

**In the Matter of:**  
**JEFFREY HAVARD**  
**V.**  
**STATE OF MISSISSIPPI**

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*BENTON, M.D., SCOTT A.*

*March 09, 2017*

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**eDeposition**  
**.COM**

844.533.DEPO



Page 2

1 ALSO PRESENT:  
Chris Van Ee

2

3 REPORTED BY:  
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1 STIPULATION

2 It is hereby stipulated and agreed by and

3 between the parties hereto, through their respective

4 attorneys of record, that this deposition may be taken at

5 the time and place hereinbefore set forth, by LORI P.

6 GALLASPY, RPR, CSR, Court Reporter and Notary Public,

7 pursuant to the Mississippi Rules of Civil Procedure, as

8 amended;

9 That the formality of READING AND SIGNING is

10 specifically RESERVED;

11 That all objections, except as to the form of

12 the questions and the responsiveness of the answers, are

13 reserved until such time as this deposition, or any part

14 thereof, may be used or is sought to be used in evidence.

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1 I N D E X

2 Examination by Mr. Jicka .....5

3 Certificate of Reporter .....128

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7 E X H I B I T S

8 Exhibit 1 marked .....5

9 Notice of Deposition

10 Exhibit 2 marked .....5

11 Notice of Service of Respondent's

12 Designation of Experts

13 Exhibit 3 marked .....5

14 Excerpt from transcript of Dr. Steven Hayne

15 Exhibit 4 marked .....11

16 Thumb drive containing file of Dr. Benton

17 Exhibit 5 marked .....118

18 Excerpt from transcript of Dr. Ayesha Dar

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1 (Exhibits 1, 2, and 3 marked)

2 SCOTT A. BENTON, M.D.,

3 having first been duly sworn, testified as follows:

4 EXAMINATION

5 BY MR. JICKA:

6 Q Dr. Benton, my name is Mark Jicka, and I

7 represent Jeffrey Havard. I've got some questions for

8 you today because you were designated as an expert

9 witness in his case. Do you understand that?

10 A That you have some questions? Yes.

11 Q And do you understand you were designated as an

12 expert?

13 A Yes.

14 Q Okay. How often have you been designated as an

15 expert for the State of Mississippi?

16 A Every case that I've ever been involved in

17 since 1997 when the federal rules changed is delineated

18 on my CV, and I don't know the exact number but several

19 hundred.

20 Q And when was the last time that you testified

21 for the State of Mississippi?

22 A Yesterday.

23 Q And would that be found on the list that you

24 had provided us --

25 A No.

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1 Q -- in this case? I'm going to let you look at  
2 Exhibit 2, which is the Notice of Service of Respondent's  
3 Designation of Experts with that list, and if you could  
4 update it for me if you can remember the cases you've had  
5 since you provided this to us, please.  
6 A I probably could easier call my office and have  
7 them print it. These are all maintained by the  
8 University. So the case yesterday was State versus  
9 Jaquarius Johnson, and that was Hinds County Circuit  
10 Court. The case on Tuesday was in the interest of -- I'm  
11 not sure I can say the name publically, but it's G.A.  
12 Q Where was that?  
13 A That was in Copiah County.  
14 Q Was that chancery court or --  
15 A That was youth court.  
16 I can't -- my phone is off, and I can't  
17 access my business calendar from here. So like I said,  
18 we can always reprint an updated CV.  
19 Q If you don't mind, if you'll send it to Brad.  
20 We'll give you a little list of homework to do if he  
21 approves, and send that to us so we can update it,  
22 please.  
23 A Okay.  
24 Q Thank you.  
25 Dr. Benton, where did you go to college?

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1 it's AAP?  
2 A American Academy of Pediatrics.  
3 Q Are you a member of the AAP?  
4 A I am, I'm a full fellow.  
5 Q And what is the American Academy of Pediatrics?  
6 A It's an organization of pediatricians in  
7 America, the largest pediatric association devoted to the  
8 health care of children.  
9 Q And you currently work for University of  
10 Mississippi Medical Center. Is that correct?  
11 A That's correct.  
12 Q How long have you worked for them, sir?  
13 A Nine years. Almost nine years.  
14 Q And before that where did you work?  
15 A At LSU School of Medicine in New Orleans and  
16 Children's Hospital of New Orleans.  
17 Q And is that part of your residency or was that  
18 in a different capacity?  
19 A Both.  
20 Q And how long did you work --  
21 A I never left the system. From --  
22 Q You should get out some.  
23 A So I worked both before I received my doctorate  
24 at Children's Hospital in New Orleans, so as I was in med  
25 school I worked there, I worked there as a resident at

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1 A The University of Southwestern Louisiana. It's  
2 now known as the University of Louisiana-Lafayette.  
3 Q The Ragin' Cajuns?  
4 A That's it.  
5 Q And where did you go to med school, sir?  
6 A LSU School of Medicine in New Orleans.  
7 Q And did you have a residency after med school?  
8 A In pediatrics.  
9 Q And where did you have that, sir?  
10 A Through LSU Department of Pediatrics in New  
11 Orleans, and it was through Charity Hospital, University  
12 Hospital, and Children's Hospital.  
13 Q And how about a fellowship after your  
14 residency?  
15 A No.  
16 Q Are you board certified?  
17 A Yes.  
18 Q And what are you board certified in, sir?  
19 A In general pediatrics and child abuse  
20 pediatrics.  
21 Q What is the body that certifies you in general  
22 pediatrics?  
23 A Both of them are the American Board of  
24 Pediatrics.  
25 Q Are you familiar with an organization I believe

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1 Children's Hospital in New Orleans, and I worked for LSU  
2 as a resident, although the check actually came from  
3 Charity Hospital of New Orleans. And I was continuously  
4 employed there until 2008. I mean, various capacities:  
5 student, resident, and professor.  
6 Q And then from 2008 to the present in Jackson?  
7 A At the University of Mississippi, yes, sir.  
8 Q And what is your current position at UMMC?  
9 A I am a professor of pediatrics.  
10 Q Do you hold any other positions at UMMC?  
11 A I'm chief of the Division of Forensic Medicine,  
12 and I'm the medical director of the Children's Safe  
13 Center for the State of Mississippi.  
14 Q Tell me about what is the forensic medicine  
15 department at UMMC?  
16 A So it's a division of the Department of  
17 Pediatrics, and it concentrates on medical legal issues  
18 dealing with children.  
19 Q What was your major at -- in Lafayette?  
20 A Biology and chemistry.  
21 Q The first exhibit to your deposition is the  
22 notice, and I'm going to show that to you. In it,  
23 Dr. Benton, I've asked that certain things be brought  
24 with you today as part of this deposition. The first  
25 thing is your entire file regarding this matter. Do we

<p style="text-align: right;">Page 10</p> <p>1 have your entire file? 2 A (Thumb drive presented to Mr. Jicka.) 3 MR. JICKA: I'm going to mark that as 4 Exhibit 4. 5 MR. WHITE: Do you have a copy of that first 6 exhibit for us? 7 MR. JICKA: Yes, yes. 8 MR. WHITE: Thank you. 9 MR. JICKA: If I forget, Brad, Sonny, y'all let 10 me know. I've got a copy, hopefully, of everything 11 for y'all. 12 Let's go off the record for a second. 13 (OFF THE RECORD 1:43 p.m.) 14 (ON THE RECORD 1:43 p.m.) 15 BY MR. JICKA: 16 Q So you've handed me a jump drive. Is that 17 correct, Dr. Benton? 18 A Yes, sir. 19 Q And if you'll tell me just generally what's on 20 that jump drive, please, sir. 21 A All the files received from the Attorney 22 General's office, the notice of deposition, all of the 23 trial record -- well, I guess everything that was given 24 by the Attorney General's office, some photographs of the 25 bathroom incident scene, my report is on there, all the</p>	<p style="text-align: right;">Page 11</p> <p>1 articles I cited are on there. Perhaps some other 2 things, but not much more. Oh, the contract for services 3 is on there. 4 Q And we can probably pull that up, but do you 5 recall when you were first contacted to work for the 6 State of Mississippi in this case? 7 A Maybe a year and a half ago. 8 Q And what were you specifically asked to do, 9 sir? 10 A I was asked to -- well, one, if I was 11 interested in reviewing the file to see if, your concern, 12 that new science was exculpatory to the original case. 13 Q And the contract that you have with the State 14 of Mississippi, are you paid an hourly rate? 15 A Actually, I don't know what it says. We have 16 people in our office that connect with them and... 17 Q We'll get Mr. Carner to pull that up and see. 18 MR. JICKA: All right. So I'm going to put -- 19 MR. WHITE: And you said the exhibit to the 20 jump drive is 4? 21 MR. JICKA: Yes, sir, Exhibit 4 will be -- just 22 stick it in there. 23 (Exhibit 4 marked) 24 BY MR. JICKA: 25 Q The money that you earn in the Havard case,</p>
<p style="text-align: right;">Page 12</p> <p>1 where does that go? 2 A To the University. 3 Q And do you receive a salary from the 4 University? 5 A I do. 6 Q Is your salary dependent on the additional work 7 that you do for the State of Mississippi? 8 A No. 9 Q The salary that you receive, is there any 10 funding that comes from outside sources other than the 11 State of Mississippi? 12 A So the funding for my division is based off of 13 a legislative mandate, the funding that's a line item in 14 the budget, the State budget. You said other than that, 15 so we receive funds for patients that we see through 16 their third-party payers. We're prohibited from 17 collecting any money directly from anyone claiming to be 18 a victim of a crime. 19 So the third-party sources we're permitted 20 to tap are Medicaid, TRICARE, and any other governmental 21 insurance. Any other third-party payers we're prohibited 22 from tapping, and the Attorney General's office will pay 23 for the medical expenses in those cases. So, for 24 example, if they have Blue Cross Blue Shield, we can't 25 bill that entity; we bill the Attorney General's office.</p>	<p style="text-align: right;">Page 13</p> <p>1 And we do receive federal @@VOCA grants, 2 Victims of Crime Act. I believe we also have some 3 victims -- let's see, Violence Against Women Act funds, 4 and I believe that's -- and we have lots of little bitty 5 grants. Grants from Sam's, Walmart. 6 Q What is the total of the grants that you 7 receive? 8 A I would be in error if I said an exact, but 9 somewhere approximately a million and a half per year. 10 Q And do you have to apply for these grants 11 annually or do they just come every year absent some 12 change? 13 A Well, I mean, the insurance, I have to maintain 14 my licensure and credentials. But as far as the 15 insurance reimbursement goes with respect to the state 16 legislature, it goes into budget review every year. With 17 respect to VOCA grants, those are annual grants, so 18 they're awarded annually, so they -- you have to reapply. 19 Each grant expires and then you have to reapply for new 20 ones. All the little business community grants are 21 individual, one and you're done. I don't handle any of 22 that; I'm aware of it. So I imagine almost everything is 23 annually renewed. 24 Q Who handles the application for grants at UMMC 25 in your department?</p>

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1 A In my division it's Rebecca Mansell.  
2 Q How much is the VOCA grant?  
3 A I'm going to kind of know off the top of the  
4 head. I think it's \$28,000.  
5 Q That's 28,000 a year?  
6 A It's only been awarded once, so we hope to get  
7 it again.  
8 Q The Violence Against Women grant --  
9 A I don't know the numbers on that. That one  
10 just -- the 28,000 just came through, that's how I know  
11 that one.  
12 Q What is your involvement, say, with Rebecca in  
13 applying for these grants? Do you provide information?  
14 Do you help fill out the paperwork? Just tell me about  
15 your involvement, please.  
16 A I'm her boss, so as far as the division goes.  
17 As far as the University is concerned, I'm responsible  
18 for her actions, so I have to sign all the grants as we  
19 are going to comply with whatever the contract says,  
20 although we have a Grants Department that's over my head  
21 to make sure I am in compliance with all of that. But  
22 that's -- she writes all the grants. She seeks them out.  
23 That's what she was hired -- one of the many things she  
24 was hired to do.  
25 Q How long has Rebecca worked in your division?

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1 record available for my review, and I gave him my opinion  
2 of those records.  
3 Q Okay. About what time frame was this?  
4 A This is latter half of 2008.  
5 Q So right after you started the job here at  
6 UMMC.  
7 A Uh-huh.  
8 Q And if you'll answer yes or no for me, please,  
9 sir.  
10 A My apologies.  
11 Q That's okay.  
12 A Yes.  
13 Q So I just want to make sure I understand this.  
14 So why did Ms. Hocker present this information to you?  
15 What is your understanding?  
16 A Well, she was the director, much as Rebecca is  
17 the director, and directors look for ways of continuing a  
18 program, which I have a vested interest also. And she  
19 thought that having this brand new program created by the  
20 state legislature if we could assist in wronging an  
21 injustice, that would curry favor going forward. So I  
22 think that was her thought process.  
23 Q And when you say director, director of what?  
24 A She was the director of it used to be called  
25 the Justice Center, but we changed it to the Safe Center,

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1 A About seven years or so.  
2 Q When we go off the record, I'll tell you to  
3 tell her hello from an old friend. Okay?  
4 A Okay.  
5 Q Before your request by the State of Mississippi  
6 to get involved in the Jeffrey Havard case, had you heard  
7 of this case?  
8 A Yes.  
9 Q Tell me what you had heard about the case prior  
10 to being contacted by the Attorney General's office.  
11 A The previous person who was in Rebecca  
12 Mansell's place was Elizabeth Hocker. And when I first  
13 moved here in the summer of 2008, no one had heard of me,  
14 and we were not generating very much revenue. And they  
15 were paying a salary to me, and Ms. Hocker thought it  
16 would be good if I offered my services to various people.  
17 So Jerry Mitchell, a reporter with The  
18 Clarion-Ledger, had written a very inflammatory article  
19 about this case suggesting that an injustice had  
20 occurred, and the material matter was things that I deal  
21 with all the time. And she suggested that we offer our  
22 services if, indeed, an injustice had occurred. And so I  
23 had initially reached out to Jerry Mitchell and without  
24 any response, and then ultimately he did respond to me.  
25 He offered what materials I guess was in the public

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1 so that subpart of the program of the Division of  
2 Forensic Medicine. The division didn't exist until I  
3 came.  
4 Q Other than Jeffrey Havard's case, have you been  
5 involved in other cases where Ms. Hocker or Ms. Mansell  
6 have asked you to take a look at cases that are in the  
7 public eye to see what your response would be?  
8 A No, this was the first and only to my  
9 knowledge.  
10 Q Tell me what you did. So you reviewed the  
11 information, and then tell me basically what you did as  
12 it related to the Jeffrey Havard case.  
13 A I did not -- this was not formal. There was no  
14 contract or money relationship. I reviewed the  
15 materials. I did not see the injustice that Jerry  
16 Mitchell mentioned. I replied to that, and that's it.  
17 Never saw or heard from him again.  
18 Q When you say you replied to Jerry Mitchell,  
19 in --  
20 A E-mail.  
21 Q -- what form? You e-mailed him?  
22 A Uh-huh.  
23 Q Do you have that e-mail that you sent --  
24 A I don't.  
25 Q -- to Jerry Mitchell?

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1 A The State may have it.  
2 Q Who were the recipients of that e-mail?  
3 A It would just be him.  
4 Q And so it would be from Dr. Benton at UMMC  
5 e-mail address to Jerry Mitchell at The Clarion-Ledger?  
6 A I mean, certainly the body would have that.  
7 The actual e-mail address we've changed. But whatever  
8 the official e-mail address system is. I think it was  
9 Peds.UMC.edu or something to that effect. It's changed  
10 since then. I know there's a statute that has some  
11 archiving of those, but I wouldn't even know how to do  
12 that.  
13 Q Well, I'll talk to the lawyers about that.  
14 They probably know.  
15 MR. JICKA: In fact, let me go ahead and make a  
16 request that y'all preserve any of the e-mails --  
17 BY MR. JICKA:  
18 Q Was it just one e-mail or was it a series?  
19 A I don't recall. This was a long time ago, and  
20 like I said, I didn't get officially involved.  
21 MR. JICKA: All right. Well, I'll just make a  
22 formal request that any e-mails regarding Jeffrey  
23 Havard's case from Dr. Benton be preserved and  
24 produced to us.  
25

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1 Q I was a little unclear about the funding part  
2 of this. You said that Ms. Hocker wanted to see if we  
3 could get some funding. What did you mean by that? Or  
4 make some money. I don't mean to put words in your  
5 mouth, but what were you saying there?  
6 A So not all this was known to me when I was  
7 being recruited and hired, but the program was a creation  
8 by the legislature. The predicate for creating it was in  
9 response to a federal lawsuit which the State had lost,  
10 Barbour versus Olivia Y., and one of the mandates from  
11 the federal monitor or whatever was that they create and  
12 update the forensic sciences in the State of Mississippi.  
13 Apparently, there were some erroneous decisions that had  
14 been made not on the best of forensic science.  
15 And in consequence, they established this.  
16 The moneys used to establish the program were from the  
17 Enron settlement -- or no, I'm sorry, WorldCom, my  
18 apologies, WorldCom settlement, and part of it was set  
19 aside. It was my understanding in recruitment that there  
20 was enough moneys for ten years worth of funding, but  
21 then after I was here it was maybe a couple years worth  
22 of funding. So it became quite apparent once I moved  
23 here that there had to be other funding sources to be  
24 identified, and that's what I meant. So Ms. Hocker was  
25 the financial agent responsible for the funding of the

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1 BY MR. JICKA:  
2 Q Did Jerry Mitchell ever use any quotes or  
3 anything, any work that you presented to him in any  
4 articles that you are aware of?  
5 A No.  
6 Q Did you ever speak with Jerry Mitchell on the  
7 phone about your thoughts about the Jeffrey Havard case?  
8 A Possibly. I don't have a direct recall but  
9 probably or possibly.  
10 Q And the e-mail, if you could just give me the  
11 substance of what you were saying to Jerry Mitchell as it  
12 related to the Jeffrey Havard case.  
13 A That I did not feel that an injustice had  
14 occurred, that there was a mischaracterization of the  
15 evidence that he had suggested that there was.  
16 Q What was the mischaracterization of evidence?  
17 A I don't really recall, but I think that it's  
18 very similar to what is being asserted now, that there's  
19 some new science that has opened our minds that was  
20 incorrectly applied in this particular case.  
21 Q And the science surrounding the shaken baby  
22 syndrome and the issues --  
23 A Something --  
24 Q -- on that diagnosis?  
25 A -- to that effect, yes, sir.

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1 program.  
2 If you know anything about UMC or  
3 universities, they're like an umbrella 501(c)(3), but  
4 they're individual divisions that are autonomous. I  
5 mean, we have to run in the red. If we don't have the  
6 money, then we lay off or we don't have jobs. So my  
7 division immediately from when I got here had to look for  
8 money, and certainly good works is one way of advertising  
9 that you deserve more money, I guess. And I'm putting  
10 words in their mouth, but I believe that was the intent.  
11 Q Let me show you Exhibit 2. Have you had a  
12 chance to look at that, sir?  
13 A I have.  
14 Q Does Exhibit 2 include your full report in the  
15 Jeffrey Havard matter?  
16 A It does.  
17 Q Have you come up with any additional opinions  
18 since preparing this report that are not included in that  
19 report?  
20 A No, sir.  
21 Q Besides the documents that are listed on the  
22 front of your report, have you reviewed anything  
23 additionally in coming to your opinions?  
24 A That's what I reviewed for this opinion. I  
25 mean, I'm constantly reading stuff that informs my

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1 opinion.

2 Q Would you say that you are up to date on the  
3 current controversy regarding shaken baby syndrome?

4 A I guess we'll find out, but relatively, yes.

5 Q And tell me what you do to try to stay abreast  
6 of new developments as it relates to specifically that  
7 diagnosis.

8 A So I'm a member of the Helfer Society. We  
9 maintain a listserv where we share complex cases and  
10 review major studies and discuss ongoing and future  
11 research. I'm also a member of the section in the  
12 American Academy of Pediatrics on child abuse and neglect  
13 known as the SCAN section, or it's the section on child  
14 abuse and neglect, SCAN, S-C-A-N. The same thing: they  
15 have a listserv, and we share information. That's a  
16 little more on the general pediatric level, and the  
17 Helfer Society are pathologists and neuropathologists,  
18 neuroradiologists, radiologists, biomechanical engineers,  
19 people that -- so that's one way.

20 I am afforded, at least up until this next  
21 budget year, three national conferences per year of which  
22 I choose conferences -- and they're detailed on my CV --  
23 that deal with this issue. Well, and other issues within  
24 the world of pediatric forensic medicine. I attend any  
25 and all local state conferences, predominantly New

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1 both for the State in the cases that you worked on?

2 A I don't know. I believe when I came here  
3 Dr. Hayne was having difficulties with the State. I'm  
4 not exactly sure when he separated from the State, but it  
5 was really close to when I came here. So these were  
6 actually cases that predated my coming here which were  
7 going to court, which I had been asked to offer opinions  
8 also.

9 Q So when you were in New Orleans, were you --  
10 did you work for the State of Mississippi from time to  
11 time?

12 A I worked for the State in terms of working for  
13 LSU.

14 Q State of Mississippi, I'm sorry.

15 A Oh, the State of Mississippi. So I did do  
16 cases in Mississippi but not much.

17 Q Okay. So there were times when you were hired  
18 by the State of Mississippi Attorney General's office  
19 before you came to UMC.

20 A No, I don't believe I've ever done anything for  
21 the state Attorney General's office while I was in New  
22 Orleans. It would mostly be youth court matters along  
23 the Gulf Coast predominantly. Maybe a few criminal cases  
24 too.

25 Q And when you said you worked earlier on the

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1 Orleans, Memphis. Again, those are detailed on the CV  
2 also. Not too much in Mississippi at present.

3 Q Dr. Benton, before you had your position at  
4 UMMC, was there someone that held that position, another  
5 physician?

6 A No. It never existed previously, to my  
7 knowledge.

8 Q When you testify in cases like the one you've  
9 done -- the two I guess you've done earlier this week,  
10 are the victims or alleged victims of the case children?

11 A Always. I'm trying to think. We will  
12 occasionally do adult cases if they're mentally impaired,  
13 but I don't believe I've ever been to court on any of  
14 those cases. So I think to answer your question  
15 correctly, it's always been children under 18.

16 Q Do you know personally Dr. Steven Hayne?

17 A I do.

18 Q And tell me about your relationship with  
19 Dr. Hayne.

20 A I have met him over the years in cases where we  
21 have intersection. He has come to my office. He,  
22 unfortunately, of late has been the opposing expert on  
23 almost every one of my cases.

24 Q Earlier on did Dr. Hayne -- make sure I  
25 understand what you're saying, did you and Dr. Hayne work

Page 25

1 same side with Dr. Hayne, what kind of cases or where  
2 were those cases located?

3 A I mean, all over the state of Mississippi. I  
4 mean, they were -- I think they were all Mississippi  
5 cases, because he was formerly the Mississippi medical  
6 examiner. I don't believe there are any not inside the  
7 state of Mississippi.

8 Q Do you know how much the contract is with --  
9 and I think I may have asked you this -- with the State  
10 of Mississippi?

11 A I don't.

12 Q But that contract is on the jump drive you gave  
13 us?

14 A It is.

15 Q So according to what you've presented, the  
16 consideration is Contractor shall be paid a fee not to  
17 exceed \$175 per hour, and you will not exceed \$50,000.  
18 Is that correct?

19 A I mean, that's what it says.

20 Q And you brought this to me, so I -- are you  
21 aware of any other rates or numbers?

22 A I am not. So I went into academics to not deal  
23 with the business end of it. That is what I think  
24 offered by the Attorney General's office, and as he can  
25 tell you and as far as I know, having been completed or



<p style="text-align: right;">Page 26</p> <p>1 executed by the University of Mississippi, I mean, the 2 process is just super lengthy. 3 Q In the preparation of your report did you 4 receive any assistance from others in your office or 5 anyone else? 6 A I mean, everybody in my office reviewed it for 7 grammatical errors. Did I get any medical assistance? 8 No. 9 Q Other than proofreading, did anyone else 10 provide any substantive assistance in this report? 11 A No, sir. 12 Q So take me through, if you don't mind, the 13 analysis that you did in the Jeffrey Havard case as it's 14 related to your report. 15 A Okay. Do you need this back? 16 Q If I can have that one back. 17 A Here, I have the original. 18 Q Great. Thank you. 19 A So again, the request was to identify if there 20 was any new science that would affect the original 21 determination of the cause and manner of death of Chloe 22 Madison Britt, who is the victim in this case. To write 23 the report I reviewed the materials that were sent by the 24 Attorney General's office focusing in on all the medical 25 records. I did not -- I skimmed through anything that</p>	<p style="text-align: right;">Page 27</p> <p>1 was of legal nature. 2 And so pages 2, 3, 4, 5, 6, and 7 is a 3 synopsis of my interpretation of what I saw in those 4 records. Actually, I went one too far; so pages 2 5 through 5. Beginning at the bottom of page 5 is where I 6 summarize my interpretation or assessment of the record. 7 So I did that first. 8 I then went back and looked at the 9 different affidavits that I guess you guys had supplied 10 and took notes and tried to group what the concerns were, 11 and then I tried to group and reply what my thoughts are 12 on that. And that comprises pages 6 through 10. And 13 that's pretty typical of how I do these. 14 Q When you go through your analysis, do you first 15 identify the injuries and then the timing of those 16 injuries and then look at the history? Or just kind of 17 take me through how you do your analysis. 18 A Well, you start with what's the evidence in the 19 case. So, I mean, I go through that and literally, much 20 like y'all do, I take notes of everything, who said what, 21 when, where, what exams were done, who did what, and I 22 summarize all of that and what can I say from that. And 23 that's the first part of this. 24 Q Do you start with the trial testimony first or 25 a history first? How --</p>
<p style="text-align: right;">Page 28</p> <p>1 A I actually start with the medical records. So 2 the trial testimony would be second. In fact, I put that 3 less than all the other stuff. So I look at all the 4 medical record. I look at the autopsy. I'm trying to 5 think of everything that was available in this case. Any 6 recorded transcripts or statements pretrial. That all 7 comes first. 8 Q Have you reviewed the trial testimony in this 9 case? 10 A I have. 11 Q Were there witnesses that you paid special 12 attention to or did you read the whole trial transcript? 13 A I read the whole thing. I mean, obviously, I 14 guess the medical aspects I was more interested in than 15 the nonmedical ones. 16 Q What were the medical records that were 17 available specifically in the Chloe Britt case? 18 A I don't have independent recall, but it's the 19 things that are on that jump drive and everything that 20 was provided by the Attorney General's office. 21 Q We'll pull that up. In your report you stated 22 it was your task to -- it says "Chief Complaint: Request 23 opinion whether there is new science that would affect 24 the original determination of the cause and manner of 25 death of Chloe Madison Britt," with her date of birth and</p>	<p style="text-align: right;">Page 29</p> <p>1 her date of death. Is that correct? 2 A Yes, sir. 3 Q What is cause and manner of death? 4 A Cause is the factual basis of what led to the 5 death of the child. Manner is a legal opinion of the 6 various ways in which one can die, such as homicide, 7 suicide, et cetera. 8 Q Is it your understanding that determining cause 9 and manner of death are mandates from the State to the -- 10 to a forensic pathologist? 11 A To the medical examiner's office, and in this 12 state it's actually to the coroner who does not have to 13 be a pathologist. 14 Q Have you had any forensic training? 15 A Yes. 16 Q What forensic training have you had, 17 Dr. Benton? 18 A So it started off at the end of my second year 19 of residency. I completed a month-long clerkship in what 20 we now call pediatric forensic medicine, or actually 21 that's what they called it back then but it's now called 22 child abuse pediatrics. 23 At the end of that I was offered by the 24 dean of the school of medicine to get additional training 25 as well as I was offered a job essentially through my</p>

<p style="text-align: right;">Page 30</p> <p>1 third year. So the offer and the money was very good, 2 and I accepted. And they sent me to various places for 3 further education, including the Center for Child 4 Protection in San Diego, California, and the Huntsville 5 Program in Huntsville, Alabama, and local programs. Most 6 of those are on my CV. 7       And so throughout my third year I was 8 mentored by Dr. Kathy Kaufman, who ran the program, and 9 every one of my cases was reviewed by her before it was 10 submitted out. And so I continued to do that the third 11 year of my residency, and then I was offered an associate 12 professorship where, again, the continuing education I 13 think I previously provided was required or mandated for 14 it. 15       I actually became -- there's only a few of 16 us that do this. I became friends with people all across 17 the country. The Helfer Society had just started, and I 18 was one of the charter members. And we started sharing 19 information. We recognized that this was building up a 20 body of knowledge that was greater than that of just a 21 general pediatrician, and so we started fellowships. And 22 I started a fellowship program, and I started training 23 fellows, which the old adage is: If you want to really 24 see if you know something, teach it, because it's sort of 25 like law school: The people who are under you are</p>	<p style="text-align: right;">Page 31</p> <p>1 constantly looking for your mistakes and challenging you 2 as a way of showing their knowledge. So I did that all 3 the way up until I came here. 4       The intent was to start a fellowship here, 5 but Mississippi, unfortunately, did not have all the 6 requisite things necessary for accreditation, and so we 7 couldn't do it. 8       Q When you say Mississippi, the med school or -- 9       A Well, the med school or Mississippi the state. 10       Q What was it missing? 11       A It was missing a second board certified. You 12 have to have two, a minimum of two board-certified child 13 abuse pediatricians in order to have a fellowship. 14       Q Are there any other board-certified child abuse 15 pediatricians in the state of Mississippi? 16       A No. But we're recruiting, so if you know of 17 anybody. 18       Q I'll keep my eyes out. 19       What is your definition of forensic? 20       A Forensic is to bring a matter to a forum. 21 That's its dictionary definition. So in this particular 22 aspect, other adjectives, it's the medical legal issues 23 surrounding pediatrics. 24       Q When did the name change to child abuse 25 pediatrics?</p>
<p style="text-align: right;">Page 32</p> <p>1       A So we started thinking that we could possibly 2 have a subspecialty in the late '90s, early 2000s, and an 3 application was made to the American Board of Pediatrics. 4 You have to first show the fund of knowledge, what the 5 factual bases are, you have to compile a full literature, 6 as in any other subspecialty. This is how they evolve. 7 And the application included the name "pediatric forensic 8 medicine," because that's what most people across the 9 country thought was a neutral, fair-sounding name. 10       Well, at that time there already were 11 pediatric -- not pediatric -- forensic pathologists, 12 there were forensic psychologists, there were forensic 13 psychiatrists. Those were already accepted through 14 American Board of Medical Subspecialties. The American 15 Board of Pediatrics said they didn't like the term 16 "forensic." It sounded too legally, and they said just 17 say what it is that you deal with. And so it was the 18 board that changed the name to child abuse pediatrics and 19 said we would never establish it if you used the word 20 forensic, even though that's what we do. 21       Q When was that, I'm sorry? 22       A I believe that was in 2005, 2006, and the first 23 boards were 2009. 24       Q And when did you first take the boards? 25       A 2009.</p>	<p style="text-align: right;">Page 33</p> <p>1       Q And once you're board certified as a child 2 abuse doctor, do you have to renew it? 3       A Yes. 4       Q How often? 5       A So the years that I took it, it was every seven 6 years. They recently last year changed it to every ten 7 years, but then added annual education requirements and 8 quality assurance requirements and read money. So yes, 9 so it's every ten years now, and I have to renew both my 10 general certificate and the child abuse certificate. 11 I've done my child abuse certificate three times, because 12 it was every seven years. And I have not yet had to 13 renew the child abuse, but it's coming up. 14       Q Dr. Benton, what is a forensic pathologist? 15       A This is a pathologist who has completed at a 16 minimum anatomic pathology, a residency -- an accredited 17 residency in anatomic pathology, and was board certified 18 in anatomic pathology. They can then apply to a one-year 19 fellowship, generally one year, and train in forensic 20 pathology or the application of pathology into medical 21 legal issues involving death. 22       Q Are you a forensic pathologist? 23       A I am not. 24       Q Do you hold yourself out as an expert in 25 determining cause and manner of death?</p>

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1 A I'm willing to give my opinion where I can  
2 apply my knowledge to it, so I guess to some degree, yes.  
3 It's not every case.  
4 Q And to be fair, I could give opinions on a lot  
5 of things, but not too many people are going to listen,  
6 you know, because I don't have the expertise on that  
7 and --  
8 A I would say a lot of people do listen to what I  
9 have to say about cause and manner of death involving  
10 children. I have been dealing with child death since the  
11 early -- or mid 1990s. We reviewed when I was in  
12 Louisiana every child death under age 18. We do the same  
13 thing here in the state of Mississippi. So we look at  
14 every child death under the age of 18, every sudden,  
15 unexpected child death. We don't look at natural deaths  
16 like cancer and stuff like that.  
17 So that affords me an experience and a  
18 background. I work with pathologists constantly. I  
19 attend most of the autopsies on the kids who I'm caring  
20 for who die. Probably at least in terms of the gross  
21 anatomy equivalent to that of a forensic pathologist  
22 minus the histopathology, which I am not an expert in.  
23 Q Okay. Fair enough. So do you have any --  
24 other than what you're talking about, observations, do  
25 you have any specific training in pathology?

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1 trauma, mostly on children who can't speak, or preverbal,  
2 nonverbal that are admitted to the Children's Hospital.  
3 I supervise an outpatient sexual abuse clinic in Jackson  
4 and one in Tupelo, and we're trying to get one up in  
5 Biloxi and Hattiesburg and should have it in the next  
6 couple of months with that grant that we just talked  
7 about. That's the clinical aspects. That's seeing  
8 living children that are referred to us by Child  
9 Protective Services, law enforcement, attorneys,  
10 emergency rooms, other physicians, and occasionally we'll  
11 take a self-referral or a parent wants us to see the  
12 child.  
13 Second job description is to teach. I  
14 teach at the medical school level. I teach at the  
15 residency level to child psychiatrists, to pediatric  
16 residents, family medicine residents, med school level.  
17 It's all med students. All third years are required to  
18 rotate through our program.  
19 And I teach at the nursing school, Allied  
20 Health school, that's usually just a lecture once or  
21 twice a year to the physical therapists, speech  
22 therapists. I teach to the dental school. That's  
23 usually a one-year introductory lecture to the third-year  
24 and fourth-year dental students. I also teach to the  
25 Allied Health dental hygiene program. And again, that's

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1 A No. I wanted to become a pathologist, I  
2 trained really hard, but I didn't do it.  
3 Q Why didn't you do it?  
4 A I enjoy pediatrics more.  
5 Q Are you aware of any entity that officially  
6 recognizes Dr. Benton's training as being sufficient to  
7 determine cause and manner of death?  
8 A The state of Mississippi by statute recognizes  
9 my authority to give cause and manner of death in which I  
10 am involved with the child. Now, so all physicians have  
11 that ability in the state of Mississippi. Now, it is  
12 deferred in suspicious deaths to the coroner's office.  
13 Q Was this considered a suspicious death?  
14 A Yes.  
15 Q So what are your specific duties as a child  
16 abuse doctor?  
17 A What are my specific duties at the University  
18 or just --  
19 Q Yes, in what you're doing right now. And if  
20 you're doing something outside of the University, please  
21 let me know that as well.  
22 A No, everything I -- all my employment is with  
23 the University. So threefold job description. I am a  
24 clinician, meaning that I see patients, predominantly  
25 inpatients of the Children's Hospital dealing with severe

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1 a once-per-year introductory lecture.  
2 Early on I was doing lectures at the Ole  
3 Miss law school with David Calder assisting his family  
4 advocacy program. We've been a little busy to do that.  
5 We keep talking about catching up. We work with MC law,  
6 and occasionally we'll give introductory lectures. More  
7 often we take their interns from Ole Miss, Alabama School  
8 of Law, and Mississippi College. It's easier to do it.  
9 They help us with legal issues, and there's always  
10 interesting things for them to get legal things. So  
11 that's the education part.  
12 And the third is a research part. I work  
13 with the Jackson State School of Public Health. I have  
14 been mentoring for the past five years a Ph.D. student  
15 looking at Mississippi adherence to federal guidelines on  
16 forensics. And happily, that project is coming to a  
17 close. But that's the main research we have done.  
18 Q And that's with JSU?  
19 A That's with Jackson State, yes, sir, School of  
20 Public Health.  
21 Q Dr. Benton, what pathologists are you currently  
22 working with in performing your duties as a child abuse  
23 doctor?  
24 A Lots. So all the Mississippi ones. So  
25 Dr. Mark LaVon. I got to think of all their names. The

<p style="text-align: right;">Page 38</p> <p>1 lady just left. I don't see them that often, so I'm 2 having trouble with their names. But there's a tall, 3 thin man. I'm sorry, this is terrible. They're going to 4 hate me, but I don't remember their names. 5 Q There's worse things to be called than a tall, 6 thin man. 7 A I mean, Lisa Funte, I have a case with her 8 right now. I can't think of that -- there's three 9 pathologists there now, and the fourth one was a female 10 that moved and I think is in Dallas now. So across the 11 country I work quite frequently with Mary Case, with 12 Karen Ross out of New Orleans, with -- I'm trying to 13 think of his name -- Schmunk, Greg Schmunk. I just had a 14 case with him recently. And Kim out at the University of 15 South Carolina. I'm blanking on her last name. Kim. 16 Her husband is a federal judge. I cannot pull the last 17 name out. I'm terrible with names. I feel badly because 18 these are people that I know. I used to teach with the 19 Uniform Services Division of Pathology. Tom was his 20 name. And that was out of Bethesda. Tom, starts with an 21 S. 22 Q Do you ever work with any biomechanical 23 engineers? 24 A Yes. Gina Bertocci out of University of 25 Louisville. Let's see. She's the one I worked with the</p>	<p style="text-align: right;">Page 39</p> <p>1 closest. She picks up the phone when I call. Mary Clyde 2 Pierce is a colleague of mine at the University of 3 Chicago, has some people that work with her. I don't 4 recall their names. And it would be more sideline, 5 meaning we'd be discussing, and they'd be there too. 6 Q I want to make sure I understand what you can 7 and cannot do as a child abuse doctor in Mississippi. 8 Can you sign a death certificate? 9 A Yes. 10 Q When was the last time that you signed a death 11 certificate? 12 A I've never signed a death certificate in the 13 state of Mississippi. The last time I signed one was in 14 Louisiana. 15 Q Have you ever certified a death in a case of 16 nonnatural causes? 17 A No. 18 Q Have you ever performed an autopsy? 19 A No. 20 Q Have you ever removed a brain? 21 A I've assisted, but I can't say that I was the 22 one doing it. I was just helping. 23 Q Have you ever examined tissues microscopically? 24 A Yes, but not for official purposes. I am not a 25 histopathologist.</p>
<p style="text-align: right;">Page 40</p> <p>1 Q Do you teach in the teaching aspect of your job 2 determining cause and manner of death? 3 A Yes. 4 Q And in what courses? Is that in all the 5 courses? Do you teach the dental students that? 6 A No. So that would be just to the medical 7 students, and that is part of the curriculum. They all 8 have to learn that, because in -- for natural deaths, any 9 that are non-sudden or unexpected they're required to 10 give a cause and manner of death on the death 11 certificate. 12 Q Have you ever testified on behalf of a criminal 13 defendant that was alleged to have killed a child? 14 A No. 15 Q Have you ever testified in the case where an 16 allegation of shaken baby syndrome was the cause of death 17 and you testified that you didn't believe that was what 18 occurred in the specific case? 19 A No. 20 Q So what was the original cause and manner of 21 death in the Jeffrey Havard case? 22 A I would have to look at that report, but I 23 believe the cause was shaken baby syndrome and the manner 24 was homicide. 25 Q In the autopsy report -- and we can pull it up</p>	<p style="text-align: right;">Page 41</p> <p>1 for you -- 2 A Actually, I did put it in here. 3 Q Okay. So the causes of death in pathological 4 findings, the immediate cause of death were changes 5 consistent with shaken baby syndrome and closed head 6 injuries. Is that correct? 7 A The order that he put it was closed head 8 injuries consistent with shaken baby syndrome, and the 9 manner was homicide. 10 Q As we sit here, is it your opinion that the 11 immediate cause of death in this case, changes consistent 12 with shaken baby syndrome and closed head injuries? 13 A I actually agreed with his modification in his 14 subsequent deposition where he said shaken baby syndrome 15 with impact or blunt force trauma. I believe this baby 16 died of blunt force head trauma. 17 Q And from your review, what was the blunt force? 18 What caused the blunt force head trauma? 19 A Don't know. I don't think that's adequately 20 explained by anything that we have seen so far. 21 Q So did you review the testimony of -- you said 22 that you reviewed the testimony of Dr. Hayne in this 23 trial regarding the cause and manner of death. Correct? 24 A I did. 25 Q Let's take a look at that. I'm going to mark</p>

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1 the testimony of Dr. Hayne as Exhibit 3. And if you'll  
2 turn with me to page 556, please, sir. Dr. Benton, I'm  
3 reading from line 5, the question: "Were you able to  
4 come to a conclusion as to cause of death in this  
5 particular case?" Do you see where I am?  
6 A I do.  
7 Q And Dr. Hayne said, "Yes, sir." Correct?  
8 A Yes.  
9 Q And then the question was: "What was that?"  
10 And Dr. Hayne -- what was Dr. Hayne's answer?  
11 A "It was consistent with the shaken baby  
12 syndrome, sir."  
13 Q All right. Do you agree that the cause of  
14 death in this particular case was shaken baby syndrome?  
15 A I would not have used that term. I don't  
16 discount that there may have been some shaking involved,  
17 but the death was from blunt head trauma.  
18 Q If we go further down to line 19, if you'll  
19 read Dr. Hayne's testimony in the Jeffrey Havard case,  
20 please, sir. And I'll tell you where to stop, if you'll  
21 just read.  
22 A Answer: "It would be consistent with a person  
23 violently shaking a small child. Not an incidental  
24 movement of a child, but violently shaking the child back  
25 and forth to produce the types of injuries that are

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1 syndrome is one, the presence of a subdural hemorrhage;  
2 two, the presence of retinal hemorrhage; and, three, the  
3 absence of other potentially lethal causes of death."  
4 Did I read that correctly?  
5 A You did.  
6 Q Do you agree with Dr. Hayne's description of  
7 the shaken baby syndrome triad in his trial testimony?  
8 A No.  
9 Q What do you disagree with?  
10 A It's interesting because at least in my field  
11 of pediatricians, we don't use the term "triad," never  
12 have, and this wouldn't be the triad that is typically  
13 discussed anyway.  
14 Q If we continue on it says, "Other etiologies or  
15 causes of death." I don't know what that means. And it  
16 says, "So it's inclusionary and exclusionary." Do you  
17 agree that shaken baby syndrome diagnosis is inclusionary  
18 and exclusionary?  
19 A I've never heard it put this way, so I'm not  
20 quite sure what is being meant when they say it's  
21 inclusionary and exclusionary. If it's -- I just don't  
22 know, so I can't agree or disagree because I'm not sure  
23 what the intent is there.  
24 Q Okay. His next sentence says, "Both  
25 inclusionary findings were present." That would be the

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1 described as shaken baby syndrome, which is a syndrome  
2 known for at least forty-five years now."  
3 Q Okay. Thank you. Do you agree that  
4 Dr. Hayne's testimony was that the cause of death was  
5 shaking alone at this point in the trial?  
6 A With what he's saying there, yes.  
7 Q He didn't testify about impact or trauma.  
8 Correct?  
9 A Within the sections that you've asked me to  
10 read, no, he did not.  
11 Q Okay. And we're going to go over a few more  
12 sections, but as you sit here and from your review of the  
13 Jeffrey Havard matter, are you aware of at any time  
14 during the Jeffrey Havard trial Dr. Hayne testifying  
15 about trauma or impact causing the death of this child?  
16 A I read this so long ago I would have to -- the  
17 short answer is no, I don't recall whether he did or did  
18 not include impact in his testimony.  
19 Q If you look down to -- just continuing on,  
20 "Coined by a Dr. Coffee...," do you know who Dr. Coffee  
21 is?  
22 A No, but I can guess who he was referring to.  
23 Q Who do you think he was referring to?  
24 A Dr. Caffey.  
25 Q It says, "...the classic triad for shaken baby

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1 subdural hemorrhage and the retinal hemorrhage. Do you  
2 agree that in Chloe Britt there was -- both of these were  
3 present?  
4 A Yes.  
5 Q "...and also there was an exclusionary  
6 component. I did not find any other cause of death,  
7 sir." Do you now understand what he means by the  
8 exclusionary component?  
9 A As I read further, yes, I now understand. But  
10 again, it's not -- I'm not used to hearing it put in such  
11 manner, but I'm listening.  
12 Q Okay. And so again Dr. Hayne is testifying  
13 that the only cause of death he found was from violent  
14 shaking of Chloe Britt and no other cause of death.  
15 Correct?  
16 A Correct.  
17 Q If you look down at the answer on 10, it says,  
18 "The type of injuries that you can see that parallel  
19 these are in motor vehicle crashes, falls from  
20 significant heights and the like." Do you agree that the  
21 types of injuries you see parallel injuries found in  
22 those types of events?  
23 A Do I agree with what he's saying, limiting it  
24 just to subdurals and retinal hemorrhages or am I  
25 applying this statement to the entire context of this

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1 child's case?  
2 Q Well, that's two great questions, so let's  
3 start with the first one.  
4 A I don't know that you can just say from  
5 subdural hemorrhage and retinal hemorrhages that it  
6 definitely parallels or has to be of that level of force.  
7 You need much more information to be able to draw those  
8 conclusions. In this particular case I do think that the  
9 forces involved in this child are about that level of  
10 violence that we would typically see that full  
11 constellation of the findings seen in Chloe Britt.  
12 Q Dr. Benton, if we look a little further down on  
13 14, Dr. Hayne says, "We're talking about very violent  
14 shaking." And then the question was: "And that was your  
15 determination as to cause of death?" And he said, "Yes,  
16 sir." Again, Dr. Hayne says that violent shaking alone  
17 is the cause of death here for Chloe Britt. Correct?  
18 A I don't know that he ever says it alone, and I  
19 go back to the previous question you asked. I don't know  
20 that he ever talks about the impact injuries to this  
21 child. So I don't know that I can affirm that he's  
22 talking about violent shaking alone.  
23 Q And again, you've already answered this, so I  
24 don't want to go back over it, but are you aware of any  
25 time that Dr. Hayne during the trial of this matter

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1 and testimony at the trial of Jeffrey Havard. Correct?  
2 There was testimony by Dr. Hayne at the trial of this  
3 case.  
4 A Yes.  
5 Q But you're referencing something that happened  
6 after Jeffrey Havard was convicted and sentenced to  
7 death. Correct? When the supplemental deposition of --  
8 A Correct.  
9 Q -- Steven Hayne -- okay.  
10 As we sit here, is it your opinion that  
11 the testimony that Dr. Hayne gave regarding cause and  
12 manner of death was complete and accurate at the time of  
13 the trial?  
14 A So just to be clear, at the time of trial in  
15 his report he said this baby died of closed head injuries  
16 consistent with shaken baby syndrome, and the manner was  
17 homicide. I'm in agreement with that. I also think his  
18 subsequent clarification adds to exactly what type of  
19 closed head injuries we're talking about. The report  
20 itself backs up the impact injuries, whether those words  
21 are mentioned or not.  
22 Q Have there been changes regarding the  
23 understanding of pediatric head injuries since 2002?  
24 A Generally speaking, yes. I mean, we're  
25 constantly evolving our knowledge about head injuries.

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1 talked about any force, blunt force, as related to Chloe  
2 Britt's injuries in this case?  
3 A Without revisiting this entire transcript, I  
4 don't know the answer.  
5 Q And as you sit here, you're not aware of --  
6 A Yes, sir, I'm not aware, sorry.  
7 Q All right. We've talked a little bit about  
8 some disagreements that you have with Dr. Hayne's  
9 testimony in this case. Are you aware of other  
10 disagreements that you have that stand out from his  
11 findings or his testimony in Chloe Britt's case?  
12 A First off, I'm not sure I disagree with his  
13 testimony. Ultimately, I agreed with his conclusion,  
14 particularly as amended in that second deposition. So  
15 overall, I might nitpick in that I don't understand some  
16 of his use of words, but I'm not sure that I disagree  
17 with his ultimate conclusion of cause and manner of  
18 death.  
19 Q In the trial you've testified -- of course, we  
20 can go back and look at it, that you disagreed with his  
21 triad description factors. Correct?  
22 A Like I said, I may take some issues with some  
23 of how he's describing things, but I don't disagree with  
24 the overall conclusion.  
25 Q And just so we're clear, there was a conclusion

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1 Q Is there controversy currently regarding if  
2 shaking can accurately be diagnosed after the fact? In  
3 other words, is there a certain set of findings that  
4 indicate that a child was shaken?  
5 A Yes.  
6 Q And what's your understanding of the current  
7 controversy?  
8 A Well, I was answering the second question, is  
9 there an understanding that there are findings for --  
10 Q I object to my own duplicative question.  
11 A So as to the first one, I believe that there is  
12 a fringe group of individuals across the world that have  
13 challenged the general consensus of what findings can be  
14 interpreted as. You can call it controversy if you want.  
15 Q What's your definition of fringe groups?  
16 A Anyone that's not using the best science to  
17 advance an argument in a medical legal field. So when we  
18 continue to use old literature, literature that had  
19 dubious methodology where you see the same discredited  
20 articles consistently being used to advance a position  
21 when other articles have taken care of the methodology  
22 and refuted that, that's a fringe use of -- it's almost  
23 an advocacy without scientific basis in some cases. In  
24 some cases there's a science basis, but the science has  
25 not been logically elaborated.

<p style="text-align: right;">Page 50</p> <p>1 Q Do you think that the American Academy of 2 Pediatrics is a fringe group? 3 A Is the American Academy of Pediatrics? No, I 4 don't think it's a fringe group. 5 Q And thank you for that correction. 6 American Medical Association, is that a 7 fringe group? 8 A I'm not aware of -- I mean, I used to be a 9 member of the American Medical Association. I'm not 10 aware of them -- I mean, if we say fringe group within 11 the realm of child abuse, I don't know that they have any 12 major positions, although they do have a section that 13 deals with pediatric issues. They're not very big in 14 abuse issues. 15 Q Would you agree that child abuse doctors are 16 also advocates for a position? 17 A Sure. I think we're all advocates for a 18 position. 19 Q Did Chloe Britt suffer injuries from shaking in 20 this case that you're aware of? 21 A I think it's possible. I think she definitely 22 sustained some severe acceleration/deceleration injuries, 23 of which shaking is one possible mechanism of that. 24 Q What is your -- what are the findings that are 25 consistent with what you just said?</p>	<p style="text-align: right;">Page 51</p> <p>1 A Predominantly the bilateral subdural 2 hemorrhages that are whole hemispheric to both sides of 3 her head. The bilateral retinal hemorrhages, which 4 include retinal folds, and they are multilayered and 5 severe. We just don't see those in accidents. 6 Q Just so your testimony is clear, you're not 7 believing that shaking alone killed Chloe Britt. 8 A No. There's plenty of evidence she had impact 9 trauma to her head and in multiple planes. 10 Q Are there other conditions that can cause 11 subdural hemorrhages? 12 A Yes. 13 Q Such as? 14 A In my report I list them all. But in my 15 experience the most common causes are trauma, and that 16 can come in three forms: inflicted trauma is definitely 17 the most common; accidental trauma, the next most common; 18 and birth trauma if we're dealing with kids under three 19 months of age, as we frequently will find subdural 20 hemorrhages. 21 Then we go down the list. And those are 22 broad sweep. So we see them in genetic and metabolic 23 disorders. We see it with coagulopathies, or bleeding 24 disorders. And there's a list of different things. We 25 can see tumors. We can see anything that affects those</p>
<p style="text-align: right;">Page 52</p> <p>1 systems indirectly, like leukemia, neuroblastoma. I 2 could look at my list and flesh it out for you, but 3 there's a list of things that can cause subdurals. 4 Q Dr. Benton, did you make a diagnosis of cause 5 of death that was separate from Dr. Hayne's findings in 6 this case? 7 A I don't think so. I think I just reaffirmed 8 his latest position. I agreed with it. I don't think I 9 set -- let me just double-check. I don't think I 10 advanced a separate position. And as I sit here now, I 11 agree. 12 Q Do you believe it's your role to determine 13 manner of death? Is that a child abuse doctor's role? 14 A So within the confines of state statutes as far 15 as for the initial first official determination, that is 16 relegated to the coroner in the state of Mississippi, so 17 I have no role. I can advocate for what I believe, but 18 it's not my official role. 19 Same thing post-determination, we do this, 20 we meet and review every death as to cause and manner of 21 death for every sudden, unexpected death. I may disagree 22 what's there, but once it's on the final death 23 certificate, we have no authority to change it or even to 24 pursue a change in it. That's just how the statutes are 25 set up.</p>	<p style="text-align: right;">Page 53</p> <p>1 Q And I know we have your list of cases here, at 2 least at the time and you're going to give us an updated 3 one, but other than the Chloe Britt case, have you given 4 opinions in a case, either whether it's the habeas level 5 or in post-conviction -- 6 A I don't know what habeas means. 7 Q Okay. So let me strike that. And thank you 8 for slowing me down because I was going to just say a 9 bunch of legal stuff and you wouldn't know any of it 10 maybe. 11 A I may or may not. I've heard habeas corpus, 12 but I don't really know what it means. 13 Q Okay. Other than the Chloe Britt case, have 14 you given reports or opinions in a forensic situation 15 after the trial has already taken place? 16 A No, I think this is the first. 17 Q Are you aware of other cases that the State has 18 asked you to get involved in, for example, regarding 19 other people that were convicted of shaken baby syndrome? 20 A This is the first. 21 Q Do you believe that Chloe Britt was the victim 22 of abuse? 23 A Yes. 24 Q Do you have an opinion that the abuse caused 25 this death?</p>

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1 A Yes.

2 Q And do you have an opinion as to what that  
3 abuse was?

4 A I mean, we can speculate as to the exact  
5 mechanisms, but I do think it involved blunt trauma to  
6 the head that had a severe acceleration/deceleration  
7 force to the head. There's also evidence of other  
8 injuries to parts of the body that in a six month old are  
9 equated with abuse.

10 Q Would a fall cause blunt trauma to a child's  
11 head?

12 A It can, yes.

13 Q And what other areas were you talking -- are  
14 you talking about as it relates to Chloe Britt?

15 A The child's got a torn frenum. The child has  
16 two bruises to the anterior thigh and also had something  
17 happen to the anal area with blood in the diaper and  
18 bruising to the rectum.

19 Q Have you reviewed or do you have any opinions  
20 regarding whether Chloe Britt suffered from any sexual  
21 assault in this case?

22 MR. SMITH: I'm going to object, and I'd like  
23 to give a basis. The sexual battery injuries to the  
24 sexual battery are beyond the scope of this remand,  
25 and it's irrelevant.

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1 statement.

2 The biggest concern for me it that there's  
3 blood in the infant's diaper that is seen in the crime  
4 lab, in the crime lab reports but wasn't pursued any  
5 further. And yes, there's no sex-specific findings of  
6 semen or sperm, but the blood in the diaper indicates  
7 something has happened before there was any medical  
8 instrumentation or, as advanced by Havard, that perhaps  
9 there was -- well, there had to have been some  
10 penetration to get into the rectum.

11 BY MR. JICKA:

12 Q The frenulum.

13 A Yes.

14 Q Just my understanding, that's the inside of  
15 your upper lip. Is that correct?

16 A It's the piece of fibrous tissue that connects  
17 the upper lip to the gums.

18 Q Did you read the trial testimony where the  
19 State decided that it was not going to pursue that as  
20 abuse or as -- or as abuse in this case?

21 A I read it. I don't recall it as we sit here  
22 right now.

23 MR. JICKA: How are you doing? This is not a  
24 marathon. I don't want to -- if you need a break --  
25 are you good to keep on trucking?

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1 BY MR. JICKA:

2 Q You can go ahead and answer.

3 A I don't have a firm opinion only because I  
4 don't think we -- I don't think all the evidence was  
5 thoroughly evaluated to come to that conclusion. I think  
6 it is possible she was sexually abused. I think it's  
7 also possible we could come to a different determination  
8 if we had the ability to go back and look at things.

9 Q What would be the type of information that you  
10 would like to see to make that determination?

11 MR. SMITH: Objection.

12 MR. JICKA: And I understand it's the same.  
13 You can -- we'll just note the objection.

14 A With what he objected, I did not make any  
15 special effort to look at this, but if you go back  
16 through the whole record, I would like to see what  
17 instrumentation was done to the child's rectum. And  
18 again, I did not take note or make note of that because I  
19 was told that wasn't an area of interest.

20 But it's clear there was a contusion.  
21 Even your own experts have seen that on the  
22 histopathologic slide. I don't necessarily agree with  
23 Dr. Ophoven when she says there has to be a break in the  
24 skin. That actually doesn't make any sense. I've done  
25 thousands of rape exams, and I don't think that's a true

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1 THE WITNESS: I'm fine.

2 BY MR. JICKA:

3 Q Dr. Benton, did you personally review the  
4 videotaped interview of Jeffrey Havard where he describes  
5 the accidental fall?

6 A No.

7 Q Where did you get your information about the  
8 fall?

9 A Transcript.

10 Q Would you agree that history is important when  
11 you're evaluating a case such as Chloe Britt's?

12 A Yes.

13 Q And why is that?

14 A Because it sets the context and perhaps other  
15 peripheral details that can modify your opinion of the  
16 factual details or objective details.

17 Q What is your understanding of the dynamics of  
18 the accidental fall as described by Jeffrey Havard?

19 A The child was in a infant tub inside of an  
20 adult tub, was removed by Havard. And I've seen the  
21 photographs of the scene, so there's a commode just to --  
22 if you're facing the tub, there's a commode just to the  
23 right of the tub that he was -- there was a towel lying  
24 over the seat of the commode. And that he had the child  
25 in hand, that apparently was trying to get to the towel,



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1 that the child's legs hit the lid of the toilet, and he  
2 was -- he used the word definitely sure that the body or  
3 torso hit the tank, was not as sure whether the head hit  
4 the tank or not.  
5 After that interaction or somewhere in  
6 that interaction he said he possibly may -- that may have  
7 been one instance where he could have penetrated the  
8 child's rectum. That the child was wiggling and he  
9 dropped the child. Actually uses the word slide and/or  
10 drop in different circumstances in the record. The floor  
11 in that area is a red carpet kind of shag, '70ish carpet.  
12 And that the child gasped, that he picks the child up, he  
13 says that the child was altered mentally, my words, I  
14 don't recall his exact words, and that he shook the child  
15 to revive the child, and subsequently grabbed the towel,  
16 brought the baby to the bedroom, and I think the child  
17 deteriorated from there. That's my understanding.  
18 Q Thank you. Did you read or view the video  
19 statement of Rebecca Britt?  
20 A I did not.  
21 Q Were you provided any information regarding  
22 that?  
23 A I definitely was not provided any video.  
24 Q Do you recall seeing a transcript of her  
25 pretrial interview?

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1 where that injury is located. Correct?  
2 A Yes, sir.  
3 Q And then Pattern, what do you mean by pattern?  
4 A Does it have a pattern. So in our field,  
5 patterns mean a lot, so such as belt buckle pattern or  
6 parallel linear patterns that would indicate contact with  
7 an object or things like that.  
8 Q Okay. And so in your field as a child abuse  
9 doctor, if there's a pattern, that could be evidence that  
10 there has been some systemic child abuse.  
11 A It doesn't necessarily imply abuse, but it does  
12 imply contact with a specific object that we then want to  
13 hear a history to explain that, and the absence of an  
14 explanation may lend towards abuse as opposed to an  
15 accident. But it's not always that simple. Some  
16 patterns are very specific. I mean, belt buckles, I  
17 mean, when you see them, particularly in repetition, you  
18 have to come up with a really good explanation why that's  
19 on a child's body.  
20 Q Have you ever worked on cases where you had  
21 cigarette burns in a pattern on children?  
22 A Yes.  
23 Q Would that be the type of pattern that would  
24 also be included?  
25 A Same thing. So we have to still listen to the

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1 A I don't think so. As I sit here, I'm trying to  
2 recall what she would've said, and since I can't, I don't  
3 think I saw that.  
4 Q Dr. Benton, what I'd like to do is go through  
5 your table of Findings of Injury on page 5 of your  
6 report, sir. Are you with me, sir?  
7 A I am.  
8 Q On the top it says Pediatric Forensic Medicine  
9 Consultation Report. Is this a chart that Dr. Benton has  
10 come up with or is this one that you have received from  
11 some other -- used from some other source?  
12 A No, I created it.  
13 Q And what I'd like to do is just kind of go  
14 through how it's set up. Okay, sir?  
15 A Sure.  
16 Q All right. So it says Findings of Injury. Is  
17 that correct?  
18 A Correct.  
19 Q And then the first column says Type. Is that  
20 correct?  
21 A Yes, sir.  
22 Q And so are you trying to identify all of the  
23 findings of injury from the evidence available?  
24 A Yes, sir.  
25 Q And then you have Location next, which would be

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1 history to it because we do see -- we don't see it as  
2 much anymore; people are smoking less. But certainly --  
3 Q That's another benefit.  
4 A Children would run past a cigarette and sustain  
5 a cigarette burn, and I wouldn't call that necessarily  
6 abusive. So yes, we do look at certain patterns, and  
7 there are certain -- I mean, I've definitely had some  
8 cases where you see their abdomens burned and their faces  
9 burned, and these aren't typically accidental areas.  
10 Q All right. So when you use the word  
11 "amorphous" on the pattern, what does that mean?  
12 A Without pattern or without shape.  
13 Q And I see --  
14 A Or it's not described.  
15 Q As you go down, it has "multifocal." What does  
16 that mean as a pattern?  
17 A I put that in quotes because that's the pattern  
18 as it was described in the autopsy report. It wasn't  
19 more specific than that.  
20 Q Does autopsy use the term "pattern"?  
21 A They should.  
22 Q Well, I'm asking did this one use the term  
23 pattern in it?  
24 A I would have to look at the report to see if he  
25 used the term pattern. But the word used relative to the

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1 hematomas to the scalp was multifocal, and it didn't go  
2 further in specifying the pattern or direction.  
3 Q The next says N slash A. What does that mean  
4 under Pattern?  
5 A Edema doesn't have a pattern, so it's not  
6 applicable.  
7 Q And we see that again with the laceration. Is  
8 that correct?  
9 A (Nods head affirmatively.)  
10 Q So frenulum laceration wouldn't have a pattern?  
11 A It doesn't, no.  
12 Q And then when you see hemorrhage, it says "not  
13 specified." What does that mean?  
14 A There was notation that there -- let's see,  
15 where is this one? The hemorrhages to the retina of the  
16 eyes were not specified at the time I wrote my report.  
17 Actually, Dr. Ophoven, who looked at the histopathology,  
18 does give us a pattern, which previous to that I didn't  
19 know the specific pattern.  
20 Q On the patterns regarding certain hemorrhages,  
21 what do you show there? As you go through the last I  
22 guess four items on hemorrhage?  
23 A So to be specific, the hemorrhage to both eyes  
24 is referring to the retina was not specified at the time  
25 I wrote this. The next hemorrhage is to the optic nerve

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1 recognition that we have to -- we can't look at things in  
2 isolation, and other factors would have to come in to  
3 further classify.  
4 So in that column I am looking at the  
5 injuries that are there and saying what specificity does  
6 that have along that continuum of reliability for  
7 defining abuse. To flesh out the scale there's normal,  
8 nonspecific, concerning, suggestive, and definitive.  
9 Normal, obviously there's no finding, so that doesn't  
10 apply to this. These would only apply to abnormal  
11 findings.  
12 Nonspecific is a finding that's been so  
13 well described in both accidental and non-accidental  
14 etiologies that you can't even look at it. Examples of  
15 that would be amorphous, bruises to the shins of a  
16 walking child. I mean, I'm more concerned if they don't  
17 have any bruises there. So we can't make any judgment  
18 call. Can you beat a child on the shins? Sure. But I'd  
19 need additional information to classify that finding. So  
20 that's nonspecific.  
21 Concerning is where the literature looks  
22 at abused kids and looks at accidental kids, and we see a  
23 higher frequency of this finding in the non-abused -- I'm  
24 sorry, in the abused population. So it should provoke  
25 concern, but it doesn't define abuse. And you should

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1 sheets, and I'm not aware of any classification by  
2 pattern of those other than to comment that they're  
3 present. The next is acute subdurals that are  
4 bi-hemispheric, acute subarachnoid hemorrhage, and the  
5 locations of that to the cerebrum, cerebellum, and  
6 brainstem. So that's the last two hemorrhages, the  
7 subdural and the subarachnoid.  
8 And they're whole hemispheric. There's no  
9 specific pattern to it that limits it down. Occasionally  
10 we will see what's called a contact pattern, which is a  
11 small subdural that usually is underlying an area of the  
12 skull that may or may not have a fracture. These are  
13 just diffuse, so there's no specific pattern to it, and  
14 that's why I put N/A for those, not applicable.  
15 Q The next column says Specificity. What does  
16 that mean?  
17 A This is something that was not totally my  
18 creation, but Dr. Adams in San Diego had evolved a  
19 classification system of looking at each injury and  
20 looking at it independent of history, looking at it  
21 independent of any other what can this injury tell us  
22 along a continuum scale of reliability where on one end  
23 we say there is no injury and that's normal, and on the  
24 other end we say, gosh, this injury alone defines that a  
25 person has been abused. In between that scale is a

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1 never use a concerning finding in isolation of other  
2 facts to come to a definitive conclusion.  
3 Suggestive is a recognition that there are  
4 scientific things out there that we may or may not know  
5 but that we can categorize or that we can theorize or be  
6 logical about and say that this finding is almost  
7 exclusively seen in abuse, but I can come up logically  
8 with reasons why it might occur in a non-abused child.  
9 And then definitive are findings -- and  
10 there's very, very few of those -- are findings that  
11 there is no other explanation. We don't need any other  
12 information to further classify.  
13 Q Okay. In Jeffrey Havard's case you didn't find  
14 any definitive findings of abuse. Correct?  
15 A Correct.  
16 Q And in this chart are you aware of other child  
17 abuse doctors or anyone else that uses the chart that you  
18 have here in front of us?  
19 A Every one I've trained. So all of my former  
20 fellows use this. I think, for whatever reason, most  
21 people move to a shorter dichotomy of just normal,  
22 nonspecific, concerning, and definitive, and they drop  
23 the suggestive. For physical abuse. They may use the  
24 five-point scale for sexual abuse.  
25 Q When did you come up with this chart,

<p style="text-align: right;">Page 66</p> <p>1 Dr. Benton? 2 A Like I said, it was based off of -- oh, this 3 chart? 4 Q Yes. 5 A Contemporaneously with reviewing the records. 6 Q I'm sorry, the format for this chart, when did 7 you come up with it? 8 A Oh, somewhere in the late 1990s. Dr. Adams 9 came out -- Dr. Adams -- and it's in the article "It's 10 Normal to be Normal," that's the title of the article. 11 It was a sex abuse article. But I was taken by how she 12 framed each of the injuries in isolation of the history, 13 because that's what forensics is about. And that's 14 something that was drilled into me when I was in San 15 Diego is that if the history determines the finding, then 16 you're not evaluating the finding; you're just taking the 17 history for it. 18 So we have to communicate to you guys or 19 whoever is interested what does the finding mean in 20 isolation as well as put it in the context, but do them 21 separately. And that's the third application of any 22 evaluation of injury. 23 Q Have you trademarked or copyrighted or -- 24 A No. 25 Q -- anything in this chart? Is it in any</p>	<p style="text-align: right;">Page 67</p> <p>1 textbooks that you're aware of? 2 A Sure, it's in -- I wrote the chapter in the 3 textbook, so, I mean, I published this. It's a shame I 4 can't remember the title of the book. 5 Q We'll get your -- 6 A It's Forensic Pathology of Infancy and 7 Childhood is the textbook. And it would be in my CV. I 8 didn't even think to look there. It's Forensic Pathology 9 of Infancy and Childhood. I wish they would page number 10 them so I -- 11 Q That's okay. So as we look on your CV in the 12 publication list, it's Book Chapter -- is it the "Sexual 13 Abuse of the Young"? 14 A It is. 15 Q And that was published in 2014. Is that 16 correct? 17 A That is correct. 18 Q So prior to 2014, are you aware of this chart 19 ever being published in any textbook? 20 A So there are charts and -- the answer is yes, 21 but maybe not exactly the way I -- so there are numerous 22 people. Dr. Adams is probably the foremost person who 23 has evolved guidelines for how to classify things. She 24 strictly limits herself to sexual abuse. She's never 25 gone into the physical abuse realm. I thought it had</p>
<p style="text-align: right;">Page 68</p> <p>1 applicability, and so I've extended it there. So you 2 will see various versions of this concept in the child 3 abuse literature and textbooks, but most of it is going 4 to be towards sexual abuse. 5 Q And that's why I meant this, you know, the 6 Benton chart as I want to call it now. 7 A No, don't call it that. 8 Q Doesn't that sound good? So the Benton chart, 9 before 2014 are you aware of it ever being published in 10 any textbook? 11 A No. 12 Q Did you publish it other than in -- the "Sexual 13 Abuse of the Young," has it been published in any other 14 textbooks or other chapters? 15 A Again, there are other people that have 16 published in reliability scales, but not what I have 17 characterized a five-point scale. I mean, there are 18 other five-point scales. Again, I'm leveraging off of 19 other people's works. And actually, if you look at that 20 chapter, I cite the evolution of these scales, so all the 21 literature that describes previous people's works on how 22 this evolved. 23 Q Who is using that textbook now, the sex 24 abuse -- 25 A Predominantly pathologists, forensic</p>	<p style="text-align: right;">Page 69</p> <p>1 pathologists. I mean, it's one of the -- one of the... 2 Q One of the good ones? 3 A Yes. I mean, those are two leading authors. 4 And I'm very sad to say Kim Collins is the pathologist I 5 forgot to say before out of the University of South 6 Carolina. 7 Q Then the final category is Consistent with 8 History. 9 A So that's the third application. So you start 10 first with what does it mean in isolation, and then the 11 third factor is to apply the history to it, is the 12 history consistent. 13 Q All right. When you do your chart, do you 14 always have an asterisk after the yes or a no? 15 A No. So this is definitely -- so it's a good 16 question. So originally -- 17 Q I'm going to have like three more the rest of 18 the afternoon, so count them up. 19 A Originally if you take any one of these in 20 isolation, the consistent with history could be true if 21 it was just that one finding, or maybe two of the 22 findings. But once you start adding up all of these and 23 we only have maybe hit the head on the lid, maybe hit the 24 head on the floor, that's not even definitive. We just 25 know the kid slid, dropped to the floor, not sure what</p>

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1 body part actually hit the floor. And now we have all of  
2 these. So I went back and I put the asterisk next to  
3 those saying the trouble is, we don't have enough history  
4 to cover all of these findings. And that's why I put no.  
5 Q Looks like you have a maybe for edema on the  
6 face.  
7 A Uh-huh.  
8 Q So that might be consistent with the history  
9 that was given?  
10 A Well, when people start dying and things alter  
11 pretty quickly, you can get edema to the face or other  
12 places. So maybe that's included in the process. It was  
13 not significant to me.  
14 Q The chart, the Benton chart on finding  
15 consistent with history, what are -- you gave me the  
16 range as it related to specificity. Is there also a  
17 range -- and I'm guessing it might be yes, no, maybe, but  
18 what are all the different findings you could have under  
19 consistent with history?  
20 A It's a dichotomy. I mean, it's either yes, no,  
21 or I guess unsure. That part of it I purposely do not  
22 offer a specific opinion because that's now invading the  
23 province of the chart artifact.  
24 Q And you agreed that child abuse doctors should  
25 not do that.

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1 the only time I will make timing statements is if it can  
2 discern the who. So, I mean, you can go down the list,  
3 but most of those our -- the limits of our ability to  
4 time are on the order of a week or more, nothing that  
5 would be of help, so I did not do anything further.  
6 Q Did you make a determination as to the possible  
7 etiologies of each of these injury findings?  
8 A I mean, I certainly considered it in each, and  
9 the ones that are labeled non-specific I didn't come up  
10 with anything. The ones that are labeled concerning I  
11 certainly leaned towards this has some predilection that  
12 something non-accidental happened to the child. The ones  
13 that are labeled suggestive, as I previously stated, are  
14 seen fairly frequently, almost to the exclusion, but it's  
15 not definitive, meaning that there are some circumstances  
16 where if you have the right history you can see these  
17 findings.  
18 Q Did you request or perform a biomechanical  
19 analysis?  
20 A No.  
21 Q Are you able to do that?  
22 A Yes. Well, with the Attorney General's money  
23 but --  
24 Q Assuming they would cut the check?  
25 A We've done that in other cases, but no.

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1 A Correct. Any of us should not do that.  
2 Q When you consider the history here, are you  
3 considering the full history or only the fall history  
4 that was described?  
5 A So all history that I took into account is  
6 summarized ahead of time, so that goes from birth to  
7 present that was available to me.  
8 Q So that would include Jeffrey Havard's history  
9 regarding the fall. Correct?  
10 A Yes.  
11 Q Would it include what happened at the ER  
12 with --  
13 A Yes.  
14 Q -- the ER nurses and so forth?  
15 A Oh, yes.  
16 Q Okay. Is it important when you're trying to do  
17 this to determine the timing of these entries, in other  
18 words, when did certain things occur?  
19 A Where able, yes.  
20 Q Did you make an attempt in the Jeffrey Havard  
21 case to make a determination as to the timing of these?  
22 A I did not only in the sense that all of the  
23 injuries that we see here are of an acute timing that our  
24 current medical understanding of the time frame is too  
25 big to be of any significance in discerning a who. So

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1 Q What is your understanding of Jeffrey Havard's  
2 description of Chloe's symptoms right after the impact?  
3 A So after he dropped her, as I previously  
4 said -- and I assume this is when she hits the floor she  
5 kind of gasped for air is his words. He then picks her  
6 up, says that he shook her side to side, and he said that  
7 she started crying again. The next recording of her  
8 behavior was that she spit up some more in the bedroom  
9 and that she had blood which he attributed to coming from  
10 her nose. And that he laid her down on her stomach but  
11 doesn't describe any other behaviors after that.  
12 Q Dr. Benton, is it fair to say that that's a  
13 pretty normal description of a concussion with an acute  
14 subdural hematoma, what he described there? Take a look.  
15 A No, I wouldn't say that that's a typical  
16 description, unh-unh.  
17 Q If someone had an acute subdural hematoma from  
18 a concussion, would these be symptoms that you would --  
19 you could expect to see someone describe, a layman  
20 describe?  
21 A No. So a layman describe. I mean, did he use  
22 the word "concussion"?  
23 Q No, I'm using the word concussion.  
24 A Okay. So restate the question, please.  
25 Q Sure. What you just read, the description of

<p style="text-align: right;">Page 74</p> <p>1 Chloe's symptoms right after impact, is that a pretty 2 fair description of a concussion with an acute subdural 3 hematoma? 4 A No. 5 Q And why not? 6 A I mean, for multiple reasons. First off, the 7 gasp for air implies impact either to the abdomen or 8 chest typically, if I had to ascribe anything to it. The 9 crying doesn't fit. I mean, I would say in the thousands 10 of cases that we look at where kids fall out of bed and 11 stuff, they pick them up and they're crying. So that 12 could fit a fall, I don't have any problems with that, 13 but that's not a concussion. 14 So in our world a concussion is an altered 15 state of mentation. We don't typically think of 16 concussions in an infant, or at least we don't use that 17 word. We think of it more in sports-related injuries. 18 I'm not saying that you can't have a concussion. 19 Now, to the second part of your question, 20 when I see a subdural like this, bi-hemispheric, whole 21 hemispheric, I use that as a marker of what else is going 22 on. So we see plenty of kids who have subdurals, and 23 they have no effect on the child whatsoever. I mean, so 24 it's not blood in the subdural space that's the problem; 25 it's the underlying pathology of the brain. And</p>	<p style="text-align: right;">Page 75</p> <p>1 generally when we do see this degree of subdural, there's 2 usually unconsciousness on the brain, and it is in almost 3 all descriptions, including invention descriptions where 4 people confess to injuring the kid, it's instantaneous, 5 and the lights are out. 6 Q If Chloe had had a preexisting injury to her 7 head, would that make her more vulnerable to concussion 8 and injury from a second event? 9 A Restate the question one more time. 10 Q If Chloe had a preexisting injury to her head, 11 would that make her more vulnerable to concussion and 12 injury from a second event? 13 A The short answer is we don't think so. So 14 there is a body of literature called second-impact 15 syndrome, which is under heavy scrutiny in a lot of -- so 16 it was published, I believe, about in the mid 1990s, et 17 cetera, and involved high-impact injuries among 18 footballers, et cetera. I think it came out of 19 Australia. 20 And we considered that. Is there a 21 priming, so to speak, of particularly the sodium or other 22 channels in the brain that might lead one to have a more 23 severe injury than one would expect. Except we just 24 don't see that in other accidental injuries. Now, we 25 certainly give that advice to families, but so far we</p>
<p style="text-align: right;">Page 76</p> <p>1 have not seen sudden death in a kid who's previously had 2 a known accidental head injury. 3 Q And you're probably watching a lot of 4 television lately, but we see football players who have 5 repeated concussions and the fact that it may -- the 6 first concussion or the second concussion may make you 7 more vulnerable as you continue to receive concussions. 8 Is that a fair statement? 9 A Yes, I think it's fair to say that severe head 10 injuries that happen repetitiously is not a good thing 11 for the brain. 12 Q And not only not a good thing, but it continues 13 to get -- you become more vulnerable after each event. 14 A If you're using vulnerability in the way I 15 think of it with the literature on second-impact 16 syndrome, I think the jury is out on that. If you're 17 using it in terms of -- and I've not seen the movie, but 18 the guy in Los Angeles that helped to establish that 19 there was pathology to the brain with repetitious injury, 20 I agree with that. So I'm not sure what to say about 21 vulnerability other than our concussion guidelines were 22 predicated off of the second-impact syndrome, whether 23 you're talking about professional football players or 24 high school or what have you. 25 And I think they're constantly under</p>	<p style="text-align: right;">Page 77</p> <p>1 evaluation. Do we want to risk anyone's life about that? 2 Well, the professional people do. I mean, they try to 3 hide their concussions because they're paid to play. But 4 in high school, you know, we'll cut it short. In 5 soccer -- I was a soccer referee -- we take no chances. 6 If you have a slight dizziness or something, we call it a 7 concussion, and you sit out and you got to sit out until 8 a significant time has passed, which we don't know what 9 that is. Is there a true vulnerability? We don't know. 10 Q In your job as a treating physician, do you 11 actually treat patients in your job? 12 A We do. Well, I mean -- 13 Q Does Dr. Benton see people as a doctor? 14 A We see living patients, and if they have 15 problems that fall within the realm of general 16 pediatrics, we will treat them for it as we're evaluating 17 the reason that they're there. 18 Q Okay. And when you say "we," that's the only 19 thing -- 20 A I'm sorry about the royal we. I do that. 21 Q Okay. Do you treat, have you treated people 22 who have had -- children who have had concussions? 23 A Not in a long time. So in my past I also did 24 hospitalist work and did some ER work, I guess for the 25 first five to six years I was starting out. As I got</p>

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1 busy with this, no. That would mostly be in the  
2 emergency room or hospital setting.  
3 Q How do you get your patients typically? Are  
4 they referred to you by an ER doctor or a primary care  
5 physician? How does it -- or a parent? How does it get  
6 to you?  
7 A So we have many vehicles. Child Protective  
8 Services, law enforcement are a major referring; the  
9 youth court under the Multidisciplinary Team Act is a  
10 major referral; emergency room physicians, as you  
11 mentioned, pediatricians, family physicians,  
12 psychiatrists, sort of in somewhat decreasing order.  
13 And we have mandatory triggers. So the  
14 University has what's known as a high-risk surveillance  
15 system, which I implemented. So there are certain  
16 diagnoses, such as subdurals, retinal hemorrhages,  
17 subarachnoid hemorrhages, all admissions for trauma, all  
18 skeletal fractures regardless of where they are, all  
19 abdominal trauma, all ingestions, all suicide attempts,  
20 all gunshot wounds, all knife wounds are referred to us  
21 automatically. I mean, there's no -- a computer does  
22 that. I mean, they're just pulling it off the chart, and  
23 we get the referral.  
24 Q When did you come up with this system?  
25 A Dan Jones was the chancellor -- vice-chancellor

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1 make sure, as Dan Jones says, that this never happens  
2 again. Is that correct?  
3 A Let me rephrase that --  
4 Q Well, answer my question, and then rephrase.  
5 Is that correct?  
6 A Yes, but I didn't tell you the second half of  
7 it. So there were also cases of inappropriate diagnoses  
8 of child abuse that led to a lawsuit and separation of  
9 the child from the parent. So the whole idea was let's  
10 get it right. So I am also notified of every reporting  
11 of child abuse, and we do a secondary screen, is there a  
12 sufficient basis to have reported that. And again, we do  
13 that within 24 hours of the notification.  
14 So it swings both ways. But I do think we  
15 try to get it right, and I'm not aware that there's any  
16 overcalling going on. Nationally if you look at  
17 statistics on the epidemiology, it's always the opposite  
18 direction. We just take the person at hand and don't go  
19 any further.  
20 Q Dr. Benton, what was the fatal injury in this  
21 case?  
22 A Closed head injury.  
23 Q Do you know when that fatal injury occurred?  
24 A By history it happened after this baby was  
25 having fun and playing in the bathtub and described as

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1 at the time who had recruited me, and the University was  
2 being sued for failing to recognize abuse in some cases,  
3 which Dan Jones is a very honorable person said we did,  
4 we're going to pay up on this, but we don't want this to  
5 happen again, what can we do.  
6 The general teaching previous to that time  
7 was not adequate to keep an open mind about whether  
8 parents or caregivers could be abusers. So we assembled  
9 a team in, shoot, two months after I got here I got hit  
10 with that charge, and we got representatives from every  
11 major division and department at the University. And we  
12 met for about two years. And as they say about the  
13 sausage making in the legislature, this is true here too.  
14 We came up with what do we want the computers to surveil,  
15 I mean, because this is, you know, putting people under  
16 the microscope type of thing. And that evolved over two  
17 years. So in 2010 the system went live and has been  
18 going ever since.  
19 Q Would you agree that UMMC is now more likely to  
20 over-diagnose child abuse?  
21 A No, no evidence of that whatsoever.  
22 Q The problem was there was some found child  
23 abuse that was not diagnosed. Correct?  
24 A Correct.  
25 Q And then a whole system is put in place now to

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1 normal. That is one logical point in time. Using the  
2 factual evidence we know that acute subdurals, acute  
3 subarachnoids you're looking at less than a week or so.  
4 There was no other markers to say that there was findings  
5 were there longer. The laceration to the frenum was  
6 fresh. We have no other history to suggest, so that also  
7 is a marker in time that it happened on that evening or  
8 afternoon.  
9 Q On page 6 of your report you write, "The  
10 literature is clear that the most common cause of  
11 subdural hematoma, subarachnoid hemorrhages and retinal  
12 hemorrhages in infancy is trauma whether accidental or  
13 inflicted."  
14 A Uh-huh.  
15 Q "It is usually from a severe  
16 acceleration/deceleration force; i.e., whiplash motion."  
17 Did I read that correctly?  
18 A Uh-huh, yes, sir.  
19 Q "The differential diagnosis has included since  
20 my training in the mid-1990s" -- and then you list  
21 things. Is that correct?  
22 A Correct.  
23 Q What specific literature are you referring to  
24 when you say the literature is clear?  
25 A You can pick up any textbook on pediatrics or

<p style="text-align: right;">Page 82</p> <p>1 pediatric imaging or child abuse specifically, and you 2 will see that that is the No. 1 etiology of subdural 3 hemorrhages. 4 Q Can you give me specifics, please? What 5 textbook are you talking about that I can pick up and -- 6 A I mean, so -- 7 Q If you want to cite your own work, you can, I 8 guess. 9 A No, I'm not -- so if you look at the body of 10 literature textbook-wise, Lori Frasier is the editor of 11 Abusive Head Trauma. I think it's in its second edition. 12 The -- gosh, who's the -- we use it all the time, and I'm 13 trying to think of the guy's name. You're hitting me 14 with all these -- I should know the names. He's a 15 professor of radiology at Harvard, and it's the bible 16 that we look at in terms of radiologic imaging or neuro 17 imaging in children. I can get it to you later, but it's 18 sitting on my desk at the office. 19 Q Is it, you think, reasonable to rely upon, for 20 example, those two textbooks that you have just testified 21 about? 22 A I think on that particular issue, yes. I mean, 23 generally speaking there's also many articles and review 24 articles that look at subdurals that will list or publish 25 some of these same lists. I did not create this list.</p>	<p style="text-align: right;">Page 83</p> <p>1 It's an amalgamation of textbooks and articles. 2 Q I think you testified earlier that, for 3 example, birth trauma can cause subdural hematoma -- 4 hemorrhages. Correct? 5 A Yes. 6 Q Do you know what the incidence of subdural 7 hemorrhages, what that -- what the rate is, what the 8 incidence rate is? 9 A Depends on what group you're talking about. So 10 the group I think we're interested in, if I can add to 11 your question, is normal term, asymptomatic infants. And 12 the incident rate in that group is close to 30, 40 13 percent. 14 Q What causes I'm going to call it SDH in birth, 15 subdural hemorrhages? 16 A So the prevailing theory is that it's a rent in 17 the tentorium, because most of the bleeding of that type 18 is in the posterior fossa of the brain. So as the head 19 conforms either to the vaginal canal or if there is -- 20 particularly if there's forceps or a vacuum that are 21 used, there's a lot of forces on the head. And the 22 tentorium is a membrane that separates the upper cerebrum 23 from the cerebellum, and the prevailing thought is that 24 there's forces that causes it to actually injure the 25 blood vessels and bleed into that area.</p>
<p style="text-align: right;">Page 84</p> <p>1 The same thing is true in C-sections, so 2 C-sections aren't immune. Being a pediatrician, that's 3 the types of deliveries we would go to, and they're not 4 as benign as you would think. It's not just cutting the 5 baby out. It does take a lot of force to still get them 6 out, particularly since ladies like those small bikini 7 cuts. Just saying there's a lot of force even in 8 C-sections. 9 And I cite the literature in my report. 10 And those are the three -- there's actually four now, but 11 those are the three main studies that look at that. 12 Q Are you an engineer? 13 A No. 14 Q Are you a biomechanic? 15 A No. 16 Q Do you know what acceleration or deceleration 17 forces are? 18 A Generally speaking, yes. 19 Q Do you know the units that they're measured in? 20 A I probably could think about it. At one point 21 I wanted to be a physics major. I read these articles 22 all the time. I would have to think about it to tell 23 you. So, I mean, you can either have linear 24 translational units or you can have angular translation 25 units. So meters per second or I can't remember what the</p>	<p style="text-align: right;">Page 85</p> <p>1 angular velocity terms are. 2 Q Do you have -- you used the word "severe." Do 3 you have a magnitude at which measurement or unit that 4 acceleration or deceleration is severe? 5 A No. I mean, I have no doubt they exist, but I 6 don't even play the numbers game. 7 Q Can this acceleration/deceleration occur in a 8 fall? Can you have forces in a fall? 9 A Yes. 10 Q And how far of a fall, if you know, would be a 11 severe fall? 12 A Generally in the literature severe fall is more 13 than two stories. You can talk about all injuries and 14 say 4 feet is about a number that is often cited. And I 15 put the general survey of all of that literature at the 16 end of my report. 17 Q So just, if you don't mind, what is the basis 18 of that opinion that you've just given? What is the 19 literature that you're relying on? 20 A So Chadwick, David Chadwick who, again, was an 21 intern of mine at San Diego, has spent his career looking 22 at falls and fall studies and how can we put that. His 23 summary -- and I can't remember how many studies that it 24 was an amalgamation of -- looked at all the possible ways 25 of heights, falls, and correlations with injuries. And I</p>

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1 believe the common correlator that comes out of that is  
2 that we don't expect any life-threatening injury under  
3 4-foot falls.  
4 Q Would you agree that falls also have a  
5 rotational force?  
6 A Some do.  
7 Q A fall as described in the history by Jeffrey  
8 Havard, would that have a rotational force?  
9 A No.  
10 Q And why not?  
11 A This is a baby who is being held. I mean, so  
12 we've got a man who is five-foot-nine holding an infant  
13 who is reaching for this towel we're talking about inches  
14 before that child -- if the child's head even hit the  
15 tank of the toilet. He then is very clear to describe  
16 that he's grasping this child. That's also slowing this  
17 child down. And the child is sliding. And even if the  
18 child fell, we're talking about less than 2-foot fall  
19 onto a carpeted surface. Every day I deal with people  
20 that have much more significant falls, and there's no  
21 significant injuries.  
22 Q And I believe you just testified to this, but  
23 does it matter the surface upon which the child hits?  
24 A To some degree, yes. Overall in this low  
25 thing, no. So most of the studies that we look at that

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1 So when we look at old studies like that  
2 where they don't do validation or some other mechanism to  
3 test the veracity of the fall and we're saying the kid  
4 died from a short fall, that's an injustice. That's a  
5 misuse of the literature.  
6 Q So you're critical of that and their lack of  
7 investigation.  
8 A I am. And so -- I mean, you can pick up any  
9 reputable review article on falls, and they'll be  
10 critical of that study.  
11 Q What do you believe the researcher should have  
12 done to verify the stories?  
13 A Well, first off, you don't publish unverified  
14 things. That's one of the biggest pet peeves we have is  
15 people that will publish what somebody says without any  
16 independent way of verifying it, and that leads to  
17 potential erroneous conclusions. I mean, it litters the  
18 literature. Particularly if our biomechanical engineers  
19 are to apply their research to real world, then you've  
20 got to mimic real-world data. And if that real-world  
21 data is corrupt, then your numbers are going to be  
22 corrupt also.  
23 So how can you do it? So the proposal of  
24 my mentor was let's use scenarios where we know that kids  
25 fall all the time: daycares. Let's put in cameras.

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1 are witnessed fall studies have linoleum over concrete,  
2 so you can't get much harder surface than that.  
3 Q Taking everything as equal, would you rather  
4 drop a child on the shag rug or on a toilet, on a  
5 porcelain toilet?  
6 A Obviously the shag rug.  
7 Q What is your understanding of the Hall study  
8 that's referenced on page 7 of your report?  
9 A Hall was an attempt to characterize fatal  
10 falls. It was published in 1989 or so. I didn't cite  
11 it. I was just merely responding to one of your  
12 pathologists who cited it. It's often cited as evidence  
13 that short falls can kill children. Unfortunately, the  
14 histories were not validated in any of those cases.  
15 In fact, that was the predicate of my  
16 mentor, David Chadwick, for saying, hey, let's do this  
17 study -- and I cite that also in mine -- let's take  
18 everything, let's not do any validation whatsoever on the  
19 history that's given, and let's see what's the incidence  
20 of short-fall deaths. Very interesting, it came up to be  
21 seven times that of a high-fall death, which you can draw  
22 either two logical conclusions: one is that there are  
23 some extraordinary forces in short falls, which I think  
24 no mechanical engineer would ever agree with; or someone  
25 is lying to us.

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1 Let's only publish cases that have the highest fidelity  
2 of knowing what happened.  
3 And I'm not saying we can't consider and  
4 look at and certainly there are cited other cases of a  
5 short fall, but for example, the case where this child is  
6 sitting down and falls backwards dead, there's something  
7 wrong with that case, and we're going to publish that  
8 simply on the word of a five year old. And that was one  
9 of the cases that was also cited by one of your  
10 pathologists to support that short falls kill. That's  
11 one isolated case.  
12 And yet, we look at Chadwick's work that  
13 shows that, I mean, we look at thousands, millions of  
14 falls. And you can even use one of the cases that you  
15 cited of Plunkett, although not totally applicable to the  
16 infant age group, short falls are rare causes of death  
17 when you have a witness structure to it. So that's the  
18 critique of that particular literature.  
19 Q And if you were going to submit this literature  
20 in a report, is that what you --  
21 A Design a study?  
22 Q Is that what you would do?  
23 A If I would design a study?  
24 Q Yes.  
25 A Well, then you use your criteria to -- I mean,



<p style="text-align: right;">Page 90</p> <p>1 if we want to inform -- and that's what research is 2 supposed to be about, what is the real world -- then 3 you're going to design a study that has fidelity on those 4 things which you have the least control over, and that's 5 the history. How can we do that? Well, if you look at 6 the history of fall literature, let's put it in context, 7 such as hospitals where there are witnesses that are not 8 familial, not related. And there's a whole body of that 9 literature which shows that almost no injuries really 10 occur, and some of these are very significant falls onto 11 linoleum over concrete. Use of cameras, again, as a way 12 of doing that to help understand those types of things. 13 And I think that if you -- and that was 14 cited in your case, and I don't disagree. So Case No. 5 15 in Plunkett was a video of a child falling off of a 16 playground, you know, 4, 5 feet, hitting the head, and 17 having a large subdural. No relevance to this case, but 18 that informs us, that tells us what types of things can 19 happen and what we need to be careful about. Believe it 20 or not, we do try to get it right. 21 Q Dr. Benton, do you have an opinion about what 22 specifically happened to Chloe Britt? 23 A I believe that she was abused. I don't know if 24 there was intent behind it. Probably not. In most of my 25 experience, there was probably some frustration. As I</p>	<p style="text-align: right;">Page 91</p> <p>1 analyzed this case in light of -- I take histories from 2 all these families. I mean, I've been doing this for 20 3 something years. I don't understand a man that, as I 4 read in these descriptions, who's got an infant who is 5 tucked into a swing, why does he respond? I mean, he 6 says in his own statement, "I'm going to leave this baby 7 alone for five minutes," and then does some fairly 8 invasive things that he's never done before and admits to 9 never having done before. 10 Somehow that child, in my opinion, 11 irritated him, and the injuries occurred. And the 12 injuries are multifocal to the head, the face, the 13 anterior thighs, and the chest. I typically don't think 14 we see CPR causing bruising to the chest, but I'll even 15 allow that one away. Then we have the rectal mucosa 16 hematoma. I mean, all of this is too much. 17 Q Any more specific than that? 18 A I'm not sure what that means. 19 Q Do you know what -- 20 A Oh, exact -- 21 Q -- he hit -- yeah, the instrument or -- 22 A No -- 23 Q -- the anything? 24 A -- because the pattern is not there. I mean, 25 sometimes we will see -- for example, let's say that this</p>
<p style="text-align: right;">Page 92</p> <p>1 was so severe he hit that toilet lid on the head. 2 There's no linear pattern or a corner pattern or anything 3 that I can say, okay, I can match that to that. So all 4 the bruises did not have a pattern to it. 5 MR. JICKA: Are you doing okay? 6 THE WITNESS: I'm fine. 7 MR. JICKA: Okay. I'm not sure I am. I may 8 take a break in just a second. 9 Are you okay? 10 THE REPORTER: (Nods head affirmatively.) 11 MR. SMITH: Before we proceed, can we go on the 12 record and just identify everyone who's in the room? 13 And I'll begin. Brad Smith, Special Assistant 14 Attorney General. And? 15 MR. WHITE: Marvin White, Special Assistant 16 Attorney General. 17 MS. IVANOV: Caroline Ivanov, attorney at 18 Watkins &amp; Eager. 19 MR. VAN EE: Chris Van Ee, engineer at Design 20 Research Engineering. 21 MR. CARNER: Graham Carner, attorney for 22 Mr. Havard. 23 MR. JICKA: And I'm Mark Jicka at Watkins &amp; 24 Eager for Jeffrey Havard. 25 MR. SMITH: Good. Thank you.</p>	<p style="text-align: right;">Page 93</p> <p>1 BY MR. JICKA: 2 Q All right. On page 6 of your report, 3 Dr. Benton, you said that the physical findings indicate 4 two patterns, one of which is severe 5 acceleration/deceleration trauma. Do you see that, that 6 you later describe as whiplash motion? 7 A Yes. 8 Q With bilateral intracranial findings and 9 absence of skull fracture and cerebral contusion. 10 A Yes. 11 Q What is the evidence of severe 12 acceleration/deceleration injury? 13 A The subdural and the retinal hemorrhages. 14 Well, to some degree even the subarachnoid bleeding. 15 Q Are you aware of national and international 16 peer-reviewed literature that does not support the 17 diagnosis that those are caused by severe acceleration 18 and deceleration? 19 A Tell me who you're referring to. No. 20 Q What's the most common cause of traumatic brain 21 injury in children Chloe's age, if you know? 22 A Six months old? Most common? 23 Q Most common cause of traumatic brain injury. 24 A Traumatic brain injury. Probably motor vehicle 25 crash.</p>

<p style="text-align: right;">Page 94</p> <p>1 Q How about falls, where would they -- 2 A Way down the list. Unfortunately, motor 3 vehicle crashes probably lead almost every list. We get 4 all of them. That's how -- I see every unrestrained 5 motor vehicle crash. 6 Q What do you do with those? Are they -- 7 A We surveil them to make sure that we're not 8 missing anything. I hate to tell you, but sometimes 9 people do stupid things: They injure their kid, then 10 they go get in a crash so they can cover up the injury. 11 Q I see. 12 A So we look for other signs that we may have a 13 history that is wrong. 14 Q So every car wreck -- 15 A We get involved. 16 Q You get involved with that comes to UMMC. 17 A We don't get as involved as the ones where they 18 suspect abuse upfront, but we do double-check. We make 19 sure was there a wreck, was there a crime scene report. 20 So we call the police and make sure that it was notified. 21 If that's true, then we back off. 22 The next thing is unrestrained. As you 23 know, it's an illegal act in the state of Mississippi, 24 although it's a misdemeanor. 25 Q So have you been involved in testifying in the</p>	<p style="text-align: right;">Page 95</p> <p>1 prosecution of cases where a child was unrestrained? 2 A No, nobody to my knowledge has ever prosecuted 3 a parent for an unrestrained death or morbidity in a 4 motor vehicle crash. 5 Q Do you have an opinion on whether those parents 6 should be prosecuted? 7 A No, I don't think they should be prosecuted. I 8 don't know what the answer is there. I mean, to some 9 degree prosecution sets a standard of -- we want to 10 believe that by prosecuting someone we're creating a 11 public health benefit, that people might alter their 12 behavior. I don't really believe that. 13 Q You've given opinions about your skepticism 14 about the history of the fall as described by Jeffrey 15 Havard. Correct? 16 A I mean, my skepticism is based on the 17 incompatibility of the totality of the findings and what 18 he said happened. That's the basis. 19 Q Your opinion is not based on physics or 20 biomechanics, though. Correct? 21 A No. Well, I mean, indirectly they are, but am 22 I using mathematical formulas to arrive at that? No. 23 Q You haven't applied the science of physics or 24 biomechanics to the Jeffrey Havard case. Correct? 25 A Physics obviously undermines everything -- or</p>
<p style="text-align: right;">Page 96</p> <p>1 underlies, excuse me, everything that happens in life. I 2 mean, that's the purest of the sciences. Well, 3 mathematics is, and then physics is based on math. So I 4 think that what we're saying is consistent with the 5 science of physics, but no, we're not doing measurements 6 or things like that. 7 Q Have you visited the scene of this incident? 8 A I have not. 9 Q So you've mentioned Chadwick many times today, 10 and you cite his paper from 2008. And you describe it as 11 an excellent meta-analysis of false studies. Is that -- 12 A I cited two studies by him. So 1991 and 2008, 13 and yes, I do think it's an excellent meta-analysis. 14 Q Are you aware of the serious statistical 15 criticisms of his conclusions? 16 A I have heard that there are criticisms, but I 17 have not actually seen them. 18 Q Do you make a diagnosis on the basis of 19 probabilities? 20 A Sure. 21 Q Couldn't Chloe have suffered a fall in this 22 situation, in this incident? 23 A Yes. 24 Q Are you aware of the AAP 2009 -- I'm going to 25 get this wrong, the American Academy of Pediatrics?</p>	<p style="text-align: right;">Page 97</p> <p>1 A Correct. 2 Q I will learn someday. Of its 2009 position 3 that changed the term shaken baby to abusive head trauma? 4 A Yes. 5 Q Would you agree that that is a substantial 6 change that took place by the AAP? 7 A It's a change in words, yes. 8 Q Are you aware of a recent Swedish publication 9 verifying the lack of correlation between the typical 10 triad and shaking? 11 A I am aware of the Swedish publication, the 12 Swedish study. I would not agree with your conclusion 13 that it verifies a lack of a triad. 14 Q Have you reviewed that study? 15 A To my knowledge, that study hasn't been 16 published in English, but we have disseminated on our 17 list a Google translate version of it. There also was a 18 preliminary publication that just happened in January 19 that was in English, and that has been reviewed, yes. 20 Q When you say we have disseminated on -- 21 A It's the royal we, but it's the Helfer 22 listserv. These are all these individuals that I told 23 you that we're all vested in looking at children who are 24 suspected of being abused and neglected. 25 Q Are you aware of multiple court cases where</p>

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1 judicial action has precluded the use of the traditional  
2 triad diagnosis for shaken baby syndrome? Are you made  
3 aware of court findings throughout the country that have  
4 occurred recently?  
5 A I know of no specific court things. I have  
6 heard that there is a defense that is being promulgated  
7 to both preclude that sort of testimony and use it as  
8 defense if there is an argument that certain findings  
9 reflect abuse.  
10 Q Do you know what it means for a report to be  
11 peer reviewed?  
12 A Yes.  
13 Q Does anyone review your opinions? For example,  
14 did anyone peer review your opinions for purposes of  
15 quality of work or your findings in the Jeffrey Havard  
16 matter?  
17 A How can I say this? So we have quality review,  
18 which is not subject to discovery or discussion, and I  
19 can't answer yes or no with respect to this report or any  
20 other report.  
21 Q There's a secret review of this?  
22 A Again, under the state statutes, quality review  
23 is permitted, and it's done without discovery. And yes,  
24 there is a quality improvement project. I can't speak to  
25 a specific case, and I won't use it to bolster my

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1 is on the peer review quality of reports at UMMC for the  
2 type of work you do?  
3 A One of them is the Trauma in Morbidity and  
4 Mortality Committee, the other one is the General  
5 Morbidity and Mortality Committee, in addition to which,  
6 because there's no one else that does what I do, we're a  
7 party to a collection of individuals from California,  
8 Tennessee, New York -- I'd have to look at the list to  
9 tell you all the different places. These are coordinated  
10 out of New Orleans where they're stripped of all  
11 identifiers and submitted and it's discussed type of  
12 thing. So that's the external peer review.  
13 Q Did this report go through an external peer  
14 review?  
15 A I cannot -- I can't -- I'm prohibited from  
16 saying that any one thing did or did not go through that.  
17 Q And I'm certainly not trying to fight with you.  
18 I just want to make sure I'm not missing the right  
19 question.  
20 A No, and I'm not trying to mislead you. And I  
21 know what you're after, but I cannot.  
22 Q Okay. The external peer review bunch from  
23 either New Orleans or California, are they other child  
24 abuse doctors?  
25 A Yes. In my -- they're all child abuse -- all

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1 statements nor -- suffice it to say, if someone is  
2 critical of me, then I'm going to change what I write, if  
3 that helps you.  
4 Q Do you know the statute number?  
5 A No, but I'm pretty -- Mark Ray at our  
6 University can cite it for you. That's true of every  
7 place I've ever been.  
8 Q And let me --  
9 A That's the only way to improve the medical  
10 process.  
11 Q And that's -- because I asked you earlier if  
12 anybody else had done work on this case, you know --  
13 A And I said no.  
14 Q You said no. You said some people had  
15 proofread it.  
16 A Correct. No one else provided substantive  
17 input into my thoughts.  
18 Q Okay. But if someone with expert  
19 qualifications had reviewed this report, you're saying  
20 you can't tell me about it.  
21 A That's correct. I'm saying I take ownership of  
22 this, and every institution you're ever going to deal  
23 with medically had a peer-review quality assurance  
24 process.  
25 Q Who is on -- this is a general question. Who

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1 board-certified child abuse pediatricians.  
2 Q Do you work at an advocacy center?  
3 A No. I work with them, but I don't work at  
4 them.  
5 Q Which advocacy centers do you work with?  
6 A All of them.  
7 Q And will you please give me the list of  
8 advocacy centers you work with?  
9 A So there are 10 currently, 11 forming in the  
10 state of Mississippi. So going from the north to the  
11 south, we have one in Southaven, I don't recall its exact  
12 name; we have one in Lafayette County, that's in Oxford;  
13 we have one in Tupelo; West Point; none in the Delta;  
14 Pearl, Mississippi; Natchez; McComb; Meridian; newly  
15 developing in Biloxi, they don't have accreditation yet;  
16 and Gulfport. Does that add up to ten?  
17 Q I didn't count, but it sounds like about ten.  
18 What are the -- what's the purpose of  
19 these advocacy centers?  
20 A So the Children's Advocacy Center was a  
21 movement that started out of Huntsville, Alabama, by a  
22 then U.S. Senator who recognized that there was not a  
23 uniform process in dealing particularly with sexual  
24 abuse. So it started off with sexual abuse, and it's  
25 still mostly dealing with sexual abuse of children. And

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1 this sort of arose out of some gross injustices or  
2 perceived injustices -- we can hash that one later, like  
3 the Martin Preschool trial -- and that people who had no  
4 training were interviewing kids. We weren't recognizing  
5 the developmental vulnerabilities of kids, et cetera.  
6       So it started with that Senator who  
7 created a process in Huntsville and then spread  
8 throughout the country saying that we need to handle  
9 child abuse issues in a coordinated or multidisciplinary  
10 fashion. Mississippi was a little bit later to that  
11 movement. You'd have to look at the statutes, but it was  
12 put into the statutes I believe in the early 2000s that  
13 all youth court jurisdictions must develop a  
14 multidisciplinary team approach.  
15       They decided to adopt the child advocacy  
16 model. The first one was in Hinds County, which has  
17 subsequently moved to Pearl, but it was in Jackson. And  
18 I'm not sure the order that -- I could guess, but I think  
19 the one in Tupelo was second and then Lafayette County.  
20 And I know the rest came later because I helped them to  
21 get their accreditation. So the others were before me.  
22       So it is a nongovernmental entity that  
23 helps to coordinate CPS, law enforcement, prosecution,  
24 mental health, pediatrics, with the intent of providing  
25 best practices for evaluation.

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1 reasonably suspected had retinal hemorrhages, we wanted  
2 to see the cases where we weren't sure. Like all falls,  
3 we looked at everyone and photographed everyone's retina.  
4 They would come behind us and do their exam. But  
5 photography is tedious. I mean, it can take about an  
6 hour or two to get good photographs of a child.  
7       Q Are you a pediatric ophthalmologist?  
8       A No.  
9       Q Did you rely on the eye findings in this case?  
10       A Yes.  
11       Q What were the findings?  
12       A Bilateral severe multilayered retinal  
13 hemorrhages with folds.  
14       Q What does that mean?  
15       A So the retina is made up of ten layers, and to  
16 be simplistic, they are the rods and cones that we see  
17 with. And then there's the nerve layers that connect  
18 that back to the optic nerve. The retina is  
19 predominantly attached -- or the vitreous is  
20 predominantly attached to the retina at the optic nerve,  
21 which is what comes from the brain to the eye. The  
22 macula, which is the part of the eye that we see best  
23 with, which is usually just to the side of the optic  
24 nerve, and to the ora serrata, or the front most  
25 attachment of the retina.

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1       Q Is part of the responsibility of these advocacy  
2 centers to assist in the prosecution of child abuse  
3 cases?  
4       A Since the DA is often involved on the  
5 multidisciplinary team, I would say yes. Since law  
6 enforcement is involved, I assume that they have probable  
7 cause that eventually could lead to a criminal action.  
8 CPS, no. The predominant there is to get to youth court  
9 and decide protection or custody issues. I can speak for  
10 mental health and myself, we are not vested one way or  
11 the other where the case goes.  
12       Q Do you have any expertise in ophthalmology or  
13 the examination of eyes?  
14       A Yes.  
15       Q What is your expertise?  
16       A So at Children's Hospital in New Orleans we had  
17 two pediatric ophthalmologists who did -- they're  
18 phenomenal. George Ellis was the president of American  
19 Academy of Ophthalmology, and they did not have time to  
20 see every single kid that we wanted them to see. So I  
21 asked them to train me in indirect ophthalmoscopy as well  
22 as I became their photographer.  
23       So the entire stint in New Orleans I did  
24 all the ophthalmic photography. And because much like  
25 here, we didn't want to just see the ones that we knew or

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1       And depending where you are, it takes  
2 certain -- certain layers appear differently. So if  
3 you're in the rod and cone layer, you're going to look  
4 and it looks like dots and blots. It's funny because I  
5 just testified yesterday, that really is the medical term  
6 for it. I mean, the poor judge, I was giving him so many  
7 medical terms, I said here's an easy one: dots and  
8 blots.  
9       There's also flame hemorrhages, so these  
10 are in the neurofibrillary layer, or in those layers that  
11 connect back to the optic nerve. So each different layer  
12 has different thresholds for injury. And then the folds  
13 occur where the attachment is to the vitreous to the  
14 retina, and it tugs on the retina and it separates the  
15 layers of the retina. And that's because of the strength  
16 of the vitreous attachment. It's equivalent in the adult  
17 world to retina detachment, but we don't -- we typically  
18 see what's called retinoschisis, not detachment, in young  
19 infants.  
20       Q How did the retinal findings affect your  
21 opinions in this case?  
22       A I think they were corroborative of an  
23 acceleration/deceleration force. And when you talk about  
24 retina folds, there's -- other than Pat Lantz's article  
25 which showed that crush injuries -- or at least one case

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1 in the entire literature crush injuries can also cause  
2 retina folds, we have not really found anything other  
3 than severe acceleration/deceleration that causes retinal  
4 folds.  
5 Q Did you review the laboratory tests that were  
6 performed on Chloe in this case?  
7 A Anything that was in the record that was given  
8 to me I reviewed, so if that helps.  
9 Q As we sit here, what did you consider important  
10 that you reviewed as it related to laboratory tests?  
11 A I don't recall. I did look at every laboratory  
12 test. If you have something specific in mind, I can  
13 either re-reference or answer the question.  
14 Q Did you look at the slides? Did you look at --  
15 A No.  
16 Q -- any slides?  
17 A No.  
18 Q Have you reviewed any X rays in this case?  
19 A My understanding there was only one X ray, that  
20 was a chest X ray, and it was described as normal. And  
21 no, I didn't review it.  
22 Q And as we sit here -- and I don't mean to beat  
23 a dead horse -- are you aware of any other lab tests that  
24 you reviewed as part of your work in the Chloe Britt  
25 case? And you're welcome to look at your report.

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1 A It is, I guess, in best terms the different  
2 possible explanations for a given finding.  
3 Q What was your differential diagnosis of what  
4 happened or what was wrong with Chloe? Did you use that  
5 in this case?  
6 A Well, so we went by finding, and I did list for  
7 you all the possible differential diagnoses for  
8 subdurals. You can almost use the exact same list for  
9 the eye, which is why I didn't make a separate list. Not  
10 quite the same list for subarachnoid hemorrhage. But  
11 generally when we see subarachnoid blood in concert with  
12 subdural, we're not dealing with a different pathology.  
13 Q Are you aware of Dr. Hayne conducting any  
14 differential diagnosis of his opinions and work in this  
15 case?  
16 A I don't recall.  
17 Q Dr. Benton, in doing your work, in doing your  
18 differential diagnosis, did you have to rely on some of  
19 Dr. Hayne's findings from the autopsy or his testimony?  
20 A Yes.  
21 Q Does subdural hematoma require rotational  
22 forces?  
23 A Mostly yes, not always.  
24 Q And what is your -- do you have a medical  
25 reference for that?

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1 A I did write down. So yes, there was a arterial  
2 blood gas, a CBC, and a basic metabolic panel that I  
3 reviewed and made some notations.  
4 Q Okay. What relevance or impact did that have  
5 on your opinions in this case?  
6 A The arterial blood gas is important because the  
7 first presenting arterial blood gas is a fairly good  
8 predictor of mortality. So in this case the arterial pH  
9 was 6.58. Very rare to have anyone survive that presents  
10 with that pH. And the other subsequent numbers describe  
11 that the kid did not have any issues with the lungs being  
12 able to ventilate, but obviously had had a period of  
13 anoxia and acidosis.  
14 The complete blood count showed that we're  
15 looking at the platelets, so that's an indirect indicator  
16 platelet and coagulation issues were normal. There was a  
17 slightly elevated white count at 12. Not too significant  
18 for a child this age. And a hemoglobin and hematocrit of  
19 10.4 and 29.6, which for a six month old is about right  
20 for what we call physiologic nadir, maybe a little bit  
21 low.  
22 The basic metabolic panel had multiple  
23 electrolyte disturbances, which would be typical for a  
24 child who is being resuscitated.  
25 Q What is a differential diagnosis, Dr. Benton?

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1 A So there are a lot of articles. I don't have  
2 any specific in mind. But so beginning way back in the  
3 1950s we looked at various mechanical means of causing  
4 subdurals. Subsequently, there's been looking at various  
5 medical things. And that's how medicine evolves. So the  
6 differential list that I have here is reflective of the  
7 different things that over time have been shown to cause  
8 subdurals.  
9 Q Do you think that biomechanics is an unreliable  
10 science in the interpretation of this case?  
11 A Loaded question there with Dr. Van Ee in the  
12 room. No. I think it has challenges. I think that  
13 there is a future for biomechanical analysis. Our big  
14 problem is the one that plagues us in general: I can't  
15 go shake a living kid. I can't go hit a living kid and  
16 see what happens and do it with enough reliability and  
17 exactness in terms of forces.  
18 So when we look at our biomechanical  
19 literature now, we're roughly stuck in the same thing  
20 that I'm critical about certain case reports with the  
21 history of people. You, as an attorney, know histories  
22 from people are frequently either inexact or unreliable  
23 or misinterpreted or flat-out lies. And somewhere all of  
24 that is mixed into our basis in which we come up with  
25 rules and measurements.

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1 So I think we're getting better at our  
2 approximations. I think that the use of mathematical  
3 modeling is still limited in that we're not sure of what  
4 thresholds exist. If we have current models that say  
5 that a child is going to die one in every hundred times  
6 they have in a short fall, it doesn't reflect real-world  
7 validity. And that's the problem.

8 So I'm not dismissive. We use it, I mean,  
9 and I encourage it. And he's done great work in the past  
10 that we've looked at. But do I apply that to a specific  
11 case? I think that's where you're going to start to get  
12 errors, much like if we start to use specific case  
13 reports, like the five month old who dies from a sitting  
14 position falling backwards.

15 Q Are you aware that there are many good  
16 scientists that might find your opinions to be highly  
17 controversial?

18 A Yes.

19 Q Are you aware of the -- I may say this wrong,  
20 but the Goudge Inquiry in Ontario, Canada?

21 A Yes.

22 Q What is your understanding of that inquiry?

23 A So in Ontario they had a problem with a  
24 pathologist that, as far as my understanding goes, had  
25 some unorthodox ways of conducting his business. And I'm

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1 differential list, that doesn't have any applicability or  
2 causation.

3 Q Would you defer to a forensic pathologist as to  
4 the cause and manner of death of Chloe Britt?

5 A Defer, what does that mean?

6 Q That they would have more training and would  
7 provide a better opinion, a more expert opinion than you  
8 would, not being a forensic pathologist?

9 A I think there are a lot of colleagues in the  
10 world that I would respect their opinion. As far as for  
11 deferred opinion, I think my opinion is just as good, and  
12 we could have a good discussion about who knows more or  
13 what. They certainly have tools that I don't have, but  
14 just like I have tools that they don't have, whether  
15 you're talking about magnetic resonance imaging and  
16 things we can do on living kids that they can't do. And  
17 there's certain things you can do to children that have  
18 deceased that I can't do. So I think we're  
19 complementary, but I think we should be each  
20 knowledgeable in the other's practice if that's the job  
21 that we're in.

22 Q As part of your job -- well, let's make it  
23 broader than that. As part of the program in the state  
24 of Mississippi, are you aware of any experts in child  
25 abuse that looked into Chloe Britt's injuries or death at

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1 not sure if they call it Judge Goudge, but it was Stephen  
2 Goudge authorized an inquiry into that pathologist's  
3 practice with specifically looking at those in which a  
4 determination of shaken baby syndrome was one of the  
5 underlying theories of causation.

6 There was an outcome from that from which  
7 they prescribed I'm not sure if the pathologist lost his  
8 job, but I think he did, and that as all of us around the  
9 country how can we improve our practice to make sure that  
10 unscientific things don't enter into a forensic  
11 evaluation.

12 Q When was that inquiry?

13 A 2007ish, I believe.

14 Q You've said that subdural plus retinal  
15 hemorrhages plus a history that you believe is not a good  
16 explanation is a diagnostic for child abuse. Is that  
17 correct?

18 A I don't think I said that here.

19 Q Do you agree with that?

20 A I think there's a lot more that has to go into  
21 it, but I think that you are starting to point to an  
22 abusive picture if you have noncontact subdural, if you  
23 have retinal hemorrhages that are of a specific nature,  
24 specifically if they have a fold or schisis and I don't  
25 have a history of trauma that fits and, you go down this

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1 the time that it occurred?

2 A Other than Dr. Hayne, I'm not aware of anyone  
3 else that might've been involved. And I know for a fact  
4 there was no board-certified child abuse pediatrician  
5 ever in the state of Mississippi before me.

6 Q Do you have guidelines that you use for  
7 investigating infant death?

8 A There are guidelines that exist, so we do use  
9 the sudden unexpected infant death investigation protocol  
10 through the Centers for Disease Control. Royal we again.  
11 The state of Mississippi does. So the coroner's office,  
12 we were able to secure grants that pays them if they do  
13 it to encourage them to do it, because that informs us  
14 why infants are dying in the state of Mississippi. So  
15 that's one protocol that I'm aware of. After that or  
16 outside of that, I'm not aware of any specific protocols  
17 that are followed in the state of Mississippi.

18 Q And so that protocol is the CDC-provided  
19 protocol. Is that correct?

20 A Yes, sir.

21 Q And when did that protocol come into effect?

22 A God, I used to train on it. Probably late  
23 '90s, early 2000s, so somewhere around that. It's  
24 constantly being modified.

25 Q That was my next question. Do you recall when

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1 was the last time it was modified?  
2 A We had a training where I was trained maybe  
3 two, three, maybe as much as four years ago. So they  
4 totally revised the form. So they constantly look at the  
5 questions that are on there. You're talking to the  
6 family of a dead infant that just died. It's fresh. So  
7 there's been many meta-analysis and statistical analysis,  
8 which questions are the most important to ask without  
9 being tedious. So the question and how the questions are  
10 asked have changed over time. I don't recall the exact  
11 last time, though. But my recollections are around  
12 three, four years ago.  
13 Q Did you note some bruises on the inside of  
14 Chloe's scalp?  
15 A Dr. Hayne did, yes.  
16 Q Do you know how she got those bruises?  
17 A I do not.  
18 Q Did you examine the subdural blood?  
19 A I did not.  
20 Q What is Terson's syndrome?  
21 A Terson syndrome was first described by a French  
22 ophthalmologist. He made an observation note that in his  
23 adult stroke patients where they had subarachnoid  
24 bleeding that he would notice ipsilateral, or same side,  
25 to the stroke hemorrhaging into the back of the eye. And

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1 A So the Sweds, much like we do, have -- in  
2 America we have an Institute of Medicine, which is a  
3 collection of some of our best scientists that sit and  
4 try to decide where we're going to go with research and  
5 things like that. So the Swedish equivalent of that was  
6 charged with this particular question, and that's who  
7 developed the report.  
8 Q What is your understanding just in a broad  
9 sense of what's included in that report?  
10 A So it was a literature review. It was not  
11 actually a study. So it reviewed I believe -- it's  
12 almost comical to say this, but it reviewed 3,000 studies  
13 and dismissed all but two. And that's one of the major  
14 critiques of it is that it's methodologically unsound.  
15 As we speak, there is a secondary review.  
16 So they were asked to present all their data before  
17 publication, because we knew it was coming. And they  
18 refused. In fact, I asked Brad Smith to request that in  
19 an official capacity because I couldn't get it, and he  
20 got a letter denying that they were going to give it to  
21 him, so that we could provide it to our own scientists to  
22 see what that meant. So that's my understanding of that  
23 review.  
24 Q What was the conclusion?  
25 A Which is interesting. So the conclusion is a

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1 that's how it started. It's subsequently evolved where  
2 any time there was bleeding in the head, subdural or  
3 subarachnoid, and ipsilateral, or same side, bleeding,  
4 that people would call it Terson syndrome. It's not  
5 technically really a syndrome. These were just  
6 observations. And as far as its applicability to  
7 children, it's questionable.  
8 Q Did Chloe have cerebral edema?  
9 A I didn't capture it if she did. And she may  
10 have died too fast to develop cerebral edema is my  
11 thoughts. So it's not in the autopsy report, and for  
12 that reason I would say no, I don't think she did.  
13 Q Did you find any evidence of fractures to  
14 Chloe's bones?  
15 A There were no skull fractures. That is  
16 specifically mentioned.  
17 Q Any other fractures?  
18 A There's no mention of any other fractures, but  
19 I also didn't see any evidence that other fractures were  
20 sought with respect to the autopsy report. Except for  
21 the skull, I mean, the skull is visible once you remove  
22 the scalp. But I'm not aware of any other X rays that  
23 looked for any.  
24 Q The Swedish report that came out in 2016, who  
25 did that report?

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1 very limited one. It says that you can't use the triad  
2 of retinal hemorrhages, subdural, and cerebral or  
3 encephalopathy to conclude that a child had been abused.  
4 Q Do you agree with that?  
5 A Yeah. I don't think anyone ever said that  
6 simply using those three findings equals abuse. I mean,  
7 I already gave you a full list of other reasons why those  
8 findings could be something else.  
9 Q So you don't have any criticism of the  
10 conclusions of the Swedish report that came out.  
11 A Oh, no, we do have -- I --  
12 Q What are they?  
13 A -- royal we. So the conclusion is more than  
14 that. So this has -- as you are aware in the fact that  
15 you're even asking me about this, this has gotten  
16 international prominence, much as the Goudge Inquiry did,  
17 much as any other of forming a basis.  
18 Now, what you probably don't know, or  
19 maybe you do know, is that the former director of the  
20 Swedish equivalent -- I can't remember what SDU stands  
21 for, but whatever those initials stand for, his son was  
22 accused in California of shaking his child to death, and  
23 he spent a good, considerable effort trying to assist his  
24 son, as any good parent would do. And it's our  
25 understanding that that's the basis of the reason for

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1 pushing for this, to come to sort of a conclusion that  
2 this is as unscientific, it lacks merit and shouldn't be  
3 used to define child abuse. That I have a problem with,  
4 and so does the rest of my colleagues.  
5 Q You would agree with me that this Swedish  
6 version of the SDU is not a fringe group. Correct?  
7 A I agree.  
8 Q The --  
9 A But the --  
10 Q -- what is your --  
11 A -- I'm sorry, I'm going to add to that.  
12 Q Yeah.  
13 A The Swedish Pediatric Society has roundly  
14 condemned what has gone on as being tainted, as not being  
15 open, as not being part of the scientific process that  
16 we're used to, which suggests why. And I think you're  
17 going to hear more about this in the next ensuing months.  
18 So it becomes to take on a fringe when there's not an  
19 openness to the inquiry.  
20 MR. SMITH: Do you need a break?  
21 THE WITNESS: I'm good.  
22 (Exhibit 5 marked)  
23 BY MR. JICKA:  
24 Q All right. Dr. Benton, let me hand you  
25 Exhibit 5, and I've given a copy to Brad. I'll give you

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1 A You can intubate many things, but it's usually  
2 the airway they're referring to.  
3 Q "Was blue around the mouth. Pupils were fixed.  
4 So I walk onto her...side first, and so I had this luxury  
5 of being able to look in her eyes because the rest was  
6 being done, and I said -- pupils were fixed which  
7 means -- which is a sign of brain dead." Do you agree,  
8 Dr. Benton, that fixed pupils is a sign of being brain  
9 dead?  
10 A It certainly goes along with brain death, but  
11 we don't use it as a criteria for brain death.  
12 Q Going on it says, "Pupils were fixed and  
13 dilated. So I look through her pupils and I see  
14 hemorrhages in her retina which means -- which is so very  
15 specific of this kind of injury." Did I read that  
16 correctly?  
17 A Yes.  
18 Q And the next question, "What kind of injury is  
19 that?" "Being a shaken baby. Retinal hemorrhages.  
20 Nothing else causes that..." Do you agree that retinal  
21 hemorrhages are only caused by shaking?  
22 A No.  
23 Q Would you disagree with this testimony from  
24 Dr. Dar?  
25 A Yes.

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1 just a second to look at that.  
2 Maybe just to focus you, Dr. Benton, I'm  
3 going to ask you questions on the bottom of 415 beginning  
4 with -- you can look at the question on 18, but going  
5 from 415, 18 through the top of 416.  
6 A Yes, sir.  
7 Q This is the direct examination of Dr. Dar. Do  
8 you know who Dr. Dar is?  
9 A If I'm not mistaken, that was the baby's  
10 primary care physician. I mean --  
11 Q Sure --  
12 A -- do you agree or --  
13 Q -- yeah, no, I'm not trying to pop quiz you.  
14 A No, I know, but I also know that you know the  
15 answer. There were three physicians in the emergency  
16 room. Dr. Dar was the primary care physician of that  
17 child.  
18 Q The question was asked, "Why don't you tell us  
19 what you observed about the baby." You see that on 415?  
20 A Yes, sir.  
21 Q And it says, "Baby was being intubated." What  
22 does that mean?  
23 A It's not very specific, but in my  
24 understanding, they're putting a tube into the airway.  
25 Q Was --

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1 MR. JICKA: All right. Why don't we go off the  
2 record, and I will organize and try to complete your  
3 deposition. Okay, sir? Thank you.  
4 (OFF THE RECORD 4:22 p.m.)  
5 (ON THE RECORD 4:40 p.m.)  
6 BY MR. JICKA:  
7 Q Dr. Benton, I have just a few more questions  
8 for you, sir.  
9 When you said that you had spoken with  
10 Dr. Steven Hayne over a period of time, have you  
11 discussed with Steven Hayne the Jeffrey Havard case?  
12 A No, sir.  
13 Q When you said that you reviewed the transcript  
14 of Jeffrey Havard regarding the history of the fall, what  
15 transcript are you talking about?  
16 A My memory -- and perhaps it's not a transcript,  
17 but there are direct quotes, I thought it was a  
18 transcript, of his description of what happened. And I  
19 thought it was a custodial interrogation.  
20 Q It's not on the stuff that you gave us, and I  
21 didn't know -- that we could find.  
22 A Everything I have on that disk is all that I  
23 had, so it's somewhere in there.  
24 Q All right.  
25 A And I'm pulling those direct quotes. I might



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1 be able to tell you from my handwritten notes, which I  
2 don't have with me --  
3 Q And that's --  
4 A -- what the source was.  
5 Q And that's the next question: Where are those  
6 notes?  
7 A In my office.  
8 Q Okay. Will you produce those notes to us?  
9 A Unh-unh.  
10 Q Answer out loud for me, please.  
11 A No, sir.  
12 Q I mean, I totally get the gist, but I want it  
13 to show in the record.  
14 A Yes, sir.  
15 Q Why not?  
16 A I mean, they're my work product. They're not  
17 organized. They are meaningful to me but probably  
18 wouldn't be meaningful or misinterpreted perhaps by you  
19 or others.  
20 Q And I understand your position. Will you do me  
21 the favor of securing those in case a court does order at  
22 some point that they be produced?  
23 A Sure.  
24 Q Don't shred them or burn them or lose them.  
25 The textbook on your desk that you were

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1 can see it -- is a letter from Brad where he's producing  
2 two DVRs to you, and looks like each of the DVRs are the  
3 same. Is that right? They were identical?  
4 A I didn't check them. I mean, that goes to our  
5 coordinator. I presume they were identical.  
6 Q Who's your coordinator?  
7 A Amanda Sanford and Candace -- why am I having  
8 trouble with last names today? That's terrible.  
9 Q Poor Candace.  
10 A Poor Candace, yes. I can't think of her last  
11 name.  
12 Q The information that was on each of these DVRs,  
13 did you download that onto this jump drive?  
14 A No. So the process at the University is we  
15 have our own secure server. My coordinator would take  
16 that, upload it, file my file to the server, which locks  
17 when it is and locks it down. It's our safe way of  
18 storing things and documenting.  
19 Q Where are the disks that -- or the DVRs that --  
20 A Destroyed. We don't keep paper. We don't keep  
21 disks. We store it on the server.  
22 Q If you'll look, do you still have Exhibit 2?  
23 Flip to your report, the report part of that Exhibit 2,  
24 please. On page 5 looking at your chart, I had a couple  
25 of follow-up questions.

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1 referencing, do you now remember the name of it by  
2 chance?  
3 A No, but I can get that to you too.  
4 Q If you will do that for me, get that to Brad --  
5 A Or if you'd like, I can look it up on my  
6 laptop.  
7 Q Sure, absolutely. Whatever you want to do to  
8 short-circuit, that's great.  
9 A Paul Kleiman, that's the editor, professor of  
10 radiology at Harvard.  
11 Now for the title of the book. One  
12 second.  
13 Q Sure. Did you say Kleiman?  
14 A Paul Kleiman, K-L-E-I-M-A-N.  
15 Shoot, I don't have the Internet. I've  
16 got to turn on my phone.  
17 THE WITNESS: Do you have Internet?  
18 MR. SMITH: Uh-huh.  
19 THE WITNESS: Just do Paul Kleiman, radiology  
20 textbook, and it should come up.  
21 A Diagnostic Imaging of Child Abuse is the title,  
22 third edition.  
23 BY MR. JICKA:  
24 Q Thank you. I see on the information you  
25 brought -- and I'll turn Graham's computer around so you

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1 If you assume that Jeffrey Havard had  
2 Chloe about shoulder height at the time that he dropped  
3 her and that the first -- that as she fell the first hit  
4 that she made was onto the toilet and then a second  
5 strike on the floor, if you look at your findings here in  
6 the types of injuries, which of those would be consistent  
7 with that assumption or scenario?  
8 A Well, I mean, he describes definitely that the  
9 leg hit the lid of the toilet first, so none of these fit  
10 the leg. Not saying that the leg didn't hit the toilet,  
11 saying it's just that there's no injury here that  
12 reflects that. He said that it's possible -- actually,  
13 he said the torso hit the tank and possibly the head hit,  
14 so I would give you, take your pick, one impact to the  
15 head on the tank possible.  
16 And then as far as the floor goes, he  
17 couldn't describe that the head hit the floor at all. So  
18 it's possible other parts fell and then the kid slumped  
19 over. So let's take worst-case scenario, the head did  
20 hit the carpeted floor, pick one other opined injury and  
21 attribute it to that. Other than that, I can't  
22 differentiate between what did because we don't have the  
23 kinematics to look at.  
24 Q The term multifocal using quotation marks, my  
25 understanding of your testimony is that that's a term



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1 that came out of Dr. Hayne's autopsy. Is that correct?  
 2 A Correct.  
 3 Q That's not a term, though, that you use in  
 4 your -- or is it a term that you use in doing your --  
 5 A I do --  
 6 Q -- differential diagnosis?  
 7 A -- but I will specify where on the head that  
 8 it's multifocal. So he -- the phrase was multifocal  
 9 scalp hematomas. I think it's important, that's why I  
 10 put it there, but I put it in quotes because in terms of  
 11 pattern he doesn't give me enough to say more than that.  
 12 Q And I guess my question is: Is this an  
 13 additional finding or injury to, for example, the bruises  
 14 above where --  
 15 A Yes. He makes a separate notation of it, and  
 16 he specifically mentions scalp hematoma. So, I mean, I  
 17 guess that's a question you can ask him, but I  
 18 interpreted it as a separate finding.  
 19 Q Okay. The scalp, what would you consider the  
 20 scalp, what part of the body?  
 21 A I know it's a six month old, but generally the  
 22 area under the hair.  
 23 Q Would the forehead -- could the forehead be  
 24 part of the scalp?  
 25 A Could be.

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CERTIFICATE OF REPORTER

1  
2  
3 I, LORI P. GALLASPY, Registered Professional  
4 Reporter and Notary Public in and for the State of  
5 Mississippi, do hereby certify that the above and  
6 foregoing pages contain a full, true, and correct  
7 transcript of the deposition of SCOTT A. BENTON,  
8 M.D., taken in the aforementioned case at the time and  
9 place indicated, which proceedings were recorded by  
10 me to the best of my skill and ability.  
11 I also certify that I placed the witness under  
12 oath to tell the truth and that all answers were  
13 given under that oath.  
14 I also certify that I have no interest,  
15 monetary or otherwise, in the outcome of this case.  
16 This the 22nd day of March, 2017.  
17  
18  
19  
20  
21  
22  
23  
24  
25

LORI P. GALLASPY, RPR, CSR

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1 Q Occiput or nasal bridge, could somebody say --  
 2 A Not nasal bridge but occiput, yes. I mean, I  
 3 see your point, but I don't have an answer. I mean, it  
 4 reads as if it's a separate part.  
 5 MR. JICKA: All right. Thank you for your  
 6 patience with me today. I really appreciate it, and  
 7 that's all the questions I have now.  
 8 MR. SMITH: No questions.  
 9 (Deposition concluded at 4:48 p.m.)  
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CERTIFICATE OF DEPONENT

1  
2  
3 I, SCOTT A. BENTON, M.D., do hereby certify  
4 that the foregoing deposition transcript is true and  
5 accurate to the best of my knowledge and belief, as  
6 originally transcribed or with the changes as noted  
7 on the attached Correction Sheet.  
8  
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SCOTT A. BENTON, M.D.

Subscribed and sworn to before me this the  
 \_\_\_\_\_ day of \_\_\_\_\_, 2017.

\_\_\_\_\_  
 Notary Public

My Commission Expires:

1 CORRECTION SHEET  
2  
3 I, SCOTT A. BENTON, M.D., do hereby certify  
4 that the following corrections and additions are  
5 true and accurate to the best of my knowledge and  
6 belief.  
7  
8 CORRECTION PAGE LINE REASON  
9 \_\_\_\_\_  
10 \_\_\_\_\_  
11 \_\_\_\_\_  
12 \_\_\_\_\_  
13 \_\_\_\_\_  
14 \_\_\_\_\_  
15 \_\_\_\_\_  
16 \_\_\_\_\_  
17 \_\_\_\_\_  
18 DATE SCOTT A. BENTON, M.D.  
19  
20 Subscribed and sworn to before me this the  
21 \_\_\_\_ day of \_\_\_\_\_, 2017.  
22  
23 \_\_\_\_\_  
24 Notary Public  
25 My Commission Expires:

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