



Deposition of:
Lyndsey Emery, M.D.

May 11, 2021

In the Matter of:
**Greenberg, Joshua v. Osbourne, M.D.,
Marlon et al.**

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IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

- - -

JOSHUA M. GREENBERG and: OCTOBER TERM,
SANDRA GREENBERG, : 2019
Administrators of the :
ESTATE OF ELLEN R. :
GREENBERG :

Plaintiffs :

vs. :

MARLON OSBOURNE, MD and:
CITY OF PHILADELPHIA :
OFFICE OF THE MEDICAL :
EXAMINER :

Defendants : NO. 01241

- - -

TUESDAY, MAY 11, 2021

- - -

Video-recorded deposition of LYNDSEY
EMERY, MD, taken remotely via Zoom, at
Philadelphia, Pennsylvania, commencing at
10:02 a.m., by Kimberly A. Wornczyk, a
Registered Professional Reporter, New Jersey
Certified Court Reporter (Certificate No.
30X100223500), and Notary Public in and for
the Commonwealth of Pennsylvania.

- - -

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14 ALSO PRESENT:

15 Robert Leventhal, Videographer

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1 (It is stipulated by and
2 between counsel for the respective
3 parties that the signing, sealing,
4 filing, and certification are hereby
5 waived and that all objections, except
6 as to the form of the question, be
7 reserved until the time of trial.)

8 - - -

9 THE VIDEOGRAPHER: Good
10 morning. We are going on the record
11 at 10:02 a.m. on May 11, 2021. Please
12 note that the microphones are
13 sensitive and may pick up whispering,
14 private conversation, and cellular
15 interference. Please turn off all
16 cell phones or place them away from
17 the microphones as they can interfere
18 with the deposition audio. Audio and
19 video recording will continue to take
20 place until all parties agree to go
21 off the record.

22 This is media unit number one
23 of the video recorded deposition of
24 Dr. Lyndsey Emery, taken in the matter

1 of Joshua M. Greenberg versus Marlon
2 Osbourne, MD, filed in the Court of
3 Common Pleas, Philadelphia County,
4 Pennsylvania, Docket Number 01241.

5 This is a Zoom dep. My name is
6 Robert Leventhal from Veritext. The
7 court reporter is Kimberly Wornczyk
8 from Veritext. I am not authorized to
9 administer an oath, I am not related
10 to any party in this action, nor am I
11 financially interested in the outcome.

12 Counsel attending remotely will
13 now state their appearances and
14 affiliations for the record.

15 MR. PODRAZA: Joe Podraza on
16 behalf of the plaintiffs.

17 MS. BERKOWITZ: Ellen Berkowitz
18 for the City of Philadelphia.

19 THE COURT REPORTER: I am going
20 to do my brief Zoom read-on and then
21 will administer the oath.

22 THE VIDEOGRAPHER: Would the
23 court reporter please swear in the
24 witness.

1 THE COURT REPORTER: The
2 attorneys participating in this
3 deposition acknowledge that I am not
4 physically present in the deposition
5 room and that I will be reporting this
6 deposition remotely.

7 They further acknowledge that
8 in lieu of an oath administered in
9 person, I will administer the oath
10 remotely.

11 The parties and their counsel
12 further agree that the witness may be
13 in a state where I am not a Notary and
14 stipulate to the witness being sworn
15 in by an out-of-state Notary.

16 If any party does have an
17 objection to this manner of reporting,
18 please state so now.

19 Hearing no objection, I will
20 administer the oath.

21 - - -
22 LYNDSEY EMERY, MD, having been
23 duly sworn, was examined and testified
24 under oath as follows:

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MR. PODRAZA: Before we proceed with questioning, Ellen, are we going to have usual stipulations?

MS. BERKOWITZ: Yes, we can.
Dr. Emery, you are muted.

THE WITNESS: I am not muted according to my screen. Can you hear me?

MS. BERKOWITZ: Yes.

MR. PODRAZA: All right. So we'll have usual stipulations?

MS. BERKOWITZ: Yes.

MR. PODRAZA: Very good.

- - -

EXAMINATION

- - -

BY MR. PODRAZA:

Q. Good morning, Dr. Emery.

A. Good morning.

Q. My name is Joe Podraza and I represent the plaintiffs in litigation involving the medical examiner's office, the City of Philadelphia, and Dr. Osbourne. Today

1 is a deposition. Have you ever been deposed
2 before?

3 A. Yes.

4 Q. How recent has it been since
5 you had your last deposition?

6 A. It's been a while, a couple
7 years.

8 Q. All right. So why don't we
9 just review some of the general frameworks of
10 a deposition.

11 The first thing is, it's a
12 question and answer format. Counsel will have
13 an opportunity to ask you a question and once
14 they are completed with the question you'll be
15 expected to provide an answer to that
16 question. Understand that?

17 A. Yes.

18 Q. Very importantly, even though
19 you're being videotaped, the court reporter is
20 capable of taking down one person at a time
21 and what they are saying. So it will be very
22 important for you to wait for counsel to
23 complete their question and counsel will do
24 their best to discipline themselves to allow

1 you to answer it and fully answer it before
2 asking further -- proceeding further with
3 questioning.

4 This is not a test of
5 endurance. If at any time you need to use the
6 facilities, just stretch your legs, you know,
7 feel free to let us know and we'll certainly
8 accommodate any reasonable request.

9 Is there any reason today that
10 you would be incapable of understanding a
11 question or responding to it truthfully
12 because of a mental state or medication you
13 may be taking, things of that nature?

14 A. No.

15 Q. All right. Then why don't we
16 start with a little bit of your background.
17 Where did you go to medical school?

18 A. I went to medical school at
19 Boston University School of Medicine in
20 Boston, Massachusetts.

21 Q. And from when to when were you
22 at the school?

23 A. The total time I spent there
24 was from 2003 to 2011 and that eight years was

1 spent doing a combined MD/Ph.D. program.

2 Q. And did that include -- did the
3 Ph.D. program include the residency
4 fellowship?

5 A. No. Those are separate.

6 Q. Okay.

7 A. Separate training. So eight
8 years just in Boston, four years in, like,
9 tradition medical school, and four years
10 pursuing a Ph.D. in a program called Molecular
11 Medicine.

12 Q. Very good. At some point, I
13 take it, you specialized in pathology?

14 A. Yes. I actually came to
15 Philadelphia to the University of Pennsylvania
16 in -- it would have been July of 2011 to start
17 a combined residency and fellowship program
18 that was four years in duration. The
19 residency program was in something called
20 Anatomic Pathology, that's basically
21 diagnostic pathology, autopsies, things
22 that -- looking at things under the
23 microscope, et cetera, and then a two-year
24 fellowship program in neuropathology.

1 Q. And you would have completed
2 that, your studies at the University of
3 Pennsylvania, by when?

4 A. It was May or June of 2015.

5 Q. And, incidentally, while --
6 when you were at the University of
7 Pennsylvania, were you predominantly studying
8 at HUP or CHOP or both?

9 A. Exclusively -- well, fair
10 question. Mostly at HUP, I mean, that is
11 where the program is associated and where my
12 training is accredited to, but they had a
13 relationship with CHOP whereby we did some
14 rotations, a few months worth of rotations
15 doing some pediatric pathology, et cetera, at
16 CHOP, but the -- my residency certificate
17 comes from the Hospital of the University of
18 Pennsylvania.

19 Q. Then at any time between
20 July 2011 to when you completed the program,
21 as I understand it, in May of 2015, did you
22 study under Dr. Rorke?

23 A. I did interact with Dr. Rorke
24 on occasion. She was, I believe, on her way

1 to retiring, so she was not there the entire
2 time I was there, but I interacted with her
3 peripherally.

4 Q. All right. So would it be more
5 social versus professional?

6 A. No, it would have only been
7 professional, but I was never directly under
8 her training.

9 Q. I see. Did she have any role
10 or participation at all in any -- I'm going to
11 call them projects or clinical performances
12 that you performed?

13 A. No.

14 Q. Who did you predominantly study
15 under when you were associated with the Penn
16 program?

17 A. For residency or for
18 neuropathology fellowship?

19 Q. We can break that down. Let's
20 start with residency and then you can talk
21 about the fellowship.

22 A. So there are 20 to 30
23 pathologists at HUP, so there were lots of
24 people whom I studied under. The program

1 director -- there was actually several in my
2 time, but that would be who anointed me a
3 pathologist, her name was Kathy Montone.
4 She's still there. I don't believe she is
5 still the program director. This is the
6 residency program director.

7 Q. Okay?

8 A. And then in my time as a
9 neuropathology fellow, the director -- I was
10 under lots of neuropathology faculty I trained
11 with, but the director of the program is --
12 his name is Zissimos Mourelatos. Rolls right
13 off the tongue.

14 Q. That's a challenge. Can you
15 help the court reporter, perhaps, on the
16 spelling of that name?

17 A. For Zissimos, sure. His first
18 name is Z-I-S-S-I-M-O-S, and then Mourelatos
19 is M-O-U-R-E-L-A-T-O-S, close to that anyway.

20 Q. At any time when you were
21 studying, either medical school, residency, or
22 fellowship, did you have any criticisms of
23 your work or anything of that nature, anything
24 that would have been less than satisfactory?

1 A. No.

2 Q. And after you graduated the
3 fellowship in May of 2015, what did you do?

4 A. I then went back to Boston for
5 a year-long -- a 12-month long forensic
6 pathology fellowship.

7 Q. And where was that at?

8 A. That was at the Boston -- they
9 call it the office of the chief medical
10 examiner. It's a state-wide system serving
11 the state of Massachusetts, but it's located
12 in Boston.

13 Q. And you studied from what
14 period of time to when?

15 A. That was from July 2015 to
16 June 2016.

17 Q. Were you within the medical
18 examiner's office in Massachusetts when their
19 accreditation was under attack?

20 A. No. I don't think -- I believe
21 they were fully accredited with -- I am
22 assuming you mean name accreditation, National
23 Association of Medical Examiners?

24 Q. Yes.

1 A. I believe -- my recollection is
2 that they were accredited without issue while
3 I trained there.

4 Q. Did the attack on the
5 accreditation in Massachusetts occur prior to
6 or after your time within the Massachusetts
7 system?

8 A. It was well before my time
9 there.

10 Q. And what was your understanding
11 of the nature of the attack on the
12 accreditation?

13 A. I honestly have no idea. I
14 don't know anything about it.

15 Q. If I suggested to you it was
16 sloppy work and failure to timely perform
17 autopsies and reports, would that help refresh
18 your recollection?

19 A. No. I don't -- I really don't
20 know anything about it.

21 Q. And when you were with the
22 Massachusetts program, who predominantly was
23 in charge of the program?

24 A. Again, there were several

1 forensic pathologists who are, you know,
2 medical examiners at that office, but the
3 program director's name is Kimberly, spelled
4 normally, Springer, S-P-R-I-N-G-E-R.

5 Q. And the facility at the medical
6 examiner's office in Massachusetts, was that
7 based in Boston?

8 A. Yes, Albany Street.

9 Q. Did you ever work in the
10 western part of the state of Massachusetts?

11 A. I did not.

12 Q. And after you completed
13 additional fellowship studies in
14 Massachusetts, what did you do then?

15 A. I came back this way
16 geographically to take my first job out of
17 training for the State of Delaware as an
18 assistant medical examiner.

19 Q. And who was the medical
20 examiner when you were the assistant in
21 Delaware?

22 A. The chief -- he is still
23 there -- his name is Gary Collins,
24 C-O-L-L-I-N-S.

1 Q. So you have familiarity with
2 Dr. Collins; is that correct?

3 A. I do. I know him and he was my
4 boss for a little while.

5 Q. Did he ever do performance
6 reviews for you as an associate medical
7 examiner?

8 A. I don't remember any, but he
9 should probably have been, but I don't recall
10 them specifically.

11 Q. Do you have any recollection of
12 any of the reviews being critical of any
13 aspect of your services?

14 A. If they happened, they were not
15 critical.

16 Q. Okay. Well, that's good to
17 know.

18 A. Best I got.

19 Q. Did you have a lot of respect
20 for Dr. Collins?

21 A. Yes. He's a great pathologist.

22 Q. When did you first get involved
23 in any aspect of the Ellen Greenberg matter?

24 A. It was the summer -- sometime

1 in the summer of 2019, and I do not know the
2 exact day or time or, you know, even week.

3 Q. Okay.

4 A. And I was approached with a
5 case number. You know, I didn't know any
6 names. I didn't know any information about
7 the case.

8 Q. Okay. Well, before we get into
9 the details of what you did and, you know,
10 some of the specifics of the exam, am I
11 correct that you do not perform neuropathology
12 services for the medical examiner's office in
13 Philadelphia?

14 A. Correct.

15 Q. All right. But you are trained
16 and certified as a neuropathologist, correct?

17 A. Yes.

18 Q. Now, who does the
19 neuropathology work for the medical examiner's
20 office in Philadelphia?

21 A. Currently, they have two
22 consultants. One's name is Juan Troncoso. I
23 have no idea how to spell that. He's
24 somewhere in Maryland. He comes up here

1 physically to Philadelphia to do the trauma
2 brains, so the injury related brains. And
3 then there is a pathologist --
4 neuropathologist at Jefferson named Larry --
5 Lawrence is his first full name -- Kenyon. He
6 does the nontraumatic brains for the office.

7 Q. Okay. And I'm sorry. I
8 neglected -- before I just jump right into the
9 Greenberg matter, you're in Delaware, you're
10 an assistant medical examiner?

11 A. Yes.

12 Q. Forgive me. I did not write
13 down when you started there. What year did
14 that start?

15 A. That was immediately following
16 fellowship, so it was July 2016, is when I
17 started, and I left there October 2017.

18 Q. And when you left there in
19 October of 2017, is that when you began your
20 association with the medical examiner's office
21 in Philadelphia?

22 A. Yes. I left the job in
23 Delaware to start my job here.

24 Q. All right. And from 2017 to

1 present, the neuropathology has been performed
2 by third parties for the medical examiner's
3 office in Philadelphia?

4 A. Yes.

5 Q. And that's the pathologist
6 you're talking about at Jefferson as well as
7 the one down in Maryland, correct?

8 A. Correct. Yes.

9 Q. And the one down in Maryland is
10 associated with Johns Hopkins; isn't that
11 correct?

12 A. I believe so, yes.

13 Q. Now, are you aware whether the
14 neuropathologists at Jefferson or the
15 neuropathologists associated at Johns Hopkins,
16 have they with been asked to consult on the
17 Greenberg case?

18 A. I do not -- I don't know.

19 Q. Okay. All right. We are in
20 the summer of 2019. You get a case number.
21 Just tell me what you remember what you were
22 told and what you were asked to do.

23 A. Yeah. It's -- I would describe
24 it as what I call a curbside -- like the

1 curbside of a road -- whereby, like, one
2 medical professional asks for some informal
3 advice, opinions in an area that is more of an
4 expert -- area of expertise for them than
5 themselves, right. So, basically, the
6 question was posed to me: "Hey, would you
7 mind taking a look at this case from 2011,
8 just the neuropathology relevant material, and
9 let me know what you think about it?" And
10 that was the extent of the conversation.

11 Q. Who asked you that?

12 A. Dr. Gulino.

13 Q. And Dr. Gulino, who is and
14 remains the medical examiner of Philadelphia?

15 A. Yes.

16 Q. All right. Was there a
17 specific aspect of the neuropathology that Dr.
18 Gulino was interested in possible
19 ramifications of that anatomic consideration?

20 A. Not that he expressed to me. I
21 was just asked to take a look without bias and
22 offer an opinion, what I saw and what I
23 thought about what I saw.

24 Q. All right. So you had no idea

1 what you were going to be looking at or what
2 the purpose was --

3 A. No.

4 Q. -- besides just, "Here it is.
5 Tell me what you see"?

6 A. Yes.

7 Q. Okay. Now, you refer to it as
8 a curbside. Dr. Gulino has kind of referred
9 to examinations and, as I understand it -- and
10 correct me if I'm wrong -- he differentiated
11 between a curbside and a thorough, full
12 examination. Do you also have that
13 differentiation?

14 A. Yes.

15 Q. Okay. Would a curbside be --
16 well, rather than I tell you, tell me,
17 materially, what's the difference between a
18 full, thorough neurological --
19 neuropathological exam and a curbside
20 neuropathological exam?

21 A. So -- and it can apply to
22 anything in medicine, right, any aspect of
23 medicine, but whereby, again, somebody has
24 additional expertise or experience in some

1 aspect of that field and a colleague -- this
2 is describing a curbside -- and a colleague
3 asks for your advice, your input, your
4 experiential knowledge and expertise about a
5 given thing. It's informal. There's not --
6 there's just no -- it's a level of formality,
7 is the difference. Whereas, I would say a
8 consultation is -- there is an understanding
9 and an agreement about what the examination is
10 and will require and then what the output of
11 that is, usually in the form, at least in my
12 experience as a neuropathologist, a formal
13 written report.

14 Q. Okay.

15 A. And, generally, in a formal
16 situation that person is compensated for their
17 time and experience.

18 Q. All right. So is there a
19 qualitative difference between a curbside exam
20 and a thorough exam?

21 A. There does not have to be
22 qualitative difference, no.

23 Q. I understand that, but I am
24 asking you, with respect to what Dr. Gulino

1 was asking you to do, was there a qualitative
2 difference between how you approached it if it
3 had been, for instance, a consultation versus
4 an informal request?

5 A. I treated the material the same
6 way I would have if I was formally consulting
7 on the case.

8 Q. Were you aware if a
9 neuropathological exam had previously been
10 performed with respect to the Ellen Greenberg
11 matter?

12 A. No. What I remember in
13 discussion was that it was unclear if there
14 had ever been a neuropathologic evaluation --

15 Q. And what discussions --

16 A. -- formal or otherwise.

17 Q. Okay. What discussions are you
18 referring to now regarding whether a
19 neuropathological exam had been performed
20 prior to yours?

21 A. It was in the same conversation
22 where I was approached to look at the material
23 and was, you know, something to the effect of
24 "I don't know if anybody has ever looked at

1 this or not," is my memory.

2 Q. Had it been shared with you
3 that there was a request to revisit the
4 Greenberg case and potentially reassess the
5 original determination and manner of death?

6 A. Not at that time.

7 Q. Again, without getting into the
8 specifics -- and we'll get into them, believe
9 me -- how long does it take to perform this
10 informal examination --

11 MS. BERKOWITZ: Objection.

12 BY MR. PODRAZA:

13 Q. -- in this case?

14 BY MR. PODRAZA:

15 Q. Well, you did an informal
16 examination, correct?

17 A. I did.

18 Q. Yes. How long did it take you
19 to perform it?

20 A. I would say, the gross
21 examination, probably 45 minutes or an hour.

22 Q. Okay. Was there any other
23 aspect of the examination besides gross?

24 A. Yep. I took some sections to

1 look at under the microscope.

2 Q. And why did you do that?

3 A. It's one way of maintaining the
4 material, number one, so that it can be looked
5 at in perpetuity and, two, it could
6 potentially have answered other questions that
7 I had about the -- about the material that I
8 was looking at, gross.

9 Q. What were the questions?

10 A. Were these -- were these
11 disruptions in the tissue that I was seeing,
12 was there cellular consequences to that. So
13 at the cellular level, me being able to look
14 at them under the microscope, were they
15 damaged or not.

16 Q. Now, 2019, I guess we can agree
17 that there is approximately -- well, more than
18 eight years since Ellen's death you're being
19 asked to perform this examination, correct?

20 A. Yes.

21 Q. All right. And you mentioned
22 that you did sections because -- one of the
23 things is to maintain the material, correct?

24 A. Yes.

1 Q. All right. What sections had
2 been done prior to your performance of
3 sections in 2019 in the Ellen Greenberg case?

4 A. I did not have that material
5 and I don't know if there were sections ever
6 taken or not.

7 Q. Did you ask?

8 A. No.

9 Q. If sections existed that had
10 been done prior to your examination, would
11 they be of any help or assistance at all to
12 you in the examination you were being asked to
13 perform?

14 A. Not in the examination I was
15 being asked to perform.

16 Q. In comparison between you doing
17 sections and then evaluating the sections
18 for -- I think you -- strike -- let me do a
19 little bit better with this question.

20 In an exam that doesn't take
21 sections versus one that does sections and, I
22 presume, has a better aspect of disruption of
23 tissues, et cetera, which exam would you give
24 more credence to?

1 A. That depends completely on the
2 case, on a case-by-case --

3 Q. How about in Ellen's case?

4 A. Reask it with regards to this
5 case, please.

6 Q. Sure. As to the findings that
7 you made when you did your examination in
8 Ellen's matter, having taken and performed the
9 sections and looked at them under the
10 microscope, in comparison to an exam that may
11 have been done that didn't take sections or do
12 a microscopic exam, from your vantage point as
13 a professional, which examination would you
14 give more credibility to?

15 A. I don't think that there's any
16 difference in credibility. I think that by
17 looking at something under the microscope in
18 this particular case may have had some useful
19 information.

20 Q. And what useful information
21 might that be versus an exam not done with
22 sections or with microscopic evaluation?

23 A. Were the things that I was
24 seeing grossly with the naked eye impacting

1 the underlying tissue and involved tissue at a
2 cellular level.

3 Q. And can you explain, how is it
4 that by doing the sections with the
5 microscopic examination you feel more
6 comfortable or confident that you can make
7 that assessment of, you know, the anatomical
8 consequences, et cetera?

9 A. Because I am able to see it at
10 a cellular level. I'm able to assess things
11 that I can't, obviously, do with a regular old
12 human eye. So it's just looking at it at a
13 finer level of detail. But there are plenty
14 of questions that can be answered without
15 histology, without looking at them under the
16 microscope.

17 Q. And yet you still felt
18 compelled to take sections and perform a
19 microscopic examination?

20 A. I did.

21 Q. What motivated you to take that
22 extra step?

23 A. Curiosity about the question at
24 hand, which was, does that -- did that

1 disruption have significance.

2 Q. Would you have felt as
3 comfortable about your examination if you had
4 not done sections, the microscopic
5 examination, and just relied on a gross or
6 naked eye review?

7 A. In this case, the microscopic
8 sections helped me form an opinion.

9 Q. And you're not aware of any
10 other pathologists or neuropathologists having
11 performed sections or microscopic examination
12 in the Greenberg case prior to yours; is that
13 correct?

14 A. I do not know one way or the
15 other. The tissue that I examined is only --
16 is the tissue that I examined. I don't know
17 what other, you know -- what happened to the
18 rest of it or who looked at the rest of it,
19 you know, to your point, eight years earlier.

20 Q. Okay. Now, what were your
21 conclusions?

22 A. So, I mean, generally speaking,
23 there are some injuries to -- of what I had to
24 evaluate, which was a limited amount of

1 material. There was a sharp force injury to
2 the dura matter, which is the covering of both
3 the brain -- one of the coverings of the brain
4 and the spinal cord -- and I'm talking about
5 in the spinal cord specifically -- and that
6 there was also disruption of the same --
7 coverings that directly covered the tissue
8 itself, so directly covered the spinal cord
9 itself, and that in those areas of what are
10 injury there's no reaction to it. So there's
11 no hemorrhage around it. There appears to be
12 no response of the surrounding environment.
13 There is further disruption -- and I am using
14 that word on purpose -- of the spinal cord
15 parenchyma. So the tissue itself, the spinal
16 cord itself in this area, that is what I
17 wanted to interrogate microscopically by
18 looking at it under the microscopic
19 examination. Both the gross findings -- so
20 what I could see with my eye and what I saw
21 under the microscope -- was that there was no
22 vital reaction to these things that -- in this
23 area of the spinal cord, of what I had of the
24 spinal cord to evaluate.

1 So my conclusions about that
2 are -- essentially, there are three
3 possibilities. One is that the sharp force
4 injury to what would have been the back of her
5 neck entered into the vertebral column, the
6 cervical vertebra, and pierced or went through
7 that dura, that layer of covering I was taking
8 about, and just didn't go any farther and
9 maybe that there wasn't sort of a long enough
10 survival interval for there to be reaction
11 hemorrhage, et cetera.

12 The second possibility, of
13 which there are two arms to, are that those
14 injuries happened postmortem, after her death.
15 One is that the sharp force injury in and of
16 itself happened period, point blank after she
17 had been deceased, so that there would be no
18 reaction to it, or that -- again, and this is
19 kind of in line with my first explanation --
20 that, while there may have been a sharp force
21 injury to her neck and to the dura, that that
22 disruption I'm seeing in the spinal cord was a
23 postmortem artifact introduced during the
24 autopsy.

1 Q. Okay. Now, I want you to
2 pretend you're a layperson. Are you
3 telling -- do I just understand what you just
4 said is there that Ellen suffered wounds after
5 she died?

6 A. I'm saying either the wound
7 didn't -- that's one possibility, yes.
8 Another possibility is that that sharp force
9 injury, or something caused by a sharp object,
10 did not disrupt or injure tissues enough to
11 cause any sort of reaction to it, hemorrhage,
12 cellular death, again, response. There is no
13 reaction to it. The injury itself, then, if
14 it happened while she was alive, is minor.

15 Q. But you can't conclusively
16 differentiate as to whether the wound was
17 administered before she died or after? It's
18 just a possibility?

19 A. Based on what I am seeing in
20 the spinal cord.

21 Q. Now, if I understood you --
22 and, again, I am not trying to put words in
23 your mouth, so please feel free to correct
24 what I am saying. I thought I understood you

1 to say that there was no reaction, such as
2 hemorrhage, et cetera, and I thought you said
3 that that could have been because she was
4 already dead?

5 A. That is a possibility, correct.

6 Q. And from your examination, did
7 the spinal column at all have any type of cut
8 or wound?

9 A. What part of the spinal cord?

10 Q. Well, I guess -- there's the
11 two wounds to the back through the neck.
12 Either one of them, did they indicate any
13 trauma of cutting or piercing or anything of
14 that nature to the spinal column in addition
15 to the dura?

16 A. There is a corresponding defect
17 of the vertebral column. So, yes, there is
18 injury to the bone -- excuse me -- the bone
19 and ligaments of the back of the spinal -- the
20 actual spinal column, the vertebral column,
21 and then there is also a corresponding cut of
22 the dura. So those two things are there.

23 Q. And based on your experience,
24 what are the anatomical consequences of that

1 type of wound?

2 A. If those injuries -- which is
3 what it appears to be based on what I have
4 examined -- stopped there, right, so they
5 go -- the sharp object, whatever it is, gets
6 through the dura and doesn't do anything else,
7 doesn't go deeper than that, there would be no
8 consequences to that.

9 Q. Well, there would be a hell of
10 a lot of pain, wouldn't there be?

11 A. Possibly.

12 Q. Yeah. Well, there's a lot of
13 nerves within the region of that dura that
14 were severed as a result of that blow,
15 correct?

16 A. So the dura is actually not
17 innervated by anything, so --

18 Q. Around it?

19 A. But if it didn't strike
20 anything around it, nothing was injured along
21 the way, there could have been minimal pain.
22 I don't know about the pain.

23 Q. Are you suggesting that there
24 were no nerves that were implicated in either

1 of those two wounds?

2 A. There doesn't necessarily have
3 to be, no.

4 Q. But you don't know? Is that
5 your answer?

6 A. I don't know for sure.

7 Q. And if the nerves had been
8 involved, can we agree that that would, from
9 your experience and understanding, result in
10 pain?

11 A. Sure.

12 Q. In fact, we are going to show
13 you some testimony from Dr. Gulino in a little
14 bit here. He even agreed that it could be
15 incapacitating pain. You agree with that?

16 A. I don't -- I don't -- not
17 necessarily, no.

18 Q. All right. Well, then, based
19 on your conclusions, could we agree that
20 homicide is not ruled out based on your
21 conclusions?

22 A. Based on my conclusions, I have
23 no opinion about the manner of death.

24 Q. You need more information, is

1 that what you're saying?

2 A. Yes.

3 Q. But based on what you saw and
4 as I understand how you've testified here
5 today, somebody else could have administered
6 the wounds that you examined to Ellen,
7 correct?

8 A. That's a possibility, yes.

9 Q. And you couldn't rule that out
10 based on your examination, right?

11 A. Correct.

12 Q. Now, are you suggesting that
13 it's also possible that Ellen was still able
14 to move?

15 A. Yes.

16 Q. And did you recreate the
17 wounds?

18 A. In what way do you mean that?

19 Q. In other words, did you
20 actually try to recreate anatomically and from
21 a physiological standpoint the nature of the
22 wounds as described by Dr. Osbourne and the
23 knife and whether it is practical or
24 impossible for her to have self administered?

1 A. No, I did not go into any
2 degree of that sort of detail.

3 Q. And do you know when the wounds
4 to the back of Ellen occurred in the sequence
5 of wounds? In other words -- let me ask it
6 this way: Presuming there is 20 wounds in
7 total that were found by Dr. Osbourne, in the
8 sequence of those wounds, where did the ones
9 in the back, the tissues for which you
10 examined, occur?

11 A. I don't know. I don't know
12 enough about the rest of the wounds to make a
13 determination about that.

14 Q. What would you need to know in
15 order to perhaps make that assessment?

16 A. I mean, I would need to review
17 the case in its entirety and there may not be
18 an answer. I may not be able to tell.

19 Q. Would the biopsy of the region
20 of the wounds assist in possibly determining
21 the timing of the occurrence of each one?

22 A. Throughout the body?

23 Q. Yes.

24 A. Not necessarily. If there's

1 hemorrhage, right, if there is bleeding around
2 the injury, she had a pulse to some degree in
3 order to hemorrhage from those injuries. So I
4 don't know that microscopically looking at all
5 of those would be useful in determining a
6 sequence of injury.

7 Q. Have you ever done that,
8 though, in a stabbing case or in an injury
9 case, biopsied the wound in an effort to
10 ascertain the sequencing of the wounds?

11 A. I have not personally, no.

12 Q. Do you know other pathologists
13 or neuropathologists who do?

14 A. In neuropathology specifically,
15 one thing that we do commonly is date to the
16 best we can, so give an age, for a type of
17 intracranial hemorrhage called a subdural
18 hemorrhage, which is not involved in this
19 case. And that's a matter of, "Is it acute?"
20 Meaning new, "Is it subacute?" sort of new, or
21 "Is it old?" you know, months to years, and
22 that's about the best we can do even with
23 those. That's the only thing that I
24 personally routinely date in my pathology

1 career.

2 Q. Okay. Walk me through what
3 happened after you reach -- you're done your
4 examination. What did you do after you
5 reached your conclusions?

6 A. Discussed them with Dr. Gulino.

7 Q. Do you recall about when that
8 discussion took place?

9 A. No, I have no idea when that
10 was.

11 Q. Would it be fair to say,
12 though, that you shared with Dr. Gulino your
13 view that Ellen could have been dead at the
14 time one or both of the wounds in the region
15 that you were examining occurred? Did you
16 share that with him?

17 A. Are you asking if I shared that
18 with him? I believe so, because it would have
19 been one of my conclusions then.

20 Q. Did you put your conclusions or
21 any aspect of your examination in a writing?

22 A. No.

23 Q. Would I be correct, though,
24 that the examination that you performed and

1 evaluation of Ellen was done during business
2 hours?

3 A. Yes.

4 Q. Okay. So it was while you were
5 being paid by the taxpayers to perform the
6 service, right?

7 A. Yes.

8 Q. Okay. And traditionally, when
9 you are in your official capacity being paid
10 to perform a service, do you generate a
11 report?

12 A. I do.

13 Q. Why did you not -- I will try
14 English this time. Why did you not do so in
15 this case?

16 A. Because one of my official
17 capacities here is not neuropathology.

18 Q. I am not understanding. Does
19 that mean you don't consider yourself
20 competent enough to do a neuropathological
21 examination as requested by Dr. Gulino because
22 it's not your official capacity?

23 A. What I am saying is that I was
24 curb-sided, I was asked to do an informal

1 examination, and the discussion that Dr.
2 Gulino and I had was that he would -- we would
3 discuss my opinions and he would incorporate
4 them into his own summary report and that
5 was --

6 Q. I'm sorry. I violated my own
7 rule of not interrupting the witness. I
8 apologize. Did you want to --

9 A. No. I am good. I am all set.
10 Thank you.

11 Q. Did Dr. Gulino ever do a quote,
12 summary, end quote, report?

13 A. I don't know.

14 Q. Have you ever seen one?

15 A. No.

16 Q. Give me one second, if you
17 don't mind.

18 A. Sure.

19 Q. The samples that were made
20 available to you for examination, were they
21 the ones that were, for lack of a better
22 statement, collected by or under the
23 supervision of Dr. Osbourne?

24 A. I would assume that, but I

1 don't know. It was what was in the stock jar,
2 which is something that we retain on every
3 case, you know, representative portions of
4 organs, and so this was just what was
5 available to me. I don't know who procured
6 that. I mean, typically, it's the performing
7 pathologist.

8 Q. Now, the trauma to the regions
9 that you examined both from a gross as well as
10 microscopic standpoint, was that caused at all
11 by any actions done during the autopsy?

12 A. It could have been.

13 Q. How?

14 A. So, specifically, the injury to
15 the vertebral column itself, to the bony
16 structure of the spinal cord and that spinal
17 cord dura, subtracting that, that -- those are
18 injuries. They are sharp force injuries that
19 the decedent had.

20 Q. All right. So those are not
21 associated with the autopsy?

22 A. Yes.

23 Q. And those, we can agree --

24 MS. BERKOWITZ: Objection. Is

1 she finished?

2 BY MR. PODRAZA:

3 Q. And those, we can agree, could
4 have been administered to Ellen after she had
5 already died?

6 A. Or while she was still alive,
7 but, yes.

8 Q. Either way?

9 A. Right.

10 Q. Okay. Now, which ones, then,
11 did you have a question as to whether the
12 performance of the autopsy itself resulted in
13 damage?

14 A. So the actual disruption of the
15 tissue of the spinal cord itself, so the
16 parenchyma, again, the tissue structure of the
17 spinal cord, had a surface defect on it that
18 was sort of irregular looking, kind of jagged
19 in appearance and almost cylindrical in shape,
20 if you're following me. And that was strange
21 to me for two reasons, number one, it just
22 didn't look like a sharp force injury, and,
23 number two, it was not in perfect correlation
24 with -- if you did line up and realign the

1 injuries of the vertebral column and the dura,
2 this defect of the spinal cord itself wasn't
3 in direct continuity with that.

4 Q. Now, presuming that this
5 disruption we are talking about now was not
6 attributed to the actual performance of the
7 autopsy, what would you anticipate the
8 physical consequences of that injury to be to
9 Ellen?

10 A. Right. So microscopically,
11 again, histologically, what I saw under the
12 microscope was that there was no response. So
13 I don't have any way to know how that would
14 have affected her. Where it is in the spinal
15 cord, things that are affected by that are
16 sort of -- coordination of movements, being
17 able to -- like, fine motor skills, that kind
18 of thing, and then pain, pain can be involved
19 in that too, and sensory perception, so your
20 ability -- your body's knowledge of where it
21 is in space and time.

22 Q. All right. So assuming that
23 the disruption that we are talking about was
24 non-autopsy related, can we agree, then, that

1 the possibility remained open that Ellen, just
2 through the consequences of that injury, might
3 have had coordination of movement problems,
4 maybe not even been able to move at all as a
5 result of that injury, correct?

6 A. I think if there were
7 coordination problems there would still
8 be able -- she would still be able to move and
9 make non-fine -- unfine motor skills.

10 Q. All right. But her skills
11 would be -- you would anticipate it to be
12 reduced or impaired?

13 A. Maybe.

14 Q. And possibly even eliminated?

15 A. I don't think that the injury
16 is severe enough or the disruption is severe
17 enough to be incapacitated.

18 Q. But we agree that we would
19 expect pain?

20 A. If there's deficit, there could
21 be pain, yes.

22 Q. What I would like to show you
23 now is what we are going to mark as Emery-1.
24 And, as I told you, this is going to be

1 testimony that Dr. Gulino provided in this
2 case.

3 A. Okay.

4 Q. We are just going to go over it
5 and, to the extent that you can, I am just
6 going to ask you if you agree or disagree.

7 A. All right.

8 - - -

9 (Whereupon, Exhibit-1 was
10 marked for purposes of
11 identification.)

12 - - -

13 BY MR. PODRAZA:

14 Q. All right. And, Doctor, we are
15 going to put this up on the screen, so let us
16 know, one, that you can see it.

17 A. I can see it.

18 Q. Okay. And then, two, as we
19 scroll through, you know, you'll be able to
20 tell my colleague when you need him to move up
21 or down or however to, you know, familiarize
22 yourself.

23 A. Okay.

24 Q. We are not going to ask you

1 today to read the entire deposition.

2 A. Thank you.

3 Q. I am going to focus on Page 55,
4 we are going to start. And if I could draw
5 your attention -- and you're welcome to read
6 whatever you'd like, but I am going to draw
7 your attention to Line 10 on Page 55. Do you
8 see that there?

9 A. Line 10, Page 55, yes.

10 Q. And there's a question: "All
11 right. Now, Doctor, in your experience, a cut
12 dura, can that be painful?" And his answer
13 was "Yes." And my question to you is: Do you
14 agree or disagree with Dr. Gulino's testimony?

15 A. I disagree.

16 Q. And why do you disagree with
17 his testimony?

18 A. I just think a blanket
19 statement of a cut dura being painful is not
20 something I agree with. Could it be, yes.

21 Q. Then I asked -- okay. And then
22 the next question was: "How painful?" And
23 his response was: "I don't know, but,
24 generally speaking, the area surrounding the

1 meninges --"

2 A. Meninges, yes.

3 Q. -- "meninges," okay, "which is
4 collectively the name of the coverings of the
5 brain and spinal cord, have nerves in them and
6 so disrupting them will be painful." Do you
7 agree or disagree with that testimony?

8 A. I disagree.

9 Q. And why do you disagree?

10 A. Because the dura itself is not
11 innervated or is innervated to a very -- a
12 much lesser degree. There are multiple layers
13 of the meninges which he's referencing, some
14 of them which sit right on top of the brain,
15 those could certainly be painful if they are
16 disrupted or injured, but the dura itself, I
17 disagree.

18 Q. Then on Page 56 at Line 13 Dr.
19 Gulino was asked: "And would the cut of the
20 dura affect an individual's mobility?" And
21 his answer was: "It would not affect their
22 mobility from a neurologic standpoint. If it
23 was so severe that it was debilitating and the
24 person just couldn't do anything else, then,

1 yes." Do you agree or disagree with Dr.
2 Gulino's testimony?

3 A. I agree with the first part --
4 the first sentence of that answer, which is
5 that it would not affect their mobility.

6 Q. And why do you disagree with
7 the remainder?

8 A. I just don't really understand
9 the rest of that.

10 Q. Okay. Then on Page 57, Dr.
11 Gulino was asked at Line 17: "Doctor, has it
12 been your experience that a cut of a dura
13 could render somebody incapable of feeling so
14 that they could self inflict or harm
15 themselves without even feeling it?" And his
16 answer is: "I can't say that I have ever had
17 a case in which that question has been posed."
18 The question then was: "Well, I'm posing it
19 right now. Based on your experience and the
20 cut of the dura, are you aware of any
21 circumstance where the cut rendered a person
22 such that they would feel no pain from that
23 point forward?" And his answer was "No."

24 A. Can I see the next part of

1 that? It's just not on the screen.

2 Q. Certainly.

3 THE VIDEOGRAPHER: Up or down?

4 MR. PODRAZA: Page 58. I think
5 you're going to have to --

6 THE WITNESS: I'm sorry. Down.
7 Can you just reread for me the second
8 part of that, the second question,
9 where you say, "I'm posing it now" and
10 then -- that question?

11 BY MR. PODRAZA:

12 Q. Sure. It was: "Doctor, has it
13 been your experience that a cut of a dura
14 could render somebody incapable of feeling, so
15 that they could self inflict or harm
16 themselves without even feeling it?" And his
17 answer was: "I can't say that I have ever had
18 a case in which that question has been posed."
19 The question then was: "Well, I'm posing it
20 right now. Based on your experience and the
21 cut of the dura, are you aware of any
22 circumstance where the cut rendered a person
23 such that they would feel no pain from that
24 point forward?" And his answer was: "No."

1 Do you agree or disagree?

2 A. I agree.

3 - - -

4 (Whereupon, Exhibit-2 was
5 marked for purposes of
6 identification.)

7 - - -

8 BY MR. PODRAZA:

9 Q. Now, in discovery -- hold on
10 one second here. Did we cover everything
11 there, Will? Yes, we did.

12 In discovery, counsel recently
13 supplied to us a form that we are going to
14 mark as Emery-2. It's a neuropathology
15 examination. And I am going to ask if you can
16 identify the form and then if you could walk
17 us through it.

18 A. I can see the form and I can
19 identify it. It is my chicken scratch of
20 notes that I took when I examined the
21 material, the neuropathology material applying
22 to Case 11-420.

23 Q. All right. And the date is
24 August 29, 2019, at least that's what has been

1 put in by handwriting?

2 A. Correct.

3 Q. Does that correspond to when
4 you recall performing the evaluation in the
5 Greenberg case?

6 A. If that's what I dated it,
7 that's when we did it.

8 Q. All right. You have no reason
9 to question that, right?

10 A. No.

11 Q. I'm sorry?

12 A. No, no reason to question that.

13 Q. All right. Then, if you could,
14 you can help us by deciphering your
15 handwriting --

16 A. Sure.

17 Q. -- and what the significance of
18 the recorded information is.

19 A. Sure. So I basically put it
20 into sections -- well, my versions of
21 categorizing the material that I was looking
22 at. I believe it was eight pieces of tissue
23 in total, just of all-comers that I evaluated
24 on August 29, 2020. There were some -- I

1 would have to look at a picture to remember --
2 some coronal sections. So when a brain is
3 dissected by anybody, whether it's a
4 neuropathologist or an autopsy pathologist, we
5 section the brain in the same way and that is
6 to -- so dissect the brain in the same way and
7 that is to make something called coronal
8 sections. It is the same -- you can imagine
9 it as the same plane that a CT scan or an MRI
10 can see it in. So sometimes that can be from
11 head down, like head to toe, or sometimes it
12 can be from front to back, forward to the back
13 of the head. In this case, in neuropathology
14 it's from the front of the head to the back of
15 the head, that is what coronal means. So of
16 what I had of coronal sections to evaluate,
17 that "NL" means normal, so they were
18 unremarkable, "SC" is spinal cord, so I am
19 saying that there's an 8.5 centimeter segment
20 of spinal cord that is available for me to
21 evaluate, I describe a 1.1 centimeter defect
22 of the posterior part of that spinal cord.
23 The next part of that is no hemorrhage," so
24 the "O" with the line through it, no

1 hemorrhage, and then in parentheses I write,
2 "Above" because there is some soft tissue
3 hemorrhage above that. It's actually in the
4 vertebral column, but I know what my notes
5 mean. And then I describe, I think it's 0.3
6 centimeter area of disruption, so that's what
7 we have been talking about, which is that
8 disruption of the actual parenchyma itself, so
9 on the surface of the spinal cord. And those
10 are just my measurements of those things.
11 "Vert" means vertebral column, so the actual
12 bones, I had just a portion of it. I did not
13 have the whole thing. And I am stating that
14 there is 1.1 centimeter defect between C2 and
15 C3, so that's where it is in the vertebral
16 column and then in parentheses posterior,
17 "Post," so it's the back of the spinal cord.

18 Q. All right.

19 A. I took sections. That's my
20 chicken scratch of a section key so that
21 anybody who looks at my -- at the slides that
22 were made knows what's in what, what's in what
23 block. So there are one, two, three -- looks
24 like six total and should be lettered A

1 through F. I just -- it's just my designation
2 for neuropathology, just microscope stuff,
3 that I use an alphabet instead of numbering
4 them. So from -- in cassettes A through D, so
5 the first four, is the section of spinal cord
6 in question, of the actual spinal cord, where
7 that 1 -- I'm sorry -- that 0.3 centimeter
8 defect was, surface defect, I sectioned them
9 in a specific way to be able to see those --
10 see that defect under the microscope, and I'm
11 saying I submitted that -- in what plane I cut
12 it in, so in the sagittal plane, I submitted
13 it in toto, meaning in total, and I'm going
14 from left to right, so in -- if you're looking
15 -- if you're reviewing the slides, if you're
16 moving from side A to B to C to D, you're
17 going from the left side of the spinal cord to
18 the right side of the spinal cord.

19 Q. Okay.

20 A. Then E is "HC," which is
21 hippocampus. On one of the coronal sections I
22 had, there was a part of the brain, it's part
23 of the temporal lobe -- I don't even know what
24 side it was on, because I only had one side --

1 but it had a structure called the hippocampus,
2 which I wanted to look at under the
3 microscope. So that's in block E or slide E.
4 And then F is cerebellum -- and "CB" stands
5 for cerebellum -- plus dentate, which is one
6 of the deep nuclei of the cerebellum. So that
7 is the summary of my notes.

8 Q. Was there a reason why you
9 wanted to take a look at the specimens -- and
10 I am going to call them E, as in Edgar?

11 A. Yes. So both E and F are -- so
12 there is a process in the brain when the brain
13 is deprived of oxygen by either a low oxygen
14 amount in the blood itself or just decreased
15 blood flow to the brain. It's called hypoxia,
16 is the process. It's on a spectrum from
17 hypoxia to ischemia. The cells -- certain
18 cells in the brain are injured sooner, they
19 die sooner from lack of oxygen than other
20 cells in the brain and it happens in a fairly
21 predictable way and in a fairly predictable
22 order. In adults, the most -- the first
23 things to be affected by decreased blood flow
24 are the hippocampus and the cerebellum. So,

1 because I actually had those to look at, you
2 know, even evaluate, I thought it would be
3 potentially helpful to assess this brain for
4 whether or not there had been some prolonged
5 hypoxia, was the brain cut off from oxygen for
6 some degree of time.

7 Q. And what were your findings?

8 A. That there were no histologic
9 abnormalities in any of the material I looked
10 at and that there was no evidence of hypoxic
11 ischemic injury.

12 Q. And in layperson's language,
13 what significance in the overall review of the
14 case did that have to you?

15 A. That there was not a prolonged
16 period of time that her brain did not have
17 oxygen.

18 Q. And does that have any
19 relevancy as to the determination as to
20 whether Ellen was dead at the time one or more
21 of the posterior wounds was administered?

22 A. No.

23 Q. What was Dr. Gulino's reaction
24 when you shared your conclusions with him?

1 A. I don't -- I mean, he made sure
2 that he understood, you know, what I was
3 trying to explain or convey and what I -- what
4 my conclusions were and that was it. I mean,
5 there was not really a reaction or a response.

6 Q. Did you speak with anybody else
7 or have you spoken with anybody else regarding
8 the Greenberg case except --

9 A. No.

10 Q. -- for you what you described
11 already with Dr. Gulino?

12 A. No.

13 Q. There were some photographs
14 that have been produced. I would like to go
15 through them and we are going to separately
16 mark them and I'm going to just ask you just
17 some questions as to, one, when were these
18 photographs taken, were you part of it or were
19 they back in 2011, you know, things of that
20 nature --

21 A. Sure.

22 Q. -- and what are they depicting.

23 MR. PODRAZA: So we'll start
24 with Emery-3, correct?

1 BY MR. PODRAZA:

2 Q. We have one exhibit of all the
3 photos, so maybe the way to do it, we'll call
4 it Emery-3 and then we'll use the alphabet as
5 to each photo, just so the record is clear as
6 to what we are making reference to.

7 A. Okay. I am not seeing
8 anything. Should I be seeing that already?

9 Q. Yes. We are going to put it up
10 for you.

11 A. All right.

12 - - -
13 (Whereupon, Exhibit-3A was
14 marked for purposes of
15 identification.)

16 - - -

17 BY MR. PODRAZA:

18 Q. We are going to call this
19 Emery-3A.

20 A. Okay.

21 Q. And what are we looking at?

22 A. So this is my photo. I took
23 it. That's my hand in the frame. So this
24 would have been August 29. And we are looking

1 at the back of -- we are looking at a portion
2 of the vertebral column that has been
3 dissected, not by me, at the time of the
4 autopsy, I presume, and it is -- so -- okay.
5 Bear with me. On the right of the -- on the
6 right of the tissue that we are looking at is
7 the first cervical vertebrae. So that's C1.
8 And then as you're going down towards where my
9 fingers are, we are going down towards the
10 toes, if you will, if this was in a standing
11 position. So it's oriented -- it should be
12 flipped -- like, if you wanted it to be in
13 sort of anatomic position, you would put the
14 right side up at the top of the screen.

15 Q. Just so people understand, as
16 you're looking at the photograph, to the right
17 would be where the head would ultimately be
18 found?

19 A. Right. Flip that.

20 Q. Right. You're going down to
21 your lower back?

22 A. Exactly. And the portion that
23 we are looking at right now is the neck, what
24 would be the neck.

1 Q. Very good.

2 A. And this is the inside surface
3 of it. So what we are looking at right now
4 from, you know, this viewpoint is where the
5 spinal cord would be. Okay. So this is
6 the -- it's the posterior aspect of the spinal
7 column, but we are looking at the inside of
8 that. So the other side, if you were to flip
9 that piece of tissue over, would be the actual
10 back side of the spinal cord, okay -- or
11 spinal column, I should say, the vertebral
12 column. And what the silver probe is pointing
13 at is a 1.1 centimeter -- because I just read
14 that off of my notes -- defect. You can see
15 it. See where there's sort of that black
16 discoloration on the right side?

17 Q. Yes.

18 A. Right below that is that linear
19 line-like defect in that tissue, in the
20 vertebral column. So I am pointing that out
21 with the probe and that is what I describe as,
22 again, that 1.1 centimeter defect between C2,
23 C3.

24 Q. And is this the injury or the

1 trauma that you don't know whether it was
2 caused by autopsy or through a wound
3 administered to Ellen?

4 A. So this I can be confident is a
5 sharp force injury, a bona fide sharp force
6 injury, you will. This is not an
7 autopsy-related finding. And I can say that
8 because I have seen the photos from the full
9 autopsy, where I can see the injury to the
10 skin.

11 Q. Let me ask you this, Doctor:
12 The outside -- well, is there any dura present
13 in this photograph?

14 A. No.

15 Q. Okay. This is just pure spinal
16 column?

17 A. Right. The bone, ligaments,
18 you know, the stuff that holds the bone
19 together, but there is no central nervous
20 system here. There is nothing related to the
21 central nervous system in this photo.

22 Q. All right. And what you
23 called, I believe, the 1.1 centimeter defect
24 is that cut?

1 A. Yes.

2 Q. That the spatula is
3 highlighting?

4 A. Correct.

5 Q. So that cut cut through the
6 outside of the spinal column?

7 A. Uh-huh.

8 Q. Into the spinal column itself?

9 A. Yes.

10 Q. Almost to the point of -- well,
11 it goes through, like, half of the spinal
12 column, would we agree, maybe a little more
13 than half the spinal column, that defect?

14 A. So I'm not sure I understand
15 where the half is coming from. I got it.
16 Half of the width you can see or the height of
17 this it's going through?

18 Q. Sure.

19 A. Right. So --

20 Q. Just so I am understanding what
21 you're saying, where that spatula is --

22 A. Yes.

23 Q. -- would be the right side of
24 the spinal column of Ellen, correct?

1 A. Correct.

2 Q. And the penetration is where
3 the spatula is and it goes 1.1 centimeters in
4 across the spinal column towards the left side
5 of Ellen's spinal column, correct?

6 A. Correct.

7 Q. And it crosses the midline
8 correct?

9 A. It does cross the midline, yep.

10 Q. And in your opinion, that would
11 not debilitate a person, that wound by itself?

12 A. No.

13 Q. Would you, though, say it would
14 be painful?

15 A. Yes. It would -- this would
16 probably be painful.

17 Q. Yes. Beyond just simply, like,
18 a stubbed toe? Can we agree on that?

19 A. Sure.

20 Q. Can you quantify it? Can we
21 quantify that a wound of this nature and
22 severity would be extreme pain?

23 A. No, I cannot quantify it.

24 Q. Well, would you anticipate that

1 the pain would be severe?

2 A. No.

3 Q. No? Would it be unrelenting?

4 A. I don't know.

5 Q. Well, in your experience and
6 based on your knowledge, a wound of that
7 nature, would you just expect it to be an
8 instantaneous source of pain and then that
9 pain would go away and stop?

10 A. I honestly don't know what
11 degree of pain this would cause and what the
12 quality of that pain would be and the duration
13 of that pain. I don't know.

14 Q. Well, can we at least agree
15 that that's pain that you and I wouldn't want?

16 A. Yes.

17 Q. And we know that this cut was
18 caused by a knife that was used to wound
19 Ellen, correct?

20 A. I have no idea what implement
21 was involved in the making of this injury.

22 Q. Except that it wasn't caused at
23 autopsy; is that correct?

24 A. This one was not caused at

1 autopsy, correct.

2 Q. Now, is there anything else --
3 let me ask here: Is there any evidence of
4 hemorrhage with this injury?

5 A. So there is hemorrhage in this
6 photo -- that's what that black discoloration
7 is -- but it's not in the usual distribution
8 to be associated with this cut. It's above
9 it.

10 Q. Okay. And the absence of
11 hemorrhage where the trauma is actually
12 situated suggests that Ellen was dead at the
13 time this wound was administered?

14 A. That is one explanation, yes.

15 Q. All right. Is there any other
16 significance that you're trying to depict with
17 this photo?

18 A. No.

19 - - -

20 (Whereupon, Exhibit-3B was
21 marked for purposes of
22 identification.)

23 - - -

24

1 BY MR. PODRAZA:

2 Q. Okay. Then let's take a look
3 at Emery-3B.

4 A. So this is that same block of
5 tissue that we had seen before flipped over,
6 turned over. So this would be, basically, the
7 spinous processes, the bumpy part of your back
8 that you can feel, and I am pointing out to
9 the same defect, again, on the right side of
10 the back of the vertebral column. You can see
11 it, but not very well. But it's the same
12 thing, just, you know, the mirror image,
13 basically. They are flipped, the inverted
14 image.

15 Q. This is that 1.1 centimeter
16 defect?

17 A. Exactly.

18 Q. Is there any other significance
19 of the photo besides what you just described?

20 A. I mean, I think, again, what is
21 significant here is that there is no
22 hemorrhage.

23 Q. And in your experience, no
24 hemorrhage, can it equate to the person having

1 been deceased at the time of the
2 administration of the trauma?

3 A. Yeah. I mean, lack of
4 hemorrhage means no pulse.

5 Q. All right. And is there any
6 other significance right now or am I missing
7 something else that --

8 A. No, I don't think there is
9 anything else important in this photo.

10 - - -

11 (Whereupon, Exhibit-3C was
12 marked for purposes of
13 identification.)

14 - - -

15 BY MR. PODRAZA:

16 Q. All right. Then let's go to
17 Emery-3C.

18 A. Same positioning of the tissue.
19 It's actually just me putting the spatula of
20 the probe through the defect.

21 Q. So --

22 A. It's a demonstration of, like,
23 this is an actual through-and-through defect.

24 Q. Right. So that spatula

1 portion, the tip, fits through the 1.1
2 centimeter trauma or cut, correct?

3 A. It does, yes.

4 Q. And it's -- the width of the
5 spatula is smaller than the width of the 1.1
6 centimeter defect, correct?

7 A. Yes.

8 Q. Okay. Is there any other
9 significance in this photo?

10 A. Nope.

11 - - -

12 (Whereupon, Exhibit-3D was
13 marked for purposes of
14 identification.)

15 - - -

16 BY MR. PODRAZA:

17 Q. All right. Then let's look at
18 Emery-3D. Now, what is depicted here?

19 A. A blurry picture of the spinal
20 cord, but, yes. So this is the portion of
21 spinal cord that I had access to. At the top
22 of the photo is the top of the cervical spinal
23 cord, so the very beginning -- or the base of
24 the head beginning into the neck and then the

1 rest of it is going down towards the feet, if
2 you will.

3 Q. Okay. And as we are looking at
4 this specimen of the spinal cord, the
5 posterior portion of the cord is not facing
6 us; is that correct?

7 A. Is now facing us. The
8 posterior portion of the cord is facing us.

9 Q. Okay. All right. And what
10 looks like to me skin, what does that reflect?

11 A. Right. So I should say also
12 that this specimen, like, this, what we are
13 looking at is exactly how I received it. So
14 the disruption or the way it's cut and
15 dissected, I have not intervened on anything.
16 This is the way I received the material. So
17 those sections going down, those cuts going
18 down, that was done before me. So what the
19 spatula is again pointing out is -- and that's
20 exactly what it looks like, is skin, that is
21 the dura.

22 Q. Okay. I'm sorry. Let me just
23 explore with you a little bit --

24 A. It's okay.

1 Q. -- because every time I hear
2 somebody say, "Well, let me just say that I
3 didn't do this. This is somebody else," my
4 antenna always goes up to say, all right,
5 well, are there any problems with what was
6 done that -- when the sample was given to you?

7 A. Nope. This exactly how I do my
8 own examination.

9 Q. Okay. So whoever took it,
10 whether it was Dr. Osbourne or somebody under
11 his supervision, as far as you're concerned,
12 it was appropriately done at autopsy?

13 A. Yes.

14 Q. All right. Now, is this
15 depicting again but from a different vantage
16 the 1.1 centimeter trauma or is this a
17 different wound?

18 A. It is the same -- it would
19 correspond with that defect in the vertebral
20 column that we were just looking at. What's a
21 little confusing about it is that it looks
22 like it's on the left side, but, actually, if
23 you wrapped that dura around, which is how
24 they would be in the body, it would actually

1 connect to the little flappy part that looks
2 like it's on the right side, that would then
3 line up to be on the right side.

4 Q. I got it. So if you
5 actually -- where the spatula is, if you
6 wrapped that portion of the dura around the
7 spinal column, you will see not only the
8 trauma to the dura but it would then align
9 with the trauma that we just discussed with
10 the spinal column?

11 A. Exactly.

12 Q. Is there any other significance
13 to this photo?

14 A. No.

15 Q. Now, up to this point are these
16 all recall photos that you directed to be
17 taken or were they provided to you from
18 autopsy?

19 A. I took these photos myself.
20 These are my photos.

21 - - -

22 (Whereupon, Exhibit-3E was
23 marked for purposes of
24 identification.)

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BY MR. PODRAZA:

Q. Okay. Then let's see what Emery-3E depicts.

A. So this is the other side of the spinal cord and I'm trying to show the alignment of that defect that we saw in the dura to the correct anatomic, like, how it would have been in the body. It's -- I am not doing a very good job of that in this photo. I am trying to. So it's dura. The same 1.1 centimeter defect is where the probe is pointing. You just cannot see it very well. And, again, no hemorrhage. There is a defect in the dura that corresponds with the spinal cord -- or the spinal column injury, but there is no hemorrhage around it.

Q. Let me ask you this, Doctor, because that raises the point, at least in my mind: When you're talking about the hemorrhage, would you have expected separate hemorrhage to the dura, separate hemorrhage to the spinal column, that both would show indications of hemorrhage?

1 A. I would expect that, yes. Yes.

2 Q. And by the fact that now the
3 dura is not demonstrating hemorrhage, as you
4 found also that the spinal column didn't,
5 would that weigh a little bit more in
6 suggesting that Ellen was dead at the time
7 that this wound was administered?

8 A. Yes.

9 Q. Is there any other significance
10 to what has been marked here as Emery-3E?

11 A. I don't think so.

12 - - -

13 (Whereupon, Exhibit-3F was
14 marked for purposes of
15 identification.)

16 - - -

17 BY MR. PODRAZA:

18 Q. I think we have an Emory-3F.
19 Yes, we do. Okay.

20 A. So, again, so that's -- it's
21 reoriented with the back of the spinal cord
22 facing up towards us in the photo. And I am
23 again just redemonstrating that that defect in
24 the dura is a full thickness defect. It goes

1 through entire thickness of the dura and I'm
2 just showing that again with the probe like I
3 did with the vertebral bone.

4 Q. All right. And this photo
5 really is demonstrating the dura puncture or
6 the dura wound?

7 A. Exactly. Yes, there is a cut
8 in the dura.

9 Q. All right. And, again, there
10 is no indication of hemorrhage?

11 A. Correct.

12 Q. Is there any other significance
13 to this photo?

14 A. In my eyes, because I took them
15 and I remember -- you know, I did the
16 examination, I can start to see this defect in
17 the spinal cord that -- or the disruption,
18 let's say, in the spinal cord itself and that
19 the tip of the probe is actually almost
20 pointing directly to it.

21 Q. Was this that disruption that
22 you felt could have been attributed to the
23 performance of the autopsy?

24 A. Yes.

1 Q. All right. But that has
2 nothing to do with the wound associated with
3 the dura and spinal column, correct?

4 A. Correct.

5 Q. That's something separate and
6 distinct?

7 A. Correct.

8 Q. Okay. Is there any other
9 significance?

10 A. No.

11 - - -
12 (Whereupon, Exhibit-3G was
13 marked for purposes of
14 identification.)

15 - - -

16 BY MR. PODRAZA:

17 Q. All right. Then let's look at
18 Emery-3G, as in girl.

19 A. And so -- yep, this is a
20 close-up photo of what we were just looking
21 at, you know, and the top part of the tissue
22 specimen itself. And what the point of that
23 probe is pointing to is that irregular little
24 surface defect. It almost looks like a

1 little, like, cylindrical curve-out, cut-out,
2 chunk of missing tissue, is grossly what it
3 looks like, kind of raggedy, as opposed to
4 rest of the surface of the spinal cord.
5 That's what I am seeing with my eyes.

6 Q. And you can't definitively say
7 what caused that?

8 A. I can't and what -- so two
9 things. What's unusual is that, again, no --
10 appears to be no reaction to it, right, no
11 vital reaction, hemorrhage, whatever, and what
12 starts to become interesting to me is that,
13 again, if we were to imagine that dura wrapped
14 around and where it should be, that disruption
15 in the spinal cord tissue itself loses its
16 continuity with the defects in the dura and in
17 the vertebral column.

18 Q. So if I can just state in
19 layperson terms, what you're saying is where
20 you see the defect where the 1.1 centimeter
21 trauma occurred through the dura, when you
22 wrap the dura around the spinal column this
23 defect that you're making reference to you do
24 not see a similar penetration or trauma on the

1 dura leading to it?

2 A. It's at the same level, but
3 it's on the wrong side of the spinal cord.

4 Q. But, similar to both the dura
5 and the 1.1 centimeter injury, there's no
6 hemorrhage?

7 A. Yes. Correct.

8 Q. Any other significance?

9 A. No.

10 - - -
11 (Whereupon, Exhibit-3H was
12 marked for purposes of
13 identification.)

14 - - -

15 BY MR. PODRAZA:

16 Q. Okay. Now, we are looking at
17 Emory-3H and I will ask you if you could
18 describe to us the significance of the photo?

19 A. Yes. So, again, same
20 orientation as the one we just saw. And I'm
21 trying to point out that surface irregularity
22 on the posterior aspect of the upper cervical
23 spinal cord with the probe. So the defect
24 itself is right above the probe. The

1 irregularity that I'm talking about and
2 curious about is above that probe, right above
3 it, in the same -- you know, millimeters above
4 the probe.

5 Q. If that irregularity was not
6 due to the performance of the autopsy, based
7 on your professional experience, what would
8 you anticipate could cause that irregularity?

9 MS. BERKOWITZ: Objection. You
10 can answer.

11 THE WITNESS: But, I'm sorry,
12 what could cause that?

13 BY MR. PODRAZA:

14 Q. Sure. If it wasn't -- let's
15 say it wasn't due to the performance of the
16 autopsy and here's this irregularity, what
17 potential explanations, particularly given the
18 situation here, where somebody has been
19 stabbed, what would you think would be a
20 reasonable explanation for it?

21 A. I would be left with -- without
22 considering or consideration for autopsy
23 artifact, I would have to conclude that that
24 was related to the sharp force injury. It

1 doesn't look like that, but it could be.

2 Q. Okay. And when you say the
3 sharp force, is that that 1.1 centimeter?

4 A. Yes.

5 Q. And how could the 1.1
6 centimeter wound potentially explain this
7 irregularity that's being shown by your
8 spatula in Emory-3H?

9 A. I mean, the same -- it would be
10 cutting the posterior surface of the spinal
11 cord.

12 Q. Would that all be in one
13 strike?

14 A. Based on -- yes, based on what
15 I have here and what I -- you know, what I can
16 evaluate, yes, it is one injury.

17 Q. All right. Now, if you take --
18 if you accept that the blade or the trauma,
19 the 1.1 centimeter trauma also accounts for
20 the irregularity that's being shown with the
21 spatula here in Emory-3H, what would you
22 anticipate the consequences to Ellen being
23 able to have, you know, normal motor skills or
24 being able to move? What impact would that

1 have, if any?

2 A. The problem is or the issue is
3 is that I don't have any evidence that there
4 was a vital response to this injury. So I
5 don't think that this injury would have caused
6 any symptoms, because there's no response to
7 it, there is no reaction to it.

8 Q. What does that mean?

9 A. There is no hemorrhage. There
10 is no tissue injury, which I know, then, by
11 looking at it under the microscope. So I have
12 all of this evidence that says there is no --
13 there's no hemorrhage or reaction to any of
14 these changes in the spinal cord.

15 Q. So what you're saying is, Ellen
16 would have been dead when this was
17 administered?

18 A. Yeah.

19 Q. Any other significance to this
20 photograph?

21 A. No.

22 - - -

23 (Whereupon, Exhibit-3I was
24 marked for purposes of

1 identification.)

2 - - -

3 BY MR. PODRAZA:

4 Q. Is there an Emory-3I?

5 A. More of the same thing. It's
6 just trying to illustrate -- the disruption of
7 that part of the spinal cord, it was very
8 subtle and it was very hard to photograph, so
9 I am just doing my best to take, you know,
10 appropriate photographs to kind of demonstrate
11 the defect that I am trying to demonstrate.
12 At least in this one, it's kind of nice,
13 because you can see the defect to the dura
14 also. And, again, but -- so right above the
15 tip of that probe is what is in question here
16 in the spinal cord.

17 Q. Okay. And, again, this picture
18 is showing no hemorrhage to the defect or
19 irregularity that's above the spatula?

20 A. Yes. For the spinal cord
21 itself or for the dura still, you know, no
22 evidence of hemorrhage.

23 MR. PODRAZA: If we could take
24 maybe a five-minute break. I think

1 that may be all the questioning I have
2 at this time. Is that okay?

3 THE WITNESS: Yes. Thank you.

4 THE VIDEOGRAPHER: The time is
5 11:24 a.m we are going off the video
6 record.

7 - - -

8 (Off the record)

9 - - -

10 THE VIDEOGRAPHER: The time is
11 11:41 a.m. This is the beginning of
12 media unit number two.

13 BY MR. PODRAZA:

14 Q. Dr. Emery, the questions and
15 the answers that you -- well, strike that.
16 The answers that you supplied to me here
17 today, was that information also shared with
18 Dr. Gulino after you completed your evaluation
19 of the Greenberg case?

20 A. Yes.

21 MR. PODRAZA: At this time, I
22 don't have any further questions.
23 Perhaps I will have some follow-ups
24 after opposing counsel is through.

1 THE WITNESS: Okay.

2 - - -

3 EXAMINATION

4 - - -

5 BY MS. BERKOWITZ:

6 Q. Dr. Emery, you testified that
7 when you began this case you were given a case
8 number. What other information did you
9 receive at that time?

10 A. None. It literally was, like,
11 "Here is a case number. Would you mind taking
12 a look at the neuropathology relevant material
13 of the brain and spinal cord and let me know
14 what you think?"

15 Q. At some point did you look at
16 the photographs from the autopsy?

17 A. I have seen, yes, the full case
18 photographs.

19 Q. And when did you look at them?

20 A. I don't recall exactly when,
21 but it would have been after -- it was after I
22 evaluated the gross tissue, you know, the
23 gross material, and it may have been even
24 after I had the microscopic material back. It

1 was after the fact.

2 Q. Did you ever read the report?

3 A. I did not read Dr. Osbourne's
4 report, no.

5 Q. You testified that you
6 conducted an informal exam and you also
7 testified that you did not treat the material
8 differently from a consultation. Could you
9 explain what you mean?

10 A. Meaning that with what I had I
11 did it the way I would have done it if I had
12 done it in a formal consultative role. I took
13 photos. I documented exactly what I did. I
14 have at least a paper record of what I did in
15 terms of the material and what sections I took
16 with a section key and so for that I
17 documented what I did.

18 Q. Did you cut any corners in
19 terms of how you conducted the examination?

20 A. No. I mean, I had limited
21 material to evaluate, you know, to examine in
22 the first place, so I examined thoroughly what
23 I had to examine.

24 Q. Okay. Regarding the cut to the

1 dura that went into the -- into the vertebra
2 that we've been discussing, earlier in your
3 testimony you said that there were two
4 possibilities for why there wouldn't be
5 hemorrhage, I think?

6 A. Right. So the main point is
7 that I don't have any evidence of there being
8 hemorrhage in direct association with the
9 injury to that defect, that 1.1 centimeter
10 defect of the vertebral column itself and the
11 dura, that there was reaction to it, right, so
12 that there was blood or the ability to bleed
13 as a result of those injuries.

14 Q. Right.

15 A. With what I have to examine, I
16 don't see that. So one conclusion is that
17 those injuries happened when the decedent no
18 longer had a pulse.

19 Q. And what's the other
20 possibility?

21 A. The other possibility is that I
22 can't see or I'm not seeing that hemorrhage
23 because it washed away during fixation, washed
24 away during the autopsy. Not so much with the

1 spinal column itself, I would still be able to
2 see that grossly, but the dura, if there was
3 subdural hemorrhage, it could be gone and I'm
4 just not able to see it. So, again, with what
5 I have available to evaluate, I don't have
6 that info -- I don't have that evidence.

7 Q. Okay. Did you -- did you
8 conclude from your examination that this was a
9 homicide?

10 A. I made -- I have no opinion in
11 any shape or form about the manner of death in
12 this case.

13 Q. Did you -- when you were
14 discussing it with Dr. Gulino, did you tell
15 him that -- that it was a homicide?

16 A. No.

17 Q. Okay. Did you find anything
18 incapacitating in what you looked at, anything
19 that --

20 A. Not definitively incapacitating
21 in the material I examined.

22 Q. Okay. Were you able to -- just
23 backing up for a minute. So can you determine
24 from what you looked at that another person

1 inflicted that wound?

2 A. No.

3 Q. Okay. Did you find anything in
4 your examination that would have made it
5 impossible for Ellen to -- assuming that wound
6 was not the last wound, is there anything that
7 you learned from your examination that would
8 make it impossible for Ellen to continue
9 stabbing herself?

10 A. No.

11 Q. Okay. Were you able to rule
12 out suicide?

13 A. I do not have an opinion about
14 the manner of death. I don't know enough
15 about the full complement of information. I
16 don't have -- I have no opinion about how
17 those injuries occurred.

18 Q. Okay. So is it fair to say
19 that you didn't learn anything that
20 invalidates the prior determination?

21 A. I think -- yeah, I think that's
22 true.

23 Q. Okay. Did Dr. Gulino attempt
24 to influence your examination or your

1 conclusions at any time?

2 A. No.

3 MS. BERKOWITZ: I don't have
4 any further questions.

5 - - -

6 EXAMINATION

7 - - -

8 BY MR. PODRAZA:

9 Q. Doctor, I just have a couple.

10 When you were performing the
11 examination of the 1.1 centimeter wound, am I
12 correct that you expected there to be
13 hemorrhage if, in fact, it was administered
14 before Ellen was dead?

15 A. I would expect there to be
16 hemorrhage, yes.

17 Q. When you were answering
18 counsel's question, I thought you
19 differentiated between the dura and the spinal
20 column when you talked about this washed away
21 effect. Am I correct about that?

22 A. You are correct.

23 Q. And, as a matter of fact, you
24 would not expect with the spinal column the

1 hemorrhage to be washed away over time,
2 correct?

3 A. Correct.

4 Q. And, in fact, in the samples
5 that you showed there was hemorrhage that
6 still existed in the spinal column, just in a
7 different area than where the 1.1 centimeter
8 wound was, correct?

9 A. Exactly.

10 Q. And, Doctor, you're an
11 intelligent woman and a very competent
12 professional. Given what you see here, could
13 you say that homicide is not a possible or
14 respectful -- or respectable consideration
15 that happened to this woman here?

16 A. I have no opinion about the
17 manner of death.

18 Q. All right. But if the 1.1
19 centimeter wound was administered after Ellen
20 was dead, can we agree that she couldn't have
21 administered that wound, correct?

22 A. That is true.

23 MR. PODRAZA: I have nothing
24 further. Thank you.

1 MS. BERKOWITZ: No further
2 questions. Thank you, Dr. Emery.

3 THE WITNESS: Thank you all.

4 THE VIDEOGRAPHER: The time is
5 11:51 a.m. This is the end of media
6 unit number two, the end of the
7 deposition.

8 - - -

9 (Deposition concluded. Time
10 noted, 11:51 a.m.)

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C E R T I F I C A T E

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I do hereby certify that I am a Notary Public in good standing, that the aforesaid testimony was taken before me, pursuant to notice, at the time and place indicated; that said deponent was by me duly sworn to tell the truth, the whole truth, and nothing but the truth; that the testimony of said deponent was correctly recorded in machine shorthand by me and thereafter transcribed under my supervision with computer-aided transcription; that the deposition is a true and correct record of the testimony given by the witness; and that I am neither of counsel nor kin to any party in said action, nor interested in the outcome thereof.

WITNESS my hand this 14th day of May, 2021.



Kimberly A. Wornczyk
Notary Public

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Commonwealth of Pennsylvania Rules of Civil

Procedure

Title 231, Chapter 4000

Depositions and Discovery

Rule 4017

(c) When the testimony is fully transcribed a copy of the deposition with the original signature page shall be submitted to the witness for inspection and signing and shall be read to or by the witness and shall be signed by the witness, unless the inspection, reading and signing are waived by the witness and by all parties who attended the taking of the deposition, or the witness is ill or cannot be found or refuses to sign. Any changes in form or substance which the witness desires to make shall be entered upon the deposition by the person before whom it was taken with a statement of the reasons given by the witness for making the changes. If the deposition is not signed by the witness within thirty days of its submission to the witness, the person before whom the deposition was taken shall sign it and state on the record the fact of the waiver or of the illness or absence of the witness or the refusal to sign together with the reason, if

any, given therefor; and the deposition may then be used as fully as though signed, unless the court holds that the reasons given for the refusal to sign require rejection of the deposition in whole or in part.

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