VIRGINIA:

IN THE CIRCUIT COURT OF THE CITY OF SUFFOLK

CERTIFIED ORIGINAL

THELMA E. MAHONE, Administrator)
of the Estate of FELICIA T.)
MADISON, Deceased,)
Plaintiff,) Case No.
v.) CL09000560-00
SENTARA HOSPITALS, et al.,)
Defendants.)

TRANSCRIPT OF PROCEEDINGS

Suffolk, Virginia

February 2, 2010

BEFORE: THE HONORABLE RODHAM T. DELK, JR., JUDGE

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(The hearing commenced at 12:00 p.m.)

THE COURT: Good afternoon.

MR. YOAKAM: Good afternoon, Your Honor.

MR. WATERMAN: Good afternoon, Your Honor.

THE COURT: All right. We're here on Thelma Mahone, Administrator, versus Sentara Obici Hospital. All right. What are we here for today?

MR. YOAKAM: Your Honor, Ted Yoakam --

THE COURT: Yes, sir, Mr. Yoakam.

MR. YOAKAM: -- for Sentara. Good to see you.

We're here on my motion to quash, and I'm happy to report to Your Honor that Mr. Waterman and I have had a conversation today and he has agreed to abandon his request for the claims file of Mr. Sweeney.

Since we were here last, I said that I would produce a privilege log, which I have done --

THE COURT: And I have attached -- placed it in -- is that what was requested be sealed?

MR. YOAKAM: No, Your Honor. That's --

THE COURT: A document is under seal.

MR. YOAKAM: And I'll get to that in a minute.

THE COURT: All right.

MR. YOAKAM: Counsel had requested that I

produce a privilege log which detailed the contents of the file, which I have done, albeit tardy. I got it to him yesterday. And it listed the materials, which I think plaintiff's counsel is satisfied, having looked at the log, that all of the items postdated plaintiff's request for medical records and follow-up letters from plaintiff's counsel. So all of that stuff was created afterwards. Based on that representation, he's abandoned his request for the claims file.

So it seems to me what we are here before the Court, the sole issue is the document that you just referred to that's under seal, and that is the policy -- the incident report, which I think enjoys privilege and should not be produced to the plaintiff. It is not a medical record. It was not created and intended as a medical record.

And if Your Honor will recall, I had submitted -- I'm sorry. I need to get my brief here real quick. We had submitted briefs on this issue some time ago, and I think the case of -- I'm going to butcher this name -- Mejia-Arevalo versus Inova Health Care -- now, that's a circuit court case, but I think the analysis in that case is dead on. And I think that the Court should pay particular attention to Judge Thatcher's reasoning in that case --

THE COURT: What is the name of the plaintiff?

MR. YOAKAM: M-e-j-i-a, hyphen, capital A-r-e-v-a-l-o, versus Inova Health Care Services. That opinion is attached to my brief --

THE COURT: All right. What is the -- Judge Thatcher, that would be Fairfax?

MR. YOAKAM: Yes, Your Honor.

THE COURT: 19th Circuit?

MR. YOAKAM: Yes, Your Honor. It's Exhibit 2, attached to my brief.

THE COURT: Oh, I see it. All right.

MR. YOAKAM: In the incident report that the Court has under seal -- and I don't know if the Court's looked at it or not. I'm not worked up about it if the Court wants to look at it. I will -- I will acknowledge it was created within 24 hours of the events at issue in this case. That's not -- that's not the issue here.

I think that the distinction that I would make -- and I think that it would tailor or fall in line with the rationale articulated by Judge Thatcher -- I think that many plaintiff's lawyers misread Riverside versus Johnson.

In that case, my reading of it is that that Court found that an incident report that described the

patient's care were -- were discoverable. And I think in this case, the incident report actually deals with another issue, and that is -- and I can't really address this without getting into the guts of it --

THE COURT: Do you have a cite for Riverside versus Johnson?

MR. YOAKAM: Yes, Your Honor. In the case of the incident report that the Court has before it, what that is describing is a protocol for the return of a spoliated -- or a unit of blood that needs to be discarded. Meaning, it can't be returned. It can't be used.

This is a -- this is the heart of a -- of the policies and procedures of Sentara Obici, creating a document that explains why that unit of blood was not -- could not be used and had to be returned to the blood bank for destruction. That's what that's about. It's not about the patient care. And that's all it's about.

All of the information that may be tangentially referred to in that incident report, readily available to the plaintiff through the medical records. And of course once he puts those health care providers under oath, he will get to the same information.

So it seems to me that the Court ought to err on the side of protecting Obici's policy and procedure,

rather than disgorging it --

THE COURT: Let me ask this, Mr. Yoakam. The Supreme Court of Virginia has held many times that there's no need to decide cases on many fronts when it can be decided on one front or one issue as opposed to many issues. It's basically -- I take it as the notion of economy of law giving. In other words, don't hand out a whole lot of law if you can just hand out a little bit.

Is that not what this report is here? Is this -- you've indicated what this incident report was about and how it really doesn't apply much to the issues of this case. But it doesn't matter -- as I hear it, it's really not a major issue.

If I consider the briefs in this case over whether this should be -- and I take it Mr. Waterman still wants his hands on it.

MR. YOAKAM: Yes, sir.

THE COURT: If I take the two briefs and I decide -- let me just ask this question. If it is of no moment, would it not be safer for you and for Obici just to give it to Mr. Waterman without the Court establishing any precedent for this? Particularly, as you said, when it really doesn't mean a whole lot.

Do you want to -- the battle over incident reports, if it's going to be fought, is this a worthy

cause, I guess, where you apparently have said it really doesn't matter, it's not a big deal in this particular case?

MR. YOAKAM: Well, this is my thought on that, Your Honor --

THE COURT: Because once I establish my own precedent, whatever it is -- and I don't know how I'm going to rule on it yet.

MR. YOAKAM: This is my view on that. There are cases, as you know, where I represent Obici, so I'm here with some regularity. And as you know, I do their medical malpractice defense. So there are -- there are issues that come up that there are incident reports that are -- that are right on point.

Case in point, the Jolley case, which I've just gotten out of. In that case, handed the incident report over to the plaintiff just for the very reason that the Court articulated. One, it went right to the issue that was involved in the case. And there was information that the -- that would lead to discoverable information, in my view. So we didn't make an issue of it. Turned it over without a squabble.

I don't know if -- it's hard to sort of frame this in its absence. But I'm sure the Court will have no recall of me fighting with the plaintiff about that. So

there are -- there are times when Sentara will voluntarily hand that over.

This is the rub, though, for the hospital. In terms of the policies and procedures about what happens in terms of -- in this case, as I had explained, it was in reference to a returned unit of blood. Is that information available to the plaintiff about how many units were infused into this patient? Yes. That's going to be readily available to the plaintiff. He can get that both through the medical record, questioning the witnesses, and the bills.

So it seems to me that in this case that's why it does become an issue for the hospital. Because the hospital has to have a procedure by which the health care practitioners, whether they're nurses or whatnot, can communicate frank information to the administration, to their superiors, about an incident.

And if those become fully discoverable, it seems to me, then, what happens is the hospital goes to a defensible --

THE COURT: Well, they become fully discoverable if the Court orders it.

MR. YOAKAM: What happens then as a result of that is then the hospital would be encouraged to create the defensible incident report, drafted with an eye

towards litigation instead of the goal.

THE COURT: I understand what you're saying. Maybe I didn't state my position too well.

You indicated that this is -- I didn't hear any urgency or stridency in your argument that this is to be kept confidential and not released, because I understood from what you said that it really is not a big deal in this case.

You don't -- I understand. You don't want a precedent that Obici's got to cough up incident reports for every malpractice case. I understand that. But that's not going to happen unless this Court issues -- unless -- if I issue -- if I order in this case that it's to remain sealed, you win. If I order that it is to be divulged, then that puts a lot of other -- that basically sets my own personal precedent for future cases.

And that's why I ask, do you want to -- is this worth fighting that battle over as to whether these things get submitted or not?

MR. YOAKAM: I think it is.

THE COURT: Okay. That's fine. That's fine.

MR. YOAKAM: I think this is exactly the kind of case to do it.

THE COURT: All right. I've got Judge Thatcher's opinion here, which I'll review. Now, you said

Riverside versus Johnson. Is that a case in point?

MR. YOAKAM: That's a Supreme Court case where --

THE COURT: Do you have a cite for that?

MR. YOAKAM: That is -- and I'm sure it's attached to the plaintiff's. It's 272 --

THE COURT: I haven't gone -- Mr. Waterman produces a lot of information. If you can tell me a cite, I can find it a lot quicker that way.

MR. YOAKAM: It is 272 Va. 518, and it's 636 S.E.2d --

THE COURT: Okay.

MR. YOAKAM: -- 416.

THE COURT: All right. Thank you.

MR. YOAKAM: I think in this case I would -- what I would suggest is that the Court deny the request at this point, allow the plaintiff to discover the case, and if the plaintiff feels that there is some issue that he does not -- can't get and suspects that it's in that incident report, then revisit the issue.

That's the way I think this ought to be handled because I'm confident that reading this record and knowing what's in it, plaintiff's counsel has the record so he knows what's in it, that he's going to be able to flush out that skeleton through the medical records and

then the discovery requests and the discovery depositions, and he won't have need of it.

And I invite the Court to look at the incident report. I don't have a problem with that at all. I don't care. Because the Court may look at it and --

THE COURT: It's not up to me to judge the harmfulness -- the degree of potential harm to Obici by divulging it because I -- it's either going to be divulged as a matter of principle -- in other words, the incident report talks about recent -- an incident report created shortly after a medical incident, is that relevant evidence for discovery.

And relevance not only is immediately relevant, but is this information such that it could reasonably be considered -- that might reasonably be considered to lead to other admissible evidence, whether it's admissible or not. Admissibility -- trial admissibility is not an issue in discovery.

MR. YOAKAM: I agree.

THE COURT: So I'll consider that.

MR. YOAKAM: And I would invite the Court to -- again to Judge Thatcher's reasoning about the rationale why these things ought to be protected and why they -- in his view, they enjoy privilege. I can't do better than his analysis because -- and that does go to

the heart of a hospital's goal to provide the best patient care.

And I'll probably end here with the fact that in my reading of that incident report, it has to do with something that is not related directly to the care of the patient, but accounting for that unit of blood.

THE COURT: And that was the one unit of blood that --

MR. YOAKAM: Correct.

THE COURT: Okay. Mr. Waterman.

MR. WATERMAN: Opposing counsel is correct that plaintiff withdraws its request for anything covered by the subpoena other than the incident report itself. I just want to be extremely clear on the record that we're withdrawing it not because it's so-called claims information but solely because of the timing.

All of the materials they have belatedly identified in the privilege log are almost a year after the fact, and all of them are after me specifically writing to the risk manager for more materials. So it's strictly a matter of timing and notice on which we withdraw the request.

That is to say, in short, it appears all of the things other than the incident report are done in anticipation of litigation on the face of it. So that's

the reason. There may be other cases in which so-called claims information, claims files or the like or however titled, may be pertinent. I just don't want this record and any letter opinion or order that Your Honor writes to be too broad as to suggest that we concede that materials of this type regardless of date are protected.

I have -- I don't believe it's attached to our significant brief, but I have the Riverside decision here for you as a matter of convenience.

THE COURT: I've got it. Oh, I'll take it. You can bring it up. Thank you. All right.

MR. WATERMAN: I am intimately familiar with that case because it was my case. I tried that case, and I briefed it and argued it to the Supreme Court. And so I'm aware of all of its nuances, and I have litigated this issue of incident reports successfully for well over a decade.

I was not in front of Judge Thatcher. But in more than 10 years, maybe now closer to 15 or more, I've probably had 10 or 12 orders, somewhere in that neck of the woods, ordering production of these. I've never had a judge not produce it, even before Riverside.

And I have -- I want to address the things said by counsel and the things unsaid by counsel but that are in his brief. And I have to take serious opposition

with the representations in the brief.

For example, in his brief he represents to the Court that incident reports have a long history of being privileged. That's just plain false. It's just plain false. And while there has been some disagreement in the circuit courts, even before the watershed Riverside case, the weight and the trend was that they be produced. And clearly, patently, unquestionably, since Riverside, they're being produced.

In fact, counsel brings to you this -- however you pronounce it -- Mejia, M-e-j-i-a, decision because that's the only -- only post-Riverside decision that I'm aware of that has denied production of an incident report on the heels of Riverside.

It's the maverick. It's the derelict on the waters of the law. And I haven't verified it, but I've been told that Judge Thatcher has a family member who is in medicine, a doctor --

THE COURT: Mr. Waterman, that's not pertinent to this case.

MR. WATERMAN: Fair enough, Your Honor. But I have --

THE COURT: I'm sure somebody if they thought that that was an issue in the case that that would have been addressed by someone.

MR. WATERMAN: Well, I understand. I'm not sure of the posture of that case now. But what I do share with you in my brief, Your Honor, are seven orders to the contrary since Riverside.

I have in my brief the Morel case, the Purvis case, Lacare, Shakshober, Justis, Anderson. All of those are my cases. And one called Matthews. But they are against -- one of them is against Sentara out of Williamsburg. That's the Justis case.

Now, to go back, Your Honor, the Riverside case is strikingly similar to this one, where in Riverside we had a nurse's note, seemingly contemporaneous nurses' notes, and we had a late addendum, and then we had an incident report turned over. And there were remarkable inconsistencies among all three, the supposed contemporaneous note, the later addendum, and the incident report.

And in addition to the inconsistencies, there was material factual information, factual patient factual care information that appeared in the incident report that was nowhere in either the initial nurse's note or in the later nurse's note.

The Riverside -- and in that case, to be very clear, the incident report wasn't simply ordered produced. It came into evidence. And the Supreme Court upheld the

admissibility of these things. So it's just incredible to me, except for this maverick Mejia decision, that people after Riverside can come in with a straight face and suggest they're not discoverable when the Supreme Court has upheld admissibility.

And if you read Riverside carefully, not only did Riverside uphold the discoverability and admissibility of incident reports, it upheld the discoverability and admissibility of quality assurance database information. That is, materials that weren't even done contemporaneously but that were taken days and more after the fact by the hospital. Data inputted into their master computer system.

And we found in that system yet more factual information about the patient care that wasn't in the initial nurse's note or the subsequent note or even the incident report. It was not until we finally drilled down to the database that we found out that the whole patient alarm system was inoperable.

So counsel's representations to you of what Riverside says and doesn't says -- says and does not say are just inaccurate. Riverside says, We're not going to be controlled by labels. You can call it quality assurance. You can call it peer review. You can call it what you want. But we're going to look to substance

instead of form. And if it is anything having to do with patient factual care, then it's being produced.

Likewise, we don't care where you keep its location. It doesn't matter whether it's a file cabinet or a computer database. The fact that you self-servingly keep it separate, that doesn't matter either. That just means you're keeping it out of the patient chart.

So Riverside is very clear. Hence, all of these other Courts have applied Riverside to the letter, except for Judge Thatcher.

Also in the brief, Sentara misleads the Court about another case of mine called Marshall. Marshall is a medical malpractice case in Williamsburg. And the suggestion in the brief on Marshall is that Judge Powell denied the request for an incident report. That's just plain false. That's false. He didn't do it.

There was no incident report. Sentara, in that case, destroyed the incident report. So -- so -- so it was a nonissue. And if there's any -- if that's not sufficient, I have brought the transcript of the Marshall hearing that clearly shows there was no incident report.

Again, the only decision out of Williamsburg on incident reports is the Justis case from 2008. And in Justis, Sentara was unsuccessful -- fought, like today, and was unsuccessful in keeping the incident report from

me. And the incident report in that case was trenchant, too, and it resolved.

In fact, my experience has been that Sentara regularly fights about these things when, in fact, they have some value. Now, I take issue with the factual representations --

THE COURT: Mr. Waterman, let me just -- I hate to interrupt you. But I would appreciate it if you would keep your arguments to legal principles rather than parties and lawyers.

MR. WATERMAN: Well, I --

THE COURT: I can't say it any clearer than that.

MR. WATERMAN: My concern, Your Honor --

THE COURT: Let's stick to the law.

MR. WATERMAN: Yes, sir. The law is that I think that particular incident report is relevant and material. This is the death of a young woman, a woman who went to the emergency room and who bled to death, Your Honor. She bled to death. And it was supposedly in the record a mystery why she bled to death.

So plaintiff cannot accept as a matter of law and fact that an incident report about blood that was meant for her is -- is pooh-poohed as irrelevant and immaterial. To me on the face it's clearly relevant and

clearly material, and we shouldn't have to go feeling around just for what they have chosen to put in the patient chart about what transfusions she got, how many she got, and when and why, when they park over here in the incident report critical information about a unit of blood she didn't get.

Did she not get that unit of blood because it was bad blood? Did she get some of that blood? Or was she supposed to get that blood but somebody dropped the ball? They just let it hang and didn't -- did not give her the IV? Or the IV wasn't working? Did it not go back to the -- could it not go into the blood bank because it was sitting out at room temperature too long because it should have been given to her because it was ordered to be given to her and wasn't given to her?

That's critical information, and we don't find that -- we don't define that by, as counsel says, just being left to count the number of units she got as she bled to death. This to me is critically important.

And in this case, too, Your Honor, if I may --

THE COURT: Yes.

MR. WATERMAN: Here's the nurses' notes, Your Honor, just by way of example. And I have highlighted a couple of things just for convenience, and I've

highlighted them on your copy as well as counsel's. These are the nurses' notes for my patient.

You'll see, I believe, that I have highlighted on the first page, you'll see -- I think it says occurred, a date and a time, and then recorded, a date and a time.

So you can see by way of that example, Your Honor, that nurses' notes ideally should be and in the ordinary course routinely are noted roughly contemporaneously when things are done. That is, the occurrence meaning when the act was done. The recording meaning when they noted it on the record. And you see that this is very close.

But here's what happens, Your Honor. This is why this case is very fishy and we're particularly interested in the emergency room -- I mean the incident report. If you turn to page 2, when you're ready, you will see -- is there highlighting on page 2?

THE COURT: Yes.

MR. WATERMAN: There, Your Honor, you'll see again starting at -- it says, occurred, 7/3. That's now --

THE COURT: Let me ask this. As I read these, I've tried to go -- Mr. Yoakam, do you have that? Let's go to page 1 where you highlighted occurred,

recorded --

MR. WATERMAN: Yes, sir.

THE COURT: It looks like from the format that the highlighted occurred, recorded, refers to the entry below that and not above that. And the reason I say that is because these notes begin with an occurred, recorded item that's not -- that must mean by the way it's situated on the page that it refers to the information following it.

MR. WATERMAN: That's my impression.

THE COURT: And I will assume that is the way this is set up on the remaining pages.

MR. WATERMAN: That's my impression.

THE COURT: Okay. All right. I wanted to be sure we're on the same page -- well, that we understand each other.

MR. WATERMAN: Well, I guess before we go to the second page, if you go to the very bottom of the first page, here they're talking about transfusions, blood transfusions. Patient is bleeding to death. That's the whole case, Your Honor.

THE COURT: Where is that? On page 2?

MR. WATERMAN: Page 1, the last notes on that page 1, it says in bold capital letters at the bottom, pre-transfusion. Two lines from the bottom.

So I'm just hearkening -- sort of digressing a moment to hearken back to say this incident report about blood and transfusions not given is really critical.

Now back to what I gave you as an exhibit, Your Honor, an example, page 2, if we go down midway on the page, I highlighted -- it says the date of July 3, 2007.

THE COURT: Yeah.

MR. WATERMAN: Okay. Now, this patient -- I don't have the exhibit. What happened here, Your Honor, you'll see that the time of occurrence of when this was supposedly done was 0015. That's 12:15 in the morning, just after midnight. But look at when it was recorded.

It wasn't -- this note wasn't recorded until more than five hours later, 0540, at 5:40 in the morning. That's after the patient was dead. So what happened here -- and if you turn, all these other -- I'll represent to you, but you can review.

If you look at every other entry on this page and all the other pages, what we have here is the nursing staff not -- I don't know if they destroyed contemporaneous records but clearly after the death of this patient constructed numerous post-death notes. Every single note afterwards are many hours after the fact.

So this record was fabricated after the death

of the patient bleeding to death, not contemporaneous --

THE COURT: You said it's fabricated? It's not true?

MR. WATERMAN: I don't know that -- it was created -- all of it was created -- all of it was made up and created after the death of the patient --

THE COURT: Well -- okay.

MR. WATERMAN: -- which is highly irregular. It's not -- it's totally inappropriate, in fact. Because you can see by the earlier pages that I pulled out for the example is nurses typically and are supposed to do this minutes after the fact.

But here we have a total absence of recordkeeping for, like, five hours until the patient dies. And then they come back, and if you trace this out, between 5:40 in the morning and 9:32 in the morning, they go back and they create numerous nursing entries that supposedly run from 12:15 in the morning to 4:10 in the morning, up to the point of death.

This is totally inappropriate, totally suspect. And it's just another reason why we need and should have that incident report because we don't -- the records that they have chosen to put in the patient chart are not contemporaneous. They're -- they're suspect.

And so we need -- that's just another reason

for us to see what's in the incident report about blood transfusions or failure of blood transfusions or inappropriate blood transfusions, which are the heart of the case. This is about a patient who bled to death. She ran out of blood. She didn't have enough transfusions.

So we vigorously dispute that they're fighting over nothing. They're fighting over something. And here our only witness to the case, friendly witness, is dead. She's the patient. All the other witnesses to this, they're employees of defendants or allied personnel. And so the records are really critical to us.

And when I was before you in the Burr versus R.C. Paving case, Your Honor, which did not involve of course a hospital incident report but was about other post-statements, Your Honor in that case found that they were not -- these were statements taken days afterwards. Your Honor in that case found that they were not taken in anticipation of litigation.

You looked at the lapse of time after the accident, which in that case was days. I think maybe even more than a week in one case. This is hours, this incident report. You placed a premium on the immediacy of recollection when the statements were taken shortly after the accident, the importance of the availability of statements taken prior to sworn testimony, and the

possible suppression of relevant evidence which would relate to witness credibility. All those factors are here.

And that case involved a death, too. I mean, the same situation where my client -- or the person for whom I was litigating wrongful death died and so could not speak for themselves. So --

THE COURT: The patient notes that you have, the nurses' notes -- I call them nurses' notes. They appear to be for the most part prepared by nurses. Where do they note the death of the patient?

MR. WATERMAN: I haven't read these in a bit, Your Honor. I'll have to see.

THE COURT: I don't think they do.

MR. WATERMAN: They -- they may not. These may not, Your Honor. But I'll represent to you the patient died, and I'll represent to you the patient died before all of these were --

THE COURT: Okay. I was just asking if there was a note as to that. But of course nurses don't normally note those things. I think physicians have to be called in.

MR. WATERMAN: I'm not sure, Your Honor. And I need to check the statute that we're arguing over, 581.17, but I thought that there was an exception, because

I didn't realize the close timing. But I thought that the statute itself provided a per se exception for records created within 24 hours. That is, things that were that close, within 24 hours, by the statute's own terms, enjoin any protection even aside from the jurisprudence on how you should treat these reports.

THE COURT: Okay.

MR. YOAKAM: Funny thing happened on the way to the forum, Your Honor. Based on what Mr. Waterman just raised, which was kind of news to me, I've gone back and looked at this -- this incident report, and it does contain some issues as to time. And based on what he had to say to the Court, I'm going to hand this over to him.

THE COURT: Do you want to take this one here (indicating)?

MR. YOAKAM: No. I've got a copy right here.

THE COURT: All right.

MR. YOAKAM: I think that's the last issue before the Court, so I guess I will withdraw my motion to quash --

THE COURT: You're withdrawing your motion to quash.

MR. YOAKAM: As to the incident report.

THE COURT: Yes, sir. All right.

Mr. Waterman?

MR. WATERMAN: This is the same as what the judge has been provided in camera?

MR. YOAKAM: It sure better be.

Can we approach, Your Honor? I just want to make sure that there's no possibility of a foul-up.

THE COURT: All right. Do you want to --

MR. YOAKAM: I do.

THE COURT: Mr. Darden, do you have something I can open this envelope with?

THE BAILIFF: Yes, sir.

THE COURT: (The Court unseals the document and hands it to counsel to review.)

MR. WATERMAN: Okay.

MR. YOAKAM: That's it.

MR. WATERMAN: Visually the same.

THE COURT: All right.

MR. WATERMAN: Plaintiff had -- there was a parallel motion, plaintiff's motion to enforce the subpoena duces tecum, which was the flip side of the motion to quash the subpoena duces tecum.

THE COURT: And that was over the incident report.

MR. WATERMAN: It's the same. I was just saying --

THE COURT: So you're withdrawing that

motion.

MR. WATERMAN: Withdrawing it because --

THE COURT: Okay. For the record, Mr. Yoakam withdrew his objections to the production of the incident report. The copy held by the Court under seal was released to Mr. Yoakam and delivered over to Mr. Waterman. And he is withdrawing his motion to produce that document.

MR. WATERMAN: Because it was satisfied. Thank you.

THE COURT: All right.

MR. YOAKAM: Thank you, Your Honor.

THE COURT: Thank you very much. Now, are there any other matters before the Court today?

MR. YOAKAM: No, sir.

MR. WATERMAN: No.

THE COURT: All right. Thank you very much. Do you want any orders on this?

MR. YOAKAM: I don't think we need any.

THE COURT: It's on the record. The Court didn't rule and now does not have to rule, so there's no need for a -- the Court hasn't ordered anything.

MR. WATERMAN: I understand that.

THE COURT: Okay.

MR. WATERMAN: I'll just get a copy of the transcript.

THE COURT: Okay. Thank you very much.

Now, Mr. Waterman, you have -- here's your case, and here is your highlighted copy of the nurses' notes. I don't need them any further.

All right, gentlemen. Thank you very much.

MR. YOAKAM: Thank you, Your Honor.

MR. WATERMAN: Thank you.

THE COURT: Was this for the trial (indicating)? You brought this today?

MR. WATERMAN: That's the file. That's actually --

THE COURT: All right. This is yours?

MR. WATERMAN: That's the Court's.

THE COURT: Oh, this goes with the court file. Okay. Fine. They have -- they've marked this, Binder is on top of the cabinet, so they can find it.

MR. WATERMAN: I'm trying to think out loud, Your Honor. I'm trying to be sensitive to the Court. Given the disposition of this motion, I would be agreeable to the Court maintaining in its record only my memorandum and disposing of the hundreds of pages of exhibits to that, but that's up to the Court.

THE COURT: I don't keep them up here, but I'm sure the clerk would be overjoyed.

MR. YOAKAM: I'm fine.

MR. WATERMAN: Is my memorandum in the top of that ring binder?

THE COURT: There is a patient's memorandum, but it goes on and on and on and on.

MR. WATERMAN: I think the patient's memorandum might be about 20 pages and might be stapled separately.

THE COURT: I have 24 pages, yes.

MR. WATERMAN: Right. We could remove that and place that chronologically in the record. And if Your Honor wanted to dispose of the binder of exhibits, given the disposition, that would be fine.

THE COURT: All right. There's a list of exhibits --

MR. WATERMAN: That's part of the --

THE COURT: -- and your cover letter. All right. I'm going to take them out. I'll staple them all together and place them in the file.

MR. WATERMAN: And I'll retrieve the binder from you --

THE COURT: Yes, sir.

MR. WATERMAN: -- if that's how we're going to handle it.

MR. YOAKAM: That's got to be about a $10 binder.

THE COURT: Okay. Thank you.

MR. WATERMAN: Thank you, Your Honor.

THE COURT: All right. Thank you very much.

MR. YOAKAM: Thank you, Your Honor.

(The hearing was concluded at 12:45 p.m.)

COURT REPORTER'S CERTIFICATE

I, Sheila H. Matthews, certify that I recorded verbatim by stenotype the proceedings in the captioned cause before the HONORABLE RODHAM T. DELK, JR., Judge of said Court, Suffolk, Virginia, on the 2nd day of February, 2010.

I further certify that to the best of my knowledge and belief, the foregoing transcript constitutes a true and correct transcript of the said proceedings.

Given under my hand this 17th day of February, 2010, at Norfolk, Virginia.

Sheila H. Matthews

Sheila H. Matthews