors'
17 Walk-In Clinics.
18 Q. That was located where?
19 A. Seven clinics in Tampa and Clearwater, owned by
20 a guy named Steve Dickey.
21 Q. Were you located at one particular clinic or did
22 you move around?
23 A. I was mostly in Countryside, but I worked all
24 over.
25 Q. Okay.

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1 A. And I was probably doing about pretty much
2 full-time there. And it was walk-in-clinic-type stuff.
3 And I was there until August of '91, when I got a job in
4 the emergency room, and I've been in the emergency room
5 since then.
6 Q. Okay. And you quit working for the walk-in
7 clinic?
8 A. Yeah.
9 Q. And other than the emergency room, you didn't
10 have any other private practice or medical practice of any
11 kind, other than opening up the back clinic about six
12 months before?
13 A. Yeah.
14 Q. This is --
15 A. I mean, not formal.
16 Q. Okay. Informally. I'm sure people at parties
17 ask you advice and that kind of stuff --
18 A. Right.
19 Q. -- but did you actually, other than -- outside
20 the emergency room, examine patients, treat patients,
21 prescribe for patients?
22 A. Other than friends, not really. I would
23 sometimes do physical exams for people. The Church has a
24 program -- it's called "purification rundown" -- where
25 someone needs a physical exam in order to just make sure

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1 they were healthy, because the program involves exercise
2 and sauna, so I would see some people for that.
3 Q. Okay. And --
4 A. Which was sort of a basic physical exam, and
5 then an Itokay" to do it.
6 Q. Where did you do these physical exams?
7 A. Usually at my house.
8 Q. And where was your house?
9 A. From '91 to '90 -- from '90 -- well, I probably
10 started those in '91 --
11 Q. Well, approximately.
12 A. Huh?
13 Q. Approximately.
14 A. I had a private house on McKinley Street.
15 Q. Is that in Clearwater?
16 A. Yeah.
17 And I was on Saturn before that, in an
18 apartment.
19 Q. Was that a church-owned apartment?
20 A. The Saturn one was.
21 Q. And McKinley one was -- you owned personally, or
22 were purchasing?
23 A. The McKinley Street was just a rental.
24 Q. Rental.
25 A. And then I built a house in '94, that's on

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1 Edgewood.

2 Q. Okay. Again, I'm not real familiar with the

3 Clearwater area. So is Edgewood in downtown Clearwater or

4 an outlying area?

5 A. You know where the mayor lives?

6 Q. No.

7 A. Glenwood area.

8 Q. I'm really not --

9 A. Highland.

10 Q. Yes. Highland.

11 A. In Clearwater.

12 MR. McGARRY: Doug's from south St. Pete.

13 MR. CROW: I live down near the Skyway.

14 MR. McGARRY: Anything north of Ulmerton is

15 completely in Georgia.

16 MR. CROW: I know where the courthouse is.

17 BY MR. CROW:

18 Q. On how many occasions would you say -- and I

19 realize this is calling for an estimate -- that you

20 performed physicals for people from the Church who were

21 fixing to go for purification rundown, and you gave them

22 this --

23 A. Maybe a couple a month.

24 Q. Couple a month.

25 A. Yeah.

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1 Q. So several dozen, then, over the period of time?
2 A. Yeah.
3 Q. Other than that, any other medical practice?
4 A. No.
5 Q. Okay. You mentioned the term "purification
6 rundown." Would you tell me generally what your
7 understanding is of that? And I realize you may or may
8 not have expertise in that, but can you give me an idea of
9 what your understanding was?
10 A. Yeah. It's a program which is designed to get
11 drug residuals -- people who've taken drugs, medications,
12 anesthetics, if they have heavy metal poisoning, PCB
13 exposure, that sort of thing, it gets stored in the body
14 fat. Even though a person, say, hasn't had drugs for 10
15 or 15 years, the drug residuals are still in the body.
16 So the purpose of the program is to get the drug
17 residuals out of the body. And it's a program that uses
18 some exercise, a blend of oils, to -- if you take the oils
19 in, then the body will sort of replace the oils that are
20 already in the body, the fat -- and then niacin, which is
21 a B vitamin, which causes the body to -- blood vessels to
22 kind of dilate; and then sauna, low temperature sauna.
23 And what happens is, the -- also, radiation --
24 build-up in the body actually comes out, and --
25 Q. Built-up radiation in the body comes out?

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1 A. Yeah.
2 Actually, it's been -- actually, there's nice
3 outside documentation, but a large study was done of
4 people that were exposed, in Chernobyl, to the nuclear
5 accident, who had radiation studies, because they had high
6 exposure to radiation. So when they do sensitivity
7 testing, what they get is -- they can measure the
8 radiation in these peoples' bodies. And after a
9 couple-of-week period on this purification rundown, their
10 radiation levels diminished by about 90 percent.
11 It also works for -- there was a firefighter
12 group in Michigan that got a big dioxin exposure, and they
13 were able to reduce their dioxin blood levels by about 90
14 percent.
15 So this is something that Hubbard discovered,
16 but there's a lot of toxicology independent literature on
17 this, which it's now being used by all kinds of groups
18 for -- for similar things.
19 Hubbard's purpose was, if a guy was still under
20 the influence of drugs or anesthetics that he had taken at
21 one point, that his mind wouldn't be quite as sharp; he
22 couldn't think quite as well. So the Church's purpose for
23 the program is to really, like, clean him up, physically.
24 **Q.** Okay. Tell me about some of these independent
25 studies. Has there been any controlled experimentation

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1 on --
2 A. oh, yeah. There's a huge literature on it.
3 There's a couple -- it's called FACE, Foundation for the
4 Advancement of Science, and something else. And if you
5 want documentation on it, I can probably get you 100
6 papers on it.
7 Q. And you're familiar with these?
8 Have you ever done the purification run --
9 A. Yeah.
10 Q. -- down?
11 A. Yeah.
12 Q. So you figure you're skilled in deciding when
13 it's appropriate; when it's not?
14 A. Well, my job was just to make sure someone was
15 physically able to do it, because it -- if someone is very
16 ill, it might be too strenuous for them. So you just want
17 to make sure they're in good health, they don't have any
18 liver, kidney problems; there's not anemia;
19 cardiovascular-wise, they're okay.
20 Q. Is there any auditing that's part of the
21 process?
22 A. No.
23 Q. So its strictly a physical process?
24 A. Physical, yeah.
25 Q. And is there any documentation in the literature

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1 you're talking about, about the effects of residual drugs
2 in the fat on a person, mentally or physically? In other
3 words, years later, is that a documented thing, in your
4 opinion, or is that --
5 A. Well, it's interesting because I -- when I did
6 the purification rundown, I was in the -- I was in the
7 sauna with a guy who had been an LSD, dealer and he had
8 taken a lot of LSD, but it had been about 10 years since
9 he'd taken it. And during the process of the sauna
10 program, he actually had re-experiences of LSD trips as
11 the drugs were coming out.
12 The thing that I noticed is that I'd had a lot
13 of prior sunburns, and you'd be sitting in the sauna, and
14 all of a sudden, from, like here down, you'd turn beet
15 red. It would burn for, maybe, 15, 20 minutes, and then
16 the skin would just go back to normal. And these are old
17 radiation injuries that the body has.
18 Q. Explain that to me again. Your skin would
19 actually turn -- discolor?
20 A. Where you got sunburn, like a prior bad
21 sunburn -- so let's say I had a T-shirt on, I got a bad
22 sunburn. What happens is that this old radiation
23 accumulation that's in the body -- or in the skin,
24 actually -- burns itself out during the process. So
25 you'll have people that'll turn on, you know, like old

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1 sunburns or things like that. And it lasts for a while,
2 and then it goes away. And when you get done with it, you
3 feel like you're cleaned up. Your skin feels soft. You
4 feel just kind of physically rejuvenated.
'5 Q. Is the redness in sunburn caused by the presence
6 of radiation or is it caused by damage to the tissue that
7 radiation has caused?
8 A. Damage by radiation the tissue's caused.
9 Q. Okay. So --
10 A. Actually, the body holds radiation. Like a
11 person's radiation exposure in their lifetime is
12 cumulative. Unless something like the purification
13 rundown is done, each body -- like you have a certain
14 amount of radiation built up, since birth, of sun exposure
15 or X-rays or things like that, and the body doesn't
16 naturally get rid of it. This is one way that, actually,
17 radiation from a body can be gotten out.
18 So if you take someone who's -- there's a group
19 in --
20 Q. Radiation in the form of light rays --
21 A. X-rays --
22 Q. -- photons?
23 A. Well, most probably X-rays, electromagnetic
24 radiation from the sun, gamma rays.
25 Q. That was -- be in the photons, correct?

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1 A. Photon is the unit of energy from that, yeah.
2 Q. So is that how it would be -- you're saying that
3 there are actually photons stored in the tissue that are
4 released by the purification rundown?
5 A. Right.
6 There's a group in Sacramento -- he's actually a
7 medical doctor, a nonScientologist that runs a secular
a purification rundown center for people who have had, like,
9 radiation treatment for cancer.
10 You know, I don't know if you're aware of this,
11 but let's say someone has lymphoma, Hodgkin's,
12 radiation -- they have radiation, they're considered cured
13 for their lymphoma, but their incidence of cancer, 10 to
14 15 years later, is very high, because of the radiation
15 damage. You can actually help these people by doing a
16 purification rundown, after you're done with it, because
17 you help the body get rid of the radiation that's still
la there.
19 Q. And these would be like gamma rays or X-rays
20 accumulated in the body?
21 A. Exactly.
22 Q. And they're released from the fat?
23 A. Mm-hmm.
24 Q. Okay. I guess I probably misstated the question
25 when I said, "Have you ever done a purification rundown"?

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1 What I actually meant was, have you directed one, as
2 opposed to experienced yourself?
3 A. No. I don't direct them. There's a person
4 who's trained to actually do that.
5 Q. Have you received any training in doing that?
6 A. No.
7 Q. Do you consider yourself to have expertise in
8 doing that?
9 A. No.
10 Q. what about auditing? Do you have any expertise
11 in auditing or that --
12 A. Yeah.
13 Q. Have you ever functioned as an auditor?
14 A. Mm-hmm. Yeah.
15 Q. Okay. so you -- you've been through that
16 process yourself?
17 A. oh, yeah.
18 Q. And you've audited other people?
19 A. Yeah.
20 Q. Okay. What level auditor are you? Is there --
21 A. It's called "Class 5 Graduate."
22 Q. Okay. And how high do the levels go?
23 A. 12.
24 Q. Okay. Have you ever participated in anything
25 called an "isolation watch"?

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1 A. No.
2 Q. Okay. Do you know what that term means?
3 A. Yeah.
4 Q. Okay. What does that term mean? Is that a
5 Scientology term or a dianetics term or a term that's used
6 by -- by Hubbard?
7 A. Yeah.
8 Q. Okay. And what is your understanding of it?
9 A. In the sense that you're talking about it, it's
10 a -- it's a way to take someone who is very upset, to the
11 point where about anything-in their environment causes
12 them mental duress or stress, you know, to the point where
13 they're so fearful that they can't really function -- to
14 put them in an environment that would be safe for them,
15 where there's just very little stimulation. You know,
16 there's just -- it's just, more or less, quiet and sedate
17 and nonthreatening --
18 Q. Okay.
19 A. -- and provide them with, you know, what they
20 need, so that they can just kind of calm down.
21 Q. What they need, in terms of what?
22 A. Physical needs. Food, water; rest, place to
23 sleep, you know.
24 Q. Is medicine involved in -- I mean medicines, in
25 terms of prescriptions, involved in that at all, or not?

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1 A. Not usually, no.
2 Q. Okay.
3 A. Hardly ever.
4 Q. Okay. Have you ever been responsible, on behalf
5 of the Church or individual Church members, for caring for
6 people who have been identified as Type 3s? You know what
7 I mean by Type 3? I think you've used that term before.
8 A. Yeah.
9 I had -- 1 saw one other girl, she was actually
10 a German girl, who was considered Type 3, and she needed a
11 physical examination. So one of the things that's wanted
12 is like a really detailed full-searching physical --
13 X-rays, everything -- to make sure there's nothing
14 physically wrong. So this girl was actually brought --
15 Q. Explain that to me again. Why is that wanted?
16 Is that something Hubbard prescribes or --
17 A. Well, yeah. He felt that -- that most people
18 who went Type 3 or who were -- who became psychotic,
19 actually had physical illnesses --
20 Q- Okay.
21 A. -- that -- that really needed to be looked hard
22 for; that if they were repaired -- you know, if they were
23 found and fixed, that they would actually be -- you could
24 help them better.
25 Q. Okay.

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1 A. So what he says is they need a thorough,
2 searching physical, with X-rays, laboratory tests
3 whatever's needed, to find out what it is. And he says
4 sometimes you'll find a broken bone that nobody found, or
5 something, where the person just isn't aware of, it but
6 it's causing them pain or problem.
7 So this girl was brought, by her boyfriend,
8 to -- I said, "Well, just bring her to the hospital,
9 because I can do a CAT-scan of her head and all this other
10 stuff, that, you know, couldn't be done at her house." So
11 she wasn't raving crazy. She was just kind of quiet, and
12 not -- just wasn't herself. So -- but she was quite
13 cooperative. I don't think she could make it on her own,
14 so her boyfriend had set up a bunch of people to be with
15 her all day, and basically stay at her house.
16 And we did the CAT-scan and urine tests and
17 blood tests and everything I could think of.
18 Q. Had this person previously been a patient, or
19 was she brought to you --
20 A. She wasn't previously a patient.
21 Q. Okay. And was there any particular reason you
22 were told she was being brought to you for the physical
23 exam?
24 A. Somebody called and said, "We just need a really
25 thorough physical on her. She's borderline, or Type 3.

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1 Would you check her out?"
2 Q. Do you recall who it was that called you?
3 A. Her boyfriend called me.
4 Q. Okay. And can I have the time frame for when
5 this was? Was it, say, before Lisa or after --
6 A. Before Lisa.
7 Q. Okay.
8 A. Probably '93, '94.
9 Q. Okay. And did you know the boyfriend?
10 A. I'd never met him before.
11 Q. So somebody obviously gave him your name and
12 phone number.
13 A. Yeah.
14 Q. Do you know who that was, or do you remember?
15 A. Might have been -- might have been Susy --
16 susy -- her name is Susy Choop. She was one of the CSs at
17 the -- at Flag.
18 Q. Okay. Case supervisors?
19 A. Case supervisor.
20 Q. And what -- when the term "Type 3's" used, what
21 do you understand that to mean?
22 A. Well, it's somebody who really isn't able to
23 take care of themselves. They're just not enough in touch
24 with themselves, or reality, to function safely, properly.
25 Q. Okay. Is that used in conjunction with the term

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1 "psychotic break"?
2 A. Whatever that means.
3 Q. Okay. Well, I understood that to be a Hubbard
4 term.
5 A. Psychotic break?
6 Q. Yeah.
7 A. No. I'm sure it's a psychiatric term.
8 Q. Okay.
9 A. Hubbard, maybe, used the term, but he didn't
10 originate it.
11 Q. Okay. What about the term "potential --" "PTS,"
12 "potential trouble source"?
13 A. That's a Hubbard term.
14 Q. Okay. And what does that mean, your
15 understanding, again?
16 A. Well, it's someone who's a -- potential trouble
17 to someone else, because they're under the influence of a
18 situation, or person where they -- they're sort of not in
19 their -- they're not -- their perception's diminished, and
20 they're not functioning enough to take care of themselves.
21 Under some sort of suppression.
22 Q. Okay. And did Hubbard consider there would be
23 three types of PTSs, and Type 3 was one of them; what
24 we've talked about?
25 A. Mm-hmm.

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1 Q. And did he define Type 3 as a person who's
2 entirely psychotic?
3 A. You've got the thing there. Why don't you tell
4 me what it says?
5 Q. Well, I'm asking your knowledge.
6 A. I mean, that's the basic idea.
7 Q. He's written a lot of stuff, so I don't know
a that I've memorized it all.
9 A. That's the basic idea, that it's someone who
10 just isn't -- 1 think it's what I said; it's someone who's
11 not -- who can't take care 'of themselves.
12 Q. Okay. And what's the difference between that
13 and someone who's psychotic, then?
14 A. Probably no difference.
15 Q. Okay. "Psychotic" normally being used to define
16 a major mental illness, a loss of touch with reality. Is
17 that the type of person that would be classified as a Type
la 3?
19 A. Yeah.
20 Q. So if a person was schizophrenic, they would fit
21 into the Type 3 category?
22 A. While they were being schizophrenic, definitely.
23 Q. And if their symptoms weren't controlled by
24 medication or something else.
25 A. Right.

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1 Q. A person who is, maybe, bipolar; in a manic
2 phase, symptoms not controlled --
3 A. Sure.
4 Q. -- they would be Type 3?
5 A. Sure.
6 Q. Obviously, you have some general knowledge of
7 this, and I'm asking questions. Are you conversant enough
8 with whatever -- Hubbard's prescriptions for handling Type
9 3s, to be able to implement that theory, philosophy,
10 course of treatment, whatever, however words you used to
11 describe Hubbard's prescriptions for these people?
12 A. Would I be able to implement it?
13 Q. Yeah.
14 A. Probably not.
15 Q. Okay.
16 A. I haven't, anyway.
17 Q. Would you feel competent to do that, or not?
18 A. I don't think so, right now.
19 Q. Okay. And what about back in '95? Were you
20 more knowledgeable --
21 A. To run somebody on that sort of thing? No.
22 Q. Okay. Or to determine what Hubbard would
23 prescribe to be done for someone who's a Type 3 and
24 psychotic.
25 A. Well, I mean, I understand the basic idea of

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1 what has to happen to the person, and what the idea --
2 sort of, what the goal is, and why it would be effective.
3 Does that mean that I would actually set it up or do it
4 myself or have it all down --
'5 1 don't know.
6 Q. Well, whose responsibility would that be, within
7 the Church structure, is kind of what I'm asking. would
a it be yours, as a physician? Would it be a CSs, as a case
9 supervisor?
10 A. At the time --
11 Q. Yeah. Back in '95.
12 A. -- it's probably under the auspices of the CS.
13 Q. So you're not sure whose responsibility it would
14 be back in '95. You believe it would be CS, but you don't
15 sound like you're positive.
16 A. I think -- yeah, that's accurate.
17 Q. Okay. Tell me about the physical you did on
18 this -- the German girl. You said that there's a
19 necessity to do a complete physical with someone who's a
20 Type 3.
21 A. Right.
22 Q. Okay. And apparently that was -- you felt the
23 necessity that it would have to be a physical you could
24 better do at the hospital, because of the technology.
25 A. Right.

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1 Q. Okay. Tell me the nature of the physical that
2 you did.
3 First of all, did you talk to her?
4 A. Yeah.
'5 Q. Okay. Was she coherent when you talked to her?
6 A. Yeah.
7 Q. Was she able to relate symptoms or medical
8 history?
9 A. Not very well.
10 Q. Okay. Did you get a medical history from the
11 boyfriend?
12 A. Yeah.
13 Q. Okay. What else did you do?
14 A. Like I said, lab tests, CAT-scan.
15 Q. What kind of lab tests?
16 A. Blood count, blood chemistries, minerals, urine
17 test, thyroid test.
18 Q. Okay. CAT-scan? Why a CAT-scan?
19 A. She had some headaches.
20 Q. So she reported that to you, or the boyfriend
21 reported it?
22 A. I think the boyfriend reported she's been
23 holding her head, and seemed like she had a headache.
24 Q. Okay. Any other aspect of the --
25 1 mean, I assume you do some type of physical

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1 exam. Do you do neurological tests? Do you look in the
2 eyes, throat --
3 A. Yeah. Full physical exam.
4 Q. Well, explain -- I'm not a doctor. I've had
5 physical exams. But just explain to me what you go
6 through.
7 A. Well, you look in their ears, eyes, nose,
8 throat, listen to their heart, check their belly, do a
9 neurologic check for the cranial nerves, their motor,
10 muscle strength, sensory exam, how they walk, a few
11 specialized tests.
12 Q. Okay. What specialized tests?
13 A. Oh, Babinski, Romberg --
14 Q. Neurological tests, you're talking about --
15 A. Yeah.
16 Q. -- for reflexes and that kind of stuff?
17 A. Mm-hmm.
18 Q. And would part of that be trying to get as much
19 history as you could, as to what the symptoms the person
20 had were?
21 A. Well, was there a physical problem; you know,
22 could you find a physical -- physical illness, physical
23 reason for why they were behaving that way?
24 Q. Okay. And then -- and this girl's particular
25 circumstance, did you find a physical reason?

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1 A. She had a urinary infection, at the time I saw
2 her, so I prescribed some antibiotics for the urinary
3 infection.
4 Q. And what happened after that? Was that supposed
'5 to take care of the Type 3 symptoms?
6 A. I didn't know if it would take care of it, but
7 that's what I found, so that's what I did.
8 Q. And after that, was she supposed to go back to a
9 CS for follow-up or --
10 A. Well, she went back to the house.
11 I actually went out to her house a month later,
12 because things hadn't changed very much. I looked at her
13 again. She had a vaginal yeast infection at the time. I
14 prescribed something for that. And then, I think, a month
15 or so later, she kind of snapped out of it. She went back
16 home. And I heard from someone, a couple months after
17 that, that she was home, and she was fine, and she was
18 functioning, and she was working. And I haven't actually
19 had any communication since then.
20 Q. So did you ever determine whether any of those
21 things were the cause of her difficulties or not?
22 A. I never did.
23 Q. So you were never able to -- although you found
24 some conditions, and you treated them, you were never able
25 to determine what the cause of her condition was?

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1 A. That's true.
2 Q. And that you were looking for one, but you
3 weren't able to diagnosis a particular --
4 A. Not that necessarily caused her mental symptoms.
'5 Q. Did you try to evaluate her mental systems in
6 terms of traditional medical practice in any way?
7 A. No.
8 Q. Is there any particular reason you did not?
9 A. What do you mean, "her mental symptoms"?
10 Q. Well, I assume that --
11 A. I mean, was she suicidal? No. Was she going to
12 kill somebody? No. I.mean, that sort of basic stuff.
13 Q. Well, whether -- some type of what would be
14 referred to as a traditional mental disease or dysfunction
15 that might be treatable through traditional medical
16 channels. Did you try to evaluate or --
17 A. Like a psychiatric diagnosis?
18 Q. Well, I don't know if it would necessarily be
19 psychiatric.
20 "Depression." That's a diagnosis, right?
21 A. Yeah. It's like -- it's a psychiatric
22 diagnosis.
23 Q. Okay. Or psychological or medical, but -- I'm
24 not sure I would agree with that, but --
25 A. Okay.

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1 Q. But you're saying that only psychiatrists treat
2 depression?
3 A. Oh, no. Every -- now you got a pill, anybody
4 treats depression.
5 Q. Okay.
6 A. Or treats the symptoms of depression.
7 Do they really treat depression? No. Do they
a mask depression? Yeah.
9 Q. You would distinguish between treating the
10 symptoms of depression and treating the underlying cause?
11 A. I would, yeah.
12 Q. And I got the impression from your comment that
13 treating the underlying cause would be more important than
14 treating the symptoms?
15 A. Definitely.
16 Q. Okay. And treating the symptoms of depression
17 may involve what?
18 A. Actually, if you're talking to me, now, the --
19 what I've discovered is that most of the people that I've
20 seen, now, who are depressed, actually, there's a physical
21 reason why they're depressed. You know, there's actually
22 a physical, nutritional problem that they're having, which
23 has caused their, you know, brain neurotransmitters to not
24 be right and for them to actually have the symptoms of
25 depression.

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1 Q. So you would say depression is caused by some
2 neurotransmitter levels being out of sync or --
3 A. Well, it's caused by the body being out of sync.
4 Sometimes it's hormonal, sometimes it's allergy, sometimes
5 it's, you know, missing nutrients.
6 Q. Is that the traditional interpretation of
7 depression, or is that a unique one you've developed in
8 your own practice?
9 A. It isn't a unique one I've developed. There's
10 actually been a sort of parallel course, in terms of
11 thoughts about mental illness and depression and what it
12 is. You know, there's guys like Linus Pauling, who's the
13 only guy in the 20th century that ever won two Nobel
14 prizes, who had some very strong ideas about what mental
15 illness is.
16 Q. I don't think he won the Nobel prize for
17 treating mental illness, did he?
18 A. No, but he got two Nobel prizes, and he's a
19 pretty smart guy, you know, pretty astute observer.
20 And he found that some B vitamins had a huge
21 influence on -- on schizophrenia. And there's a whole
22 group called -- of people who do what's called
23 orthomolecular psychiatry, and these are psychiatrists who
24 use sort of a -- this kind of approach versus your sort of
25 typical "shock them and drug them" approach, and have --

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1 have good successes with it.
2 Q. Okay. So there are psychiatrists, then, that
3 use an approach that you find is helpful to patients with
4 mental illness?
5 A. Sure.
6 Q. And I take it you -- the traditional psychiatry,
7 in terms of using medications, you disagree with or
8 have --
9 A. Well, I have a ton of experience with it.
10 Q. You've done it yourself or you've seen --
11 A. I've done it and I've seen it.
12 Q. Okay.
13 A. I mean, I work in an emergency room, where
14 probably 10 percent of all emergency rooms are
15 psychiatric-problem people, and probably 90 percent of the
16 overdoses and the suicides that we see are people who
17 overdose on the drugs that psychiatrists give them, so I
18 have a lot of experience with regular medicines and
19 regular psychiatry. I do it every day. And I think I've
20 kind of come to this idea because I've seen what that
21 does, and what it produces, and then I've seen sort of
22 what you can do with a person if you really take the time
23 to figure out what's wrong with them and then work with
24 them that way; that their chance of doing better is really
25 better. So that's what I'm basing it on.

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1 Q. Is this something you've developed in the last
2 couple years, or is this over your entire career?
3 A. No, this is something I've learned in, probably,
4 the last probably year, so it's -- it's, you know, Hubbard
'5 would write that there was, physically, something wrong'
6 with these people. And when I did physical -- like a
7 physical exam on this girl, I usually was not satisfied
8 that I didn't find anything. It just wasn't true for me.
9 I just didn't think what he said was correct.
10 The last year or so, I've been -- I've been
11 working with people and looking at sort of a physical exam
12 as, you know, a little more sensitive way, like what's the
13 biochemistry? What's going on, biochemically, with these
14 people? You know, do they have abnormal proteins in their
15 blood or -- you know, there's sort of a whole way -- you
16 know, is their hormone status normal? Which is really a
17 physical thing.
18 And if you look at it you find problems with
19 these people, and when you correct it, they get better.
20 And you're not really giving them a drug to mask, you
21 know, why they're feeling depressed, and they're not
22 really even handling that their father died. What you're
23 really handling is their tryptophan level, and their blood
24 is low because they're taking pepsin, and they're not
25 digesting proteins, and their brain can't produce

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1 serotonin, and that's why they're depressed.
2 I mean, it's a real -- there's a real physical
3 problem.
4 Q. So most things that we would characterize as
5 "psychosis" or -- you feel that there is an underlying
6 medical cause and medical treatment?
7 A. Well, it may not be every one, but I know, just
8 in the case of one of the areas I worked in, is -- is in
9 this whole area of children, which are diagnosed as
10 hyperactive and attention deficit disorder, and these
11 people are put on amphetamine dosages. And I used to be a
12 pediatrician, and I put them on it, too.
13 And then, what I've found since then is, about
14 70 percent of these kids are food-allergic, and you can
15 actually take a movie of them, where you give them the
16 food extract, and they turn crazy, and you give them the
17 antidote for the food extract and they turn normal. And
18 there's actually some documentation for this. And that's
19 just one example.
20 But you look at this kid, and you could have
21 this kid walk into a pediatrician's office or
22 psychiatrist's office, and the mother will tell you, in
23 five minutes, "This kid is nuts," and you look at this kid
24 and say, "This kid is nuts." I mean, he's actually crazy.
25 And then you find out this kid can't take tomato sauce,

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1 and you give him extract of tomato sauce, he actually goes
2 crazy, and you give him the antidote, he doesn't go crazy.
3 He's actually normal.
4 And there's -- if you -- if you're interested in
5 seeing the films or reading the literature on it, there's
6 a professor of pediatrics at University of Buffalo in New
7 York, who's done a lot of nice research on this.
8 So it just has had me look at what are the --
9 what is wrong with these people, and what are the
10 solutions that really will help them? To put a kid who's
11 allergic to tomato sauce on Ritalin is to me not the right
12 thing to do, because that's not what his problem is. He's
13 not deficient in Ritalin. The problem is, he's got
14 something else going on that needs to be discovered.
15 Q. So the bottom line, if I understand your general
16 philosophy -- your general medical philosophy in this
17 area, is, don't treat the symptoms, but try to, through
18 fairly extensive examination, learn the underlying cause.
19 A. Right.
20 Q. Okay.
21 A. I didn't know this in 1995, but that's what I
22 believe now.
23 Q. Okay. You didn't -- you didn't believe that in
24 1995; that learning the underlying cause is important?
25 A. I mean, I didn't know it like I know it now. I

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1 mean, I didn't -- you know, it was something -- I wasn't
2 that interested in it, and I just wasn't -- I know it now,
3 and I've had a lot of experience with it. I know it
4 works.
5 Q. In the last year --
6 A. Yeah.
7 Q. -- two years in treating mental illness, so you
8 do that on a regular basis?
9 A. No, no. Treating people with various medical
10 problems, some of which -- some of which is part of the
11 package, is that they're depressed or --
12 Q. Okay. Let's go back to -- I want to try to --
13 one of the things that has come up since the statement
14 that we took from you, is that you had indicated you
15 recalled a couple of prescriptions that you had issued.
16 One was chloral hydrate, and you thought there was a
17 prescription for Valium.
18 We've since determined that there was a chloral
19 hydrate prescription issued by you on the 29th of
20 November, and there was an earlier Valium prescription
21 issued.
22 Have you had occasion to refresh your
23 recollection on that, since your statement or --
24 A. Yeah.
25 Q. Okay.

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1 A. Yeah.

2 Q. So how did you refresh your recollection?

3 A. In a -- in the civil case depo.

4 Q. Okay.

5 A. I saw the prescriptions.

6 Q. Okay. So -- and we've also received testimony
7 that there was yet a third prescription. The prescription
8 we found is for injectable Valium.

9 A. That was the first prescription, on the 20th.

10 Q. Okay.

11 A. I don't think that was the third. I don't think
12 that was the third --

13 Q. I didn't mean that. I said there were three. I
14 didn't mean sequentially, but that we have testimony that
15 there was also a prescription for Valium tablets. Do you
16 recall anything about that?

17 A. No.

18 Q. Okay.

19 A. I actually hadn't recalled, on the Valium, that
20 it was injectable or what it was, either, or liquid. But
21 the only prescriptions I've seen, that were subpoenaed,
22 were those two, and --

23 Q. Okay. And if I recall correctly, the Valium
24 prescription was issued to David Houghton.

25 A. Correct.

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1 Q. And it's your statement you didn't recall having
2 any contact with Houghton, so I want to go back now and
3 say, okay, "I want to exhaust your knowledge on all the
4 contact and all the conversations you had with anybody
5 concerning Lisa."
6 First of all, when you were working in New Port
7 Richey and living in Clearwater, there was a reference to
8 you having lunch with Janice Johnson, in the statement,
9 and learning something about her. Where did that lunch
10 occur, do you remember?
11 A. Harrison's Restaurant.
12 Q. And is that in Clearwater?
13 A. Yeah.
14 Q. And when was that, in reference to Lisa's death?
15 A. Probably a month before.
16 Q. Okay.
17 A. Probably a month before any of it, so probably
18 middle of October.
19 Q. Okay. Were you ever at the Fort Harrison during
20 the time that Lisa was staying there, the 17 days prior to
21 you seeing her at the emergency room on December 5th?
22 You were never there, physically?
23 A. I don't know if I was ever there, but I didn't
24 know she was there, and I didn't -- no contact with her or
25 anything about her.

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1 Q. I understand that. That's why I'm not asking
2 that question. I'm asking, did you go to the MLO office?
3 Did you talk to Janice Johnson? Did you talk to David
4 Houghton? Were you in the vicinity? Do you recall being
5 around at all?
6 A. With anything with regard to Lisa, no.
7 Q. Regardless of --
8 A. Was I in the FH then? Could have been. Don't
9 know.
10 Q. And no one asked you to come by and look at
11 Lisa?
12 A. No.
13 Q. Would that have been a difficult thing for you
14 to do, if someone --
15 A. Would it have been difficult?
16 Q. Yeah.
17 A. No.
18 Q. So if someone asked you, you could have come by
19 on your way to work or on your way home from work and
20 looked at her?
21 A. Yeah.
22 Q. That would not have been a difficult thing?
23 A. No.
24 Q. Do you know if any other doctor looked at her?
25 A. Don't know.

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1 Q. Okay. Tell me, now that we've got some new
2 information and you've refreshed your recollection on the
3 prescriptions -- 1 don't know if that's jogged your memory
4 on --
5 A. It's pretty bad on this.
6 Q. -- it. But tell me what the first contact is
7 you recall concerning Lisa McPherson and --
8 A. I remember getting a call -- I think it was at
9 my house. It was either at my house or my wife's office.
10 My wife had a nursing agency, which is in that same
11 building.
12 Q. On Garden?
13 A. On Garden.
14 Q. Okay.
15 A. So I don't know -- and it was late. It was like
16 10:00 or 11:00 at night. And I'm not sure -- I can't
17 remember who-all was on the phone. I think it was Alain
18 Karduzinski and Houghton. I don't know if Janice was on
19 the phone or not. It was a combination of one or all
20 three. I don't remember.
21 But the gist of the conversation was, they had a
22 girl -- they might have told me her name, but I'd never
23 heard of her before, never knew her -- who was Type 3
24 Q. And who made the determination that she was Type
25 3?

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1 A. I don't know.
2 Q. Did you make it?
3 A. No, I didn't make it.
4 Q. Okay. Go ahead.
5 A. That's what I was told.
6 Q. Okay. And what -- I know you've given me the
7 gist, but I would like all the details, okay?
8 A. Okay.
9 Q. So go ahead and give me the gist --
10 A. Well, I can make some stuff up, but I just --
11 Q. That's okay.
12 A. I don't have it very well.
13 Q. Well, whatever you have, I want to get today,
14 so --
15 A. Okay.
16 Q. You can start out with the gist, and then we'll
17 go back and get all the details you can remember, okay?
18 A. Okay. So she wasn't -- she was -- she was at
19 the Fort Harrison, and she was -- and they wanted to do
20 some processing with her, but she just wasn't sleeping.
21 And they wanted to know if there was something that she
22 could -- that I could suggest or give to them to help her
23 sleep.
24 And that's really what I remember of it.
25 Q. Okay.

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1 A. And I think I said -- now, she could probably
2 take something like chloral hydrate, or she could take
3 some -- that there were very few things that came as a
4 liquid that you could give someone.
5 Q. Okay. And why was it -- a liquid necessary --
6 A. Well, that she would take, you know, in terms of
7 swallowing a tablet or something.
8 Q. And why was swallowing a tablet a problem?
9 Because you haven't mentioned that, so far, anything they
10 told you. So that's why I want to --
11 A. Okay. I think she said that she was taking
12 Smoothies and taking liquids. I'm not sure about -- maybe
13 it was something about eating, but I don't recall. But
14 she was distraught, and that she couldn't sleep.
15 Q. Distraught about what?
16 A. Well, whatever the type C -- Type 3 scene was,
17 which I didn't get into with them.
18 Q. You didn't get any details of her behavior?
19 A. No.
20 Q. Are there physical causes for insomnia, other
21 than Type 3 behavior? I mean, can people have physical
22 problems that cause them to be unable to sleep?
23 A. Well, actually, my sort of attitude on the thing
24 was that I wasn't -- I was -- it was like curbside advice.
25 They needed a little help.

1 I knew Alain. I trusted Alain. And I knew -- I
2 knew Dave Houghton.
3 Q. Okay. My question was, are there physical
4 problems that can cause insomnia?
5 A. Are there physical problems?
6 Q. Yeah.
7 A. Sure.
8 Q. Did your conversation with them eliminate them?
9 Had they diagnosed away the physical problems?
10 A. No.
11 Q. Did they relate any medical history of this
12 woman to you: Whether she had a fever; whether she didn't
13 have a fever --
14 A. No.
15 Q. -- how much she was eating; how much she was
16 drinking; whether she was dehydrated; whether she was not
17 dehydrated?
18 A. No.
19 Q. Did they tell you how old she was?
20 A. Probably.
21 Q. You don't remember?
22 Tell you her height and weight? Don't know?
23 A. Don't know.
24 Q. Tell you whether she was pregnant?
25 A. Didn't come up.

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1 Q. Did they tell you whether she had problems with
2 glaucoma?
3 A. No.
4 Q. Did you -- was it your understanding that the --
5 that this person was unable to relate or converse with
6 them in a coherent manner, to tell them what her symptoms
7 were, or to understand her need for treatment, or did you
8 not get into it?
9 A. Didn't get into it.
10 Q. So you don't know whether you're dealing with a
11 coherent patient or an incoherent patient at the time
12 you're talking to them?
13 A. True.
14 Q. And you don't know whether you're dealing with a
15 patient who's consented to treatment or a patient who's
16 not consented to treatment?
17 A. True.
18 Q. And that subject never came up? They never told
19 you if she was incapable of consent --
20 A. No.
21 Q. -- or that she was capable of consent?
22 A. No.
23 Q. Is there any reason that you didn't ask that?
24 A. Well, it was foolish. I'll tell you that. I
25 mean, it was --

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1 Q. It was foolish not to ask or it was foolish to
2 do what you did?
3 A. It was foolish to do what I did.
4 Q. Okay. I'm -- 1 appreciate that, but I kind of
5 want to get into the details of what they related to you
6 and --
7 A. See, what I can tell you -- I can't remember the
8 specifics of it, but I can tell you that what I got out of
9 it, or what I was left with, was, she wasn't sleeping.
10 She was basically okay. She wanted some help to -- some
11 suggestions or something to help her sleep. And they
12 thought that they could bring her through whatever the
13 thing was. And that there wasn't a physical situation
14 with her, *or* a physical-illness situation with her, and
15 that she didn't really want official medical advice or a
16 physical exam or -- I mean --
17 Q. I'm not --
18 A. -- anything like that.
19 Q. Prescribing injectable Valium would qualify as
20 medical advice, wouldn't it?
21 A. Absolutely.
22 Q. Okay.
23 A. There's no -- I'm not trying to justify it.
24 Q. Well, you said they didn't want that, but that's
25 precisely what they did want. They wanted medication of

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1 some sort, correct? They wanted a prescription, did they
2 not?
3 A. They wanted something to help her sleep.
4 Q. Okay. And they called you because you can
5 prescribe and they couldn't.
6 A. Yeah. I mean, if I would have come up with
7 something else, they might have taken that, too.
8 Q. Okay. But, again let's go back to -- to the --
9 Did they tell you she was incapable of
10 swallowing? How did you -- who was going to administer
11 this shot of injectable Vaiium? Was that discussed?
12 A. Well, you know, when I first -- when I -- when I
13 first saw the prescription for injectable Valium, I
14 thought, "Jeez, how could I have done that?" But then, as
15 I've been thinking about it since then, I think it was
16 liquid, and she could take it by mouth, and that was a way
17 she could take it.
18 Q. So the preparation for injectable Valium can be
19 taken orally?
20 A. Yeah.
21 Q. You're sure?
22 A. Yeah.
23 Q. Okay. And so there was not -- is this a
24 different dosage, whether it's taken orally or taken by
25 injection?

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1 A. Five milligrams by mouth is about -- is a really
2 mild dose. 10 milligrams by mouth would be a higher dose.
3 Q. And what is an injectable dose?
4 A. Well, between five and 10 milligrams. It's the
5 same.
6 Q. Same dosage; no difference?
7 A. Right.
8 Q. Okay. And did you include instructions --
9 A. See.
10 Q. -- on the prescription as to how it should be'
11 administered, and how often, and --
12 A. It says on there, I think, two cc's IM or
13 something or other.
14 Q. What's that mean?
15 A. "IM" means "intramuscular."
16 Q. And would those have been instructions you gave
17 to the pharmacist or --
18 A. I probably did.
19 Q. So how did we get back to taking it orally,
20 then? Because "IM" doesn't mean "orally," does it?
21 A. No, but it can be given orally. So I honestly
22 don't remember -- this is recollection later, that this is
23 something she could take by mouth.
24 The other thing about this, I was talking to, I
25 think, Janice. At the time, I thought that she was --

1 actually had a license, and was okay, and that she was
2 going to classes over here in Tampa to get her Florida
3 license. I think that's what she told me when I met her
4 the day before. And that she'd been in practice. And I
5 thought I was talking to somebody who was actually a
6 doctor, and who was familiar with this stuff, and who
7 could handle this stuff.
8 Q. I understand that.
9 But are you saying that you recall talking to
10 Janice, that first conversation, then, and that's why you
11 relied on Janice's expertise? Because I didn't
12 understand, your initial conversation or recall that, she
13 was involved in the conversation.
14 A. Well, I told you that I'm not sure which of the
15 three were on there.
16 Q. So if you don't understand which of the three,
17 then, I'm asking you, how are you relying on her expertise
18 as a physician, if you don't even recall she was the one
19 you talked to?
20 A. Well, because I know even if she wasn't on the
21 phone, she was mentioned as part of it, or she'd seen her,
22 or she was involved with it.
23 Q. Okay. Were you told, then, that Janice was
24 responsible for her care in some way?
25 A. Well, I was told that Janice was involved with

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1 it. Whether she was responsible or not, I don't know.
2 Q. Were you told that Janice had performed a
3 physical exam of any kind on her?
4 A. I don't know that.
'5 Q. Were you told that Janice had made a
6 determination that she had no physical illnesses that were
7 causing the insomnia?
8 A. Don't know that.
9 Q. What did these people on the phone represent as
10 being their authority to seek medical advice for a patient
11 that you did not see and didn't speak.to? In other words,
12 what authority do they have to get advice on behalf of
13 someone else? Did they represent that Lisa told them Lisa
14 wanted them to call you? Or what was their authority to
15 you to prescribe medication for a patient that you did not
16 know and had not seen?
17 A. Well, they really had no authority. It was my
18 responsibility. And I shouldn't have done that.
19 Q. Okay.
20 A. And that's not --
21 Q. Well, did they represent to you that --
22 A. Well, they -- what they represented to me was
23 that they were -- that they were handling her, and that
24 this is what, you know, they thought that she needed
25 something to help her sleep.

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1 Q. Did they tell you, at that point, that she was
2 psychotic?
3 A. Well, they probably told me she was Type 3,
4 which is what -- she was psychotic, yes.
5 Q. Okay. Does that mean that she's the same as
6 clinically psychotic or --
7 A. Yeah.
8 Q. -- is it a different terminology?
9 A. No, it's the same.
10 Q. Okay. So what were you prescribing the
11 medication for?
12 A. Help her sleep.
13 Q. Okay. And you had no real idea what the cause
14 of the lack of sleep --
15 A. I assumed that she was psychotic. She was very
16 sort of emotionally upset, way wound up, and she couldn't
17 sleep.
18 Q. Okay. So you assumed she was in some kind of
19 manic phase, and you were prescribing medication to treat
20 these psychotic symptoms?
21 A. I was prescribing something to help them (sic)
22 go to sleep.
23 Q. So -- but did you assume, at the time you were
24 treating it, that it was a symptom of psychosis?
25 A. Lack of sleep. Yeah.

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1 Q. And that can, indeed, be sometimes a symptom of
2 depression; sometimes a symptom of manic phase and a
3 bipolar disorder?
4 A. Oh, sure.
5 Q. And there are a multitude of other causes, as
6 well.
7 A. Yeah.
8 Q. Is there a danger in treating that symptom
9 without seeing the patient?
10 A. Absolutely.
11 Q. Was what you did'in the normal course of
12 practice, or outside of it?
13 A. Never done it before.
14 Q. Does that mean "no"?
15 A. No.
16 Q. Okay. That it wasn't in the normal course of
17 practice?
18 A. No.
19 Q. I take it, at this point, then, you were not
20 aware of the nature of her behavior and, in fact, that she
21 was delusional or hallucinating? That wasn't told to you?
22 A. Don't recall.
23 Q. Urinating and defecating on herself?
24 A. Don't remember. Don't recall.
25 Q. Okay. Not eating, not drinking regular?

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1 A. Same. I mean, I think if any of these things
2 would have come up, it would have been a completely
3 different ballgame.
4 Q. Okay. Well, then, my question is, why did you
5 prescribe an oral medication or an injectable medication,
6 if it didn't come up?
7 A. What came up is that she needed something to
8 help her sleep. I mean, that was sort of the issue.
9 Q. I mean --
10 A. Why didn't I ask all those things?
11 Q. No --
12 A. God knows.
13 Q. Did they ask you for something that she didn't
14 have to swallow?
15 A. Like I said, I don't remember, at the time, what
16 happened. We were just looking at the prescription. I
17 thought, "Jeez, maybe --" I was thinking that maybe she
18 could take it by mouth.
19 Q. Okay. Well, I -- Valium comes in pills, doesn't
20 it?
21 A. Sure.
22 Q. And that's the easiest way to find it, isn't it?
23 A. Yeah.
24 Q. Okay. By writing a prescription for IM, as
25 opposed to the pills, that implies to me a conscious

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1 decision to choose one form of the medication that's
2 probably less accessible, less available over another
3 that's more commonly used.
4 A. Right.
5 Q. And that implies that maybe they did tell you
6 that there was a problem with her eating or drinking,
7 which would, again, key in, as you just said, a whole
8 'nother ballgame. So I'm trying to reconcile what you
9 just told me what you did, and I'm having difficulty with
10 it, and I'm asking you for an explanation.
11 A. Right. And I'm telling you, I don't really
12 remember that I could give you an explanation now, so -- I
13 really don't remember. So I'm not really sure.
14 Q. So you can't explain.
15 A. I can't explain why I did it in the first place.
16 So after that, everything else is pretty much out the
17 window.
18 Q. You understand I'm not concerned with just what
19 you did; I'm concerned with what you were told and what
20 involvement these other people had.
21 A. Right.
22 Q. So it's important to me to get accurate
23 testimony concerning what they told you or what they
24 represented to you or what they failed to represent to
25 you.

1 A. Right. I understand that.
2 Q. And that's -- so you -- you can't help me any
3 more on whether they told you there was a problem of her
4 eating or drinking.
5 A. I can't.
6 Q. Okay. Is that -- is that not a fairly common
7 problem, with -- with extremely psychotic patients; their
8 inability to take care of themselves, in terms of eating
9 and drinking normally?
10 A. Not to the extent that happened to her.
11 Q. Okay.
12 A. I mean, it's really -- it's rare to see a
13 psychotic person, even if they're, like, a psychotic
14 person, that will not drink enough fluids to stay sort of
15 alive. That's my experience.
16 Q. Okay.
17 A. But I've seen thousands of these kind of guys,
18 street people, who don't have two nickels to rub together,
19 and they may come in, in a completely psychotic state, but
20 they're rarely in the hospital, you know, probably, as
21 part of this experience. But I never let one go through
22 without blood work, you know, the whole deal, and it's
23 rare to actually find one that's way out of sorts.
24 Q. Did they indicate to you that they wanted to run
25 a purification rundown on her?

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1 A. No.
2 Q. They didn't tell you that?
3 A. I don't recall that at all.
4 Q. So if that was their plan, they didn't disclose
5 it to you?
6 A. I don't recall anything about it.
7 Q. Did they tell you she was going through an
8 isolation watch?
9 A. Yeah. They said she was Type 3, and she was in
10 isolation.
11 Q. Okay. And did you understand that means that
12 they didn't talk in her presence? Is that one --
13 A. As little as possible, yeah.
14 Q. so that meant they probably weren't conversing
15 with her about her symptoms and asking her what was wrong.
16 A. Actually, if a person on a Type 3 watch
17 originates communication, people talk to them.
18 Q. Right. That wasn't my question.
19 A. Yeah.
20 Q. They weren't talking to her and asking her about
21 her symptoms and what was wrong. Would that be common
22 practice, in an isolation watch?
23 A. I guess so, but having never been there and done
24 it, I --
25 Q. You don't know that.

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1 A. -- I'm not sure.
2 Q. Okay. Anything else you can tell me about that
3 initial conversation with **Alain** Karduzinski, **Mr.** Houghton
4 or Janice Johnson?
5 A. No.
6 Q. Okay. You prescribed the Valium. I take it,
7 then, that your recommendation to them was use the Valium
8 to get her to sleep.
9 A. Mm-hmm.
10 Q. Okay. And that was the advice you wound up
11 giving them.
12 A. Right.
13 Q. Okay. Did you authorize them to force-medicate
14 her?
15 A. No.
16 Q. Okay. Did they ask for that authorization?
17 A. No.
18 Q. So you never authorized them to medicate her
19 against her will or without her consent.
20 A. No.
21 Q. Okay. What was the next thing -- the next
22 contact or information you had concerning Lisa McPherson
23 after that first conversation?
24 And -- well, I assume you called a pharmacy,
25 okay --

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1 A. Right.
2 Q. -- so that was the next thing that happened.
3 A. Right.
4 Q. Did you talk back to anybody after you called
5 the pharmacy? You call back and say, "It's going to be at
6 this pharmacy," or did you just assume you would find out
7 that, since they gave you the pharmacy name? In other
a words, was there a follow-up conversation after you talked
9 to the pharmacy to get the prescription? Did you talk
10 back to anybody else?
11 A. I don't recall.
12 Q. Okay. What happened next, then?
13 A. Well, then I just forgot about it. I went on
14 with my regular stuff.
15 And I got a call nine days later.
16 Q. Nine days later.
17 A. 29th.
18 Q. So no one's given you any input on this?
19 A. Zero.
20 Q. Okay.
21 A. And I had forgotten about it.
22 Q. And I take it that, other than, "here's some
23 Valium to help her sleep," you authorized no treatment, no
24 actions on their part, in terms of their care for Lisa.
25 A. Correct.

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1 Q. You didn't authorize them to medicate her in any
2 way; you didn't prescribe any --
3 Is that a "no"?
4 I better ask these questions one at a time.
5 A. No. The answer's "no."
6 Q. You didn't give them any advice on what symptoms
7 to look for or not look for?
8 A. No.
9 Q. You didn't give her (sic) any advice on how to
10 treat her psychosis?
11 A. No.
12 Q. Didn't give them any advice on diagnosing what
13 was wrong with her?
14 A. No.
15 Q. And did you give them any advice to -- that
16 would suggest restraining -- that would authorize them to
17 restrain --
18 A. No.
19 Q. -- her against her will?
20 A. None.
21 Q. Did you authorize them to hold her down and use
22 a syringe to medicate her with Benadryl and aspirin?
23 A. No.
24 Q. Did you have any knowledge that that was
25 occurring?

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1 A. No.
2 Q. And in your earlier conversation, had you
3 suggested that to them?
4 A. I might have suggested Benadryl to them.
5 Q. What about a mixture of Benadryl and aspirin?
6 A. Not aspirin.
7 Q. So if they came up with that concoction, it
8 wasn't under your direction.
9 A. Correct.
10 Q. And I take it that, even as to the Benadryl, you
11 didn't authorize them to -- to medicate her without her
12 consent.
13 A. No.
14 Q. Okay. You, as a doctor, might have that
15 authority, but you didn't confer that to them?
16 A. Correct.
17 Q. Okay. Tell me about the next conversation, on
18 the 29th.
19 A. Okay. So then there was a call, nine days
20 later, which I don't really recall very well; probably
21 worse than the first one. And I think I talked to Alain,
22 and he said they hadn't given her the Valium; that she was
23 taking liquids, she wasn't eating very well, and that
24 sleep was still a problem. Otherwise, she was okay --
25 Q. Okay.

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1 A. -- that she was fine. That things were okay.
2 Q. Okay. Things were okay.
3 Was Janice on the phone?
4 A. I don't remember.
5 Q. Okay. Why would you trust Alain's
6 representation of a patient's physical or mental
7 condition? I take it you did trust it, and went on to
8 prescribe the chloral hydrate, so I'm asking, why didn't
9 you demand to speak to Janice, or at least someone with
10 medical knowledge? Because --
11 Does Alain have any medical knowledge, that you
12 know of?
13 A. No. He's just a very reliable guy. I mean,
14 my -- my experience with him in the past has been that, if
15 he was running something, he was on top of it completely;
16 that if he had people doing things for him, or look into
17 things for him, that the data he was getting was accurate.
18 Q. Did he represent to you that he was on top of
19 Lisa's situation?
20 A. Yeah.
21 Q. In other words --
22 A. Yeah.
23 Q. -- did he imply to you or tell you directly,
24 "Here's what's happening;" that he knew the details of her
25 condition, when you talked to him?

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1 A. That was my assumption, but yeah.
2 Q. And he certainly didn't tell you anything to
3 suggest he really didn't know what was going on.
4 A. No, or that there was any problem with her.
5 Q. Okay.
6 A. That there was any physical problem with her.
7 And he didn't ask me to see her or to come see her or --
8 Q- And I take it you didn't ask to see her, either.
9 A. No.
10 Q. Okay. Let's go over what he said.
11 You said he said she's taking fluids. Didn't
12 tell you how much --
13 A. No.
14 Q. -- But -- she's taking fluids, but you don't
15 know --
16 A. The main -- the reason he called was, "Sleep is
17 still a problem, you got any other ideas? Is there
18 anything else you can do?"
19 Q. Did he tell you that they had done anything
20 instead of the Valium?
21 A. Don't recall him telling me anything like that.
22 Q. Okay. For instance the aspirin and Benadryl
23 mixture. Did he tell you that?
24 A. I don't recall that.
25 Q. Do you think you would recall if he told you

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1 they had held her down and put it down her mouth? Is that
2 something that would stick out to you as being --
3 A. Might. I don't recall anything like that, so I
4 can't tell you for sure.
5 Q. Well, would you --
6 A. I just don't know.
7 Q. Would you have been concerned if-she had to be
a held down to be medicated? Would that be a red flag this
9 ought to be handled different than what's going on; do you
10 need to see the patient?
11 A. Yeah.
12 Q. And you didn't get any red flags out of that
13 conversation.
14 A. I didn't get any red flags.
15 Q. Okay.
16 A. I mean, basically -- see, this -- if you want --
17 a good description of the term "PTS," okay, I was PTS on
18 the situation. I really wasn't really looking at it. I
19 sort of had -- a friend called me. "I need a little
20 help." Give him a little help. Calls me back, "It's a
21 little problem, not quite right. Need a little more
22 help." Not, "Will you be involved, or will you handle the
23 patient; will you take care of her; will you do this
24 thing?"
25 Q. I understand you weren't -- and Lisa was'not

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1 really a patient of yours, at the time.
2 A. Correct.
3 Q. You didn't know her, never saw her, until she
4 showed up at the emergency room, dead.
5 A. True.
6 Q. Never spoke to her, either.
7 A. Never.
8 Q. Okay. Tell me everything that you can --
9 Now, is Janice on the phone? Because my
10 recollection is -- and -- is that, previously, you
11 thought -- you talked about Janice and Alain on the phone
12 together, in one of these conversations.
13 A. One of these -- okay --
14 Q. And I don't -- last time, we didn't talk about
15 the Valium conversation, I don't think, because I don't
16 think you were -- you recalled it as specifically, now
17 that you've looked at the -- at the data on the
18 prescription. You've got a little more detail.
19 A. Right.
20 Q. But do you recall -- 1 guess what I'm saying is,
21 here you're fixing to issue another prescription; you've
22 kind of told me that you were relying on Janice's
23 expertise, and you thought she was licensed, yet you
24 haven't related anything to me to suggest that you ever
25 spoke to her. Maybe you didn't.

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1 A. Well, I wasn't sure about the first time, and
2 I'm not sure about the second time. I'm pretty sure it
3 was at least Alain the second time, and it could have been
4 Janice the second time. I don't think Houghton was around
5 the second time.
6 Q. So you don't have any specific recollection of
7 talking to Janice over the phone?
8 A. Not -- no. Can't --
9 Q. But do you have a specific recollection of
10 talking to Alain?
11 A. Yes, I think so.
12 Q. And he related this information to you that she
13 was doing okay, she wasn't eating, and sleep was a
14 problem.
15 A. Sleep was a problem. She was taking in liquids,
16 yeah. I'm not sure about the eating part.
17 Q. Okay. Go ahead. What else did he tell you?
18 A. She hadn't -- they hadn't done the Valium.
19 Q. Did he tell you why?
20 A. No, not that I remember.
21 Q. Okay. Well, let me ask you this: Did he tell
22 you he had overruled it because he felt it would affect
23 the later processing or auditing?
24 A. Hmm. Don't know that.
25 Q. Okay. That doesn't ring a bell at all?

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1 A. Not that he told me.
2 Q. Okay. Would you be concerned if he had
3 overruled your suggestion for a drug without discussing it
4 with you? Would that have been --
5 A. No, no, no. Not in that case. I mean, it was
6 like, "You can try this," but it wasn't like, "Okay, this
7 is the order. Do it."
8 Q. Okay. When you prescribed the Valium, did you
9 give it to them as something they could use, then, to
10 handle it, or were they just saying, "We want something in
11 case it continues"?
12 A. No, they wanted it then.
13 Q. Okay.
14 A. And actually, when I found that they hadn't
15 given it to her, I was just as happy, because, fine, I'd
16 rather not do the drug.
17 Q. Okay. Were you concerned that you had a patient
18 that hadn't been sleeping for nine days, or that they had
19 a patient that hadn't been sleeping for nine days?
20 A. I wasn't sure if it was just off and on or
21 whether she just really hadn't slept in nine days.
22 Q. Did you ask?
23 A. I don't know.
24 Q. You don't know whether you asked?
25 A. I don't know.

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1 I think -- what I -- what I remember about it is
2 that it wasn't, like, nine days straight with no sleep;
3 it's just that she hadn't -- she wasn't sleeping very well
4 or very long, and that he wanted to try to do some sort of
5 processing with her, and that, unless she got some sleep,
6 he wouldn't be able to do it.
7 Q. Okay.
8 A. And would something be more effective or --
9 Q. Did you have a concern that, after nine days, no
10 one was attempting to treat her psychosis?
11 A. Well, I think **they** were attempting to treat her
12 psychosis.
13 Q. Who was attempting to treat it?
14 A. **Alain.**
15 Q. Okay. And what authority does he have to treat
16 psychosis?
17 A. Well, he's got whatever relationship he's got
18 with his parishioner to do that --
19 Q. Okay. And what was your --
20 A. -- which is an agreement --
21 Q. And what was your understanding of what he was
22 doing to treat the psychosis --
23 A. Well, the purpose --
24 Q. -- since she hadn't gone through the auditing
25 yet you didn't understand there was going to be an

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1 introspection rundown. So what was your understanding --
2 A. Well, I mean, if they're in isolation, that's
3 part of the treatment. It's -- just try and calm down
4 their environment, try and get them in a safe environment
5 so that you could process them. I mean, if they're -- you
6 might not be able to process them until they're sort of
7 settled down.
8 Q. Well, is it your understanding that processing
9 helps to cure mental illness?
10 A. That processing helps to cure mental illness?'
11 Q. Yeah. Psychosis.
12 A. Well, if someone is psychotic, and they have had
13 a -- according to Hubbard, if someone is psychotic and
14 they have the prescriptions that he does for Type 3
15 handlings, which I don't have experience with, will it
16 help somebody? According to him, it will. Do I have
17 direct experience in it? I don't.
18 I actually saw this one girl --
19 Q. Is that -- let me ask you this: Is that a
20 medically-accepted treatment for psychosis?
21 A. By the -- by the --
22 Q. Of the medical profession.
23 A. Will the board accept it? No. No.
24 Q. Okay. So you just assumed that someone was
25 treating her psychosis; you didn't really ask, and'he

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1 didn't really explain.
2 A. Well, I know, for a Scientologist, the treatment
3 of psychosis is processing that occurs with the isolation.
4 Q. Okay.
5 A. I mean, that's the --
6 Q. And does that assume that the person has
7 consented to undergo that procedure or consented to
8 undergo auditing?
9 A. Yeah.
10 Q. Okay.
11 A. You couldn't really be audited without your own
12 consent.
13 Q. Okay. And so someone who's psychotic and
14 incapable of consent, what's to be done with them?
15 A. Well, that -- they would -- that they work out
16 with them and their family and who's ever handling them.
17 Q. And that gets back to my authority (sic). They
18 never represented they had talked to the family; they'd
19 talked to next-of-kin; they had any legal authority to
20 treat this patient.
21 A. I don't know that.
22 Q. Don't know that, one way or another.
23 A. No.
24 Q. Okay. Tell me everything else in the
25 conversation we haven't talked about.

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1 A. That's what I recall of it.
2 Q. Did you ask if anyone had done a physical exam?
3 A. No.
4 Q. Did you ask if she was running a fever?
5 A. No.
6 Q. Okay. And then what did you say, if anything?
7 A. Well, I must have said, "You can try the chloral
8 hydrate. It comes in a capsule. It can be given as a
9 liquid. You can break the capsule and the stuff will
10 squirt out." And that was pretty much it.
11 Q. Okay. Were you concerned that this woman had
12 not eaten solid food for nine days, or did you assume that
13 that wasn't the case?
14 A. I didn't assume -- you know, I didn't assume, at
15 the time, that it was a problem; you know, that there was
16 a problem with that. The problem I was getting from them
17 was -- was this thing that they needed help with her
18 sleep, but that there wasn't any other situation; that she
19 was being watched 24 hours a day; someone was with her all
20 the time; you know, that she was in what I -- what I had
21 always considered to be a safe environment; that Alain was
22 a competent guy; that Janice was competent; and that the
23 people who would watch her were actually -- you know, they
24 were decent people, trying to help her; and that she
25 was -- that she was in good hands.

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1 I mean, that's the -- that's the -- that's my
2 experience with Alain and -- and what he does. And
3 that's -- that's --
4 Q. But you never had contact with him in this kind
5 of situation before, where they're caring for a psychotic
6 patient, have you?
7 A. No, but I'd have other contact with him in other
8 circumstances, and he was, you know --
9 Q. You considered him trustworthy, and --
10 A. Absolutely.
11 Q. -- and if there were significant problems, he
12 would have related them to you?
13 A. Absolutely.
14 And if he would have felt there was any physical
15 situation or physical endangerment to her, that he would
16 not have sat on it.
17 Q. Okay. Well, did he relate to you that she had
18 attempted to harm herself --
19 A. I don't recall that.
20 Q. -- and they had removed breakable objects from
21 the room so she couldn't harm herself?
22 Don't recall that?
23 A. Don't recall that.
24 Q. Did he tell you that she was banging her head
25 against the wall?

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1 A. I don't remember that, either.
2 Q. Did he tell you that she was standing in the
3 toilet?
4 A. I don't think so.
5 Q. Did he tell you that she was delusional?
6 A. Don't recall.
7 Q. Did she (sic) tell you -- did he or she --
8 **Alain** -- 1 know you talked to; Janice may have been
9 there --
10 A. Mm-hmm. Yeah.
11 Q. Did -- did someone tell you that, again, she was
12 urinating and defecating on herself?
13 A. I don't recall it.
14 Q. Did they tell you that she was --
15 A. Actually, he didn't really tell me much more, or
16 anything, that made me think that there was -- that it was
17 any more than she just needed to sleep.
18 Q. Okay. Well, the reason I'm asking that, had you
19 known the severity of those psychotic symptoms, would you
20 have -- had he related that to you, would you have
21 insisted on seeing her or insisted that she be seen by a
22 doctor?
23 A. Probably.
24 Q. Were you aware that she had undergone a
25 significant weight loss during her stay at --

1 A. No.
2 Q. -- the Fort Harrison?
3 And other than just the brief reference, in the
4 first conversation, that she was Type 3, did he ever
5 relate to you that she was completely incoherent, in terms
6 of being -- they couldn't get any information from her;
7 she --
8 A. I don't recall it.
9 Q. Okay. You think you would have recalled it if
10 he told you any of those things that I'm relating?
11 A. Well, if he had run down this list to me, "Look,
12 she's standing in the toilet; she's defecating all over
13 herself; she's banging her head against the wall; she's
14 completely incoherent; she's not taking anything," I think
15 I would have thought, "Well, jeez, maybe this is not a
16 person who's --" you know, I think so. It would have rang
17 a bell.
18 Q. Okay. I think, in that conversation, you
19 prescribed, I think, 30 tablets, was it? 30 capsules?
20 A. Yeah.
21 Q. And again, this is a sedative?
22 A. Yeah. It's a light --
23 Q. What are the effects of a sedative on appetite
24 or water intake?
25 A. Oh, this is a light sedative, so usually,' after

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1 a couple-of-gram dose, somebody would probably sleep for a
2 couple hours. Chloral hydrate's actually used in children
3 to put them to sleep for, like, EEGs and CAT-scans.
4 Q. I was asking, does it suppress appetite or --
5 A. Well, I suppose, if you gave it around the
6 clock, it might, but as a -- as a -- you know, a couple.-
7 time -- you know, one-or-two-time sleep remedy, it's --
8 probably wouldn't have any affect on it.
9 Q. And what's the effect of sedatives on someone
10 who's bipolar or manic depressive?
11 A. Well, it might have -- might settle them down
12 and make them -- help them go to sleep.
13 Q. Okay.
14 A. It might not.
15 Q. Could it harm them, do you know?
16 A. Could it harm her?
17 Q. Yeah. Do you know what the effect could be on
18 a n - -
19 A. Could you overdose? You'd sleep a long time.
20 Q. No, I'm not talking about overdose. I'm talking
21 about the effect of getting a sedative in someone who's in
22 a manic state, of a bipolar disorder or schizophrenic.
23 A. would --
24 Q. My question was, what was the effect? And I
25 think you said, "Would it hurt them? No," was your

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1 response.
2 A. Okay.
3 Q. Does that sound like what you intended to say?
4 A. Yeah.
5 Q. Okay. Would it help them treat the underlying
6 mental illness?
7 A. The underlying mental illness?
a Q. Yeah.
9 A. No. Nobody's claiming it would.
10 Q. Okay. So when you were prescribing that, you
11 were not attempting to deal with the underlying mental
12 illness. YOU didn't even know what the underlying mental
13 illness was.
14 A. True.
15 Q. YOU didn't know the severity of it and you had
16 no way to diagnose it, from the information you were
17 given.
18 A. Correct.
19 Q. Okay. What happened next?
20 A. I got a call in the emergency room, on the 5th
21 of December, at -- sometime after 7:00. It was Janice.
22 Q. Are you relatively certain on the time?
23 A. I know it was after seven, because the night
24 shift guy comes at seven, and he was there, so --
25 Q. Okay.

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1 A. Exactly what time, I'm not sure, but I know it
2 was after seven.
3 Q. Okay. Going back -- you said no one had told
4 you physical problems. Had anyone told you that she had
5 been unable to walk --
6 A. No.
7 Q. -- for several days?
8 A. No.
9 Q. Would that have been a very serious red flag, if
10 you'd have known that?
11 A. Yeah.
12 Q. would you have insisted on the patient being
13 seen by a doctor, if you had known that?
14 A. Yeah.
15 Q. Okay. Go ahead. Shortly after seven, December
16 5th --
17 A. So sometime after 7:00, on December 5th, I got a
18 call from Janice, who said, "Remember the girl who Alain
19 had talked to you about before -- I and Alain had talked
20 to you about before --" I don't remember which she --
21 III saw her about 6:30, and she'd gotten a sore
22 throat that morning, and she'd had diarrhea during the
23 day, with some weight loss. I think she's got a strep
24 infection, and I'd like permission to give her an
25 injection of penicillin."

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1 And I said, "Wait a minute. I can't do that.
2 She needs to be seen by a doctor. Why -- you better take
3 her over to Morton Plant and get her looked at."
4 She said -- I said, "If she's really sick," I
5 said," she needs to be seen by a doctor. If she's really
6 sick, I'm too far away. You better take her to Morton
7 Plant, because it's 45 minutes up here."
8 And she said, "No, she's not that sick. Will
9 you see her?"
10 So I said, "Well, if you think it's safe, and
11 she's not really ill, I will see her, but I'm leaving at
12 10:00, and I don't want you to show up at five to 10,
13 because I'm out of here. So if you come right away, I'll
14 take a look at her."
15 So she said -- and I emphasized -- I know I said
16 this -- this happened a couple of times, about, "if she's
17 really not -- if she's really sick, you better take her
18 someplace close," and she assured me that that wasn't the
19 problem. And then I hung up.
20 And then we were busy. We were busy, and I
21 didn't even think about it.
22 And then, at 9:30 -- and I'd actually forgotten
23 about it. I thought, "Well, they changed their mind.
24 They went someplace else. Who knows?"
25 And then, about 9:30, I hear the -- the ward

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1 clerk from up front say, "Patient needs assistance at the
2 double doors," which is where the ambulances come in, and
3 then the patient care technician went back there. And the
4 next thing I hear is, he's yelling, "Help, help, help,"
5 and he's got this girl draped over a wheelchair, you know,
6 like this.
7 Q. Okay. So you're --
8 A. I ran out there, 'cause he said, "We need help."
9 And I see him wheeling in this girl.
10 And it still didn't dawn on me who this was,
11 because she looked, you know, horrific.
12 Q. Horrific?
13 A. Yeah.
14 Q. And when you say "draped over the wheelchair,"
15 it sounded like she was sitting sideways, legs over one
16 arm, head --
17 A. Head and arms flailing back like this.
18 Q. And no -- no voluntary movements --
19 A. No.
20 Q. Did she appear dead?
21 A. Well, dead, or just dead, or close to dead,
22 or --
23 Q. Okay.
24 A. Yeah, she looked dead.
25 So they wheel her in the treatment room. We

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1 start in. And then I thought somebody said, "What's her
2 name," or, "What is it," and then I thought, "Oh, my God,
3 this is the girl."
4 So we do CPR. We do the whole deal, what we do.
5 And -- and I think we did it for, like, 20 minutes, but
6 there was no heart rate when we got her.
7 And she looked -- told you guys this last time,
8 but she -- I -- I have a specialty in infectious diseases,
9 and, like, I've seen a lot of people who've had
10 overwhelming sepsis with meningococcus, and that's what
11 she looked like.
12 so during the code, I injected her with a big
13 dose of antibiotics. And then, as soon as the code was
14 over, I thought, "Oh, jeez, you know, if she is septic,
15 maybe there's some risk to us," and I drew a blood culture
16 and we sent that off.
17 Q. Do you recall whether you drew that personally
18 or --
19 A. I did it personally.
20 Q. Because a nurse recalled doing it, or thought
21 she did it, but --
22 A. I think I did it.
23 Q. Is there some reason you only drew one? Isn't
24 it more common to draw two blood cultures?
25 A. Well, if they're alive, you draw two, just

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1 because one might be contaminated.
2 Q. But they can't be contaminated when they're
3 dead?
4 A. Well, they could.
5 The whole thing was just such a fiasco --
6 Q. I'm asking -- normally, you would draw two
7 because of the risk of contamination. That risk lessen,
8 when they are dead, or increase?
9 A. No. The same.
10 Q. Is there any reason you didn't draw two?
11 Because of the urgency of the situation, or you just don't
12 do it?
13 A. Just didn't do it.
14 Q. Okay.
15 A. It was just like a "maybe" situation, if you've
16 got three colonies, because it was a skin contaminant,
17 wouldn't make any difference. If you've got a big dose of
18 something and it was meningococcus, everybody would take
19 antibiotics for a couple days.
20 I really wasn't thinking of it in terms of the
21 diagnosis for her later. I was thinking we had three or
22 four people around there with close contact, and maybe
23 that's what was wrong. It was just sort a kneejerk, "just
24 do it."
25 Q. Okay.

1 A. So we finished the code, and she was dead.
2 And then -- so then I went out to find out who
3 was out there, and they said, well, Janice Johnson was
4 there, and one other person.
5 So I had them put Janice Johnson in the -- in
6 the head nurse's office, and I went in there and I talked
7 to her, and I basically said, "How could you do this?"
8 You know, "How could you bring this person like this to
9 me?" And --
10 Q. Referring to the terrible condition she was in?
11 A. Yeah. Dead. Like when was she breathing or,
12 like, what?
13 Well, she thought she was still breathing at
14 Palm Harbor. That's about halfway. And --
15 Q. Did she explain why --
16 A. She didn't even -- she was like -- she was --
17 she couldn't even talk. And I was so exasperated, I just,
18 like, hollered at her for a while, like, "What is going on
19 here?" You know, "This is horrible."
20 Q. You were just yelling at her, venting at her?
21 A. Yeah.
22 Q. Did she give you an explanation --
23 A. No.
24 Q. -- for her conduct?
25 A. No.

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1 Q. Did she give you an explanation for the
2 condition the patient was in?
3 A. No.
4 Q. I take it you were shocked to see --
5 A. I was shocked out of my wits.
6 Q. When I say "shocked," I mean not shocked that
7 she was dead or almost dead, but the physical appearance
8 of the patient.
9 A. Yeah.
10 Q. Okay. So she looked horrific, as you said. You
11 did not expect a patient in that condition.
12 A. Oh, from Clearwater, to be driven --
13 Q. Yeah.
14 A. -- no.
15 Q. Going back to your conversation from Janice, was
16 anybody else on the conversation, that you recall? Was
17 Alain in on that conversation?
18 A. No. I don't think anybody -- I think it was
19 just Janice.
20 Q. Did Janice give you any explanation for wanting
21 to come to you? In other words, this patient was scared
22 of doctors, or that -- scared of psychiatrists, and she
23 wanted a different environment up in New Port Richey? Was
24 there any conversation --
25 A. No.

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1 Q. -- like that?

2 A. No.

3 Q. So she didn't give any explanation to you for

4 why she wanted the patient to see you?

5 A. No. I mean, I just assumed that she was a

6 Scientologist. She trusted me. You know, I'd see her.

7 Q. Again, "she" being the patient or "she" being

8 Janice?

9 A. Janice.

10 Q. So Janice trusted you because she was a

11 Scientologist?

12 A. Yeah.

13 Q. Did she relate to you that -- in that phone

14 call, that the patient was severely dehydrated?

15 A. No. What I remember, sore throat, diarrhea, but

16 not -- not real sick.

17 Q. Not real sick.

18 A. Not real sick.

19 Q. so if she had indicated that she had noticed the

20 symptoms of severe dehydration before calling you --

21 A. Yeah.

22 Q. -- she didn't relate that to you.

23 A. No.

24 Q. Would that have been something you would have

25 expected her to relate to you as something pertinent to

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1 your decision of where she should go?
2 A. Absolutely.
3 Q. And again, in that conversation, she didn't tell
4 you anything about either the severity of the psychosis
5 that she had observed over the last 17 days -- did she
6 tell you about the weight loss?
7 A. She told me -- and after -- in part of the
8 afterwards, that she thought she'd lost 12 pounds during
9 that day.
10 Q. During that day?
11 A. Yeah.
12 Q. In a single day.
13 Did she say where she comes up with a 12- --
14 A. I don't know that. Either she weighed her or
15 she'd had a lot of diarrhea during the day, but she didn't
16 tell me that on the phone.
17 Q. That was after she was at the hospital?
18 A. Yeah. Because she looked like she lost 12
19 pounds that day.
20 Q. Well, I --
21 A. She looked acutely dehydrated.
22 Q. "Acutely" meaning over a period of days, over a
23 period of hours, over a period of weeks, as opposed to --
24 A. Acute. Hours, probably.
25 Q. And how can you tell that from chronic?

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1 A. No. She just -- I mean, she just -- she just
2 looked -- she actually just looked like someone in septic
3 shock. so I -- I -- when I put it together with what she
4 looked like, it looked like it was -- it was sort of --
5 rather acute.
6 Could it have happened over a longer period of
7 time? It's possible.
8 Q. Okay. Well, my question is, did she look
9 dehydrated --
10 A. Oh, yeah.
11 Q. -- regardless of --
12 A. Well, definitely, she was dehydrated.
13 Q. Severely dehydrated.
14 A. Severely dehydrated.
15 Q. You can't tell, from looking at her, whether the
16 dehydration occurred over a couple of hours or a couple of
17 days or over a 17-day period.
18 A. That's true.
19 Q. Okay. And you can't tell whether she lost 12
20 pounds in one day or 12 pounds in a week or two weeks --
21 A. No.
22 Q. -- in looking at her.
23 A. No.
24 Q. Okay. Going back, did Janice indicate to you --
25 I guess Janice kind of gets you thinking that infection is

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1 a problem, by talking about the strep throat and the sore
2 throat and wanting penicillin.
3 A. Mm-hmm.
4 Q. Did she mention any other symptoms?
5 A. Sore throat, diarrhea.
6 Q. For instance, you've -- you've identified --
7 there are marks on her hands and arms, and some in the --
8 in the ankle or foot area, that you previously thought
9 might be septic petechia.
10 A. Right.
11 Q. And I'll discuss that with you a little later,
12 as to whether it is, and what makes you think that.
13 But I assume that that's a -- that's a -- if you
14 were right, that would be a very severe symptom, and
15 something that was dramatic, and should have been
16 reported, and have caused her to go to Morton Plant, as
17 opposed to New Port Richey.
18 A. Yeah.
19 Q. Okay. Did she relate to you --
20 A. No.
21 Q. -- that she had those marks?
22 A. No.
23 Q. When -- did she tell you that she looked --
24 "she" being Lisa -- looked septic?
25 A. No.

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1 Q. Okay. So -- sepsis a term that -- because
2 Janice has used that phrase as saying, "I thought she
3 looked septic." I'm not trying to mislead you, here,
4 but --
5 A. Mm-hmm.
6 Q. -- you don't recall her telling you --
7 A. If she --
8 Q. -- that she -- that she used that word as
9 opposed to you inferring that from the sore throat and the
10 request for penicillin?
11 A. True.
12 Q. When you said she looked like she had been in
13 septic shock when you saw her, we've already talked about
14 the severe dehydration --
15 A. Mm-hmm.
16 Q. -- we've talked about the marks that you saw --
17 A. Right.
18 Q. Okay. What other things, physically, did you
19 see to make you believe that this was a septic shock
20 condition?
21 A. Well, that's enough.
22 Q. Okay. I understand. And we'll get back to
23 that.
24 A. I mean, here she is, dead.
25 Q. I mean, you understand --

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1 A. Dehydrated, petechiae and purpura all over her.
2 That was enough.
3 Q. Well, you understand that there -- people are
4 not in agreement with you that those are petechiae. In an
5 autopsy, there was no hemorrhaging. It was strictly an
6 abrasion. So I'll talk with you about that --
7 A. Okay.
8 Q. -- later.
9 A. Okay.
10 Q. But -- but you believed it was septic petechiae,
11 when you looked at it.
12 A. Right.
13 Q. Okay. So assuming that you got the septic
14 petechiae, assuming that you see and notice the symptoms
15 of severe dehydration --
16 A. Right.
17 Q. -- and she looks, to some degree, emaciated,
18 like she's lost weight --
19 A. Right.
20 Q. -- other than those things, were there any
21 physical manifestations that made you believe that sepsis
22 was the cause of her condition or death?
23 And I know you get a blood test later, but I'm
24 not asking about that yet. I'm talking about when she was
25 in the emergency room, when you said she looked like she

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1 was -- had died of septic shock, or she was in septic
2 shock. I want to know all of the symptoms that led you to
3 that conclusion. We've mentioned a couple. Was there
4 anything else?
5 A. No.
6 Q. Okay. I take it, then, that severe dehydration
7 can be caused just by dehydration and not necessarily as a
8 result of septic shock; that what -- your primary basis
9 were these marks that you believe were septic petechiae.
10 A. Right.
11 Q. And if those turned out not to be septic
12 petechiae, that would, perhaps, change your conclusion.
13 A. Oh, no. Not necessarily.
14 Q. Okay.
15 A. No, no.
16 Because you can get leakage of blood vessels
17 from endotoxin, from the bacteria, without actually
18 having --
19 Do you have tissue bacterial stains?
20 Q. I don't have them with me.
21 A. No, no. But have they been done?
22 Q. I'm sure there have been stains from various
23 tissues, and I don't know of anybody that's concluded that
24 she died of septic shock, other than you. Now, there may
2s be some defense experts that suggest that. The ones that

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1 I've been privy to have not.
2 A. No, but have the -- have the pieces of skin been
3 taken, and done bacterial stains on the -- on the infarct
4 areas?
'5 Q. Why don't you let me ask the questions, okay?
6 A. Okay. Well, you're telling me that they
7 weren't, so I just -- 1 just want to know if you really
8 have -- were all of them looked at, so we know they were
9 negative.
10 Q. I can't answer that question right now --
11 A. Okay.
12 Q. -- But --
13 A. And --
14 Q. And I'm not in a position to tell you that's
15 what needed to be done, either, because everybody may not
16 agree that that was the appropriate thing to do. And I'm
17 just telling you that simply so I don't mislead you. I'm
18 not trying to -- 1 don't want to ask you a series of
19 questions on one premise and make you think that that's
20 been confirmed by somebody else --
21 A. Okay.
22 **Q.** -- but I want to focus on what you saw and what
23 you witnessed, and that kind of thing.
24 A. Okay.
25 Q. I think you misunderstand my question.

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1 Assuming that those marks you saw were not
2 hemorrhages, but abrasions --
3 A. Okay.
4 Q. -- and I realize that may be -- you may be
5 certain that they were, so it may be a difficult
6 assumption for you to accept --
7 A. Okay.
8 Q. -- but if they were, in fact, abrasions and not
9 hemorrhaging, then that would not be indicative of septic
10 shock.
11 A. Well, the -- you could have -- and -- you could
12 have septic shock with or without hemorrhages and
13 abrasions. It's -- it's not a -- it's a --
14 Q. Okay.
15 A. It's an "and" thing, not an "or."
16 Q. I'll try it again.
17 A. Okay.
18 Q. If, in fact, those were abrasions --
19 A. Yeah.
20 Q. -- and not hemorrhaging of some sort, there
21 would be no physical symptoms, that you observed at the
22 time of her death, that would lead you to conclude it was
23 septic shock. The only other basis, then, would be the
24 blood test, later, that you got the results on -- later,
25 on, is that correct?

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1 A. Well, septic shock can just be fast death, you
2 know. You know, diarrhea, fast death. Could just be --
3 that could be septic shock, itself, without necessarily
4 having skin changes. So does it -- would it --
5 Q. I --
6 A. So if she would have come in, dead, with no skin
7 abrasions, would I have said, "No, septic shock's not
8 possible*?
9 Q. No. I'm not asking you to say it's not
10 possible.
11 I'm saying, was there anything that specifically
12 pointed to it, and would lead you to believe it, other
13 than the marks on her arm?
14 A. And her appearance, no.
15 Q. Okay. What, about her appearance -- okay.
16 Let's go back. Other than the severe dehydration and the
17 marks on her arms, what, about her appearance, suggested
18 shock; septic shock?
19 A. Now, do you mean just the marks on her arms or
20 any of the areas that I was concerned about?
21 Q. Any of the areas. Describe them to me.
22 A. Well, you got the pictures. And I can't
23 remember where -- there were multiple areas.
24 Q. I'm not sure you acknowledge that the autopsy
25 pictures accurately reflected exactly what you saw at the

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1 emergency room, so --

2 A. So ask me your question again.

3 Q. Tell me about the marks -- describe them to

4 me -- all the marks you saw on her body.that you --

5 indicated to you that it might be some septic component

6 that caused her death.

7 A. It looked like superficial blood in the

8 superficial areas of her skin, in multiple areas.

9 Q. Tell me the areas. Talking about the face?

10 Talking about the back? Talking about --

11 A. Well, there were some on the face.

12 I can't remember where they all were. I know

13 you've got pictures of all the areas where they were,

14 but -- so a lot of those areas, it looked like -- across

15 the pelvis, there was some old bruises, which I'm not

16 talking about --

17 Q. Mm-hmm.

18 A. It was just -- it's just the look.

19 I was going to bring you a picture, today, from

20 an infectious disease textbook, of a person with septic

21 shock, what they look like. And that -- she just looked

22 exactly like that. I couldn't find the book.

23 But anyway, that was sort of like, "Oh, maybe

24 that's what happened."

25 Q. Okay. So where was -- other than the marks that

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1 you're talking about, and the petechiae, where were the
2 other marks that you refer to as purpura?
3 Is that the term you used?
4 A. Yeah.
5 Q. What did you mean by that?
6 A. Purpura is petechia that are grouped, that are,
7 like, together. It's, like, big areas of petechiae. They
8 look like superficial bruises, or they could look like
9 abrasions, too.
10 Q. Okay. Did you do anything, at the time of her
11 death, to try to distinguish whether they were abrasions
12 or petechiae --
13 A. No.
14 Q. -- other than look at them visually?
15 A. No.
16 Q. When you have septic shock, are the petechiae
17 only in one area of the body or --
18 A. No. They could be anywhere.
19 Q. Is there any reason why they would be
20 concentrated on the exposed areas; hands, wrists, feet? I
21 mean, trying to distinguish between those and abrasions,
22 where she might have been held down in those areas --
23 A. Yeah.
24 Q. -- because that's where it appears to me that
25 those -- those marks were.

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1 A. Right.
2 Q. Okay. They were all concentrated there, in
3 those areas.
4 A. See, the vessels in those areas are tiny, and
5 they're so -- I don't know. It -- it's -- that's usually
6 what you see.
7 Now, whether they're -- just any little bump
8 will get them bleeding, and that's what happens or -- or
9 people just are moving those parts more than other parts,
10 I'm not sure, but that's common.
11 Q. Okay. Just to be on the extremities?
12 A. More concentrated there, yeah.
13 Q. Okay.
14 A. I mean, it didn't look out of place to me, or
15 incongruous to me, that it could be like that.
16 MR. CROW: Okay. Why don't we take about a
17 10-minute break?
18 (A recess was taken.)
19 BY MR. CROW:
20 Q. Okay. We're back on the record, after a short
21 break.
22 I've got some photographs I'll show you in a
23 little bit, and we'll talk in more detail about some of
24 the things we were talking about generally.
25 A. Okay.

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1 Q. I take it -- other than the 12-pound weight loss
2 and diarrhea, did Janice convey anything else to you in
3 that conversation, after Lisa was pronounced dead? I
4 thought those things came in the conversation at the --
5 A. Yeah. Just thinking.
6 I asked her, just, "Why did you bring her up
7 here like this?" And she just didn't have an answer.
8 Q. Okay. Did you have any conversations with
9 Janice or Alain, or anyone else, after the fact; after
10 that point?
11 A. I have not talked'to Janice since then.
12 Q. Okay,.
13 A. Or Alain.
14 Q. Okay. Any particular reason? I mean -- I mean,
15 seemed like there are a lot of unanswered questions. I
16 realize there's litigation. Maybe you don't think it's
17 wise to do that. But have you intentionally avoided her,
18 or it just hasn't happened, or --
19 A. I actually haven't seen either one of them
20 around, so I haven't run into them.
21 Q. In the last two years?
22 A. Yeah.
23 Q. Okay.
24 A. I think I saw her once in the hall down there,
25 but I didn't talk to her.

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1 Q. Were there any other doctors that were
2 utilized -- you're aware, now -- at least I think you were
3 asked about the magnesium chloride injections.
4 A. I have no idea where that came from.
'5 Q. Were there any other doctors, that you knew,
6 that a Scientologist might use, other than yourself?
7 A. There's a GP down there, named "Jackson," that a
a lot of people were seeing, but I don't think he --
9 Q- No one else?
10 A. No.
11 Q. Did you authorize Janice, or anyone else, to
12 give magnesium chloride injections?
13 A. No.
14 Q. Do you know of any therapeutic purpose of
15 magnesium chloride injections?
16 A. Magnesium can be a light sort of muscle
17 relaxant, sedative, but -- that's probably why she gave
18 it. We use it in the hospital for migraines, heart
19 arrhythmias.
20 Q. It's a muscle relaxant?
21 A. Yeah. Mild.
22 Q. And if you gave it intramuscularly, would it
23 have any systemic effects, I mean, other than --
24 A. It usually makes people feel a little, like,
25 warm and a little relaxed. It's not really a sedative.

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1 It just -- it just makes them feel kind of -- kind of just
2 like warm, just relaxed.
3 Q. Okay. But -- but I take it, it is a drug. It
4 would have to be prescribed --
5 A. Oh, I think so, yeah.
6 Q. -- to get it in an injectable form?
7 A. Yeah.
8 Q. Prescription would be required --
9 A. Yeah.
10 Q. -- by a doctor?
11 A. Yeah.
12 Q. And he would have to authorize the injection?
13 A. Yeah.
14 Q. Okay. And you didn't authorize any injection.
15 A. No. I didn't prescribe it.
16 Q. And they wouldn't -- did you have that in your
17 hospital, that they could have gotten it from you, if they
18 wanted to?
19 A. No.
20 Q. Did they ever ask you for that?
21 A. No.
22 Q. So just make sure I've, again, exhausted your
23 knowledge, do you have any earthly idea where Janice
24 Johnson, or anyone else, would have gotten injectable
25 magnesium?

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1 A. None.
2 Q. And you've heard nothing since to suggest the --
3 A. No. I've wondered about it, myself. Thought
4 maybe she brought it with her. I don't know.
5 Q. What are the symptoms of dehydration? Are you
6 familiar with the symptoms of dehydration?
7 A. Yeah.
8 It just depends on how much. You know, could go
'9 from --
10 Q. Have you seen the vitreous readings on her?
11 A. I have, and I'm just not familiar with the
12 technology or what they mean.
13 Q. Well, assuming that they reflect the actual
14 blood readings, would that be extremely severe
15 dehydration?
16 A. I can't tell you anything about it. I don't
17 know whether they really reflect the blood or not. I've
18 heard controversy both ways.
19 Q. What you heard about this?
20 A. I've heard sometimes they're accurate and
21 sometimes they're not.
22 Q. Okay. And who told you that?
23 And I'm talking about not, say, potassium, which
24 is fairly volatile after death, but blood urea nitrogen,
25 creatinine --

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1 A. Yeah.
2 I can't answer you anything about it, because I
3 just am not knowledgeable about it.
4 Q. Were you knowledgeable about blood urea
5 nitrogen, creatinine and sodium chloride levels in a
6 living patient?
7 A. Yeah.
8 Q. Would a level of 300 for blood urea nitrogen be
9 extremely excessive?
10 A. A blood level?
11 Q. Yeah.
12 A. Yeah.
13 Q. Would that be sufficient, perhaps, to cause
14 death?
15 A. Could be, sure.
16 Q. okay. Do you recall the other levels of the
17 other electrolytes from the autopsy --
18 A. Yes.
19 Q. -- in the vitreous?
20 A. Yeah.
21 Q. Yeah.
22 A. No -- we don't have a blood level 300, though.
23 We don't have any blood levels.
24 Q. YOU mean you didn't take any blood levels.
25 A. Right.

1 Q. Yes. I understand that. I'm asking to
2 correlate that as if it were a blood level.
3 A. Yeah. I have no idea if that's true or not; if
4 it correlates.
5 Q. That's why I asked you to assume it, okay?
6 A. Okay.
7 Q. But you don't have enough knowledge to say it
8 wouldn't correlate, either. You don't know, either way.
9 A. Correct.
10 Q. Okay. So you can't offer anything, in terms of
11 what the vitreous says or doesn't say, about her state of
12 hydration.
13 A. Right.
14 Q. Some other expert will have to enlighten us on
15 that.
16 A. True.
17 Q. But if those levels turn out to be reflective of
18 blood levels, they would be reflective -- those levels of
19 blood urea nitrogen in the blood, that high, would be --
20 A. Bad news.
21 Q. -- Extremely high.
22 A. (Nods head).
23 Q. Can you tell me how symptomatic a person would
24 be, with that type of a -- let me see the --
25 A. If their serum BUN was 300?

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1 Q. Yeah.
2 And I was going to try to get the chloride and
3 sodium levels for you.
4 Again, assuming these were serum levels instead
5 of vitreous -- I'm not asking you about Lisa. I'm asking
6 you about any patient -- if they had serum levels of urea
7 nitrogen of 300 milligrams per deciliter; creatinine, 2.6;
8 glucose, 15 milligrams; chloride 161; potassium 180 --
9 A. 180?
10 Q. Yeah.
11 A. The -- people can be alive at creatinine at two
12 and a half. That's not a big deal.
13 The rest of them are probably not compatible
14 with being alive.
15 Q. Okay. And is -- how symptomatic --
16 THE WITNESS: What?
17 MR. FELMAN: Interesting way of putting it,
18 "not compatible with being alive."
19 BY MR. CROW:
20 Q. As the sodium level increases, and these other
21 evidence of dehydration increases, what would a patient,
22 clinically, show?
23 In other words, I assume it takes a while for --
24 some period of time for levels -- serum levels that high
25 to get there. But assuming that this occurred gradually,

1 over a two-week to 17-day period, what, in your opinion,
2 would be the symptoms that a patient would show, as it
3 became progressively worse, or do you know?
4 A. Well, I mean, with dehydration, progressive
5 dehydration and electrolyte imbalance -- again, depending
6 on what it is , you can see anything from irritability to
7 sort of somnolence. You can see seizures. And then you
8 see coma. And you could get either or -- you know, either
9 extreme, along the way.
10 And it doesn't necessarily have to take a long
11 time. YOU could have a person with a very bad diarrhea,
12 like a cholera patient; they could have changes in their
13 sodium in a matter of hours, if they have massive
14 diarrhea, either going very low, if they're dumping
15 sodium, or if they're just dumping water, you would go
16 from 140, which is normal to 170. I think I've seen
17 somebody live who actually got to 180, in a --
18 It isn't necessarily a 17-day process. It could
19 be, you know, in a couple-of-hour process. I don't know
20 if that has any relevance to her, but that can occur.
21 Q. And what can cause that in a couple of hours?
22 You're saying that they -- you can get a blood
23 urea nitrogen from normal levels up to 300 in a couple of
24 hours?
25 A. Never seen a 300, but I've seen 150. I've seen

1 sodiums go from 140 to 100 or from 140 to 180.
2 Q. Okay. Other than infants, have you seen it in
3 adults?
4 A. Well, it's reported in cholera victims, where
5 they have a toxin in their colon, and their colon just
6 dumps, and so you can get it.
7 Q. Assuming that we don't have evidence of that, is
8 there any other medical condition, other than severe and
9 continued --
10 1 assume you're talking about almost continuous
11 diarrhea, over a period of three or four hours?
12 A. Well, it would be a lot. You know, a couple of
13 liters, just like woosh, woosh, woosh, woosh (phonetic).
14 YOU know, assuming she's got a -- you know, if
15 this staph has a toxin, an enterotoxin, is it possible?
16 Sure, it's possible.
17 So I don't know what her blood electrolyte
18 levels were, and I don't know if the assumption is valid.
19 But is it unusual, yeah. Is it --
20 Q. Well, I guess I'm asking, as someone approaches
21 180, how symptomatic are they?
22 A. Definitely symptomatic.
23 Q. Okay.
24 A. They would either be difficult to arouse or have
25 seizures. You would know it. They wouldn't be right.

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1 Q. Would it be consistent with someone who starts
2 to become so weak they're unable to walk?
3 A. Sure.
4 Q. Be consistent with someone who it becomes very,
5 very difficult to arouse?
6 A. Mm-hmm.
7 Q. Is it possible that those symptoms could occur
8 over several days, rather than several hours --
9 A. Yeah.
10 Q. -- if it was a gradual thing, as opposed to the
11 acute thing, such as the toxin or diarrhea you described?
12 A. Yeah.
13 Q. In other words, we've got a couple mechanisms,
14 and they may be combined, in any individual case --
15 A. Right.
16 Q. -- or a gradual reduction in intake of fluids,
17 over a 17-day period, some diarrhea or extensive diarrhea.
18 So you can have a fluctuation, depending on what facts I
19 ask you to assume in answering a question.
20 A. Right.
21 Q. And there is not -- I noticed, from the autopsy,
22 that there was an indication that she had defecated on
23 herself, but I didn't see any indications of diarrhea or
24 any descriptions of diarrhea on clothing at the hospital.
25 Do you recall her having soiled herself with

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1 diarrhea?
2 A. Don't recall.
3 Q. Okay. Did you note that in -- anybody note that
4 in any of the hospital records or --
5 A. I don't think so.
6 Q. Okay. Would that have been a significant thing,
7 since you were concerned about diarrhea or a septic shock,
8 that you would have noted that as being symptomatic of
9 that, or would you have ignored it?
10 A. I don't know. I think, if she would have come
11 in, you know, like, full of stool I might have remembered
12 it, but I don't -- it wasn't something I was thinking of
13 at the time.
14 Q. Well, I guess what I'm getting at is, is it --
15 we don't have any evidence of diarrhea on the way to the
16 hospital. Assuming that she had diarrhea once or twice
17 during the last day of her life, how symptomatic would she
18 have been that last day? Would -- if these -- if she had
19 serum levels as I've indicated?
20 A. Depends how much diarrhea there was in the one
21 or two. --
22 Q. Okay.
23 A. I mean, we're working on a third-generation
24 assumption here, so who knows?
25 Q. You can't --

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1 A. I can't tell.
2 Q. You can't say?
3 A. I don't know.
4 Q. Okay.
5 A. Yeah.
6 Q. Is there anything about -- if --
7 Well, you don't know about the --
8 Anything -- have you had experience in treating
9 pulmonary embolism?
10 A. Mm-hmm.
11 Q. And how many occasions have you treated a
12 person, say, in the emergency room, that's had a pulmonary
13 embolism?
14 A. Maybe 20 or 30.
15 Q. And how many have died?
16 A. 20 or 30.
17 Q. Most of them did?
18 A. Yeah.
19 Q. You were unable to save them?
20 A. No.
21 Q. Okay. At the time they got to the emergency
22 room, had the embolism been thrown long before they got to
23 the hospital, or was it thrown in the emergency room, or
24 can you tell?
25 A. You can't tell.

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1 Q. Okay.
2 A. Usually, when it's thrown, it's -- that's it.
3 Q. Death comes pretty quickly?
4 A. Yeah.
5 Q. Do have you any quarrel -- I realize this is an
6 unfair question, since you did not do the autopsy, but I
7 assume the embolism or the description of the embolism has
8 been made known to you in your civil deposition.
9 A. Mm-hmm.
10 Q. Do you have any disagreement with that being a
11 factor in the death of Lisa McPherson?
12 A. No.
13 Q. Is there a relationship between septic shock and
14 an embolism, or not?
15 A. Sure.
16 Q. Tell me what your understanding is.
17 A. Well, there are a bunch of case reports of young
18 women with sepsis and acute pulmonary emboli. I did,
19 like, a five-minute search on the Internet, and I think I
20 gave you three cases.
21 Q. Okay. I don't have --
22 A. They're in the prior -- they're in the prior
23 records.
24 And I didn't really look very hard. I just had
25 seen it before. And then, when this thing sort of came

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1 up, I thought, "Gee, is there -- am I just dreaming or
2 have I just seen it?" And it's reported. It's known.
3 so --
4 Q. Well, I'm asking, do we know the causative
5 factor, in your mind, as to why there's a relationship?
6 Is it because the shock causes dehydration, is it because
7 shock causes the blood to coagulate or a combination of
8 factors --
9 A. Probably a combination.
10 Q. -- or is it unknown?
11 A. Well, I think it's -- I think it probably
12 depends on the case, but those are all possibilities --
13 Q. Okay.
14 A. -- dehydration, hypercoagulation --
15 Q. Are those factors that will cause a thrombus and
16 an embolus?
17 A. Sure.
18 Q. What about immobility?
19 A. Sure.
20 Q. What, in general, are primary causes of a
21 thrombus and an embolus; the most common?
22 A. Post-op is probably the most common.
23 Q. Okay.
24 A. Somebody who's in bed, who's had an operation
25 and who gets a deep vein -- you know, probably hip

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1 surgery, prior to -- everybody's anticoagulated these
2 days, but prior to that, it was probably hip surgery is
3 the most common cause, and cancer would probably be right
4 up there. People with cancer, who are ill, anyway,
5 probably the second cause. And then there's a whole group
6 of them, like, who knows? It's relatively young, healthy
7 people, who may or may not have varicose veins; who may or
8 may not have minor injury; who may or may not be on birth
9 control pills or estrogen supplementation, who get a
10 clot -- it may be silent -- who then show up with either
11 sudden death or shortness of breath or something like
12 that. A lot of them, it's just like idiopathic. It's
13 just not sure. And then there's all these sort of
14 peripheral risk factors.
15 Q. And what are the risk factors?
16 A. Obesity, varicose veins, immobility,
17 dehydration, estrogen. There's probably some other
18 medicines that may make a difference in it.
19 Cardioarrhythmia, cancer, surgery.
20 Q. Surgery?
21 A. This is off the top of my head, but these are
22 sort of the --
23 Q. Okay. I've got -- and I'm not going to mark
24 this at this time. This is just, really, for -- I might
25 mark them so that we can tell, later, what you're pointing

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1 at, but right now, I just want to get some general
2 information.
3 I don't know if you've ever seen all the autopsy
4 photos or not. I know you've seen the photos of the
5 hands.
6 Have you seen the autopsy photos?
7 A. I don't know.
8 THE WITNESS: What did Dandar show us?
9 MR. FELMAN: Can we go off the record?
10 MR. CROW: Sure.
11 (Discussion was held off the record.)
12 BY MR. CROW:
13 Q. I'm going to show you a series of photographs
14 that I believe show the external skin surfaces in the
15 autopsy. And we talked about marks on the body, and you
16 described, if I understood you correctly, two different
17 types of marks. Maybe I misunderstood you.
18 But I'd kind of like you to just look at these,
19 and maybe we can discuss that in a little more detail.
20 Are you familiar with what lividity is?
21 A. Yeah.
22 Q. So you would be able to distinguish lividity, in
23 a postmortem shot, from what you saw at the autopsy. I
24 don't know if you would confuse --
25 A. I don't know. Let me see what they look like.

1 Q. Well, you described the --
2 Okay. Just take a few minutes to look through
3 those, and maybe we can discuss that in a little more
4 detail.
5 A. Actually, I think the stool was postmortem,
6 because I did a vaginal exam on her, because I thought
7 there might have been -- you know, just to make sure there
8 wasn't a tampon in there. And I don't recall her being
9 soiled, so this picture with the --
10 Q. Feces --
11 A. This may have been after she got to the -- after
12 we finished jumping on her for 20 minutes.
13 Q. Okay.
14 A. The CPR.
15 Q. Okay. There are a number of reddish-brown
16 discolorations, both in the feet and the ankle areas, and
17 also around the wrist and hands. And are the marks you're
18 referring to -- were there marks other than those that you
19 were talking about, that were indicative of sepsis, that
20 you see here?
21 A. This looks very -- this looks very indicative of
22 sepsis, these kind of --
23 Q. You're pointing to marks on the right wrist?
24 A. Yeah.
25 Q. The top surface of the right wrist?

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1 A. Yeah.
2 Q. Okay. Does that look like it's underneath the
3 skin, as opposed to an abrasion, or can you tell from the
4 photograph?
5 A. I can't tell.
6 Q. What about the marks on the knuckles? There's
7 marks on the prominence of the knuckles, and looks like
8 there's small circular marks in between the knuckles, in
9 the indentations. Can you --
10 A. This is dicey, at best, to try to --
11 Q. Understood.
12 A. Yeah. So I'm not sure.
13 Q. YOU can't tell whether those are abrasions or --
14 A. This looks more like an abrasion.
15 Q. This stuff on the knuckles?
16 A. Looks like there's a little scabbed area there.
17 Q. Okay. You mentioned some other discolorations.
18 I'll show you a picture of the face. Is that what you
19 recall her looking like at the time?
20 A. Well, there's a lot of lividity in the face,
21 which wasn't there. This sort of -- these purplish
22 lines --
23 Q. The mottling?
24 A. The mottling wasn't there.
25 Q. Okay. But as far as the -- the appearance of

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1 the face, the eyes --
2 A. Yeah.
3 Q. -- is that accurate, as to what you recall --
4 A. Yeah.
5 Q. -- at the time of death?
6 A. Yeah.
7 Q. Any marks on there that you would attribute to
8 sepsis? I thought you said there was some purple or
9 discoloration. I wasn't sure if you were indicating on
10 the face.
11 A. Yeah. I can't tell from that. I think the
12 thing on the nose, I did, trying to intubate her.
13 Q. Did you try to intubate her through the nose,
14 initially?
15 A. No, but it was rough and, you know, I don't
16 know -- sometimes with the laryngoscope, you can hit them
17 in the nose or --
18 Q. Here's a picture of the left hand.
19 A. Yeah. See, this is -- this stuff looks like
20 septic petechiae.
21 Q. Okay. Now, this is the left hand. And we've
22 got some marks above the wrist, at the bottom of the
23 hand -- the base of the back of the hand.
24 A. Yeah.
25 Q. Fairly large blotch. And you've got some small

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1 circular ones all through the knuckles.
2 A. Right.
3 Q. Are you saying that looks like --
4 A. It's compatible with it.
5 Q. As far as from the photographs, could it also be
6 abrasions, or can you really tell?
7 A. I can't tell.
8 Q. Okay. And here's -- I think that's the back of
9 the left --
10 A. Elbow?
11 Q. No. It's --
12 A. Foot.
13 Q. -- in the Achilles tendon area. I don't know
14 all the medical terms.
15 But can you tell whether that --
16 You've also got pictures where you've got some
17 marks on the front. And again, we do have testimony that
18 she was restrained forcibly, on a couple of occasions
19 sometimes, or extended periods, or held around the feet or
20 the hands. Are those consistent with abrasions or
21 consistent with some other marks or --
22 A. I can't tell.
23 Q. YOU can't tell, one way or another?
24 A. I can't tell.
25 Q. Can't tell whether these are petechia or

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1 abrasions?
2 A. No. This looks petechial, but it's far away and
3 not very clear.
4 This looks more like an abrasion.
5 Q. Is that more clear?
6 A. Yeah. That looks petechial.
7 But this is very conjecturish.
8 This looks a little older. It looks more
9 scabby, so it looks more like an abrasion, this one does,
10 on the heel.
11 Q. Okay. What about'the abrasions on the skin? Do
12 you have any idea how those are --
13 A. See, we probably bagged her with a mask when she
14 came in, and this may have been -- we may have done this
15 too, you know, until we got the laryngoscope out --
16 Q. Okay.
17 A. -- because the mask would hit her on the chin.
18 It might hit her on the nose like that.
19 Q. Okay. What happened to my picture of the right
20 hand?
21 This is a close-up on the area of the right
22 hand. Does that aid you in evaluating it at all?
23 Let me get you the distant shot --
24 A. That's the inside. That's not the back, is it?
25 Q. Yeah. See, this is the hand here, like that --

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1 A. Oh, up there. Okay. Okay. Okay.
2 Q. Be like this.
3 A. Yeah.
4 Q. I think, if you compare the marks, you can see
5 how they match up.
6 A. Yeah. Okay.
7 I'm not sure. This actually looks a little
8 thicker.
9 Q. A little thicker, as in --
10 A. Yeah.
11 Q. -- might be a scab *or* an abrasion?
12 A. Yeah.
13 MR. FELMAN: I'd like to make a comment. I
14 don't know if you want it on the record or off the record,
15 but I think it's important for my client; which is that I
16 think these photos that -- that photo, in particular, is
17 different from the one that he was shown in his first
18 statement. I'm not sure if we're going to be able to tell
19 which exact photos he was shown in his first sworn
20 statement with you all and which ones he's looked at now.
21 And I don't want there to be any kind of argument that
22 he's saying different things, because I think that
23 particular photo may be one that he wasn't shown the first
24 time around. So I'm a little bit concerned about the
25 confusion, in terms of what we've identified.

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1 I just want to make it clear that I think that
2 it's not real clear which photos he was talking about in
3 his first sworn statement and which ones he's talking
4 about now.
5 MR. CROW: Okay.
6 MR. FELMAN: It's not really an objection;
7 just an observation that I want to make clear.
8 BY MR. CROW:
9 Q. Okay. You told me that you had examined -- done
10 a physical examination -- thorough physical examination,
11 before the Lisa McPherson situation came up, of a girl
12 from Germany, who was identified to you as being a Type 3.
13 A. Mm-hmm.
14 Q. Why did you not perform an examination on Lisa,
15 if, in fact, that's what you felt is required for someone
16 that fits in that category?
17 A. It was a mistake. Should have been done.
18 When he called me, I sort of took it as not
19 officially on the record. It was a sort of, "help." " See
20 if this works." I guess I assumed that, if there was
21 really a problem, that he would either get ahold of me
22 or -- or get ahold of somebody else. And it was -- I
23 guess I didn't realize, at the time, that, by doing this,
24 I was really sort of getting involved in it, and had
25 responsibilities in it.

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1 Q. Okay. Well, regardless of whether you had
2 responsibilities or not --
3 A. There's no question, it should have been done.
4 Q. Okay. You seemed to indicate that it was
5 necessary to evaluate the patient.
6 A. Right.
7 Q. And you issued prescriptions without doing that.
8 A. Right.
9 Q. Now, whether you think you're getting involved
10 or not getting involved, in your opinion, was it necessary
11 for you, or someone, to do a physical examination of Lisa
12 McPherson at the outset of her stay?
13 A. Yes.
14 And it's actually church policy, and it wasn't
15 implemented either.
16 Q. Okay. There's actually a policy for -- for
17 handling people that are on 24-hour watches or --
18 A. Physically ill people need to see a medical
19 doctor and get a full examination before they're processed
20 or handled. That's the policy.
21 Q. What about the policy on people that are
22 psychotic?
23 A. They would fit --
24 Q. Okay.
25 A. -- yeah.

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1 Q. And is there a written policy, you're aware of?
2 I mean, do they -- just what you heard?
3 A. No. It's a written policy. It's called
4 "Physically 111 PCs."
5 Q. And a person who was Type 3 would fit in that
6 categorization?
7 A. Yes.
8 Q. Did anyone tell you about what had happened at
9 Morton Plant?
10 A. After.
11 Q. Okay. Who told you that?
12 A. You guys might have told me.
13 Q. Okay. But you didn't hear it from anybody at
14 the Church --
15 A. Huh-uh.
16 Q. -- that you recall?
17 so --
18 A. 'Cause I saw you guys, like, the next day.
19 Somebody came up, and then I went down there.
20 Q. You say "you guys." You're talking about the
21 Clearwater Police Department?
22 A. Yeah.
23 Q. Probably not to the people in the --
24 SGT. ANDREWS: Not us.
25

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1 BY MR. CROW:
2 Q. In the courtroom -- I mean --
3 A. No.
4 Q. — in —
5 Because you gave a later statement, to the State
6 Attorney's office, that we've talked about. You're
7 talking about an earlier statement to the police, that
8 they probably disclosed that to you, and you were unaware
9 of it until they told you.
10 A. Yeah.
11 Q. I want to exhaust'all your contact with people
12 from the Church.
13 Did you have any more conversations? And the
14 reason that I kind of assume that there is, is because
15 they quarantined everybody, based upon somebody's belief
16 that there's sepsis. I don't know if that's strictly from
17 Janice coming back or if Alain or someone else called you
18 to discuss those terms and you told them what to do.
19 So after Janice leaves the hospital, did you
20 have any conversation with Alain, with Marcus Quirino,
21 with anybody, that would lead them to believe that
22 meningococcus or some other very infectious disease should
23 be handled, and the people should be taken care of in some
24 fashion, or quarantined?
25 A. No. I think I talked to Humberto Fontana,

1 that -- when the blood culture came up, which was the next
2 day, that there was a positive blood culture, and that she
3 may have had an infection.
4 Q. Okay. And what bacteria was the blood culture
5 positive for?
6 A. Staph Aureus.
7 Q. And is that something that is an infectious
a disease?
9 A. Yeah.
10 Q. And what disease does it cause, other than --
11 A. Well, anything from skin pustules and boils and
12 funicles to deep bone infections and sepsis and
13 pneumonias.
14 Q. I mean, it causes infection if it gets in an
15 open sore, but it's not a disease, is it, like pneumonia?
16 A. Well, pneumonia is a disease, but the agent
17 might be staphylococcus.
18 Q. Okay.
19 A. You know, the bacterial thing that causes it,
20 pneumonia is generic. Just says the lung's infected.
21 Doesn't tell you what the bacteriology is.
22 Q. Is Staph Aureus commonly found on the skin?
23 A. It can be. There's different types of Staph
24 Aureus.
25 Unfortunately, this staph was never typed. But

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1 it can be on the skin; it can be in the nose.
2 Q. So what would -- what, in effect -- if she had a
3 staphorius infection would call for a quarantine?
4 A. Well, she had it in her blood, and there are
5 some strains of staphorius that produce toxins, which
6 cause shock, sepsis, all the stuff that, possibly, she
7 had. And those aren't your sort of run-of-the-mill staph
8 that colonize in peoples' skins, and they may be
9 infectious.
10 so I think that's what the concern was.
11 Q. Okay. Are you thinking of a particular strain
12 or -- that can you identify for me, or --
13 A. Well, there's toxic shock syndrome. It's a
14 staph that's actually -- the bacteria is actually infected
15 with a virus which causes the staph to produce these --
16 these toxic proteins.
17 Q. Okay. I've never heard -- and obviously, I'm
18 not a doctor -- I've never heard of that being
19 communicable from one person to another very easily, as
20 opposed to it occurring and be generating in a body, in a
21 very specific condition, like with a tampon or something
22 like that.
23 A. It's true. It's not.
24 Q. Okay. Then what was, again, the concern that
25 would cause people to be quarantined based upon staphorius

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1 being found in the blood type?
2 A. Well, you'll have to ask them that. I didn't --
3 that wasn't my order.
4 Q. So you didn't suggest to them that they do that?
5 A. No.
6 Q. Okay. Did your -- did you have any
7 conversations with anybody else, other than Mr. Fontana,
8 after the -- after -- you've related the conversation you
9 had with Janice, when you were yelling at her --
10 A. Mm-hmm.
11 Q. -- and she was, to some degree, unresponsive in
12 giving an explanation?
13 A. I called the coroner a couple times. I think
14 you have notes on --
15 Q. I'm interested in your conversations with --
16 A. The Church?
17 Q. Yeah.
18 A. I think a couple -- 1 don't know if it was a
19 week or two afterwards. I can't remember this guy's name.
20 Anyway, somebody from the Church, from Los
21 Angeles -- he wasn't a lawyer, but one of their legal
22 people -- came down, and just wanted to know what
23 happened, and I probably spent an hour with him, maybe an
24 hour and a half, just like this, like what happened.
25 Q. Okay. Answering questions?

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1 A. "What did you do, what did you hear, what did
2 you say"?
3 Q. Anybody else? I'm sure you conferred with your
4 lawyer.
5 A. No, I didn't have a lawyer.
6 Q. I'm not talking -- I'm talking about now.
7 MR. FELMAN: Are you asking any
8 conversation he's had with anybody at the Church, ever?
9 MR. CROW: No. Conversations after the
10 last conversation with Janice Johnson, with people at the
11 Church, about this episode.
12 A. Oh. Well, then the -- things were sort of quiet
13 for a while. And then, a year later, this whole thing
14 came up, the St. Pete Times or the Tampa Tribune got this
15 thing --
16 Oh, actually, in, I think, May, the autopsy
17 report came out, and I got a copy of that. And that
18 bothered me, 'cause I thought it was very inaccurate, as
19 to what was -- what had happened and what I had discussed
20 with the coroner. But he was not interested at all in
21 what I had to say.
22 BY MR. CROW:
23 Q. Did you specifically talk with Dr. Davis or did
24 you talk with Dr. Wood? Who did you speak with?
25 A. Talked to Dr. Davis.

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1 Q. Okay. And how many conversations did you have
2 with him?
3 A. I had two. I had one right afterwards, where I
4 called him and said, "I'm concerned about this. I got a
5 positive blood culture. I've got somebody who may be
6 septic. Make sure that, in the autopsy, you get the
7 tissue and you do the bacteriology, because this could be
8 important."
9 He said, "I'm not interested. I got a cause of
10 death." And, "Forget it."
11 And then, a year later, in December, '76 -- or
12 '96, when all the stuff came out in the papers, he was
13 quoted in the papers as saying, "There was no infection,"
14 or something like that. And I -- I don't -- I called the
15 office, and I couldn't get him, and then I wrote him that
16 letter. And I think you have that.
17 Q. The "Dear Medical Examiner" letter?
18 A. Yeah.
19 Q. Wasn't written to Davis specifically.
20 A. Yeah. I don't know if he was even there, still.
21 Q. I don't think he was.
22 But you specifically talked to him on the phone.
23 A. Yes.
24 Q. Okay.
25 A. Done on the 5th, right; night of the 5th.

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1 Culture came back on the 6th, and I talked to him the
2 morning of the 7th.
3 Q. I realize you're not in a position -- or at
4 least, if I understand your prior testimony, you're not in
5 a position to say what the cause of the thrombus or the
6 embolus was in Lisa McPherson. Do you feel you have
7 sufficient information that you can give an opinion on
8 that?
9 A. Well, I mean, in terms of the things we were
10 talking about before, she's got some risk factors. She
11 was septic, she was dehydrated, she was --
12 Q. She --
13 A. -- was possibly immobile. She was female.
14 She's the right age.
15 So those are all risk, factors.
16 Q. Okay. Would -- the thrombus, as you know from
17 the autopsy, was, I think, in the left popleiteal vein --
18 did I pronounce that correctly?
19 A. "Popliteal," yeah.
20 Q. "Popleiteal"?
21 A. Yeah.
22 Q. Is there any particular significance of that
23 being the site of the thrombus?
24 And I guess what I'm asking is -- is -- you've
25 indicated that surgery can be one of the predisposing

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1 factors: Immobility; dehydration; sepsis, if it's
2 established; age; gender.
3 Does getting a minor bump or bruise, or even a
4 significant bump *or* bruise, cause a thrombus to form at
5 the location of the jury?
6 A. Well, usually not.
7 But if you look at the histories of women who
8 get this, some of them say, yeah, there was minor local
9 trauma in the area, you know, a week before or 10 days
10 before, or couple days before.
11 Q. And would this be the area where the thrombus
12 is, or would that be in some other area of the body?
13 A. Well, usually these thromboses are leg
14 thromboses. The popliteal vein. That's where they are.
15 Q. I guess what I'm asking is, if you get an injury
16 to the knee, the shin, is that going to cause a thrombus
17 to the back of the knee? Is there a relationship there
18 or --
19 A. Don't know.
20 Q . Would it be significant as to where -- if she
21 had a leg injury and, if so, where the leg injury was, in
22 relationship to the thrombus, or is that something that we
23 just don't know the connection?
24 A. We don't know. Possibly. We don't know.
25 MR. **McGARRY:** I have one question.

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1 EXAMINATION
2 BY MR. McGARRY:
3 Q. YOU mentioned birth control pills being a
4 factor that might play a role in the thrombus.
5 A. Yeah.
6 Q. Why is that?
7 A. It's estrogen, and estrogen's a risk factor for
8 deep vein thrombosis. So I mean, before somebody ever
9 gives somebody birth control pills, they should check with
10 them about varicose veins, prior clots, something like
11 that. And if they have it, they shouldn't take them.
12 I'm not sure why, but it's a risk factor.
13 I don't know if she was on birth control pills
14 or not.
15 EXAMINATION (Resumed)
16 BY MR. CROW:
17 Q. SO you've identified a number of possible
18 contributing factors to the formation of the thrombus.
19 A. Mm-hmm.
20 Q. In terms of the -- an embolus being thrown off
21 the thrombus, is that something that is predictable, in
22 terms of occurring, ordinarily, a set period of time, or
23 can it happen a day after, two weeks after, a month after?
24 Is there normally some time frame that is considered
25 normal?

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1 A. The problem is, usually, you don't know, because
2 most people who have deep vein thrombosis, deep vein
3 clots, if they come into a hospital or an emergency room,
4 and they've got a swollen, painful leg, and you get them
5 in and anticoagulate them, it's not that common for those
6 people to then throw clots.
7 Usually the people who come in with clots are
8 people where it isn't this obvious; inflamed leg. What
9 they present with is sudden death or severe shortness of
10 breath, and then you look later -- you know, they come in,
11 and you're like, "What's going on?" And you do an X-ray,
12 and you don't find anything, and do you a lung scan, and
13 you might get it. And then, if you do an ultrasound of
14 their leg later, you say, "Oh, yeah, arthritis. There's a
15 clot down there." But the person wasn't symptomatic.
16 So the answer is, usually, you don't get it on
17 the bad ones.
18 Q. I guess what I'm asking is, there's no normal
19 time frame for an embolus to be thrown after the thrombus
20 is formed or after an injury or after --
21 A. Well, usually you don't know.
22 Q. Okay.
23 A. So it may be an experimental," Is there one?" I
24 couldn't --
25 Q. Okay.

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1 A. Maybe a week or 10 days, but I don't --
2 experiencewise, no.
3 Q. Okay. And is there -- assuming a person is --
4 has been immobile, does, then, moving the person increase
5 the risk that an embolus is going to be thrcwn at that
6 point? IS moving or jarring -- is that a factor in --
7 A. Could be.
8 Q. It's possible, but you can't really say
9 definitively?
10 A. Yeah. I can't.
11 Q. I take it that, unless the person is expressing
12 pain, or there's inflammation that diagnosing the deep
13 vein thrombosis is a difficult thing?
14 A. Yes.
15 Q. Did you see any -- and I'm not sure that you
16 even looked at the back of her legs. Did you notice any
17 injury, any swelling, anything that would indicate that,
18 at the time of her death -- or did you even examine her
19 for that?
20 A. I wasn't looking -- it didn't -- actually, I
21 wasn't thinking pulmonary embolus when she came in.
22 Q. I understand.
23 A. But I didn't notice anything on the leg that
24 made me think -- the leg didn't look swollen, didn't look
25 different, didn't look red, you know. But we weren't --

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1 you know, it wasn't one of these exams where you're
2 starting with her toes and --
3 Q. You were trying to resuscitate her and --
4 A. She was dead, and we were trying to resuscitate
5 her, and we were saying, "Oh, jeez," you know.
6 Q. Do you know Dr. Megan Shields?
7 A. Yeah.
8 Q. Okay. Did you see her at any point in time in
9 '95?
10 A. No.
11 Q. Okay. I understand she was here at some point
12 in time.
13 A. Don't know that.
14 I actually met her, for the first time, about a
15 month ago.
16 Q. Okay. So you wouldn't have had any contact with
17 her.
18 A. No.
19 Q. Okay. Did you know Laura Arrunado?
20 A. I've met her.
21 Q. When, in relationship to Lisa's death?
22 A. No. Didn't see her at all at Lisa's death.
23 Q. I mean, did you meet her before Lisa's death or
24 after Lisa's death?
25 A. I probably met her doing one of these physical

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1 exams. I probably talked to her on the phone. She could
2 call saying, "Can so and so get a physical exam," for the
3 purif. thing.
4 Q. So she would call not as a patient but as a
5 liaison to have you examine someone else?
6 A. Right.
7 Q. I'm just going to -- 1 had mentioned this
8 before. And this is an HCO bulletin of November, '65,
9 written by -- purportedly written by L. Ron Hubbard, and I
10 want to show you -- it's got three types of PTSs. And
11 we've listed and we've talked about how that was defined.
12 A. Mm-hmm.
13 Q. And Lisa was described to you as a Type 3, and
14 you concluded that, based upon what they told you, she was
15 a Type 3.
16 A. Right.
17 Q. And in this, Hubbard indicates that Type 3 --
18 and I'll let you read it so you don't have to take my word
19 for that. It says, "It -- Type 3 is beyond the facilities
20 of orgs not equipped with hospitals, as these are entirely
21 psychotic."
22 Okay. You want to read that? And if there's
23 anything else you want to read in there, to put that in
24 context, feel free to do that. I'll give you whatever
2s time you need.

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1 Would you agree that the Fort Harrison, based
2 upon, at least, that publication, does not appear to be,
3 according to the teachings of Hubbard, an appropriate
4 facility for Lisa to have been at?
5 A. Absolutely.
6 Q. Okay. Do you want to look it over anymore or --
7 A. No. There's no -- 1 have no qualification (sic)
8 with that.
9 Q. Are you --
10 Okay. Is there any reason that you didn't say
11 anything or do anything, knowing that these people were
12 being kept -- that Lisa was being kept at a facility that
13 was inappropriate for her condition?
14 A. Oh, I tell you, I'm a lot more tuned into this
15 now than I was before. So I just was probably, basically,
16 just unaware.
17 Q. Well, you've certainly dealt with psychotic
18 patients a lot --
19 A. Right.
20 Q. -- yourself.
21 A. But we see psychotic patients that don't end up
22 in hospitals, in the --
23 Q. Psychiatric hospital.
24 A. Yeah. Right.
25 Q. Okay.

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1 A. I mean, basically, the emergency room screen is,
2 if you're psychotic, but you're not suicidal, and you're
3 not homicidal, and looks like you've been making it, you
4 probably won't get in a psych hospital, unless you've got
5 some money. So -- I mean, that's sort of the basic --
6 Psych hospitals don't take them all, either.
7 Q. Okay. I don't think I have any more specific
8 questions. Let me ask something generally. And it's
9 going to be somewhat vague, but again, I want to -- you
10 know what we're investigating. You have a good idea of --
11 I've asked you questions for a couple of hours, now. And
12 this is the second time we've talked to you.
13 A. Mm-hmm. Right.
14 Q. I don't want to miss something that you feel is
15 significant, either forensically or factually in this
16 case, because I don't think to ask the magic question.
17 And I know that there may be things that this vague
18 question won't prompt you on, but if there's anything,
19 sitting there, that you think I need to know, the police
20 need to know, and I don't want to miss it simply because I
21 don't ask the specific question to prompt it -- so I'm
22 giving you an opportunity, if you think there's something
23 that -- where my examination hasn't been complete, where
24 you feel like there's information that I missed, that I
25 should know, to make a decision one way or another, I

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1 would like you to relate that to me now, so that I
2 don't -- you don't leave here today and not telling me
3 everything you think needs to come out in the
4 investigation.
5 A. Okay. I think the only thing that -- I think --
6 1 mean, you can't wear this hat, as an investigator, but I
7 can just tell you, this as a -- just as -- it's sort of my
8 experience with the Church and what's happened, is that I
9 think that these are -- that these -- the people that I
10 know that were involved in this thing, at least **Alain**
11 and -- 1 didn't know Janice that well, but -- or I suppose
12 the people that took care of her -- that these people were
13 actually trying to do something right, and got in over
14 their heads, and didn't know it, and really wanted to help
15 her, or see her get better, and that it just went -- just
16 didn't go.
17 And that, you know, that sort of the -- if you
18 read the newspapers, or if you talk to Dandar, or you talk
19 to people who just have this very -- you know, the mayor
20 or, you know, some of these people who have sort of old
21 axes to grind, or the St. Pete Times -- and these are --
22 these are -- they have a sort of vendetta going about how
23 bad the Church is, or how bad the people are, or what they
24 want, or that they're evil, or this whole thing --
25 That it's -- it just is not -- it just is not

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1 that way.

2 I consider myself pretty much a normal guy. You
3 know, I work in a normal job. I have a normal family.
4 You know, I haven't been a criminal. This is the first
5 bad thing I've ever been involved in, really. I may end
6 up director of this emergency room. I was just asked
7 to -- I'm a good doctor, you know what I mean? And
8 it's --

9 Anyway, I think that this -- this -- you know, I
10 think it -- this is not -- obviously, a good thing didn't
11 happen, and it's horrible that this girl died. But were
12 these guys intending to do her in or do harm or hurt her
13 or anything like that? Just -- it's just not -- just
14 wasn't -- it just wasn't like that.

15 And I'm just not saying that because I know what
16 went on or had any intimate involvement of this particular
17 scene; it's just that my experience, at being around these
18 guys for the last 17 years, is that -- that I've always --
19 you know, I've always been treated well, and my family's
20 been treated well, and my -- you know, that --

21 Q. So --

22 A. It's been good.

23 Q. Okay.

24 A. You know, it's been helpful.

25 Q. Anything else?

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1 A. That's the only thing.
2 Q. Okay.
3 A. I mean, that's the only sort of unsaid thing
4 that I --
5 Q. So -- and -- so it's your perception that there
6 was no maliciousness or intent to harm Lisa.
7 A. No. I mean, I know --
8 Q. You're not suggesting that there wasn't
9 negligence in her treatment, are you?
10 A. Well, I think there's this line between criminal
11 negligence and -- whatever negligence is. And is this
12 criminal negligence? And I'm not sure of what your
13 definition of "criminal negligence" --
14 Q- I didn't ask you about criminal negligence; I
15 just said negligence in general.
16 A. Was there some negligence? Yes. Was it
17 intended? No. Was there a better way to do it? Yes.
18 should she have gotten medical care? Absolutely.
19 Q. Let me ask you this: Seeing as how you didn't
20 authorize the forced medication; seeing as how you didn't
21 authorize injections of magnesium chloride; seeing as how
22 you didn't authorize her to be treated for either -- a
23 psychosis, other than the one prescription for not
24 sleeping, was Janice Johnson practicing medicine when she
25 injected her?

1 A. Yeah.
2 Q. And --
3 A. Is that correct? No.
4 Q. And would you consider the practice of medicine
5 when someone force-medicates someone with a syringe and
6 they don't have your approval or their authorization or a
7 doctor's authorization to do that?
8 A. No. That's wrong. No question about it.
9 Q. And that's the practice of medicine --
10 A. Yeah.
11 Q. -- in your opinion?
12 A. Yeah.
13 MR. CROW: Okay. I don't think I have
14 anything else. Okay.
15 THE DEPOSITION WAS CONCLUDED AT 12:33 P.M.
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1 CERTIFICATE OF OATH

2 STATE OF FLORIDA)

3 COUNTY OF PINELLAS)

4 I, the undersigned authority, certify that DAVID
MINKOFF personally appeared before me and was duly sworn.

5

WITNESS my hand and official seal this 22nd day
6 of May, 1998.

7

8

9 DONNA M. KANABAY, RPR, RMR, CRR,
10 Notary Public - State of Florida.

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1 REPORTER'S DEPOSITION CERTIFICATE

2 STATE OF FLORIDA)

3 COUNTY OF PINELLAS)

4 I, DONNA M. KANABAY, Registered Professional
Reporter, certify that I was authorized to and did
5 stenographically report the statement of DAVID **MINKOFF,**
and that the transcript is a true and complete record of
6 my stenographic notes.

7 I further certify that I am not a relative,
employee, attorney or counselof any of the parties, nor
8 am I a relative or employee of any of the parties'
attorney or counsel connected with the action, nor am I
9 financially interested in the action.

10 DATED this 22nd day of May, 1998.

11

12 DONNA M. KANABAY
RPR, RMR, CRR.

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