Direct and Cross Examination of Neurologist Gary Kay, PhD in a Traumatic Brain Injury Case

May 4, 2018.

This is the redacted trial transcript of Gary Kay's testimony in a case tried in April, 2018 in the Circuit Court of Fairfax County. This transcript includes the direct and cross examination of **Dr Kay,**, a local neuropsychologist who is hired with some frequency to testify on behalf of insurance companies in cases where a traumatic brain injury is alleged to have occurred.

This transcript may be valuable and important to lawyers who are facing Dr. Kay in a trial and we will be happy to provide the unredacted copy to those lawyers. (This copy does not have either our client or the young defendant identified. Neither deserved to have to go through this trial.)

Dr. Kay testified that his testing revealed, contrary to the opinions of the treating neurologist and the treating neuropsychologist, that the plaintiff has "awesome memory for guy his age."

State Farm, who hired Dr. Gay to evaluate the plaintiff and testify against him, never offered a penny to settle the case.

The jury returned a verdict of $450,950. State Farm did not appeal the verdict.

Additional transcript from this trial is available at BrianInjuryTrialTranscript.com

Unredacted transcript and other information about Dr. Kay is available to plaintiff's attorneys from

BenGlassLaw
3915 Old Lee Highway, 22B
Fairfax, VA 22030
info@benglasslaw.com

V I R G I N I A

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

BARRY PLAINTIFF, Plaintiff, -vs- BENJAMIN T. DEFENDANT, Defendant.	CL-2017-0000832

Circuit Courtroom 4J
Fairfax County Courthouse
Fairfax, Virginia

Wednesday, April 18, 2018

The above-entitled matter came on to be heard before the HONORABLE RANDY I. BELLOWS, Judge, in and for the Circuit Court of Fairfax County, in the Courthouse, Fairfax, Virginia, beginning at 10:00 o'clock a.m.

APPEARANCES:

On Behalf of the Plaintiff:

JAMES S. ABRENIO, ESQUIRE
BENJAMIN GLASS, ESQUIRE

On Behalf of the Defendant:

HEATHER K. BARDOT, ESQUIRE

* * * * *

C O N T E N T S

* * * * *

E X H I B I T S

Ms. Bardot is up at the podium calling a witness, it means it's part of her case, and obviously when Mr. Abrenio and Mr. Glass are up it's part of their case, and there's going to be a little going back and forth.

So the Plaintiff is not done with their case yet. They will be resuming tomorrow, possibly even today if Ms. Bardot finishes early. But that's what we're doing.

Ms. Bardot, you may call your witness.

MS. BARDOT: Right. Just for clarity, I will be putting on three experts today: Dr. Kay first, who I will call now, and Dr. Miller, and Dr. Tuwiner.

THE COURT: Okay.

MS. BARDOT: Thank you.

Whereupon

GARY KAY

a witness, was called for examination by counsel on behalf of the Defendant, and having been duly sworn by the Clerk of the Court, was examined and testified, as follows:

DIRECT EXAMINATION

BY MS. BARDOT:

Q Dr. Kay, if that binder is in your way, please feel free to move it out of your way.

A Sure.

Q Could you please state your full name and your business address for the jury.

A Sure. My name is Gary Glen Kay, and my office is located at 4900 Massachusetts Avenue, Northwest, Suite 240, Washington, D.C.

Q What is the name of your practice?

A Washington Neuropsychological Institute.

Q Can you please tell the jury your educational background, and if you need to refer to your CV, it's Exhibit 3 in the white binder.

A So my background is that I went to UCLA undergraduate, studied psycho-biology, and then for graduate school I went to Memphis State University, which is now called the University of Memphis, and they have a joint program with the University of Tennessee School of Medicine in what was called neuroclinical psychology, what we call neuropsychology.

It was a specialty program toward a Ph.D., and I finished my Master's and my Ph.D. in that program.

And while I was doing that I was in the Health Professional Scholarship Program with the U.S. Navy. So upon completion of graduate school I came out here to

Bethesda, Maryland, for my internship at the Naval Hospital at Bethesda.

And then upon completion of the internship, I was at the Navy Hospital in San Diego, Balboa Naval Hospital, and Director of Neuropsychological Testing and Psychology.

Q Did you serve in the military as well?

A Yes, I did.

Q Can you tell the jury what your military service was?

A So I began with the scholarship program and then as Director of Psychological Testing at Balboa Naval Hospital, and then when I came back here, my reserve opportunities, I kind of didn't want to work at Bethesda, do what I did every day at Georgetown, so I took my opportunity with the Naval Investigative Service, which is now NCIS, but it was NIS, and I was the behavioral science consultant to the regional office bureau for NIS for I guess a couple -- two or three years in reserve duty.

Q Following --

A I left as a Lieutenant Commander.

Q Following that, can you tell the jury what your work history has been?

A Certainly. So after I came off of active duty and moved out here, for about one year I joined -- the former head of training of psychology at the Bethesda Naval Hospital invited me to join him -- he was retiring -- to join him in practice in Bethesda.

So I did that for about a year and then got offered an incredible opportunity to go to Georgetown's Department of Neurology to establish the Neuropsychology Division -- this was about 1985/1986 -- at Georgetown.

So they really wanted a neuropsychology presence in the Department of Neurology, so I established that, founded that department, and stayed there full time until about 1999.

And then I -- we continued to provide service to Georgetown. We rented space in the Department of Neurology but moved off campus. I took the neuropsychologists with me and we opened an office not far from Georgetown. And that was called Georgetown Neuropsychology Associates.

And then after about two or three years with that, I opened the Washington Neuropsychological Institute and doing research of the pharmaceutical companies, doing a lot of aviation neuropsychology.

And then a colleague from the NIMH who was frustrated like I was with doing big clinical trials for pharmaceutical companies and working with these big contractors who actually run those projects but don't have a background in the kind of testing that we do, called cognition -- this colleague and I went down and started a company down in Florida -- St. Petersburg, Florida -- called Cognitive Research Corporation, and that was founded in 2006.

That's called Cognitive Research Corporation, which is a CRO, contract research organization. We're the people who design and monitor and report on clinical research trials to the Food and Drug Administration, sometimes to the Federal Trade Commission.

We have contracts with the National Highway Transportation Safety Administration. A lot of our work is focused on driving safety and the impact that medications have on driving.

Q Do you have any teaching positions?

A I still have one -- I am not active at all -- at Georgetown. I've never kind of resigned or anything. I still am listed as Associate Professor of Neurology.

More of my teaching -- I do a lot of teaching,

a lot of continuing education teaching to psychologists and neuropsychologists.

I actually organize and run an annual aviation psychology seminar on behalf -- really for the Federal Aviation Administration, but we invite psychologists and neuropsychologists from across -- around the world come for that training, which we've been doing for six years.

Q Are you licensed in your profession?

A I am.

Q What licensure do you hold and in which jurisdictions?

A I'm licensed as a psychologist in the District of Columbia and in the State of Maryland.

Q What does it mean to be Board Certified?

A It means that you're recognized for your competence and expertise within your field, that people have reviewed your credentials, you've submitted a work sample, you've taken a written examination, you've taken an oral examination as well.

That's the typical process. And I'm a Board Certificate Diplomate in the American Board of Professional Neuropsychology, so I have the ABN diploma.

I also have a diploma from the American Board

of Assessment Psychology, which is more recognition for the work that I've done in aviation neuropsychology.

I developed a test called CogScreen. I'm the author of that test. And that test is used around the globe for evaluating pilots. It's a requirement for pilots with head trauma, HIV, depression, ADHD. So the work I've done in test development led to the ABAP diploma.

Q Can you explain to the jury what the field of neuropsychology entails?

A Certainly. So unlike -- you know, you're familiar with the clinical psychologists and therapists. One of the real specialties of psychology is assessment, and psychologists for a long time would do a personality assessment, things like the Rorschach, which are commonly known, the MMPI for personality disorders.

But beginning -- really, it became quite popular beginning in the '40s after World War II, and after that really there was a need for evaluating brain function and understanding that the tests that are used for measuring things like intelligence and other aspects of thinking could be used to evaluate the severity of damage to the brain, to identify lesions located in the

brain.

So neuropsychologists before there were MRI scans and CT scans -- that's how old I am -- basically we assisted neurosurgeons -- I worked within a neurosurgery office in Memphis, Tennessee, where we would help identify the location of lesions before they would go ahead and do treatment for a tumor or for epilepsy.

So these tests were found to be sensitive to the presence or absence of brain dysfunction, to the severity of such dysfunction, and could be used to localize the brain's function by using behavioral tests.

So neuropsychologists became very involved in assessment of brain function and some neuropsychologists are involved as well in rehabilitation of patients who have a stroke or seizures, epilepsy.

And so those are the kinds of things. But really what neuropsychology is involved in is evaluating brain function using standardized tests.

Q How much of your work is forensic work, meaning evaluating cases that are in litigation and providing expert testimony?

A Well, as I said, I'm very involved -- my primary company is a research company down in Florida, and

that represents probably easily 60 percent or more of my time -- maybe 65 percent.

So that leaves my clinical practice, about 35 percent of my time, or maybe even less, because I'm still the publisher of the CogScreen test and I have to handle all the issues related to that test and test development.

Of my limited clinical time, about half of the income that I generate from clinical comes from forensic, but it probably doesn't represent half of my time. It's just more lucrative than the work that I do as a consultant to the Federal Aviation Administration, pays me $100 an hour I'm embarrassed to say, and I get a better income from the work that I do in forensics, so it's helps cover the loss leaders of what I do. I mean -- so that's kind of it.

Q What do you charge hourly for forensic work?

A I think at the time that I saw Mr. PLAINTIFF it was $350 an hour.

Q Other than writing the protocol that you talked about a moment ago, do you write any other standardized testing in your field?

A Yeah. I'm involved with, you know, the CogScreen test. I was an author on the manual for the

Wisconsin Card Sort Test.

I developed a version of Trail Making, a test called Trail C.

I developed a memory test that I called the Name Face Memory Test.

And I've worked on other -- worked on tests in psychology called Boundary Violations that was published.

Q Are some of those tests in fact tests that were administered to Mr. PLAINTIFF by both you and Dr. Wilken?

A Well, the Wisconsin -- actually I didn't re-administer the Wisconsin Card Sort Test because you shouldn't administer that more than once. So that was administered by Dr. Wilken.

I don't think there's -- we both administered some tests that are in common, but in terms of tests that I authored or wrote the manuals on, I don't think so.

Q Do you in your field of practice train other neuropsychologists how to administer and score tests?

A All the time. That's a big part of my life, is training neuropsychologists. Right now I've just traveled for the last five weeks hitting research sites around the country, training the neuropsychologists how to

do a standardized battery for a new Alzheimer's Drug and the whole, you know, group of testers supposed to administer it in a very standardized way so we can see if the drug is safe and effective.

I've got another trial where I was training people how to do testing for looking at a new migraine drug. And before that I was Director -- at Georgetown I ran the post-doctoral training program which trained neuropsychologists typically over a two year period.

They would come to Georgetown for two years of training under my supervision.

Q Did you, in fact, train Dr. Wilken?

A Yes.

Q In a calendar year, on average how many times would you say you administer neuropsychological testing?

A I would say, you know, at least twice a week, and probably, you know, 45 or close -- over 45 weeks a year, so at least 90 times a year I'm administering myself neuropsychological testing.

Q When doing the neuropsychological testing, is the protocol different depending on whether it is a patient or whether it's a forensic case?

A It actually differs by -- even by the kind of

patient you see. So if I have a patient who is coming to me for evaluation of Alzheimer's, I'm going to use tests that are appropriate for that kind of evaluation. If I'm doing --

Q So let's see -- I don't mean to cut you off, but all other things being equal, you've got the same kind of patient with the same kind of complaints, traumatic brain injury for instance -- if they're a patient or if they're forensic, do you evaluate them the same or is there a different protocol?

A Well, there's a different standard in a forensic case. There are certain things that we're kind of considered responsible to do by our ethics.

And one of them is that in a forensic case you will test the patient's effort, you'll do -- effort testing will be included in your test battery.

So I have colleagues who do effort testing all the time, but I'm seeing -- mostly airline pilots are my predominant patients that I evaluate.

I saw an airline pilot yesterday in fact and I did not give the Captain any effort testing. He was extremely motivated to get back to the cockpit. So there's, you know, no question about their motivation and

effort.

In a forensic case, whether I am working on Plaintiff's side or on the defense side, I'm held responsible for doing effort testing. So that's one area of difference.

I think the only other one I can say off the top of my head would be I would not do an abbreviated test when I'm doing forensic. I give the full test. I don't want to be challenged because I only gave part of a test.

I might short things if it wasn't forensic where I wasn't going to be challenged.

Q Could you look in the white binder at Exhibit No. 3 and let me know if that represents your curriculum vitae?

MR. GLASS: Judge, we stipulate that it is and I have no objection to its admissibility.

MS. BARDOT: I would move that in then.

THE COURT: Okay. It's in.

(The document referred to above was marked as Defendant's Exhibit No. 3, for identification, and received in evidence.)

MS. BARDOT: Your Honor, could I put the

document screen on, please.

BY MS. BARDOT:

Q I'm showing you Page 6 of Exhibit No. 3. It should come up on your screen, Dr. Kay.

THE COURT: I don't think it has yet.

Okay.

BY MS. BARDOT:

Q Dr. Kay, do you want to look on your screen right there in front of you?

A Oh, I was looking way over there, but I really can't see that very well. Okay.

Q Can you not?

A Yes, I can see this one (indicating).

Q Okay. Those would be two presentations that you wrote, one on assessment of frontal -- two presentations that you gave; one on assessment of frontal lobe dysfunction and one on neuropsychological study of cognitive functioning and sleep apnea; correct?

A Correct.

Q So you have given presentations regarding how sleep apnea affects neuropsychological testing?

A Yes. And I've written quite a bit on the area too.

Q I'm going to show you Page 7. This would be another presentation that you gave -- correct? -- effects of hypoxia on neuropsychological testing in patients with obstructive sleep apnea?

A That's correct.

Q This would be an area of expertise for you; correct?

A Absolutely.

Q Now, I asked you to get involved in this case to conduct neuropsychological testing to determine whether Mr. PLAINTIFF suffers from cognitive deficits which could be related to an automobile accident of June 10, 2015; correct?

A That's right.

Q In order to conduct a thorough review of the case, can you let the jury know what records you reviewed?

A You provided me records from his primary care doctor named Feola. There were records from Dr. Kayloe, neurologist. There were reports -- well, one of the reports from Dr. Wilken; the other one Mr. PLAINTIFF kindly provided to me when he came to see me because it wasn't included.

There was a record from his hospital visit.

There was a record from his ENT. There was a record of a deposition of Dr. Feola, and there was a deposition of Mr. PLAINTIFF.

There were some interrogatories. There was -- let me think what else was in there.

Q You got all the subpoenaed records, two binders like this (indicating); correct?

A Correct.

Q Regardless of whether or not they were helpful?

A Correct.

Q And you reviewed all of the documents that were sent to you in order to make sure that you had a thorough background; is that fair?

A Well, when I would see documents that are not applicable or relevant for neuropsychology, I would flip on and continue. But yes, they were -- I saw that they were there. I didn't necessarily utilize them.

Q Okay. You looked at Dr. Wilken's test results and also the raw data; is that correct?

A Eventually, yeah.

Q Can you explain to the jury what the raw data is?

A Sure. So when I'm administering or Dr. Wilken is administering the test where you're actually recording Mr. PLAINTIFF's responses, where you actually do the scoring, that's the raw data. So these are answer sheets is another way to think of it.

The answer sheets and the forms -- let's say there was a drawing test where he would actually draw on the form, that would be the raw data.

Q Are those materials the type of materials that are typically released to non-professionals or are they typically held pretty close to the chest?

A For test security reasons, as you can imagine, these tests are used for high stakes decision making, hiring people, making a determination about who is well and able to go back in the cockpit, for example, you don't want these to get out. It would ruin the validity of the test. So we're very careful about release of these tests.

Now, with the internet it's kind of frightening about how much has found its way, but we still try our best and we're held ethically responsible by our -- I mean you could lose your license to practice if you were irresponsible in releasing these tests, made them publicly available.

Q So usually that raw data is exchanged between neuropsychologists; is that fair?

A Correct.

Q And you were able to get Dr. Wilken's raw data directly from him so you could consider it in your analysis?

A I did.

Q How did the raw data inform your opinions, if at all?

A Oh, it was critical that I get that because I didn't have all of the scores from his report. He reported some scores in his text, his narrative report, but he didn't really include all the scores. I didn't know where he got percentiles from.

So by looking at the actual raw data, I would actually find percentiles that I would need for generating kind of a spreadsheet I create so that I can look across time, how did Mr. PLAINTIFF perform on these measures across time, what were the scores that he obtained -- not just a percentile, but even the raw score, how many did he get right, you know, which I can't tell from looking just at the report that Dr. Wilken wrote.

Q Are the records that you have just referred to

the type of records which professionals in your profession rely upon to formulate opinions?

A Yes.

Q Did you also have an opportunity to interview and test Mr. PLAINTIFF?

A I did.

Q Are those two processes essential to the ability to render a neuropsychological evaluation?

A Well, I mean seeing the data -- not in every case -- but in terms of a forensic case and to do the assessment you had requested, yes, it would require that I would have all of the data, have the records, and even let you know if there were other things that I thought that I needed.

Q Did you have everything that you believed you needed to do a full assessment of this case?

A Yes.

Q When did you interview Mr. PLAINTIFF?

A At the time of my evaluation. Where is my -- oh, my report here.

THE WITNESS (Directed to the Court): May I look, Your Honor?

THE COURT: Yes, of course.

THE WITNESS: That was on January 17th of this year.

BY MS. BARDOT:

Q What was his appearance when he arrived?

A Nothing out of the ordinary.

Q He wasn't --

A He was well groomed. He was, you know, dressed appropriately. He came by himself for the evaluation.

Q During the interview part of his exam, how long did that last?

A I don't usually record it with this degree of specificity, but this time for some reason I wrote down 53 minutes. I couldn't tell you why.

Q Do you remember anything about his affect during the interview period?

A No; just kind of normal interaction, interchange. You know, we had a court reporter. I basically indicated that was a bit unusual. I just explained what the nature and purpose was of the exam and basically he had been through two prior exams.

He was very helpful. I mean I didn't have to -- I was at a disadvantage because I didn't know what

tests were given most recently. I knew there had been a second test.

And he informed me -- he was very informative. He informed me that there had been another exam that had been done and provided it to me, which was great, because it would have been hard to do without that.

Q Was there any flatness to his affect during the clinical exam?

A Not that I -- that I found or noticed.

Q What did he tell you during the interview which was pertinent to the opinions that you formed, and you should feel to look at your report?

A Sure. Well, there's a lot that he told me that is pertinent.

Q Just walk right through it with me.

A Well, importantly for a neuropsychologist first is that he had recall of the time prior to the crash.

Q Why is that important?

A Because one of the ways we measure severity of head injury is relative to any kind of amnesia that occurs, so we always get a measure of amnesia from before, you know, events that occurred before a crash occurred,

and if you remember things that happened the day of, the morning of, the week -- you know, so even go back further. That's called retrograde amnesia.

And then we look at, you know, amnesia that occurs after a crash or an incident, you know, for how long a period of time before you regain continuous memory -- anterograde amnesia.

And so those measures of retrograde and anterograde amnesia are critically important in evaluating severity and actually predicting outcome. Those are very good predictors of whether somebody will continue to have problems after they have injured their head.

Q Did he report to you any retrograde or anterograde amnesia from the accident?

A No.

Q So you said those would be good predictors of outcome.

If a patient had no retrograde or anterograde amnesia, what would you expect? What would your opinion to a reasonable degree of certainty in your field be as to the likelihood of a good outcome?

A You would expect a good outcome.

Q Go ahead. What else did he tell you that was

useful and helpful to you, or important to your opinions?

A There was this momentary period that he doesn't recall, which he told me could have been seconds or minutes.

He told me in terms of the level of fear, telling me how this impacted him emotionally, he said he actually thought he was going to die, and so that tells me just how frightened he was by this impact. He said he had never felt anything like that before.

He remembered, you know, moments after the accident the OnStar system in his car came on and he remembered that.

And he told me that he was feeling confused and fuzzy when his wife later took him to INOVA Fairfax Hospital, and that would suggest to me possibly an altered state of consciousness, so if he's not feeling his normal way of thinking, as he says he is feeling fuzzy and confused.

And that his wife he told me had told him that he was thinking more slowly, and so another kind of sign that his thinking wasn't all there.

He mentioned that Dr. Kayloe -- or he reported to Dr. Kayloe that he had sustained a loss of

consciousness in the crash. And so when I hear that, that actually is something which is a predictor too of a more serious head injury, would be a concussion where one loses consciousness, where there is a time where the person is out, okay, non-responding.

Q Did you review records to determine whether his report of loss of consciousness was consistent with what was reported after the accident?

A The contemporaneous records, the records of the time, don't reflect a -- don't reflect any loss of consciousness. He reportedly did not have a loss of consciousness to the hospital.

And so, you know, there's basically a discrepancy there between what is in the records and what he has reported to Dr. Kayloe.

Q Did you see Dr. Feola's record from June 10 of 2015?

A I did.

Q Was there also a discrepancy between what he reported to Dr. Kayloe --

A Yes.

Q -- and what he reported to Dr. Feola as far as loss of consciousness?

A I'm sorry. I talked over you. And the answer is yes, he did tell Dr. Feola that he didn't have a loss of consciousness.

Q All right. I interrupted you. Go ahead and tell me what else you learned from Mr. PLAINTIFF that you used in your evaluation.

A Well, I mean what he told me was that he had had a concussion with loss of consciousness. So that would go into my thinking at the time about how serious his injury was, that he would have a concussion with a loss of consciousness.

That confirms -- if it's true, would confirm that he had a concussion and that even that early on with Dr. Kayloe on July 1st -- so just three weeks later -- he was having, you know, headache, cognitive difficulties, some balance difficulties.

It's important he had noticed -- he told me he had been prescribed Elavil. This is a drug originally used as an antidepressant, which actually does cause some sedation.

People actually sometimes prescribe it for sleep problems. It's off label, but they prescribe it for that. And it does not help your memory. It is actually

an anticholinergic drug, so it disrupts memory function, and that would not be helpful. He was having -- but it does sometimes help with pain, like headaches.

But he was having daily headaches and memory problems.

And then there is the note about him getting a CPAP, which is the treatment -- Continuous Positive Airway Pressure. It's a mask that one wears. There are different kinds. Some just go over the nose, some that go over most of the face.

And a CPAP is the most effective treatment we have for obstructive sleep apnea. So there's a mention early on that he was receiving treatment for CPAP.

He told me he had seen Dr. Wilken, so I knew that he had seen a neuropsychologist before, and he saw him a second time at 23 months. The first time was eight months after the injury, and a second time at 23 months.

One of the first things that Mr. PLAINTIFF and I did is I had Mr. Wilken's -- Dr. Wilken's report there, and I said, "Here's a list of what I pulled from Dr. Wilken's report of the symptoms that you were having. I want to know whether you're still having these symptoms or not."

So I would go through with him in a list wise way the different symptoms to find out if he was still having these same problems.

Many of the complaints he had relate to difficulties with memory, to difficulty learning or remembering things. He said that he can't recall what he's read, said, or heard, that he can't recall what he's done on that day, he forgets what he's doing. He forgets where he's going when he's driving. He could repeatedly watch a movie without recalling what he had seen before.

These are all examples Mr. PLAINTIFF provided me about his memory changes. He said he had trouble keeping track of a plot or characters if reading a book.

He said that he had become dependent on taking notes and he needs to write everything down or he'll forget, that if he looks later on at his notes they don't make sense to him sometimes, and so they don't help.

He reported that he can only account at best for the past few hours. He finds it hard to reconstruct more than that.

So he's describing to me a very serious level of amnesia, amnesia being an acquired memory disorder, difficulty learning and retaining information, being able

to then retrieve or even recognize information that -- something that occurred before.

And there are disorders in neurology that can cause very profound amnesia where people just don't retain the information. So he's describing that.

He stated that he has forgotten -- he reported he forgets how to use his cell phone and computer, not as much he said as before, but he was still having that.

Now, that's interesting, because that is not remembering content or remembering a narrative, a sequence of events that occurred, but remembering how to do something. It's a totally different area of the brain that does that. It's called procedural memory and it's actually mitigated by totally different structures in the brain.

And it would be -- it's highly unusual. There are people who have very serious amnesia -- couldn't tell you what happened yesterday or last week -- but they can still go golfing, they still can -- they don't lose their procedural memory. That was interesting that he said he lost that as well.

He said that several times a day he doesn't know where he's at, and that's a suggestion that he has

serious problems with orientation, that he's disoriented, and so this can occur even if he's in places which are familiar to him. It's not just in strange places.

He said he's dependent upon his GPS. Even familiar places can look unfamiliar. That he spends a lot of time looking for missplaced objects, and he loses track of time, and that his orientation to time varies over the course of the day.

So this is an individual -- and I work with patients with Alzheimer's Disease; we do a lot of Alzheimer's research in our company -- and he's presenting with very serious -- if these were real symptoms, very serious impairments in his memory and his orientation that would be associated with very significant brain damage.

Now, he had other cognitive complaints. He told me that he was easily distracted, that if he was doing something he is distracted, it's hard for him to focus on more than one thing at a time.

He told me he felt that he was very inefficient at doing things, that things that would have normally taken him minutes were taking him hours.

He stated that he would start things and not finish them, that he couldn't organize his papers, his

thoughts.

So again, he's presenting to me, Ms. Bardot, a very severe degree of impairment, which would be suggestive of extensive brain damage.

He said that he had a number of complaints that were more of an emotional nature, that in fact -- and relating to people, so trouble in actually that people were misperceiving him he told me, that people saw him, they think he's angry even when he doesn't feel angry.

So in addition to cognitive changes he's telling me that he's having troubles in social perception. He's telling me that he has trouble relating to friends and family, that he doesn't feel his emotions the way he did.

So, you know, he had suffered a loss of I think it was a friend and he just didn't have the feelings that he would expect. He said he felt nothing.

He told me that he was also uncomfortable around people, didn't socialize with people.

So all of this suggested a significant personality change, which would again be consistent with a very serious level of brain damage possibly.

He even said that he is no longer an

extrovert, which is what he was.

Now, on the other hand, I then go into the interview and say -- I want to find out what is he doing, what are the activities that he's engaging in.

And he told me that he was responsible for dropping off and picking up his granddaughter from the school bus -- first grade granddaughter -- and had not had any problems dropping her off but that he had to rely upon his alarms -- and he showed me his phone -- to -- on his phone to remind him to pick her up in the afternoon.

And then I asked him about his, you know, kind of prior work. I understood that he was an attorney. He told me that he was a workaholic, that he had tried to resume his work activity in March 2017, and, you know, that is a good long time after a June injury; okay?

So we're talking, you know, almost 10 months later he tried to go back to work to do some bookkeeping but was discouraged. He didn't feel like he could perform.

And he said the inability to work was really something that bothered him because it was a big part of his identity, and that he's been told by his neurologist that it's unlikely he'll ever return to law, and he

indicated that that was very difficult, as you can imagine, for him.

I asked him about as well, I wanted to know what kind of rehabilitation he had done, had he seen any kind of rehabilitation doctor, and he told me he had not -- there were insurance problems but he had done some online -- you guys hear about, like, Lumosity and some of these things that you can get to to advertise -- some of them are in trouble with the Federal Trade Commission -- their claims.

But the fact is that he had tried some of these activities online but hadn't done any, you know, one to one working with a cognitive therapist, something that he said was on his agenda, that he would want to do it.

Lastly, I wanted to know about how he was feeling physically, and he told me that he continued to experience frequent headaches, particularly if he kind of over-exerted himself, you know, that they were aggravated by planning things, by paying bills, they don't occur as much if he is watching TV, and they've gotten worse over the last few months he told me, and that that was being addressed by his neurologist.

I was wondering if he was in pain, and he said

the pain was less now in his left arm than following the crash, and that the pain in his leg, lower back, neck, and shoulders had resolved.

Because one of the things, in neuropsychology if you're doing testing, if somebody is in pain, they're going to have a hard time focusing. So he did not indicate that he was having that problem when I saw him.

I always want to know what kind of medication somebody is taking. He told me he was taking thyroid replacement. That's important and good, because if your thyroid is very low that can affect your cognition, particularly your attention and memory.

He is taking a drug to lower cholesterol, Propranolol, which is a drug sometimes used for hypertension, sometimes used for anxiety.

He was prescribed Vivance, which is an amphetamine, that is used for treatment of ADHD in children and in adults.

And he is prescribed Elavil, which is an antidepressant, but as I said before, sometimes doctors give it for pain or for sleep, but it actually is not good for your memory.

We don't let pilots, for example, take -- we

do let them take some antidepressants. We prohibit them from taking Elavil, because it causes cognitive problems.

He didn't mention taking any medication for his diabetes.

I asked him about his sleep apnea, because as you heard, it's something which I have published and written about quite a bit. So he said he was treated surgically in 2006 or 2007, that he uses his CPAP, but not to the extent he would like.

A lot of people find it very difficult to keep that mask on, and it's very important. I was involved in a very major trial looking at what benefits there are from chronic CPAP use and how much it changes cognition. It really is important to be regularly using it, and you lose that benefit after a couple of days of not using it.

So he said he did tolerate the mask, usually around three hours of mask time per night. He told me he doesn't feel daytime sleepiness, but he's been -- he had been in the past prescribed a drug specifically for treatment of the daytime sleepiness that can continue to occur in patients who are even still getting CPAP, and that's a drug called Provigil or a newer version of it called Nuvigil.

And he had been prescribed that, but he had been switched to Adderall, which is a stimulant, and then to Videx, a different stimulant, and if he doesn't take that stimulant, he feels more run down.

He told me he had never had a prior head injury. That's very important for a neuropsychologist to know.

And he did not mention anything about previously being diagnosed with Attention Deficit Disorder.

He didn't mention he had any prior medical problems with memory or with fatigue. He didn't tell me that those problems preexisted.

Q Were you able to determine after you did your interview through your review of records that in fact there was a prior history of fatigue and memory issues?

A Yes.

Q Did you take that into account as you evaluated Mr. PLAINTIFF?

A Absolutely.

Q What did you learn from your review of records was the prior history with regard to fatigue and memory issues?

A That those basically go back to about 2000. I mean we're talking that 18 years earlier -- this is from the deposition of Dr. John Feola -- that on a visit on October 19th, 2000, it mentions he's got a history of sleep apnea, headaches, obesity, hypothyroidism.

He considered him to be at 70 percent due to his fatigue it lists on there, memory loss. He was without chest pain and vertigo.

And a quote from -- "He had been complaining of short-term memory loss, which isn't uncommon in" and that's the end of the quote, obstructive sleep apnea.

So that's, you know, clearly documented 18 years ago.

Q Did you note whether or not the complaints of memory loss and fatigue continued up until the time of the accident?

A Yes. I find complaints of -- you know, related to attention and memory. He was being seen in 2013 for all -- for Attention Deficit Disorder and fatigue. He was again 70 percent of his capability according to the doctor.

He was needing to follow up on ENT regarding CPAP. He was still symptomatic.

You know, he was having headache, tension-based, bothered him for two weeks.

Later he developed another condition which is a neuropsychological condition of Type 2 diabetes, which is known to have effects on cognition as well.

In August of 2015 he was listed by his doctor as being at 50 percent of his capacity.

Q When was that?

A August 11th, 2015.

MR. GLASS: Your Honor, the doctor can testify to what he reviewed and can give his opinions. But -- and I let him go. But he's reciting hearsay now. This stuff is not in evidence. I know the jury has heard some of it. But procedurally he's giving hearsay versus what opinions he derived from those.

THE COURT: Okay. You're talking about the factual statement just now?

MR. GLASS: Yes, sir.

THE COURT: Okay.

MS. BARDOT: I believe all of this has come into evidence through other people at this point. I don't think he's gone over any history that's not been put into evidence.

THE COURT: But are you referring specifically to the reference that he just testified to, the 2015?

MR. GLASS: Well, I should have jumped up when he was reading Dr. Feola's deposition which isn't in evidence. But --

THE COURT: Okay. That was a while ago.

MR. GLASS: That was a while ago. I let that go.

THE COURT: All right.

MR. GLASS: But yes --

MS. BARDOT: I'll move on.

THE COURT: Okay.

BY MS. BARDOT:

Q So you've reviewed the entirety of the records and found the history that you've just explained; correct?

A Correct.

Q Once you interviewed Mr. PLAINTIFF, got the history from the record, did you also -- well, let me back up.

As you interviewed Mr. PLAINTIFF for this almost one hour period, did he have to use any notes to recall what he conveyed to you?

A No, ma'am.

Q Did you perceive any difficulties in his ability to recall or provide you with information during your interview?

A No.

Q Did you notice any halting speech during your clinical interview or at any time during your examination?

A No. During the entire day we spent he was fluent in his speech and his speech was connected and organized.

He didn't talk off topic, have tangential speech, or seem to be looking for words. There's a word -- use circumstantiality -- for somebody that can't think that this is a bottle. They go, "Well, it's a thing and you put water in it and you could carry it around and they sell them and they're made out of plastic," and they'd say -- because they can't think of the word bottle. There was none of that.

Q How long did you test him for?

A I don't remember right now. Probably -- I mean the exam normally takes most of the day, so it would have been until the afternoon.

Q Who administered the actual testing?

A Me.

Q Do you always do your own testing?

A Yes.

Q Do you have an opinion to a reasonable degree of certainty in your field as to whether it's better to do your own testing or have somebody else do your testing?

MR. GLASS: Objection. That's not something that's been designated.

THE COURT: Sustained.

BY MS. BARDOT:

Q Why do you do your own testing?

A By doing my own testing, I can -- if I listen to his complaints, then I can make sure that I'm getting the right tests, that I can add a test to the battery based on his performance on a test, so I can actually tailor the exam to what is occurring in the exam.

Now, if I have a student doing it or just a paid technician doing it -- which we're not allowed to do in the District of Columbia -- then in fact there's no alteration. It's like, "Just give this battery of tests. This is what you're going to give." You tell the student to do it and the student gives the testing.

Q Once you did your testing and then reviewed Dr. Wilken's testing, did you create a spreadsheet that

showed the different testing over the period?

A I did.

Q That's part of your report that we've designated; correct?

A Yes.

Q If I could show you up on the screen, is that this document that's appended to the back of your report?

A That's correct.

MS. BARDOT: Your Honor, I'm going to use this demonstratively to explain the testing and what his results were and what he found.

THE COURT: Is there any objection?

MR. GLASS: No, sir.

THE COURT: Okay.

BY MS. BARDOT:

Q So let's walk through your report. And to the extent it is helpful to refer to the spreadsheet that I put up, would you do that?

A Absolutely.

Q And as we walk through this report, I want you to give your opinions only to the extent that you are comfortable giving them to a reasonable degree of certainty in your field; okay?

A I understand.

Q The first nine pages of your report go through your clinical interview and your review of records; correct?

A That's right.

Q If we go to the bottom of Page 9 of your report, it says, mental status examination, test behavior, test effort.

Do you see that?

A I do.

Q Tell me what you captured there and what you found and what the purpose of that was.

A So this is an area where in your report you describe what you have observed in the person's behavior, in their mood, their effort, and how hard are they trying, their level of anxiety, were they particularly nervous, how upset were they.

But you really describe the quality of their speech in terms of volume, was it fluent or halting. And that's what goes into that section of the report.

You also look at the person, their grooming and kind of their demeanor. You're really describing how the person was interacting with you. That's apart from

the other scores.

There is a part about scores in there because we do indicate the results from effort testing sometimes in that section as well, so how does somebody do on tests that are designed to detect if somebody is basically not trying on testing.

Q You've already told us about his grooming and his speech.

Did you make a determination and come to a conclusion as to his level of effort when you saw him?

A Yeah. I felt that he was showing very -- you know, showing normal effort on the testing. I had no doubts about the fact that he was trying to do well on these tests.

Q I'm going to ask you first what tests you administered.

A Sure.

Q Go ahead and just tell the jury.

A All right. So the first test -- you've all heard about the IQ tests. The standard IQ test that we give is the Wechsler Adult Intelligence Scale, which currently is the Fourth Edition.

And I gave him just the test of processing

speed. These were areas where he had had some problem.

And I gave him the test of auditory attention called Digit Span. So I repeated just that portion because he had done fine with those before, which you will see when I show you the chart. And --

Q Okay. Are those depicted on Page 1 of the chart?

A Yes. Page 1 would be really good to show here.

Q Go ahead and tell us where that test is captured and what you observed and sort of what you observed over time from the three tests you looked at.

A Now I realize this is an Elo touch screen monitor here in front of me, so I would assume that it has touch capability?

Q It does.

A Okay. Cool. We use the same one for doing testing of pilots. These are very good monitors. Compliments to the Court.

(Laughter.)

THE WITNESS: Okay. So the tests listed on the left side there are the sub-tests from the Wechsler Adult Intelligence Scale. And you can see -- just to give

you an organization for this -- Dr. Wilken's first exam is on the far right. It says, "Dr. Wilken, February 10th, 2016."

And then Dr. Wilken's second exam, May 9th, 2017. And then left is the exam I conducted on January 17th, 2018.

And I showed where I had the raw score and -- actually, what you're looking at here, I would say this version you have here is before I got the raw data.

BY MS. BARDOT:

Q It is.

A So it's devoid of the richness of what I -- what we now have.

MR. GLASS: May we approach the bench, Your Honor?

THE COURT: Yes.

BENCH CONFERENCE

MR. GLASS: We've never received anything supplementing his initial designation, which was his report. He didn't have the raw data. So to the extent he's now going to offer opinions based upon the raw data, we've never seen the opinions in writing in a supplementation report.

So I'm prepared for his report, not supplement.

MS. BARDOT: Your Honor, we got the raw data long after the designations were filed. We had to come to court and fight over that.

We weren't asked to supplement at that point in time. And I don't think he was able to get the raw data until very recently. Dr. Wilken was not very good in getting that information to him.

THE COURT: Do you have to be asked to supplement? Don't you have an obligation to supplement?

MS. BARDOT: An expert designation.

THE COURT: I think the answer is yes, that you do have an obligation to supplement. And I think you --

MS. BARDOT: Well, you allowed their experts --

THE COURT: Let me just finish.

But I think you have objected to some -- in some cases their experts going beyond their expert designation. I think I've sustained some of your objections.

MS. BARDOT: No. You've allowed it. For

instance, with Peder Melberg, he looked at an abundance of documentation that was never referenced in any of his reports in getting ready for trial today, and he was able to testify as to all those things and he was able to put in fact information from those things into the record, even though he didn't consider them in his report.

And I objected to it. I said I relied upon what he indicated in his report he had reviewed as the rules require.

And you said "Overruled." And you let him go into all those things he had reviewed in getting ready for trial.

And you did it with their other experts as well. Dr. Kayloe didn't have any records. She had nothing as she wrote her reports, but she got them all in getting ready for trial and she was allowed to testify to them over objection.

And I just ask that I get the same ruling.

THE COURT: What's your response to that?

MR. GLASS: I don't think there was an objection to Dr. Kayloe. I know what happened with Dr. Melberg.

But I think if he's going to give opinions

about raw data that he seems to think this is significant now in this case, that we should have been told what the opinions are.

THE COURT: The --

MS. BARDOT: I mean it's astonishing, because I know what happened with Melberg. "Yeah, we get that benefit but you don't."

THE COURT: Well, but it was also my recollection that I sustained some of her objections as to beyond the expert designation.

Do you disagree with that? I thought I had sustained some of them.

MR. GLASS: Correct. When we were doing it you sustained her objections. We weren't allowed to do it. That's what I'm asking you to do now.

MS. BARDOT: That was only with regard to their expert giving rebuttal to information which wasn't in evidence.

Peder Melberg clearly just testified to documents he hadn't reviewed when he wrote his report, that he never supplemented, that he reviewed in order to get ready for trial. You overruled my objection.

THE COURT: All right. I'll allow it.

MS. BARDOT: Thank you.

THE COURT: Go ahead.

OPEN COURT

BY MS. BARDOT:

Q Dr. Kay, just give me one moment, please.

A Sure.

Q Is this better for purposes of allowing you to make comparisons?

A Far more accurate, yes.

Q Okay. So we were talking then about the testing that you had done for intelligence I believe; is that accurate?

A True.

Q So get us back on track if you could please.

A Okay. So this -- to get you guys back oriented --

THE CLERK: Is this to be published?

THE COURT: What's that?

THE CLERK: Is this to be published? This one wasn't identified as a --

MS. BARDOT: Yes, just for demonstrative.

THE COURT: Okay.

MR. GLASS: Just to be clear, may I have a

continuing objection to --

THE COURT: Yes. You have a continuing objection to the raw data -- to him referring to the raw data. That's my understanding.

MR. GLASS: Yes, sir.

THE COURT: Okay.

MR. GLASS: I'm not sure exactly what he's going to do with it, but to the extent he's critical of the way Dr. Wilken did it, I'm going to have an additional objection on that.

THE COURT: Okay. Well, we'll get to that.

MR. GLASS: I'll see.

THE COURT: Okay. Go ahead.

BY MS. BARDOT:

Q Go ahead, Dr. Kay.

A Okay. So basically this is the data I obtained from the review of -- when I had -- finally had the raw data from Dr. Wilken I transposed the scores, which you're certainly welcome to go and check every one of my scores on here -- and basically showing the raw score obtained on the test, and then it shows for ease and simplicity the percentile.

The percentile for you guys on the jury would

be your first percentile is like the lowest score let's say of a hundred people.

And then the score at the other end is the guy out of 100 who has the top score of 100 people, and 50 is the average; right? Okay. So that tells you -- again, you're looking for high scores there.

And when we look here, the -- if we actually start not at the very bottom, because that's just a measure of word reading, but above that, we start off with at the bottom of that whole column full scale IQ -- you all hear about IQ scores -- those are very normal kind of scores, 105, 110. He got 110 at May 9th and 105 on February 10th.

His working memory, which is his ability to concentrate -- and I'm showing -- actually I'll put it on here. So this right here (indicating), it's working memory, 108. This is his performance with Dr. Wilken on May 9th, and that's at the 70th percentile for his age.

You can see that it wasn't as high when he was tested back in February of 2016. And that is something which we definitely focus on.

Let me erase. It says erase. I can erase it. You have to touch the corner on the screen.

THE COURT: Do you want to get rid of that circle? Is that what you're trying to do?

THE WITNESS: Yes. Okay. I was trying to show you that score.

The other score very important in measuring somebody with a head injury would be how quickly they're responding to things, how quickly they're processing information. That's referred to as processing speed. So you see that measure here, processing speed.

And when he was first tested on that, he had a score back in 2016 at the 70th percentile. He was complaining of being very slow. But in fact, only 30 percent of people his age could do better than him.

When he came back and saw Dr. Wilken the second time in 2017, his score dropped to the 30th percentile, so he had this dramatic decline in performance from 2016 to 2017.

When he was given the exact same test by myself, you'll see here he went to the 95th percentile. So at this point when I saw him only five percent of people his age could do as well as he could do with respect to speed of processing information.

Q In your opinion, is that which you just

outlined consistent with what you would expect to see in a traumatic brain injury -- in a mild traumatic brain injury?

A No.

Q And can you explain why not.

A Well, processing speed, people feel -- well, actually with kind of more of a moderate TBI at maybe six, eight months like this, if this was a moderate TBI, maybe I would see a decline at eight months, more like what he showed in 2017, so the person would be below average.

But then you would expect that they would get better over time, so maybe that 70th percentile -- these are like in the wrong order. They just don't make sense like this. You don't get worse as a result of your traumatic brain injury, and a very mild TBI would not produce an insignificant deficit.

So you can see actually at eight months injury he's fine. He's 70th percentile. There's no deficiency.

The only time he shows a deficiency is in 2017, and in fact in 2018 in spite of that interview and describing to me how impaired he is, we see that he's actually at the 95th percentile.

Q Now, is there any particular test related to

general intelligence that you can show on this chart which is particularly sensitive to measuring traumatic brain injury and the ongoing effects of it?

A That's kind of a funny question, because actually general intelligence is not sensitive to traumatic brain injury. We've published that since the 1960's. We've known that actually more specific tests are needed to evaluate changes in brain function, that just relying on IQ was not very good.

And so in fact we did much better by using measures which we later discovered to be sensitive to the severity of injury and to recovery from injury. But your general IQ is not.

Q Then you looked at attention, and in particular processing speed; is that correct?

A Yes. So the measures that are -- again, from this, from the WAIS, the measures which are most sensitive to recovery in a TBI would be processing speed like we talked about and the working memory.

Q Tell us what you found with respect to working memory and what conclusions you drew as a result of what you observed.

A Well, you can see that his scores with Dr.

Wilken were completely normal on the working memory. That's your ability to hold information in your mind temporarily.

And specifically, the sub-tests that go into this working memory are -- you see a sub-test on here called arithmetic I'm going to circle now. Okay? And his scores on that were very excellent. This is actually holding information in your mind.

He doesn't get to see the math problems. He doesn't get to use a calculator. You know, you read a problem to him. If I have 35 toys and seven children, how many does each child get? Okay? You do it in your head. Mental arithmetic.

And so you have to actually hold the information and do an operation on it in your head, no paper.

So that's considered working memory, and his score at the first evaluation of Dr. Wilken, 75th percentile. The second evaluation, 95.

So he listens. He holds the information in his head. He processes the information and then he gives his answer within a certain amount of time.

Q Do you have an opinion as to whether that is

consistent with ongoing sequelae of a traumatic brain injury?

A Well, there would be -- it would be consistent with having normal working memory and actually very good working memory -- auditory working memory, except we look and we see something which is odd up here -- one which is certainly odd -- which is his ability just to repeat digits.

Q Can you explain what that test is, how it's done?

A Very simple. So if I say to you, "Listen to these numbers and when I stop repeat them back to me: three, five, seven." You would say, "Three, five, seven."

So with that, you're not doing any operation on it at all. You're not changing it around or converting it. You're just repeating it back.

Psychologists who have studied this refer to it as span of apprehension. It's not even sensitive. Intellectually deficient people often can still do it. It doesn't really -- it's just the ability to repeat something back. You don't do any operation.

And typically most of have the ability to repeat back seven digits, plus or minus two. It's a good

thing our phone numbers were seven digits at one time. All right.

He was only able to repeat back five digits, and he repeated five digits at both the 2016 and 2017 exam. With me he got up to six, which is more normal. Twenty-five percent of people can do at least that much, but not a great score.

So on this just repeating things back, he was a bit weak, and he had been even weaker when tested by Dr. Wilken.

Q You said that was unusual. What opinion did you draw with regard to why that was unusual?

A Well, I would say that the digit span part doesn't get me particularly excited. The digits backward, though, getting only four, that is more unusual. So he was able to repeat, you know, just four digits backward, and that is working memory. Yet his working memory -- it's inconsistent with the arithmetic score.

So we have two scores that kind of don't -- which are highly correlated. Normally people who score well in one score well in the other, so the scores move together.

And here we get this separation that doesn't

really make sense. That's what I'm pointing out as being odd.

With me he still had trouble with it, only got to five digits backward. He was just able to repeat five digits in reverse order.

Q Did that lead you to draw any conclusions as to what that was consistent with?

A Just some oddity of attention is what I took it to be, that obviously he has the capability of holding numbers in his head and even doing operations on it, which are far more, you know, demanding than simply repeating the numbers forward or backward.

Q You've also on this chart under 5/9/2017 highlighted the symbol search in the coding.

Can you tell me what significance, if any, you drew with respect to the testing over time --

A Sure.

Q -- on those two measures?

A So processing speed, which you saw was very good, is based on performance on symbol search and coding. Okay?

Symbol search, you basically look at symbols, two symbols, and then you have a line of symbols and you

basically mark whether the two on the left are represented by the ground on the right, so it's just a cancellation test, just a visual perceptional speed. Do as many as you can for two minutes.

So he got 34 of them correct when he was tested in 2016. But he dropped down, only getting 24, in the same time interval tested by Dr. Wilken, when tested in 2017.

So there was a decline from the 75th percentile to the 25th percentile. That's a huge drop, you know, suggesting there is something very different about him when he's tested in 2017, that there's a decline in his speed of processing.

The same thing held for coding, which is a test where you're just doing -- you've got these nine number and symbol pairs, and then below you just have numbers; you have to copy into a blank underneath the number the corresponding symbol.

You do as many as you can for two minutes, and he got 65 in 2016 and he only got 56 when retested in 2017. But --

Q Did you reach a conclusion or an opinion to a reasonable degree of certainty in your field what the

declines in the symbol search and the coding were consistent with?

A Well, it's not consistent with recovery from traumatic brain injury. There's something else going on is the answer that you get. When you look at data like this, very clearly you look for an explanation. This is not TBI.

Q Why do you say that?

A Well, in TBI you either would stay the same if you're not recovering further, or you would get better. You wouldn't decline this significantly. It's beyond the variability that people have just from day to day.

Q Is there anything else on this chart that was significant in drawing your conclusions, or have we pretty much covered that page?

A We've pretty much covered that page.

Q All right. I'll show you the second page.

A Let me clear this.

Q This has -- let me see if I can get it all on there. There we go.

A Sure.

Q This has attention, memory. Those are two areas you test as well; correct?

A Correct.

Q Walk us through on the attention section what you did, what you found, what conclusions you drew.

A So the first test listed under attention is called the trail making test. You may have seen this or heard of it. It basically is a test where you just draw a line, like the kids' dot-to-dot where they make pictures; 1 to 2, to 3, to 4, to 5, 6. You're looking around the page for the next number.

So it's visual scanning, searching, speed.

He does the test in 30 seconds in 2016, which is smack dab middle average range. He takes 49 seconds to do the same test when he repeats it in 2016. That drops him to the third percentile, and that's a huge drop in performance.

Q That's simply drawing a line from 1 to 2, to 25?

A Yes.

Q Okay. Then when you saw him, how did he do on that?

A So think about it, it's taking about two seconds for a number that he's connecting 1, to find 2, to find 3.

When I did it, he did it in 25 seconds, so like one second per connection, which is fine.

Q Was that subsection of the test, the Trails A, in your opinion consistent with what you would see if somebody was suffering the sequelae of a mild traumatic brain injury?

A No.

Q Would that be for the same reasons you indicated earlier?

A Yeah. I mean it certainly could have been somebody with a TBI, a mild TBI, because look. He's normal in 2016. It might be somebody who had some other thing happen to them between 2016 and 2017, but -- like another TBI or something else happened to them.

But that's -- it wouldn't be due to the original TBI.

Q You're not aware of any second TBI with respect -- second alleged TBI with respect to Mr. PLAINTIFF?

A No. He told me he had only had one head injury.

Q What is the -- do you call it PASAT?

A So this is a test that I usually wait until the end of the day, because people get really upset with

this and cry. It's called the Paced Auditory Serial Addition Test.

And this is a test where Mr. PLAINTIFF listened to a recording, and basically it's a man's voice, and all you hear on it are numbers one through nine with a space between the numbers. So you hear 3, 7, 5, like that. That's what it sounds like.

And what your job is is to add the number you just heard to the one that came before it and say what the total is. So if you hear 3, 7, you would say 10.

Q So let me just try --

A It's adding what you heard. Yes.

Q Doctor, let me try this with you. So let me do this. So it would be like this. You do it.

A Okay.

Q 3, 7.

A 10.

Q 5.

A 12.

Q 4.

A 9

Q 3.

A 7.

Q 8.

A 11.

Q 9.

A 17.

Q For how long do you do that test?

A So there are 49 pairs of numbers. So it's hard, if you think about it, because you're distracted by the number you say, but you're -- I don't know if I got them all right there. I might have gotten them wrong. Who knows? You guys tell me.

But the fact is, it's a very challenging test. It's one that we use -- it actually is one that was developed specifically by a woman named Gronwall in Australia to evaluate people's recovery from traumatic brain injury, because it could measure residual effects.

Like the person pretty much had recovered, but if you give them this test, you could still show that their brain wasn't totally back yet.

Q How did --

A So it's a great test. What?

Q How did he do on this?

A He did fantastic. He got the 45th percentile on series one, which is there is more time between the

numbers. Series two there is less time between the numbers.

With pilots if you read -- were to read our protocol for evaluating concussion --

MR. GLASS: Objection to pilots.

THE COURT: Sustained.

BY MS. BARDOT:

Q Let's try to stick --

A Okay. Well, in evaluating concussion recovery we only require series one and two, because that's considered adequate. And what we see is his performance was completely average in the two times that he was tested by Dr. Wilken.

So he's not showing any deficiency in his performance on the two series that we give for measuring concussion recovery.

Q What is the Conners CPT?

A So that's a measure of visual vigilance. So if you want to know -- it's often given in evaluations for ADHD because it is sensitive to ADHD and the treatment of ADHD with stimulant medication.

So it's a very long test. It's the most -- it's the longest test that he took. Actually on the

screen numbers -- rather, letters appear, ones about this big (indicating), one at a time, you know, A through Z. And his whole task is just to hit the space bar whenever he sees a letter presented, except if the letter is "X." He's not to hit the letter "X."

So you're supposed to hit every letter as quickly as you can, and we measure how quickly you hit, but don't hit the letter "X."

So omissions, referring to if you miss hitting one of the letters, which you shouldn't if you're not falling asleep. Commissions is hitting the X's that you've been told not to hit.

And he hits more X's than 26 percent of people on the first testing; more X's than 83 percent of the people on the second time. So that's a little bit -- 87 percent of the people -- that's a little bit telling.

But, you know, he has a diagnosis of ADHD, but he's on a medication that particularly helps with this test. So he did pretty well. It might be the medication that's helping him.

There's two interesting things here, is that over the course of the test or the duration of the test, that 20 minutes, he became less consistent, more variable

in his response time as the test went on, because he was starting to get tired, and he did so more than 86 percent of people.

The other thing is that when the time between the letters varied, he had trouble kind of keeping up with them. He became more variable with the time differences between letters.

And that can refer -- relate to having this ability to stay alert, at the same, maintaining your level of alertness, which you're all struggling to do.

So maintaining your level of alertness basically he was, you know, worse than 97 percent of people.

Q To what did you attribute those findings?

A They're completely classic of ADHD, which he has a diagnosis of.

Q Then other memory, what are you doing there? What are you finding?

A So under memory on this page what we're looking at is his ability to learn a list of words. So basically you read to him a list of words and you say, "Mr. PLAINTIFF, listen to this list," and you read the list. "Repeat it back to me in any order as many words as you

can."

And so the list that Dr. Wilken had administered at his office in 2016, a 16 word list, CBLT, I didn't get the printout so I couldn't see all the scores, but he said that by Trial 5, by the fifth trial, Mr. PLAINTIFF remembered 14 of the 16 words. That's very good. It's the 84th percentile. Only 16 percent of people his age and years of education will do that well. That's a pretty impressive ability to learn.

Across the five trials in 2016, you add up the total number of words he recalled, he's at the 88th percentile. Only 12 percent of people are able to do as well as him for his age and years of education.

So his ability to learn unstructured, as Dr. Wilken referred to it -- unstructured verbal information is pretty exceptional.

And then when we're looking at -- after the trials 1 through 5 it says interference. That's evil psychologists. After we teach you this list of words, we say, "Now I have a second list of words for you, Mr. PLAINTIFF and when I stop, just tell me the words from the second list." He's heard the first list five times.

"So don't tell me the items on the first list,

just the second list," and he got seven correct. Now, that would be a measure to look for frontal, you know, dysfunction potentially, and he didn't show any decline relative to his initial trial, so he didn't have proactive interference.

And then we look at short delay. So immediately after that new list, we say, "Mr. PLAINTIFF, what were the words on the original list? Can you tell those to me now?"

He gets nine of those words right back in 2016. He actually gets 15 of them right in 2017. That's only two percent of people are going to be able to do that. That's pretty darn impressive; okay? It must help, him training to be a lawyer. All right.

And then delayed recall. He gets 11, which is above average; 68th percentile in 2016; 14 out of 16 when he's tested in 2017.

So with Dr. Wilken's testing of verbal learning and memory, this guy is pretty extraordinary. He is far above average.

Q Let me go to the next page and try to get through this.

A Sure. So -- and I saw the same result.

Basically he had nearly the same percentile.

I gave a totally different word list, called the Rey Auditory Verbal Learning Test, which is 15 words. It's actually harder, because the list that Dr. Wilken gave Mr. PLAINTIFF is a little easier; it actually has groups of items. Some items are furniture items. Some might be animals. Some might be vegetables. Some are spices. Okay?

So if you remember in your head, oh, yeah, there are tools, "Oh, yeah. There is a wrench and a chisel and," so it's a little bit easier.

With the one I give, there are 15 unrelated words, and he actually did perfectly fine and got really the same scores.

Q What's the Heaton Story Learning and what were the outcomes of that testing?

A Oh. The Heaton Story is a long story that you tell him. It's about a paragraph long. You read it to him and you ask him to repeat the story back to you, to tell it in the same way that you told it, and then you give him points for the different content that he can recall immediately.

Now, you would actually -- for most people,

like my person I tested yesterday, you would repeat the story several times until they get at least 15 of the content items. So you might tell them the story three times or four times and then they finally hit the criteria. That's not unusual.

He got 16 on the very first telling of the story. So it's very unusual and Dr. Wilken commented on this, he got 16. He didn't get to hear the story a second or third time. So that kind of made it hard to -- because you don't then test the delayed recall for hours later.

Q How would you characterize that?

A So that's story learning and story memory. He showed amazing auditory working memory. If I tell you a paragraph length story and you can tell me 16 items from that story, you've got a good auditory working memory.

Q So let's fast forward down to Brief Visuospatial Memory Test Revised.

What is that?

A So this is a test where I show him a card with six designs on the card. So I'm going to hold this card right here in front of you for 10 seconds, study this card.

Then when I take it away, I want you to

reproduce all of the designs and put them where they were initially on the card. You're going to be a human Xerox machine. We take it away.

So we do that three times so we can measure his ability to learn this non-verbal -- there are no words here; just non-verbal information, and so -- because he had problems remembering locations, and things like that.

His scores were extraordinary. He scored at the 99th percentile on Trial 1 the first time I showed him the card. You can get a possible 12 points. He got 10. He got 11 on Trials 2 and 3, which is 92nd and 87th percentile. His overall total recall is the 96th percentile.

Thirty minutes later -- or 25 minutes later, I would say to him -- you know, put this piece of paper in front of him and say, "Remember those designs that you drew for me previously; draw them again." And he scored at the 86th percentile, very impressive.

Q So what does that you?

A That he's got -- not only does he have good verbal memory, he's got a really good visuospatial memory.

Q Go to Page 4, which carries on memory.

What am I looking at here? What's

significant?

A All right. So there's some more scores from the memory tests, and then I gave him a test where he actually was blindfolded and he has blocks in front of him.

Q Which test are you referring to?

A The Tactual Performance Test.

Q Okay.

A After he was actually blindfolded, puts the blocks onto the board three times without my ever telling him to memorize it, I put a piece of paper in front of him, and said, "Mr. PLAINTIFF, draw for me all of the shapes you can recall and put them where they were relative to each other on that board" that he never saw -- I mean never has seen to this day.

So he did good at remembering the location -- actually correctly located six objects. He didn't really make a shot at the other, you know, four. So his total objects recalled is weak, but his location score was really good. So he actually knew the correct location of all six that he had recalled. That's kind of an unusual way to do it.

I gave him one other memory test which looks

at not your ability to learn and retain, but -- and this is because of his complaints -- not only to be sensitive to his complaints, but something that Dr. Wilken had not tested that I would have tested if he would have seen me as a clinical patient, and that is his prospective memory, his ability to remember what he is planning to do. And --

Q Is that what this missed is?

A Yes, the missed is. So his overall score on that was weak, and he remembered all of the tasks when I said later on, "What were you supposed to do when I did X?" or, you know, would ask him questions about it, he got all of those right.

But in terms of properly doing the task, he would get to where he would look at the little clock that we have and said, "You know, Dr. Kay, I'm supposed to do something in 10 minutes. I can't remember what I'm supposed to do. I remember you told me to do something when it got off to 10; I just can't remember what it is."

When there were events that occurred he did better, but looking at the clock and remembering what he was supposed to do when the clock turned 10, he didn't do well. And that --

Q What --

A -- was consistent. That's one thing that was very consistent with his report, is kind of forgetting to do what he planned on doing.

Q Did you draw a conclusion to a reasonable degree of certainty in your field as to what that was consistent with?

A Yeah. That's -- in the absence of any deficit of learning and memory, which we've shown, the kind of forgetting to do those things that he's supposed to do, where he'd recognize, "Oh, yeah, that's what I was supposed to do," and in the absence of frontal lobe dysfunction, which we will talk about in a moment, it really suggests to me that he is preoccupied.

He -- it's really much more on a psychiatric basis that he just -- he's got other things on his mind that are upsetting him, that are bothering him, and he's like, "Oh, yeah, I was supposed to do that."

Q What about psychomotor; what are we looking at there?

A Well, I have one other thing. And the other thing that occurred to me was, you know, ADHD patients, one of the most common symptoms -- and I think the Plaintiff actually gave out the ADHD RS as an exhibit --

it's an Attention Deficit Hyperactivity sort of scale of symptoms -- one of the most common symptoms of adult ADHD is forgetfulness.

I'm sorry. Go ahead.

Q No. Go ahead. So what is the psychomotor?

A So that was measuring his finger tapping speed. He just goes like this (indicating) as fast as he can, basically clicking on a Morris Code key that's connected to a little counter and we see how many times he can click in periods of 10 seconds and we take his average across five trials, and he was slow -- a little slow on that, 44 when you would expect to get 50 or more.

So he's not that far off, but it was slower. I didn't see any of the neurologists or anybody reporting noticing any kind of either weakness or slowness in his motor function before, but I saw this slowing. I'm not sure what it's due to.

Q Okay. And how about language? What are you doing there? What are your findings?

A So on language I'm measuring his ability to sequence letters from like -- we heard -- talked about before the 1 to 2, to 3, to 4. I developed a version of the test where you go from A to B, to C, to D, and you

look -- and normal healthy people who don't have reading problems or language problems or left hemisphere stroke, their score on that would be the same as their score basically on the number sequencing, and he did it. He got about the same score. So there was no problem there.

But he did -- it's very good speed. He demonstrated good psychomotor speed.

The other test I gave him was a test where we say, "I want you, Mr. PLAINTIFF, to generate as many words as you can think of beginning with the letter" and then we tell him a letter, like it could be D, and he'll go, "dog, donkey."

You know, he's not allowed to use capitalized words like Delaware or David, people's names, but we would see how many words he can generate in a minute.

Now, Dr. Wilken had given that test in 2016 and 2017. For three letters, and you count up the total for the three letters, he got nearly the same score every time he was tested. He got 29 words in 2016, 27 words in 2017, and 28 words, which was basic -- or yeah -- 28 words with me using different letters, you know, so we don't give them the same letters each time.

So he got about the same score ever time.

Q What's the Boston Naming?

A Boston Naming is a test where we show him pictures of common objects and say, "What do you call this?" So it's his ability to name objects, pictures of objects.

And his scores on that completely -- well, actually his score on that was better in 2016 than in 2017, but he only couldn't name three objects in 2017, not a big deal for me.

Q Okay.

A Just you don't expect somebody to have more trouble, to do that from a head injury.

Q Okay. Let's try to move this along.

A Sure. So the spatial basically refers to nonverbal problem solving. Like I would show him the picture of -- like let's say it was -- I'll mention a real item -- it was like a cane. But it's like -- it's broken up into pieces and scattered onto a card.

Now, if you look at that, if you put those together, what would it make, what could you organize these items to -- what would it create if they were put together. So it's visual, it's perceptual organization. He did fine on that.

Q How many --

A Yes.

Q Go ahead. The executive, what are you measuring with executive testing?

A So what we're measuring with executive is planning, organization, prioritization, his ability to deal with novelty, his ability to do deductive reasoning and problem solving. He did great. I mean we're looking at mental flexibility with Trail B, 91st percentile.

With the Category Test, he actually -- that is extraordinary, only 21 errors. So his ability to reason and use deductive reasoning to solve problems -- good for a lawyer again -- but he did very well on that.

With a test he had obviously never seen and still hasn't seen where he's blindfolded and he has this task to put these blocks of different shapes into like a child's shape sorter using one hand at a time, his scores were fine -- a totally novel task -- a very sensitive task to brain dysfunction.

Q Did you find that these results were consistent or inconsistent with any claim of cognitive impairment due to a brain injury?

A They are surprisingly normal for a man who

presented himself with having such severe problems with memory that he experiences, disorientation that he experiences, slowness that he reports, yet he is fast, his memory is sharp, his attention -- he's got some difficulties with attention, but he is in good shape.

Q With regard to the declines that you see in Dr. Wilken's testing, you had mentioned at the outset that he had regiven a test that he should not have regiven.

Is this that test?

A No. The Wisconsin Card Sort Test, of which I am an author of the manual -- is a test, if you read our manual, we say it's kind of like a joke where if you hear the punch line, the first time it's kind of funny, but to hear it again, it's not so funny. It doesn't really work to repeat it. That's the Wisconsin Card Sort Test.

I wish we could give it repeatedly. It's a nice test, you know, and I'm proud of my work on it. But you don't really give the test a second time because once somebody has done it, they know the rule.

And so he gave it to him a second time, and --

MR. GLASS: Objection.

THE WITNESS: -- what you see on it is he actually did worse --

MR. GLASS: Objection.

THE COURT: Hold on. Hold on.

MR. GLASS: This is what we talked about yesterday. Now he's nitpicking at the way Dr. Wilken did the report. I was stopped yesterday from asking about that. Ms. Bardot had an objection that there is some case out there that says you can't do that.

THE COURT: Okay.

MS. BARDOT: He's interpreting the scores that are within the report that Dr. Wilken testified about.

THE COURT: The objection is sustained. Move on.

MS. BARDOT: We'll move on.

BY MS. BARDOT:

Q When you looked at -- did you also do a Halstead Impairment Index?

A I did. So one of the most sensitive indexes going back 50 years in neuropsychology to identifying brain dysfunction or non-brain dysfunction is called the Halstead Impairment Index where you take individual scores that have been identified as being especially sensitive to the presence of brain dysfunction, and what group of scores maximally separates the healthy from the brain

impaired, and that's the Halstead Impairment Index.

Using those seven scores, Mr. PLAINTIFF actually scored in the normal range. He does not show evidence of brain dysfunction, which is completely incompatible again with his presentation with his complaints. You did an MMPI II?

A I did.

Q What is that?

A So the MMPI II is a personality inventory, 567 questions, true/false questions, and you basically answer each statement -- you read a one sentence statement, you decide if that statement is true or false as it applies to you. And these would be weird questions like, "I like Mechanics Magazine," true or false. Why are they asking that?

And then you answer all these questions and it compares you on a scale basis with people with depression, with anxiety, schizophrenia, mania, various conditions, and so you're not really focused on the individual items, but on the scales and severity within those scales.

Q What did you find a conclusion to be from the MMPI II that was given to Mr. PLAINTIFF?

A Well, he shows a very distinct personality

profile. He was honest and consistent in his responses, but he presented -- the profile with Scale III, which measures basically somebody who is in a great deal of repression and denial, who rejects psychological interpretation, prefers that, "My problems must be medical, there must be a medical thing going on here," and -- but they'll deny that -- their depression even if you're seeing all kinds of evidence of depression, and they're trying to -- their anxiety will be converted into physical symptoms.

So that's how they will express. You know, people can express their depression by feeling sad, being tearful, or they could express their depression by, "I'm in pain, you know, my body isn't working, I can't think."

People who are depressed who basically say, "I've lost confidence in my mental abilities," very common, yet in fact when you test them, they actually do well. So, you know, that's a very common, you know, thing.

So this profile, a 3-1-2 profile, the hysteria scale is way up and there's basically -- the depression scale is not as high as we see for the, you know, -- because it's really helping to control by his repression

and his denial are -- so he's basically dealing with stress and unhappiness and whatever's going on, which could be work or marital or whatever -- we don't know -- but instead of dealing with that directly, it's dealt with indirectly by development of physical symptoms and complaints.

Q So then in conclusion, once you looked at all the test results, you looked at Dr. Wilken in February of 2016, Dr. Wilken in May of 2017, you had the benefit of looking at all the medical records and the depositions, and doing your own testing and evaluation, what conclusion did you reach to a reasonable degree of certainty in your field as to whether or not Mr. PLAINTIFF suffers from any cognitive deficits from a mild traumatic brain injury which can be related to the accident of June 2015?

A I came to the conclusion that Mr. PLAINTIFF does not have cognitive deficits which can be attributed to the minor head injury that he suffered in, you know, twenty --what was it? -- in 2015.

Q Right.

And did you come to a conclusion as to what you would attribute the self-reported deficits to?

A Well, a combination of personality factors,

but also these are problems that he had reported for 18 years, problems with memory, problems with fatigue, problems with attention. These are all preexisting problems.

And the other explanations are his obstructive sleep apnea and the extent to which his thyroid is under control and the extent to which his diabetes, and add that to the effects of aging, because aging doesn't help any of us with cognition, but it is more accelerated when you have these other health conditions.

Q And this was a conclusion that you reached on your own without having reviewed any reports by Dr. Tuwiner or Dr. Miller, my other experts; correct?

A That's correct.

Q You have not ever seen those, have you?

A Pardon?

Q You've never seen those reports, have you?

A I don't think you provided those.

Q Based on the testing results that you have regarding Mr. PLAINTIFF, do you have an opinion within a reasonable degree of certainty in your field regarding whether he is capable of working full time as an attorney?

A From the best of what I can tell, he certainly

has the mental abilities to perform as an attorney.

Q That's all I have. Thank you.

THE COURT: Okay. We're going to take our recess. We'll resume at 2:00 p.m.

* * * * *

(Whereupon, at approximately 1:02 o'clock p.m., the jury retired from the courtroom, and the hearing in the above-entitled matter was recessed for a luncheon recess, to resume at approximately 2:00 o'clock p.m., that same day.)

* * * * *

CERTIFICATE OF REPORTER

I, ROBERTA F. KERNS, a Certified Verbatim Reporter, do hereby certify that Melissa Alberts, a Verbatim Reporter, took the stenographic notes of Pages 1 through 148 of the foregoing proceedings, which I thereafter reduced to typewriting; that the foregoing is a true record of said proceedings; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were held; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

_____

Roberta F. Kerns, CVR
Certified Verbatim Reporter

A F T E R N O O N S E S S I O N

(The Court reconvened at approximately 2:12 o'clock p.m.)

MS. BARDOT: I just had Dr. Kay get back up on the stand.

THE COURT: I'm sorry?

MS. BARDOT: I just had Dr. Kay step back up there. I'm sorry.

THE COURT: That's where I want him.

MS. BARDOT: I'm trying to move things along. Thank you.

(Whereupon, at approximately 2:13 o'clock p.m., the jury reentered the courtroom, and resumed their seats in the jury box.)

Whereupon

GARY KAY, M.D.

a witness, was re-called for further examination by counsel on behalf of the Plaintiff, and having been duly previously sworn by the Clerk of the Court, was examined and testified further, as follows:

CROSS EXAMINATION

BY MR. GLASS:

Q Good afternoon, Dr. Kay. As I was sitting

here listening to you testify before the lunch break, it struck me that it sounds like you characterize Mr. PLAINTIFF as having really a superlative memory.

A A very strong memory.

Q A very -- like just an amazingly awesome memory for a guy his age; right?

A Well above average.

Q Okay. Any significant memory deficits at all you found in your testing?

A Well, the prospective -- we call it prospective memory, but I tried to explain that in the absence of any memory deficit that the inability to kind of follow through on planned events to do, things to do, at certain times, or when an event occurs could be due to other factors: attentional factors, executive function factors.

But it didn't seem to be due to him having a deficit in his recall.

Q And that's I think is the Missed Test?

A Missed.

Q What am I going to do, what am I supposed to do 10 minutes from now.

A Yes.

Q We'll come back and talk about that.

A Sure.

Q So whenever we read in the medical records, the 20 year history of medical records about complaints of memory loss, whatever that was, isn't significant enough to have shown up in your testing; correct?

A Right. We did not see any evidence -- and going back to the 2016 exam, the 2017, and 2018.

Q Well, to be clear I'm talking about the records you reference that date back 20 years --

A Sure.

Q -- you were asked about in direct examination where there are complaints of memory loss, they were not significant, were they?

A There was some testing from that time, so we don't know what his performance was in memory testing at that time, but his performance in memory testing beginning in 2016 looked good.

Q Well, we know that he kept working --

A That's correct.

Q -- right up until five months after the accident; right?

A That's correct.

Q He told you he was a workaholic; correct?
A That's correct.
Q He loved his job; right?
A I don't know if he said he loved his job, but he used the term workaholic.
Q Did you see anything at all in your examination of him, your questioning, anything about the records that suggest that he didn't like what he did for a living?
A I heard nothing along those lines.
Q Now, in terms of the obstructive sleep apnea, again a long history of that.
A Yes.
Q But no cognitive damage reflected in your testing from obstructive sleep apnea; right?
A Well, it may be mitigated by the use of the Vyvanse that he takes. That would certainly be something which could help. So -- but we --
Q Absolutely, absolutely. So certainly no permanent brain injury from a long history of severe obstructive sleep apnea; right?
A Well, we don't know how he would look on testing if he was fully treated and successful in

treatment of the sleep apnea. We don't have those scores.

Q But your testing with his sleep apnea shows he's got awesome memory.

A He did very well, yes.

Q I think right at the end of the examination before we went to lunch, you were asked a question about, you know, does he have any cognitive deficits, and your answer was, your view is he has no cognitive deficits resulting from his minor head injury; is that right?

A That's right.

Q Did I hear that correctly?

A You did.

Q So you agree that he had a head injury in this accident?

A I think the way I expressed it was that at worst he had a minor head injury based on the self-report data, based on the hospital records, and everything I reviewed, yes.

Q And you would disagree with anyone who came in here and said, "The only injury he sustained in the accident was a chest wall injury from the seat belt."

A Well, based on his self report, you know, he basically made a claim of an alteration in his level of

consciousness, which would suggest to me that he may in fact have sustained a concussion.

Q We'll come back and talk about that in a few minutes.

A Sure.

Q Now, you said that -- I think you said like doing the forensics, it's lucrative, more lucrative than the government work; right?

A You bet.

Q And I guess your clinical practice is somewhere it sounded like between 30 and 35 percent of your professional life; right?

I know you have this other business involved with the CogScreen.

A Well, that's separate. The Cognitive Research Corporation is the company that I have in Florida that does clinical drug research trials. CogScreen is a separate thing that publishes tests.

Q I'm sorry; you have two different things.

A Two different things.

Q The CogScreen is the thing for the pilots; right?

A That's -- well, it's used for pilots. It's

also used in clinical drug trials.

Q But somewhere between 30 and 35 percent of your time is seeing real people and doing testing; right?

A Or reviewing records. I get a lot of --

Q Sure.

A -- records that are sent to me, and I also get test results from treatment facilities around the country asking me to evaluate the data from those evaluations.

Q Okay. So in terms of forensic work, which is the work not from your patients -- I mean you have patients. You have --

A Pilots.

Q You have pilots, okay, sent to you by the FAA?

A No. They're sent to me -- they come on their own, they're sent by aviation medical examiners, they're sent by airlines.

Q Do you have like any -- not to be derogatory towards pilots -- but real people, like people who call you up and say, "I'd like a clinical exam"?

A I do. Every year there's a couple, not too many, because I certainly don't market myself for clinical practice, I don't accept insurance, and I don't have a back office.

Mr. PLAINTIFF saw a very small little operation in my clinical practice. So I don't really -- I used to at one time have a big clinical practice certainly at Georgetown. But at this point, I only see a couple a year -- patients with Parkinson's or somebody who begs me to see a demented relative.

Q Sure. So like the local neurologists in Washington and Northern Virginia, they don't send you patients like Dr. Kayloe sent Mr. PLAINTIFF to Dr. Wilken for evaluation?

A Yeah. I think most of them -- actually no. I get a couple a year from -- one neurologist still does send a couple, so I can't say it's absolute. But most of the neurologists that I worked with at Georgetown all think I'm in Florida, which is my primary residence.

Q Oh, Florida?

A Yeah.

Q That's why you don't have a license in Virginia?

A Pardon? No, I don't have a Virginia license.

Q How much do you make from this forensic work each year? You must have some idea.

MS. BARDOT: Your Honor, I'm going to object.

May I approach?

THE COURT: Yes.

BENCH CONFERENCE

MS. BARDOT: I filed a motion to quash on their subpoena to Dr. Kay asking how much he makes a year in forensic work.

That motion was granted, and they were not provided that information as a result of that motion being granted. So I don't think they can do a background against that in the course of this trial.

THE COURT: Well, the way I understand it, the question that is being posed now is to ascertain what percentage of his income is based on testifying.

MR. GLASS: I asked a dollar amount. I didn't actually ask a percentage.

THE COURT: But you're not asking him specifically now that he's testifying; right?

MR. GLASS: I'm asking how much money he makes each year from forensic work, dollars, $50,000 --

THE COURT: Compared to -- just as a raw number?

MR. GLASS: As a raw number.

THE COURT: Okay.

MS. BARDOT: Which is what the Court has already quashed in the motion.

THE COURT: Did the Court quash the question, or did the Court quash the subpoena for it?

MS. BARDOT: The question and having -- see, what happened was, two things.

There was a subpoena for it and I filed a motion to quash. I'm sorry; I misspoke.

And then there was an interrogatory to my client asking for that very information. The Court sustained my objection to him having to answer that question and told him the only questions he had to answer, which we have, was how much my firm has paid him over a three year period and how much he was paid by State Farm over a three year period, none of which is significant enough with Rohrbaugh.

So what they're now doing is doing an end run of the Court's order saying that my objection to that question was inappropriate and they weren't allowed to have the information.

THE COURT: Right. So I have to base my decision on what is happening in front of me right now, and I deem the question to be relevant. And because I

deem the question to be relevant, I'm going to allow it.

The trial judge always has the authority to make rulings on relevancy as matters arise.

MS. BARDOT: I would just note --

THE COURT: I mean I understand that --

MS. BARDOT: It goes beyond the work law, too, which is --

THE COURT: Let me finish.

MS. BARDOT: I'm sorry. I thought you were.

THE COURT: I interrupted you, so I apologize for that.

But obviously the way our court operates, many judges address matters in pretrial motions as I do regularly on Friday. But when you're actually in trial, the trial judge has to make decisions on relevancy.

And even though the interrogatory was granted, your request in the interrogatory was granted and the interrogatory on the documents was granted, I don't see that that limits the Court from finding this question to be relevant.

MS. BARDOT: It also wouldn't be relevant under Rohrbaugh. Rohrbaugh says that what would be relevant is, how much he gets paid for forensic work doing

work for my client. It's not how much he gets paid for forensic work --

THE COURT: Does that decision that you're referring to say that his overall income in forensic is irrelevant?

MS. BARDOT: It says you have to show a substantial connection between the amount he receives from the client at issue, and they cannot do that as they know from the answers to interrogatories that I have provided, because that's what shows bias.

It would be like me asking their doctors, which I wasn't allowed, "How much work do you -- how much money do you make from doing all plaintiffs work?" It's not relevant. The bias is if he has a bias in favor of my client.

And that's why the Court ruled that way on the interrogatories, because it's consistent with the case law. That's why I wasn't able to get from their experts how much money he makes from doing Plaintiffs work, because it doesn't establish the bias under case law.

THE COURT: So do you believe that that case you're referring to ought to control the Court's decision on this matter?

MS. BARDOT: I think it does control the Court's decision.

THE COURT: Do you have that decision?

MS. BARDOT: This (indicating) is the part I would cite. It's underlined.

THE COURT: That will save me some time.

MS. BARDOT: It's right here. It's also on Page 5. This doesn't line up the same as mine.

THE COURT: So you want to ask how much he gets from forensic work? Does --

MR. GLASS: How much -- I'm sorry. Go ahead.

THE COURT: Hasn't he already addressed what percentage of his practice is forensic work, because I just heard him say that he does almost no clinical work at all?

MS. BARDOT: Correct.

MR. GLASS: He said earlier on direct that half of his clinical work is forensic, and clinical work is 30 percent to 35 percent of his total life, work life.

THE COURT: So tell me the relevance of knowing how much he gets from forensic work as opposed to how much he got from State Farm.

MR. GLASS: So I'm not doing State Farm, and

that's really what this case is about.

If the guy makes $10,000 a year or the guy makes $500,000 per year doing forensic work, I think that's significant. I don't actually know the answer to my question, but I think I'm entitled to cross examine on bias, on experience --

THE COURT: Bias towards Ms. Bardot?

MR. GLASS: No, no, no, no, no.

THE COURT: Or towards insurance companies generally?

MR. GLASS: No. Just that he's a hired gun. He doesn't have patients.

THE COURT: But isn't the issue his percentage of his income is --

MR. GLASS: I think --

THE COURT: I mean can --

MR. GLASS: Go ahead. I'm sorry.

THE COURT: Can't you ask what percentage of his income is based on his forensic work? Let's say he said 90 percent. Let's say that was his answer.

Doesn't that accomplish your purpose? Why does the jury need to know whether that number is $400,000 or $200,000?

MR. GLASS: Because I know jurors are impressed by big numbers whatever the percentage is. That's my answer to you. I can do the percentage. See, I don't -- this --

THE COURT: Okay. I'll let you do the percentage.

MR. GLASS: Okay.

MS. BARDOT: Well, let me -- if I can just make the record. I think if --

THE COURT: Are you objecting to him asking about the --

MS. BARDOT: Yes. I am.

THE COURT: Let me finish.

-- what percentage of his income is forensic work?

MS. BARDOT: Yes. I am. I don't think it's permissible, and I think if you look at --

THE COURT: Hold on a second. I need counsel to hear what she's saying. She can't be talking to me by herself.

MS. BARDOT: I don't think it's permissible, and if you look at the language I cited from Rohrbaugh, it says, "The jurors were entitled to know his interest or

bias in his relation to the party ultimately liable." And it goes on to say, "The relationship between a party and a witness, particularly an expert, is such as to make proof of their financial dealings, sufficiently probative to outweigh prejudice."

So it doesn't allow you to say how much generally do you get from this, how much do you get from insurance carriers, how much do you get from that. You've got to make a connection.

THE COURT: That's different than saying, "What percentage of your income is derived from forensic work?" That question I hear all the time.

MS. BARDOT: All right.

THE COURT: All right. Overruled.

MS. BARDOT: All right. Thank you.

THE COURT: To that extent.

MR. GLASS: To that extent?

THE COURT: To that extent.

OPEN COURT

BY MR. GLASS:

Q All right. Let me ask a better question, a different question.

What percentage of your overall income is from

forensic work?

A Of my what income?

Q What percentage of your overall income in your profession life is from your forensic work?

A So my professional income?

Q What other kind of income is there?

A All right. Like if I made some money from property, things like that.

Q Exactly. Your professional income. Your Ph.D. scientist income.

A I don't know really. I mean I'd have to give you like an estimate.

Q An estimate is good.

A I thought we did something where we came up with a dollar amount.

(Pause.)

THE WITNESS: I would say it's in the nature of about 10 to 12 percent.

BY MR. GLASS:

Q How many cases a year would that be -- forensic cases a year?

A One case last year would have been a third of it.

Q You had one big case?

A Yeah. One big case for the Department of Justice.

Q So in a typical year how many cases -- you answered a different question.

How many cases do you get sent for forensic evaluation, either medical records or people?

A Like reviewing records, doing IME's, or --

Q Correct. Because we know that neurologists except for on rare occasions aren't sending you real patients.

A Well, actually I get real patients that are real pilots --

Q Real pilots.

A -- that are being evaluated for their brain injuries and for their neurologic conditions. You're diminishing --

Q But if --

A You're diminishing my aviation neuropsychology Practice. Thank you.

Total number of cases that get referred -- I mean, I don't necessarily see all the people -- I would say it's on the order of, you know, one to two a month.

Maybe 18 -- 12 to 18 cases in a year get referred.

Q And this isn't the first time that you have been on the other side of a case where one of Dr. Wilken's patients is claiming cognitive injury from an accident or trauma or something, and you've been hired to be the opposing expert; right?

A That's correct.

Q How many times has that happened?

A I have no idea.

Q How do they know to call you?

A I think I'm very well respected as a senior neuropsychologist here in the Washington, D.C., area as the former director of neuropsychology at Georgetown. And I've trained a good portion of the neuropsychologists who are practicing here.

Q I'm sure you're an awesome trainer too.

A A good teacher?

Q A good teacher.

A I hope so.

Q So the folks who've trained under you, they know how to do the testing; right?

A I hope so, yes.

Q The doctors whose records you reviewed -- Dr.

Feola, Abidin, Kayloe, Wilken -- they all got involved in the care and treatment of Mr. PLAINTIFF before any lawyers were involved; right?

A I have no idea.

Q You know that Dr. Feola is his long-time treating physician, primary care physician?

A That's correct. That part I do know.

Q Dr. Abidin was a long-time ENT physician?

A I don't remember the date he started working with him. I think you're right on that. I believe you're correct.

Q Sure. And it was Dr. Feola who referred Mr. PLAINTIFF to Dr. Kayloe?

A I think that may be correct.

Q Dr. Kayloe referred Mr. PLAINTIFF to Dr.

A Wilken?That's right.

Q Do you have any doubt in your mind that Dr. Feola, Dr. Kayloe, and Dr. Wilken were trying to get this man back to being able to work as a lawyer?

A That that was one of their objectives?

Q Yes, sir.

A I would assume. I mean, we'd all hope that, yes.

Q Is there any doubt in your mind that based upon your clinical interviewing and your testing that he wants to be back as a lawyer?

A I believe he believes that.

Q Now, the very first line -- and feel free to look at it -- it's in Page 15 of your report. The very first line of the summary says that, "Based upon the review of records and the current neuropsychological assessment, Mr. PLAINTIFF appears to have possibly sustained at worst a mild concussion in the motor vehicle crash in June 10 of 2015."

What was the evidence for his mild concussion? Was it in your view totally his self report?

A Yes.

Q Self report of what?

A Self report of basically being fuzzy, just basically his description of an alteration in his level of consciousness. He felt and his wife described that he was slowed down.

So it's not, well, his self report. He said that his wife said that he was slowed down.

Q Would you know what his wife observed and told the people in the emergency department?

A I would normally see what's printed in records and then what he told me.

Q So it's not entirely a self report? It's based in part to your knowledge her report.

A His recollection of what she said.

Q Right. I'm sorry. What did you say? His --

A His recollection of what she said.

Q Okay, okay. I understand what you said.

Now, again, your view as I understand it is that there is nothing at all that prevents Barry PLAINTIFF from practicing as a lawyer today?

A Actually, I don't know that I said that. we were talking about cognition.

I think that emotionally he's not in a good spot. And I think that he -- I see his description of the irritability, his lack of joy, his failure to experience things as really serious signs of depression, as well as the -- you know, basically he's lost confidence in his mental abilities. He does not -- you know, he can't trust -- he doesn't trust what, you know, he remembers.

That is very disruptive. You know, who would hire him as their attorney if he was describing himself as having impairments such as he described? He --

Q All right. We'll get to that.

A Okay.

Q And I don't mean to cut you off.

A No. That's fine.

Q And the psychological side, in your view, has nothing whatsoever to do with this car accident and the treatment he got for the car accident; correct?

A I don't see the direct, you know, causal issue there.

Q I'll ask it a slightly different way.

Had he left his parking lot 10 minutes earlier or 10 minutes later that day in June, had the accident not happened, you're of the view that he would not be working today because of his psychological condition; correct?

A I'm sorry. I had trouble following that. If -- I should let you repeat that.

Q If the accident never happened, your view is that because of his -- that his psychological condition would be exactly the same, and he would not be working as a lawyer; correct?

A No. I don't know to what extent this may have triggered, or disrupted, slowed, interfered with his life, and/or the depression kind of kicked in.

Q Exactly. So at least in part, this car accident is a cause of whatever psychological condition you say he has which is preventing him from working as a lawyer today; right?

A There's a relationship between -- we didn't have him being impaired in terms of going to his job and doing all that prior to the crash. So --

Q So in other words, again, had the accident not happened the overwhelming likelihood is that he would still be working as a lawyer?

A We don't know that. I mean, depression can come on in people all the time. Depression is a very common human condition. And this may have been the event that was distressing and caused him to go into that depression.

That depression could have occurred through some other factor in his life as well. I don't know.

And the description of him from before, going back in his records to 2000 and all, where he's describing memory difficulty, concentration difficulties, feeling fatigued, that sounds very much like there was some underlying depression.

Q Which did not stop him from working as a

workaholic, 60 hours a week, on weekends, as a lawyer; correct?

A He was working up to that time, you're correct.

Q And so you wouldn't say that it's just a coincidence that he had the accident and that he is not working as a lawyer?

It's not just pure coincidence, is it?

A No. I didn't say it's a coincidence, no.

Q No. There's a causal effect from that accident, which at least in part in your view is, plays a role in his not being able to work today.

A There is a time line change there, so we would follow his time line. Up to the point of the crash, as you said, he's working. After that point we see a big change in his functioning.

Q And there's nothing else in his life that you know about around that time that would have caused and kicked off a depression which you say prevents him from working today.

A I mean, one thing I noticed was that in like March of that year, he had ceased taking a salary. So there were obviously some financial issues going on.

And so I'm not familiar with every other factor in his life. He didn't present to me, and I don't know of any other factors -- I don't even know -- I'm not certain of that factor. I'm not trying to say I do. But if we knew more we might be able to find that there's some other explanation.

Q Sure. And that's the important point here in court, which is you can't point to anything else, say with any degree of certainty that this other factor kicked off the depression you're saying he has that prevents him from being a lawyer?

THE COURT: I did not understand the question. I did not understand that last question.

MR. GLASS: I'm sorry. Short-term memory.

BY MR. GLASS:

Q I think the question, and that's my point, that you can't point to anything else in this record, in this man's life that was going on around the time of the accident or several months later which kicked off the depression which you say prevents him from being a lawyer today.

A Not that I know of, you're right.

Q Dr. Kay, you went down a long list of things

that Mr. PLAINTIFF told you either he couldn't do or he had difficulty with, and I think you said -- and we'll go through them, but I think you said, "If these things are real symptoms, he has a serious brain injury."

Do you remember that discussion?

A Yes, sir.

Q So things like -- one of the things he complained to you about was he watches a movie and can't remember that he's seen it before, would be a sign of a serious brain injury; right?

A Well, of a memory problem potentially, yes.

Q Okay. Now --

A We all -- we all have experiences of "Oh, did I watch this TV show before?" But if this is a constant theme, then yes that becomes a --

Q And certainly if we have a list two pages long of these types of complaints, it's not just a, you know a brain fart -- right? -- a momentary laps of concentration; right?

A Correct.

Q It's a serious brain injury.

A That would be a serious brain dysfunction, whether injury or struggle or disease. But it would be

indicative of brain damage.

Q Right. Now, is he lying about this when he told it to you?

A I did not -- I indicated before that I thought he was not feigning, and I thought he was showing good effort. So these are things he believes.

Q And if they are true and believed to be true, they are evidence of a brain injury; correct?

A If those things were real, which we know they're not from the testing, then in fact if they were real they would be evidence of very serious neuro-cognitive deficits, something like dementia. He would be demented, basically, with the description he gave.

Q And if they are believed to be true in his life, they are signs of a serious brain injury, and they came from this car accident; right?

A I think the word is that if they are --

MS. BARDOT: Objection.

THE COURT: Hold on. Hold on a second.

MS. BARDOT: First of all, he's asking him to give a medical diagnosis, which a neuropsychologist is not able to give, and he's already said he doesn't consider the factors to be true.

So there's not a foundation for the question.

THE COURT: Your question was if he believed it to be true or if it was true, because you said believed.

MR. GLASS: I said -- I'm sorry. I said if it -- if they are believed to be true.

THE COURT: You mean if factually they're true?

MR. GLASS: Yes, sir.

THE COURT: Okay. So ask your question again, and then we'll see if there's --

MR. GLASS: Let me just -- I don't want to get bogged down on this.

BY MR. GLASS:

Q You gave a list, and I'm sure that you remember. I'm going to just mention a couple of things from the list that he told you that he can't do, which you believe he's wrong about; okay?

You think he's wrong and I guess lying to you when he says he needs to keep notes for everything.

A That he's lying to me?

Q That's what --

A Did I indicate that he was lying? I don't

believe I've ever indicated that he was lying, sir.

Q Well, that's what I'm asking you.

A Did I say that? No. I did not say he was lying.

Q Well, are you saying today that when he tells you that he needs to keep notes for everything that he's lying about it?

A I think that's how he feels, sir. That's a subjective experience. That's his perception.

Q Do you think he's actually keeping notes?

A I don't care if he's keeping notes. I'm telling you that's his perception.

Q Do you believe --

A Does he need to take notes based on the testing? Probably not. He actually could do a better job than most of us here.

Q And if it is believed that he does need to take notes for his memory --

A Believed by who?

Q A jury.

A Okay. So if the triers of fact believe --

Go ahead. I'm just trying to understand your question.

Q Well, if they believe that these things that he's told you and his doctors since the date of this accident are true --

A They're his beliefs.

Q -- that his --

A They truly are his beliefs. That is what Mr. PLAINTIFF believes.

Q So he believes he writes -- or wrote confusing emails, but he didn't? They're not confusing?

A I haven't seen those confusing emails.

Q I know you haven't.

If he says he believes he has difficulty multitasking, you think that he doesn't have difficulty multitasking?

A I --

Q Let me finish asking my question.

A Sure.

Q And I'll try. The temperature's going up.

A Yes.

Q If he says, "I have trouble multitasking," are you saying that he's telling you that but he doesn't actually have problems multitasking? That's all.

A You're understanding right, because I'm saying

he doesn't, because he actually took a test. It's one of the few tests we have in neuropsychology to measure divided attention.

Ms. Bardot didn't ask me about it, but it's called the Brief Test of Attention, specifically designed for measuring divided attention. He got a perfect score. So for a guy who's got a problem with divided attention, he sure did pretty well. So no, I don't think he has that deficit.

Q If he tells you that he believes he's unable to interpret legal cases, you don't think he has that deficit either?

A I believe he believes he has that.

Q If he tells you he misses deadlines for court stuff, you don't believe that happened?

A I didn't say that I didn't believe what he is reporting. I believe that that's his perception, and I don't have the data on his -- I didn't review his documents, and that's not actually a very standardized way.

There could be many explanations for a lawyer missing a deadline.

Q Missing a deadline is not something that one

perceives. I mean it either is on or off. It's an 0 or a 1; right? You miss or you make it; right?

A (No response.)

Q I take it you've worked with a lot of lawyers, right, because you do this forensic work? You know the kind of stuff we do?

A I've got a pretty good idea.

Q All right. So you agree that either based on your general knowledge or what you've read about him, that, you know, part of what he did in his life is he has to go out and get and maintain clients?

A Is there a question?

Q That's part of what he would have to do before he had this car accident?

A I don't know how much he had to market and if that was part of his job.

Q That's fine.

We lawyers and you neuropsychologists often have to multitask?

A I believe that a lot of us have to divide our attention between things.

Q Do you know what he did in terms of management of others -- other people at his firm?

A No. I do not.

Q You would expect him to need to read to acquire new knowledge -- right? -- be able to read and interpret.

A Yes.

Q And then write and think?

A I would assume those are important abilities for an attorney.

Q Think logically?

A For an attorney, that is an important ability, yes.

Q Keep track of dates and appointments, things like that?

A Well, I think keeping track of dates, many of us are more reliant upon a number of devices, like calendars and appointment things, so we don't necessarily have to keep those in our head. It’s pretty hard as you get to your point in life to keep all of your meetings and appointments and schedule in your head.

Q Do you know much about what he did in his particular job?

A No.

Q Do you have a sense of how many hours he

worked a week?

A I don't know how many hours he worked a week.

Q Do you have a sense of what the lawyers who worked with him, how they evaluated his performance before the accident?

A I have not seen anything on that.

Q Or after the accident?

A No, sir.

Q His work ethic was good though; right?

A I don't really know that much about his work ethic.

Q You talked about one of the things that he told you was happening in his life was he had a responsibility to pick up and drop off his daughter I think at the bus stop -- or his granddaughter.

A Granddaughter, he told me.

Q No one ever said anything to you about he's the primary caretaker for his granddaughter; right?

A I don't remember seeing that.

Q Right. That's not what he told you in the interview; right?

A I can check my notes. I don't think -- I didn't write that down.

Q You talked a little bit about obstructive sleep apnea, and you gave some grand rounds, I don't know when it was, 20 years -- 18 to 20 years ago.

A Thirty years ago I think.

Q Thirty years ago. Grand rounds is when you walk around the hospital with the residents?

A No, sir. That's when I was invited to speak by the Chairman to lecture the Department of Neurology and Neurosurgery to the neurologists and neurosurgeons, and other community neurologists and neurosurgeons would come to hear an academic lecture.

Q And you had some -- because you studied and have some familiarity with obstructive sleep apnea -- and this CPAP, are you familiar with what CPAP actually is?

A On a very personal basis and also on a very academic basis.

Q I'm sorry. So you use it?

A Yes. I do, everyday.

Q Are you able to tolerate it?

A Absolutely.

Q A lot of people can't though; right?

A That's correct.

Q I mean, it's a machine that you wear while

you're trying to sleep at night; right?

A I do.

Q It's kind of mask. I don't necessarily mean you, because I don't want to ask about you. But that people, that patients wear, it's a mask-like device or some sort of a hose apparatus, and then they're supposed to sleep with it.

A lot of people just -- even though it's supposed to help sleep it doesn't, because it's disruptive to have a mask on your head while you're sleeping.

A Well, people learn to sleep with it, and I've been involved with the Sleep Center of Georgetown for as you saw, 30 years.

And I've been involved in sleep apnea research all that -- during a lot of that time. And I've published in the area in terms of the effects on cognition so I'm very familiar with it.

Q I'm sorry. Would you say that again.

A I'm very familiar with the condition.

Q You would agree that people with traumatic brain injury can have good days and bad days?

A Just like the rest of us.

Q In the situation where someone comes in for a

full day of neuropsychological -- the battery of tests, that's a pretty structured, safe environment in that cell phones aren't going off, people aren't sending you emails, people aren't walking in to interrupt you, you're not trying to answer an email while you're talking on the phone to somebody; right?

A On my good days that's what it is.

Q That's exactly right.

A I do have some bad days, but on the good days that's what it's like. I should be a pretty quiet, controlled environment, yes.

Q The day he came in to see you, I mean he knew this was a really important event in the life of his case here; right?

A I believe so.

Q I mean he wasn't coming in distracted.

A But people often come in anxious, and that is for them a distraction.

Q Was he anxious?

A Was he anxious? I didn't see him as being particularly anxious.

Q He didn't have anything to distract him that day.

A Well, things in his own mind. I didn't see anything externally -- you know, like any sweating, shaking, trembling, you know, those kind of outward signs of anxiety were not evident.

Q That Missed Test we talked about earlier, that's the thing -- you know, your wife sends you to the grocery store and says get ten things, and you get there and you forget a portion of the list; right?

A memory for intentions of what I'm supposed to do, what I'm supposed to do at 6:30, to pick up a kid, or go to a soccer game, or something. That's what we're talking about there; right?

A Prospective memory test? Yes.

Q Right. And he tested poorly on that; right?

A Yes.

Q You also gave him a test, and I think it was called a Sea Shore --

A A rhythm test.

Q Rhythm test. Where you're listening for a series of sounds, and as I understand it, but you can tell me if I'm wrong, you then listen to another series of sounds to see if they are the same or not?

Did I get that pretty much right?

A It would sound pretty much like this.

I'm sorry to the court reporter.

Q Go ahead.

A Beep, ba deep, beep. Beep, ba deep, beep. --

Same or different; that's all. And you do that 30 times.

Q And that's one of the tests for working memory, because you have to keep the one rhythm in your head?

A It's a test of auditory sequence perception. So it's -- in terms of actually having to hold information in your head, you immediately just say same or different.

So you hear it, and you compare it to the one that came before it. You're comparing two sequences. But it's not a very big demand. It's a very low demand on working memory.

It is sensitive to brain dysfunction, probably to aspects of functioning of the temporal lobe of the brain, particularly on the non-language side of the brain. That's why it's part of the Halstead mix.

Q And that's the test he scored in the 13th percent? You described it as weak.

A So --

Q So let me finish my question if I could, please.

A I'm sorry. Go ahead.

Q He falls in the borderline range.

A That's what I would call it.

Q What is borderline?

A So basically, it's more defined mathematically as scores that fall below one standard deviation, but not one-and-a-half standard deviation. So they're between the fifth and the fifteenth percentile.

So we -- what a good neuropsychologist does is basically be aware of how many scores really are occurring in that range. We're all allowed to have a couple of bad scores without being called brain impaired. But if you have a whole lot of scores that fall into a particular range, that's unlikely, and so that's called base rate analysis: how often does somebody get a score that falls in a particular range? That's what we want to look at. Not just that you have a score that's bad.

The one score bad might be mean that in that particular area he could have a hearing problem. It's also a test of musical ability, by the way. Yes.

Q It is true we don't look at like one set of

tests either to determine whether someone has a brain injury from trauma?

A You're right. So we -- a good neuropsychologist looks for confirmation or disconfirmation. So you look basically across testing, across visits, you would look within a particular domain, and that's how you would evaluate it, not by any one score. You can have one bad score. That's not a big deal.

Q You could have a good day or a bad day doing neuropsych tests too; right?

A Well, I think it's a very important point you raise, because if somebody's having a bad day and they're basically not attentive that particular day, they're in pain, a good neuropsychologist basically says, "We're not going to do testing today. I'm going to have you come back." And definitely I do that.

If somebody's having a clearly bad day, they are emotionally upset, then why would you continue to go ahead and test them, if they're having a really bad day, if they're not attending to, if they're not following instructions.

Now, if they're like that all the time, they

have -- it's all bad days. That's different.

But if they say, "I didn't sleep last night, my kids were up," why in the world would you go ahead and do the testing? You're measuring the effect of that bad day.

Q I agree with you. He was having a great day that day, wasn't he?

A I'm sorry?

Q I agree with you. And he was having a great day that day he was in your office, wasn't he?

A I wouldn't say you would ever refer to that day with me as a great day. I guess if -- if you want to put words in his mouth.

Q Because it was a forensics exam, you had these embedded tests to make sure that he was trying hard?

A Well, trying, yeah. I don't know about trying hard, but yes, was he showing good effort on testing? That's what we look for is good effort.

Q Because some people come in and they try to fake the test. They try to score lower to fake you out; right?

A I hope not. The first thing I do is -- and he will tell you this -- I coach -- not coach, but I direct

them that it's very important that they try their best on all these tests. These tests are norms on people who are trying to do well.

And so I say, "It's very important that you do your best on these tests and allow the tests to show me your deficits. You don't have to demonstrate a deficit. Let the test demonstrate it for us."

Q When someone has trauma and they're knocked unconscious, how do they know?

A How do they know what? Is there a question there?

Q Yes. How do they know -- when they're asked, for example, in the emergency department, "Did you lose consciousness?," how does someone even know what the answer to that question is, if they were the person who lost consciousness?

A Well, there are many ways. People tell you they've had an impact and that basically, you know, the next thing they knew, somebody walked up to their window, and that's how they know.

So they basically through whatever kind of experience they have, it shows them that there's a period of time that they can't explain.

Q Right. So a series of events that we know happened but the person has no recollection of would be an example of someone explaining, "I think I blacked out, lost consciousness"; right?

A That could be the case.

Q All right. So in your examination of Mr. PLAINTIFF and your interview of him and when you were looking at the records, this was one of the important factors that you believe supported your view of the case -- of this case -- and that is that he had no documented loss of consciousness; correct?

A It's one of the factors I tried to explain to Ms. Bardot that reflects severity of injury and reflects, as I told you guys about, the expected outcome. So you look for various factors that are predictive of outcome. That's what I use it for.

Q Right. And again, your view was he had no documented loss of consciousness; right?

A That's not my view. That's facts from the case, from the records.

Q Does he have any memories -- is there any record at all that shows that he had a memory of hearing the screech of the brakes?

A I can't recall.

Q Is there any documented record of him reporting a memory of the crash of metal on metal?

A I can't recall.

Q Is there any documented recording of a memory of the explosion of the air bag?

A I can't recall.

Q That air bag makes a really big sound, doesn't it?

A Thankfully, sir, I have not ever heard it, so I don't know.

Q What he does remember is becoming aware that the air bags had deployed; right?

A I remember he said the air bags had deployed. I don't remember if that's the moment that he became aware about -- my recollection was it had more to do with the OnStar -- didn't he say, "I heard the OnStar"?

Q Sure. And the OnStar you would expect would take some period of time after the collision before -- like you see in the commercial, there's a voice coming into your car that says, "Are you okay?" Right?

A I don't know how long that takes.

Q But in any event, he can't tell people about

hearing the sounds of the skidding and hearing the collision of metal on metal, or hearing the explosion of the air bag; right?

A I said I don't remember what he reported during that period of time.

Q He doesn't have a memory about it.

MS. BARDOT: Objection; lack of foundation.

THE COURT: Sustained to whether he has a memory of it.

BY MR. GLASS:

Q You asked him about the accident?

A Right.

Q He didn't tell you anything about hearing the screech of brakes, the crash of metal on metal or explosion of the air bag; right?

A Well, you kind of tell me in a court order that I'm not supposed to depose him, and I don't -- I really try and stay -- steer clear and not get in trouble with you when I'm doing that interview.

So I don't really get into those kinds of details, because you kind of prohibit me from doing that.

Q Did you see those kinds of details in any of the medical -- any other of the medical records that you

looked at in your careful review of this case?

A What I saw was the emergency room and his primary care doctor saying he did not lose consciousness.

Q What did he tell Dr. Feola about whether he lost consciousness?

A Did I report that in my --

Q Take a moment.

A -- report? I'll look if we have it here.

(The witness examined his file.)

"He did not lose consciousness" is what I recorded.

Q And what about with Dr. Kayloe?

A The story changed at that point.

Q So do you think he's like making it up when he changes the story, as you just said?

A I think people embellish, and I don't know that it's an evil thing. I think that they're trying to come up with an explanation in their own mind for how they're feeling.

I don't try to describe any untoward kind of motive for him -- for Mr. PLAINTIFF at all.

Q What did he tell you?

A He told me he lost consciousness.

Q So is he embellishing that? I mean this is two-and-a-half years after the accident.

A I think -- what I said -- you actually said it properly earlier that I said there's no documented loss of consciousness at the time of injury in terms of having like, you know, I often look at ambulance records from first responders. If a person was unconscious they'll say if the unconsciousness occurred. That's what I'm looking for.

The people who basically make documentation and don't have a part in the legal case, what did they record? That's what I'm looking for. That's all.

Q Okay. You've reviewed the emergency department records from INOVA Fairfax Hospital; right?

A Yes, sir.

Q And part of what was recorded by the radiologist when they took the clinical history was that he had a headache.

A Did I write that, do you remember?

Q I can put it up on the screen for you real quick.

A That would be great. Thank you.

Q I highlighted it for you.

And would you agree with me that what we're looking at is the CT head --

THE COURT: Is that in evidence?

MR. GLASS: No, sir.

THE COURT: So you're just showing it to him?

MR. GLASS: Yes, sir. Just him. Thanks.

THE COURT: Okay.

BY MR. GLASS:

Q What we're looking at is the radiology report from the CAT Scan that somebody ordered in the emergency department; right?

A Right. But you just said that the radiologist wrote this down, or interviewed him? Because I doubt the radiologist ever laid eyes on Mr. PLAINTIFF.

Q Who signed the report?

A The radiologist signed the report.

Do you think that clinical history came from a radiologist talking to Mr. PLAINTIFF?

Q Okay. It came from somewhere; right?

A Yeah. It came from somewhere.

Q Read it out loud.

A It says, "Clinical history," which just basically comes from the order that comes from the unit,

from ED, "55 year old male patient with headache and confusion. Status, post head injury during MVC air bag deployment."

Q So someone in the unit. It's not Mr. PLAINTIFF -- it's not Mr. PLAINTIFF, but someone in the unit is typing in an order for the CT Scan; correct?

A Correct.

Q And they're doing a CT scan because they suspected he has a head injury.

MS. BARDOT: Objection; lack of foundation, calls for speculation.

THE COURT: Why they're doing the CT Scan is beyond his ability to address.

BY MR. GLASS:

Q Let me ask it this way and we'll see if this is okay.

Do you know why they ordered the CT scan?

MS. BARDOT: The same objection, Your Honor. It calls for speculation, lack of foundation.

THE COURT: Well --

MR. GLASS: He may know.

THE COURT: Well, but he's not a physician, so I'm not going to allow the question.

BY MR. GLASS:

Q You did look at these records and they formed part of your conclusion here, because you -- because one of the factors that you thought was important was that he had no loss of consciousness, no diagnosis of concussion, no amnesia, things like that; right?

A Correct.

Q That play a big role in your evaluation, your testimony here today; correct?

A A big role is kind of a misstatement. I said they play a role in my evaluation of the severity of injury and likelihood of outcome.

Q Because if there was loss of consciousness, a head injury, amnesia, that portends a worse outcome for the patient than if he didn't have those things; right?

A You've got that correct.

Q And the number one diagnosis at the emergency department that night was head injury; right?

A I don't know what the order was. It might have been neck strain. I have no idea what the order --

Q I'll pop it right up there.

A They have head injury on it.

Q All right. And that's ordered in number as

well; right?

A You know, I have no idea. As the Judge said, I'm not a physician. I don't know if when hospitals code diagnoses if there's any importance of the order in which they list them on there.

Q Okay. Fair enough.

You don't disagree that he presented with confusion at the hospital then?

A I've seen that reported, yes.

Q And that his wife also said, "Hey, look. He doesn't seem like he's all there."

A I saw that.

Q Words to that effect; right?

A Yes.

Q And that he complained of immediately feeling confused and fuzzy? You don't disagree that that was one of the complaints that he made at the emergency department that night; right?

A I think that's correct. I'm not sure. Let me look.

Q And the --

MS. BARDOT: Wait a minute. He said, "Let me look." Let him answer the question please.

MR. GLASS: Oh, I'm sorry. I'll let you look, here you go.

THE COURT: Do you have it there?

THE WITNESS: Yeah. Thank you.

BY MR. GLASS:

Q You're familiar, are you not, with just what's called the review of systems?

A Yes, I am.

Q And in the neurologic review of systems, which is the doctor evaluating the patient; right? --

A Yes, sir.

Q -- the very first words are "positive for confusion"?

A Followed by, "negative for headache", which kind of contradicts your earlier term, doesn't it?

Q Well, there is -- true. There is conflicting information in the chart as to whether or not he reported a headache; correct?

A Apparently from what you just shown us --

Q So it's not -- I'm sorry.

A From what you've just shown us, yes.

Q So it's not true to say he didn't have a headache in the emergency department; right?

A What's true is that there's this contradiction in the record.

Q Just like there's a contradiction -- there's a variance about whether or not he lost consciousness or not?

A There's no contradiction of that, it being recorded that he didn't lose consciousness.

Q When they discharged him they gave him instructions for a head injury; correct?

A On which ones they passed out, I might have a note to that effect.

Q Here you go. Look at your screen if you like. I'll show you.

A Okay. I see it.

Q Discharge instruction, it gives instructions for a --

A Actually it's in my notes too. "Discharge instructions provided for head injury, NOS."

Q Head injury --

A And he was told, "You do not seem to have a serious brain injury."

Q Right. And one of the reasons that a neuropsychological exam takes five, six, seven hours is

because you often miss -- health clinicians can miss serious brain injury in an emergency department; is that right?

A I think that's a gross misrepresentation of what's done in the emergency department. In fact, they would be held liable if they missed a serious brain injury, like a brain bleed, something that required attention.

Q Sure.

A I think they would be really disturbed to hear that they have a likelihood of missing serious brain injury. Some mild TBI, they might miss. A serious brain injury, even a moderate brain injury, they're not going to miss.

Q We're not talking bleeds and hemorrhages and --

A We're talking about a moderately severe brain injury or a severe brain injury, they're not going to miss.

Q There has been some mention in this case about medications that he was on at the time he presented to the emergency department.

Are you familiar with the medications that he

was on?

A Yes.

Q And there's been a suggestion that he was on Oxycodone at the time he was admitted to the emergency department.

MS. BARDOT: Your Honor, first of all, this goes beyond direct. Second of all, he's not a medical doctor to diagnose -- he can't even prescribe medication, so I think this is beyond the scope of his --

THE COURT: Overruled.

BY MR. GLASS:

Q I put the page up.

Oxycodone, percocet, that's what they gave him to take with him after he had been to the emergency department; right?

A That's -- that appears to be.

Q The discharge prescription --

A That and Cyclobenzaprine, which is Flexeril.

Q Flexeril, that's a muscle relaxer.

A Yeah. It has an effect on driving of about a .15 BAC.

Q Thank you for that.

A They just published it.

Q And finally, we just now talked a minute ago about serious brain injury and mild traumatic brain injury.

That MRI can be normal in someone who has a mild traumatic brain injury; correct? That's why we have guys like you, neuropsychologists, who come in to do your all day long testing; right?

A Well, you have me around for other reasons too. But an MRI can be negative in a mild TBI.

Q Thank you, Doctor.

REDIRECT EXAMINATION

BY MS. BARDOT:

Q Dr. Kay, you are not a medical doctor; correct?

A That's true.

Q And you don't make medical diagnoses or differential diagnoses because you're not permitted to; correct?

A I make diagnoses within the DSM-5, which some people would call medical. Those are psychiatric mental health disorder diagnoses.

Q Your role in this case, as in your normal practice, is to perform testing to evaluate a patient to

see what their brain function is; correct?

A That's correct.

Q And that's what you did in this case?

A That's correct.

Q In doing that for the purposes of this case, you gave Mr. PLAINTIFF the benefit of the doubt, that he may have sustained a mild concussion; correct?

A That's right.

Q Because that's what his neurologist suggested, so you said I'll take that worst case scenario and go from there to give him the benefit of the doubt; correct?

A Correct.

Q And there was nothing objective that you saw in the emergency room records or in the reports of the accident that suggested that there was anything objective to support his subjective complaint of confusion. It was just self reporting; correct?

A That's what it is. If the hospital said -- you know, sometimes they'll write the person didn't know what time of day, they're disoriented. They didn't indicate that he was disoriented at all.

Q And you did not actually in this case, because you weren't asked to and you're not a medical doctor, make

a diagnosis as to whether the accident triggered any sort of depression; correct?

A I was not asked that, no.

Q And in fact, Mr. PLAINTIFF and his experts deny he has depression; correct?

A I believe I can say that's the case for Dr. Wilken. I don’t remember if anyone else thought that he had depression.

Q Okay.

A They haven't provided him with treatment for depression, which I would recommend for him. But no, they have not recommended it.

Q Certainly, given his symptoms as you saw them, treatment would be effective most likely in making him better; correct?

A Yes.

Q Now, you were asked by Mr. Glass, you know, basically if the accident happened -- if he had left 10 minutes earlier and the accident hadn’t happened, would he still have had this constellation of symptoms the next day.

And you indicated that you were aware of some changes that were going on leading up to the accident, and

one of them you mentioned before you were cut off was that he had this change of income in March of 2015.

Do you recall that?

A Correct.

Q And a change in income can be a significant financial stressor that can lead to a trigger of some depression and emotional problems; correct?

A Certainly.

Q I think you testified on direct that you were also aware that in February 2015 and March 2015, he was reported -- that he had returned to Dr. Abidin to start getting additional treatment now again for his sleep apnea, which had worsened; correct?

A Correct.

Q I think you also indicated that in that same time frame he had now declined so much so, that when he reported to Dr. Feola he was at 50 percent; correct?

A Yes. That was when I got cut off. I was saying it was 50 percent.

Q And that was a significant change in his functionality leading right up to the accident; correct?

A Well, that was in February. I don't know by June how he was.

Q And you know in March of 2015 he continued to complain of memory loss and confusion; correct?

A I don't remember how far those records went. Can I take a quick look at Dr. Feola's notes?

Q Yes.

A It will just take me a second, I promise.

(The witness examined his file.)

The last record I have is May so -- May 26th.

Q And if you'd look at Exhibit No. 6 in that white binder, which is in evidence --

A Sure.

Q -- on the fourth page.

A Page 4 of 4?

Q Yes. Are you aware that at May 11, 2015, he is reporting memory loss and confusion in the weeks prior to the accident; correct?

It's in the check box, at the top of the page.

A Oh. Yeah. He says memory loss and confusion, yes.

Q So what you've now indicated is that leading up to the accident we have a change in the beginning of January where he's at 50 to 60 percent.

He now has diabetes, which you indicated could

be a factor which would affect your cognition and ability to function; correct?

A Correct.

Q And we have February 13, 2015, where he's got memory loss and confusion.

A Yeah. I do think it's important for the jury to understand that the diabetes effect that I'm referring to is an insidious -- it's a slow affect, not like overnight maybe.

You do have an episode of very serious hypoglycemia, so that can be terrible for you, but just your hyperglycemia, your high blood sugar, over a long period of time is having a diminishing effect on brain function.

Q That's fair enough. I appreciate the clarification. So let's just back up.

So January of 2015, he's declined now 50 to 60 percent of his usual functioning as reported to Dr. Feola; correct?

A Correct.

Q A significant change; right?

A Right.

Q And then we've got February of 2015 where he's

got memory loss recurring; correct?

A Correct.

Q We've got his change in income in March of 2015, which puts the financial pressures upon him; correct?

A I think that's correct.

Q We've got May 11, 2015, just before the accident, where now in addition to memory loss he's got confusion added in; correct?

A Correct.

Q You have not done any sort of differential diagnosis, nor would you, to determine whether this constellation of symptoms leading up to the accident, versus the accident, versus something else, was the trigger for his now self reported inability to function; correct?

A That's right.

Q You were asked by Mr. Glass, was there anything documenting that he had a memory for hearing screeching of brakes, metal on metal, explosion of the air bag; do you remember that?

A I remember him asking me that.

Q Do you remember if there was anything

documented either way with respect to those issues?

A No. I don't think there was that I remember seeing.

Q Sure. You were asked by Mr. Glass, "What did Mr. PLAINTIFF tell Dr. Feola regarding the accident?"; do you recall that?

A I remember him asking. I told him what I read in the chart.

Q And you saw Dr. Feola's deposition transcript?

A Yes.

Q I'm going to put it up for you here and ask you to look at Page 52. And this is Dr. Feola's deposition outlining what he was told by Mr. PLAINTIFF about the accident. Take a look at that for me please.

MR. GLASS: Hearsay objection.

MS. BARDOT: He asked him what he told Dr. Feola. He can't ask him and then say I can't tell -- ask him to look at what he told him.

THE WITNESS: Can you focus that, Ms. Bardot?

MS. BARDOT: Oh, I don't know.

THE WITNESS: It could be my eyes.

BY MS. BARDOT:

Q No, it's not.

A That's better. They get stuck in a particular focal length. All right. And then he did --

Q Wait a minute.

A That would make it real hard for me.

Q Right here it says, "And then as he described the accident, he was in Vehicle A going through an intersection, and the person in Vehicle B ran a red light and hit him on the driver's side. The air bags deployed." That plus AB means air bag. "He had the seat belt on, which is seat belt.

Do you see that?

A Yes.

Q So he in fact did tell Dr. Feola in some detail exactly what occurred; correct.

A Apparently, yes.

Q He recalls that he was pulling out, another car ran a light, the other car hit him, and the air bags deployed.

A He just -- he didn't mention anything about screeching there.

Q Right. But I mean, he didn't mention it either way. He didn't -- it's just in absence.

A It's not there.

Q Okay. And you don't know what type of doctor saw him at the emergency room; correct?

A An emergency room doctor, I would presume.

Q Right. So you don't know if it was a neurologist?

A No. Well, most often you're not going to see a -- you could, but most often you're not going to see a board certified neurologist in the emergency department.

Q Right. So when they put, "Head injury unspecified," you don't know how they came to that conclusion, what they meant by that, what test they did, whether they just believed that he had confusion because he said so?

You don't have any basis for knowing if there was anything to support "head injury unspecified"?

A I think it's based on the patient's report (inaudible).

Q Because there's nothing else in there that would support it other than his subjective complaint; correct?

A Correct. It wasn't demonstrated by the exam. It wasn't demonstrated by the imaging.

Q Thank you. That's all I have.