In the Matter of:

JEFFREY HAVARD

V.

STATE OF MISSISSIPPI

BENTON, M.D., SCOTT A.

March 09, 2017

IN THE CIRCUIT COURT OF ADAMS COUNTY, MISSISSIPPI

JEFFREY HAVARD — PETITIONER

V. — CAUSE NO. 02-KR-0141-J

STATE OF MISSISSIPPI — RESPONDENT

DEPOSITION OF SCOTT A. BENTON, M.D.

Deposition Taken at the Instance of
The Petitioner
In the Offices of the
Mississippi Attorney General
Jackson, Mississippi
On Thursday, March 9, 2017
Commencing at 1:36 p.m.

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ALSO PRESENT:
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I N D E X

E X H I B I T S

STIPULATION

It is hereby stipulated and agreed by and between the parties hereto, through their respective attorneys of record, that this deposition may be taken at the time and place hereinbefore set forth, by LORI P. GALLASPY, RPR, CSR, Court Reporter and Notary Public, pursuant to the Mississippi Rules of Civil Procedure, as amended;

That the formality of READING AND SIGNING is specifically RESERVED;

That all objections, except as to the form of the questions and the responsiveness of the answers, are reserved until such time as this deposition, or any part thereof, may be used or is sought to be used in evidence.

* * * * *

(Exhibits 1, 2, and 3 marked)

SCOTT A. BENTON, M.D.,
having first been duly sworn, testified as follows:

EXAMINATION

BY MR. JICKA:

Q Dr. Benton, my name is Mark Jicka, and I represent Jeffrey Havard. I've got some questions for you today because you were designated as an expert witness in his case. Do you understand that?

A That you have some questions? Yes.

Q And do you understand you were designated as an expert?

A Yes.

Q Okay. How often have you been designated as an expert for the State of Mississippi?

A Every case that I've ever been involved in since 1997 when the federal rules changed is delineated on my CV, and I don't know the exact number but several hundred.

Q And when was the last time that you testified for the State of Mississippi?

A Yesterday.

Q And would that be found on the list that you had provided us --

A No.

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Q -- in this case? I'm going to let you look at Exhibit 2, which is the Notice of Service of Respondent's Designation of Experts with that list, and if you could update it for me if you can remember the cases you've had since you provided this to us, please.

A I probably could easier call my office and have them print it. These are all maintained by the University. So the case yesterday was State versus Jaquarius Johnson, and that was Hinds County Circuit Court. The case on Tuesday was in the interest of -- I'm not sure I can say the name publically, but it's G.A.

Q Where was that?

A That was in Copiah County.

Q Was that chancery court or --

A That was youth court.

I can't -- my phone is off, and I can't access my business calendar from here. So like I said, we can always reprint an updated CV.

Q If you don't mind, if you'll send it to Brad. We'll give you a little list of homework to do if he approves, and send that to us so we can update it, please.

A Okay.

Q Thank you.

Dr. Benton, where did you go to college?

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A The University of Southwestern Louisiana. It's now known as the University of Louisiana-Lafayette.

Q The Ragin' Cajuns?

A That's it.

Q And where did you go to med school, sir?

A LSU School of Medicine in New Orleans.

Q And did you have a residency after med school?

A In pediatrics.

Q And where did you have that, sir?

A Through LSU Department of Pediatrics in New Orleans, and it was through Charity Hospital, University Hospital, and Children's Hospital.

Q And how about a fellowship after your residency?

A No.

Q Are you board certified?

A Yes.

Q And what are you board certified in, sir?

A In general pediatrics and child abuse pediatrics.

Q What is the body that certifies you in general pediatrics?

A Both of them are the American Board of Pediatrics.

Q Are you familiar with an organization I believe

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it's AAP?

A American Academy of Pediatrics.

Q Are you a member of the AAP?

A I am, I'm a full fellow.

Q And what is the American Academy of Pediatrics?

A It's an organization of pediatricians in America, the largest pediatric association devoted to the health care of children.

Q And you currently work for University of Mississippi Medical Center. Is that correct?

A That's correct.

Q How long have you worked for them, sir?

A Nine years. Almost nine years.

Q And before that where did you work?

A At LSU School of Medicine in New Orleans and Children's Hospital of New Orleans.

Q And is that part of your residency or was that in a different capacity?

A Both.

Q And how long did you work --

A I never left the system. From --

Q You should get out some.

A So I worked both before I received my doctorate at Children's Hospital in New Orleans, so as I was in med school I worked there, I worked there as a resident at

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Children's Hospital in New Orleans, and I worked for LSU as a resident, although the check actually came from Charity Hospital of New Orleans. And I was continuously employed there until 2008. I mean, various capacities: student, resident, and professor.

Q And then from 2008 to the present in Jackson?

A At the University of Mississippi, yes, sir.

Q And what is your current position at UMMC?

A I am a professor of pediatrics.

Q Do you hold any other positions at UMMC?

A I'm chief of the Division of Forensic Medicine, and I'm the medical director of the Children's Safe Center for the State of Mississippi.

Q Tell me about what is the forensic medicine department at UMMC?

A So it's a division of the Department of Pediatrics, and it concentrates on medical legal issues dealing with children.

Q What was your major at -- in Lafayette?

A Biology and chemistry.

Q The first exhibit to your deposition is the notice, and I'm going to show that to you. In it, Dr. Benton, I've asked that certain things be brought with you today as part of this deposition. The first thing is your entire file regarding this matter. Do we

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have your entire file?
A (Thumb drive presented to Mr. Jicka.)
MR. JICKA: I'm going to mark that as Exhibit 4.
MR. WHITE: Do you have a copy of that first exhibit for us?
MR. JICKA: Yes, yes.
MR. WHITE: Thank you.
MR. JICKA: If I forget, Brad, Sonny, y'all let me know. I've got a copy, hopefully, of everything for y'all.
Let's go off the record for a second.
(OFF THE RECORD 1:43 p.m.)
(ON THE RECORD 1:43 p.m.)
BY MR. JICKA:
Q So you've handed me a jump drive. Is that correct, Dr. Benton?
A Yes, sir.
Q And if you'll tell me just generally what's on that jump drive, please, sir.
A All the files received from the Attorney General's office, the notice of deposition, all of the trial record -- well, I guess everything that was given by the Attorney General's office, some photographs of the bathroom incident scene, my report is on there, all the

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articles I cited are on there. Perhaps some other things, but not much more. Oh, the contract for services is on there.
Q And we can probably pull that up, but do you recall when you were first contacted to work for the State of Mississippi in this case?
A Maybe a year and a half ago.
Q And what were you specifically asked to do, sir?
A I was asked to -- well, one, if I was interested in reviewing the file to see if, your concern, that new science was exculpatory to the original case.
Q And the contract that you have with the State of Mississippi, are you paid an hourly rate?
A Actually, I don't know what it says. We have people in our office that connect with them and...
Q We'll get Mr. Carner to pull that up and see.
MR. JICKA: All right. So I'm going to put --
MR. WHITE: And you said the exhibit to the jump drive is 4?
MR. JICKA: Yes, sir, Exhibit 4 will be -- just stick it in there.
(Exhibit 4 marked)
BY MR. JICKA:
Q The money that you earn in the Havard case,

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where does that go?
A To the University.
Q And do you receive a salary from the University?
A I do.
Q Is your salary dependent on the additional work that you do for the State of Mississippi?
A No.
Q The salary that you receive, is there any funding that comes from outside sources other than the State of Mississippi?
A So the funding for my division is based off of a legislative mandate, the funding that's a line item in the budget, the State budget. You said other than that, so we receive funds for patients that we see through their third-party payers. We're prohibited from collecting any money directly from anyone claiming to be a victim of a crime.
So the third-party sources we're permitted to tap are Medicaid, TRICARE, and any other governmental insurance. Any other third-party payers we're prohibited from tapping, and the Attorney General's office will pay for the medical expenses in those cases. So, for example, if they have Blue Cross Blue Shield, we can't bill that entity; we bill the Attorney General's office.

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And we do receive federal @@VOCA grants, Victims of Crime Act. I believe we also have some victims -- let's see, Violence Against Women Act funds, and I believe that's -- and we have lots of little bitty grants. Grants from Sam's, Walmart.
Q What is the total of the grants that you receive?
A I would be in error if I said an exact, but somewhere approximately a million and a half per year.
Q And do you have to apply for these grants annually or do they just come every year absent some change?
A Well, I mean, the insurance, I have to maintain my licensure and credentials. But as far as the insurance reimbursement goes with respect to the state legislature, it goes into budget review every year. With respect to VOCA grants, those are annual grants, so they're awarded annually, so they -- you have to reapply. Each grant expires and then you have to reapply for new ones. All the little business community grants are individual, one and you're done. I don't handle any of that; I'm aware of it. So I imagine almost everything is annually renewed.
Q Who handles the application for grants at UMMC in your department?

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

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

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

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

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

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

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

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

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opinion.
Q Would you say that you are up to date on the current controversy regarding shaken baby syndrome?
A I guess we'll find out, but relatively, yes.
Q And tell me what you do to try to stay abreast of new developments as it relates to specifically that diagnosis.
A So I'm a member of the Helfer Society. We maintain a listserv where we share complex cases and review major studies and discuss ongoing and future research. I'm also a member of the section in the American Academy of Pediatrics on child abuse and neglect known as the SCAN section, or it's the section on child abuse and neglect, SCAN, S-C-A-N. The same thing: they have a listserv, and we share information. That's a little more on the general pediatric level, and the Helfer Society are pathologists and neuropathologists, neuroradiologists, radiologists, biomechanical engineers, people that -- so that's one way.
I am afforded, at least up until this next budget year, three national conferences per year of which I choose conferences -- and they're detailed on my CV -- that deal with this issue. Well, and other issues within the world of pediatric forensic medicine. I attend any and all local state conferences, predominantly New

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Orleans, Memphis. Again, those are detailed on the CV also. Not too much in Mississippi at present.
Q Dr. Benton, before you had your position at UMMC, was there someone that held that position, another physician?
A No. It never existed previously, to my knowledge.
Q When you testify in cases like the one you've done -- the two I guess you've done earlier this week, are the victims or alleged victims of the case children?
A Always. I'm trying to think. We will occasionally do adult cases if they're mentally impaired, but I don't believe I've ever been to court on any of those cases. So I think to answer your question correctly, it's always been children under 18.
Q Do you know personally Dr. Steven Hayne?
A I do.
Q And tell me about your relationship with Dr. Hayne.
A I have met him over the years in cases where we have intersection. He has come to my office. He, unfortunately, of late has been the opposing expert on almost every one of my cases.
Q Earlier on did Dr. Hayne -- make sure I understand what you're saying, did you and Dr. Hayne work

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both for the State in the cases that you worked on?
A I don't know. I believe when I came here Dr. Hayne was having difficulties with the State. I'm not exactly sure when he separated from the State, but it was really close to when I came here. So these were actually cases that predated my coming here which were going to court, which I had been asked to offer opinions also.
Q So when you were in New Orleans, were you -- did you work for the State of Mississippi from time to time?
A I worked for the State in terms of working for LSU.
Q State of Mississippi, I'm sorry.
A Oh, the State of Mississippi. So I did do cases in Mississippi but not much.
Q Okay. So there were times when you were hired by the State of Mississippi Attorney General's office before you came to UMC.
A No, I don't believe I've ever done anything for the state Attorney General's office while I was in New Orleans. It would mostly be youth court matters along the Gulf Coast predominantly. Maybe a few criminal cases too.
Q And when you said you worked earlier on the

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same side with Dr. Hayne, what kind of cases or where were those cases located?
A I mean, all over the state of Mississippi. I mean, they were -- I think they were all Mississippi cases, because he was formerly the Mississippi medical examiner. I don't believe there are any not inside the state of Mississippi.
Q Do you know how much the contract is with -- and I think I may have asked you this -- with the State of Mississippi?
A I don't.
Q But that contract is on the jump drive you gave us?
A It is.
Q So according to what you've presented, the consideration is Contractor shall be paid a fee not to exceed $175 per hour, and you will not exceed $50,000. Is that correct?
A I mean, that's what it says.
Q And you brought this to me, so I -- are you aware of any other rates or numbers?
A I am not. So I went into academics to not deal with the business end of it. That is what is I think offered by the Attorney General's office, and as he can tell you and as far as I know, having been completed or

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executed by the University of Mississippi, I mean, the process is just super lengthy.
Q In the preparation of your report did you receive any assistance from others in your office or anyone else?
A I mean, everybody in my office reviewed it for grammatical errors. Did I get any medical assistance? No.
Q Other than proofreading, did anyone else provide any substantive assistance in this report?
A No, sir.
Q So take me through, if you don't mind, the analysis that you did in the Jeffrey Havard case as it's related to your report.
A Okay. Do you need this back?
Q If I can have that one back.
A Here, I have the original.
Q Great. Thank you.
A So again, the request was to identify if there was any new science that would affect the original determination of the cause and manner of death of Chloe Madison Britt, who is the victim in this case. To write the report I reviewed the materials that were sent by the Attorney General's office focusing in on all the medical records. I did not -- I skimmed through anything that

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was of legal nature.
And so pages 2, 3, 4, 5, 6, and 7 is a synopsis of my interpretation of what I saw in those records. Actually, I went one too far; so pages 2 through 5. Beginning at the bottom of page 5 is where I summarize my interpretation or assessment of the record. So I did that first.
I then went back and looked at the different affidavits that I guess you guys had supplied and took notes and tried to group what the concerns were, and then I tried to group and reply what my thoughts are on that. And that comprises pages 6 through 10. And that's pretty typical of how I do these.
Q When you go through your analysis, do you first identify the injuries and then the timing of those injuries and then look at the history? Or just kind of take me through how you do your analysis.
A Well, you start with what's the evidence in the case. So, I mean, I go through that and literally, much like y'all do, I take notes of everything, who said what, when, where, what exams were done, who did what, and I summarize all of that and what can I say from that. And that's the first part of this.
Q Do you start with the trial testimony first or a history first? How --

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A I actually start with the medical records. So the trial testimony would be second. In fact, I put that less than all the other stuff. So I look at all the medical record. I look at the autopsy. I'm trying to think of everything that was available in this case. Any recorded transcripts or statements pretrial. That all comes first.
Q Have you reviewed the trial testimony in this case?
A I have.
Q Were there witnesses that you paid special attention to or did you read the whole trial transcript?
A I read the whole thing. I mean, obviously, I guess the medical aspects I was more interested in than the nonmedical ones.
Q What were the medical records that were available specifically in the Chloe Britt case?
A I don't have independent recall, but it's the things that are on that jump drive and everything that was provided by the Attorney General's office.
Q We'll pull that up. In your report you stated it was your task to -- it says "Chief Complaint: Request opinion whether there is new science that would affect the original determination of the cause and manner of death of Chloe Madison Britt," with her date of birth and

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her date of death. Is that correct?
A Yes, sir.
Q What is cause and manner of death?
A Cause is the factual basis of what led to the death of the child. Manner is a legal opinion of the various ways in which one can die, such as homicide, suicide, et cetera.
Q Is it your understanding that determining cause and manner of death are mandates from the State to the -- to a forensic pathologist?
A To the medical examiner's office, and in this state it's actually to the coroner who does not have to be a pathologist.
Q Have you had any forensic training?
A Yes.
Q What forensic training have you had, Dr. Benton?
A So it started off at the end of my second year of residency. I completed a month-long clerkship in what we now call pediatric forensic medicine, or actually that's what they called it back then but it's now called child abuse pediatrics.
At the end of that I was offered by the dean of the school of medicine to get additional training as well as I was offered a job essentially through my

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third year. So the offer and the money was very good, and I accepted. And they sent me to various places for further education, including the Center for Child Protection in San Diego, California, and the Huntsville Program in Huntsville, Alabama, and local programs. Most of those are on my CV.

And so throughout my third year I was mentored by Dr. Kathy Kaufman, who ran the program, and every one of my cases was reviewed by her before it was submitted out. And so I continued to do that the third year of my residency, and then I was offered an associate professorship where, again, the continuing education I think I previously provided was required or mandated for it.

I actually became -- there's only a few of us that do this. I became friends with people all across the country. The Helfer Society had just started, and I was one of the charter members. And we started sharing information. We recognized that this was building up a body of knowledge that was greater than that of just a general pediatrician, and so we started fellowships. And I started a fellowship program, and I started training fellows, which the old adage is: If you want to really see if you know something, teach it, because it's sort of like law school: The people who are under you are

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constantly looking for your mistakes and challenging you as a way of showing their knowledge. So I did that all the way up until I came here.

The intent was to start a fellowship here, but Mississippi, unfortunately, did not have all the requisite things necessary for accreditation, and so we couldn't do it.

Q When you say Mississippi, the med school or --

A Well, the med school or Mississippi the state.

Q What was it missing?

A It was missing a second board certified. You have to have two, a minimum of two board-certified child abuse pediatricians in order to have a fellowship.

Q Are there any other board-certified child abuse pediatricians in the state of Mississippi?

A No. But we're recruiting, so if you know of anybody.

Q I'll keep my eyes out.

What is your definition of forensic?

A Forensic is to bring a matter to a forum. That's its dictionary definition. So in this particular aspect, other adjectives, it's the medical legal issues surrounding pediatrics.

Q When did the name change to child abuse pediatrics?

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A So we started thinking that we could possibly have a subspecialty in the late '90s, early 2000s, and an application was made to the American Board of Pediatrics. You have to first show the fund of knowledge, what the factual bases are, you have to compile a full literature, as in any other subspecialty. This is how they evolve. And the application included the name "pediatric forensic medicine," because that's what most people across the country thought was a neutral, fair-sounding name.

Well, at that time there already were pediatric -- not pediatric -- forensic pathologists, there were forensic psychologists, there were forensic psychiatrists. Those were already accepted through American Board of Medical Subspecialties. The American Board of Pediatrics said they didn't like the term "forensic." It sounded too legally, and they said just say what it is that you deal with. And so it was the board that changed the name to child abuse pediatrics and said we would never establish it if you used the word forensic, even though that's what we do.

Q When was that, I'm sorry?

A I believe that was in 2005, 2006, and the first boards were 2009.

Q And when did you first take the boards?

A 2009.

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Q And once you're board certified as a child abuse doctor, do you have to renew it?

A Yes.

Q How often?

A So the years that I took it, it was every seven years. They recently last year changed it to every ten years, but then added annual education requirements and quality assurance requirements and read money. So yes, so it's every ten years now, and I have to renew both my general certificate and the child abuse certificate. I've done my child abuse certificate three times, because it was every seven years. And I have not yet had to renew the child abuse, but it's coming up.

Q Dr. Benton, what is a forensic pathologist?

A This is a pathologist who has completed at a minimum anatomic pathology, a residency -- an accredited residency in anatomic pathology, and was board certified in anatomic pathology. They can then apply to a one-year fellowship, generally one year, and train in forensic pathology or the application of pathology into medical legal issues involving death.

Q Are you a forensic pathologist?

A I am not.

Q Do you hold yourself out as an expert in determining cause and manner of death?

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A I'm willing to give my opinion where I can apply my knowledge to it, so I guess to some degree, yes. It's not every case.

Q And to be fair, I could give opinions on a lot of things, but not too many people are going to listen, you know, because I don't have the expertise on that and --

A I would say a lot of people do listen to what I have to say about cause and manner of death involving children. I have been dealing with child death since the early -- or mid 1990s. We reviewed when I was in Louisiana every child death under age 18. We do the same thing here in the state of Mississippi. So we look at every child death under the age of 18, every sudden, unexpected child death. We don't look at natural deaths like cancer and stuff like that.

So that affords me an experience and a background. I work with pathologists constantly. I attend most of the autopsies on the kids who I'm caring for who die. Probably at least in terms of the gross anatomy equivalent to that of a forensic pathologist minus the histopathology, which I am not an expert in.

Q Okay. Fair enough. So do you have any -- other than what you're talking about, observations, do you have any specific training in pathology?

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A No. I wanted to become a pathologist, I trained really hard, but I didn't do it.

Q Why didn't you do it?

A I enjoy pediatrics more.

Q Are you aware of any entity that officially recognizes Dr. Benton's training as being sufficient to determine cause and manner of death?

A The state of Mississippi by statute recognizes my authority to give cause and manner of death in which I am involved with the child. Now, so all physicians have that ability in the state of Mississippi. Now, it is deferred in suspicious deaths to the coroner's office.

Q Was this considered a suspicious death?

A Yes.

Q So what are your specific duties as a child abuse doctor?

A What are my specific duties at the University or just --

Q Yes, in what you're doing right now. And if you're doing something outside of the University, please let me know that as well.

A No, everything I -- all my employment is with the University. So threefold job description. I am a clinician, meaning that I see patients, predominantly inpatients of the Children's Hospital dealing with severe

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trauma, mostly on children who can't speak, or preverbal, nonverbal that are admitted to the Children's Hospital. I supervise an outpatient sexual abuse clinic in Jackson and one in Tupelo, and we're trying to get one up in Biloxi and Hattiesburg and should have it in the next couple of months with that grant that we just talked about. That's the clinical aspects. That's seeing living children that are referred to us by Child Protective Services, law enforcement, attorneys, emergency rooms, other physicians, and occasionally we'll take a self-referral or a parent wants us to see the child.

Second job description is to teach. I teach at the medical school level. I teach at the residency level to child psychiatrists, to pediatric residents, family medicine residents, med school level. It's all med students. All third years are required to rotate through our program.

And I teach at the nursing school, Allied Health school, that's usually just a lecture once or twice a year to the physical therapists, speech therapists. I teach to the dental school. That's usually a one-year introductory lecture to the third-year and fourth-year dental students. I also teach to the Allied Health denial hygiene program. And again, that's

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a once-per-year introductory lecture.

Early on I was doing lectures at the Ole Miss law school with David Calder assisting his family advocacy program. We've been a little busy to do that. We keep talking about catching up. We work with MC law, and occasionally we'll give introductory lectures. More often we take their interns from Ole Miss, Alabama School of Law, and Mississippi College. It's easier to do it. They help us with legal issues, and there's always interesting things for them to get legal things. So that's the education part.

And the third is a research part. I work with the Jackson State School of Public Health. I have been mentoring for the past five years a Ph.D. student looking at Mississippi adherence to federal guidelines on forensics. And happily, that project is coming to a close. But that's the main research we have done.

Q And that's with JSU?

A That's with Jackson State, yes, sir, School of Public Health.

Q Dr. Benton, what pathologists are you currently working with in performing your duties as a child abuse doctor?

A Lots. So all the Mississippi ones. So Dr. Mark LaVon. I got to think of all their names. The

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lady just left. I don't see them that often, so I'm having trouble with their names. But there's a tall, thin man. I'm sorry, this is terrible. They're going to hate me, but I don't remember their names.

Q There's worse things to be called than a tall, thin man.

A I mean, Lisa Funte, I have a case with her right now. I can't think of that -- there's three pathologists there now, and the fourth one was a female that moved and I think is in Dallas now. So across the country I work quite frequently with Mary Case, with Karen Ross out of New Orleans, with -- I'm trying to think of his name -- Schmunk, Greg Schmunk. I just had a case with him recently. And Kim out at the University of South Carolina. I'm blanking on her last name. Kim. Her husband is a federal judge. I cannot pull the last name out. I'm terrible with names. I feel badly because these are people that I know. I used to teach with the Uniform Services Division of Pathology. Tom was his name. And that was out of Bethesda. Tom, starts with an S.

Q Do you ever work with any biomechanical engineers?

A Yes. Gina Bertocci out of University of Louisville. Let's see. She's the one I worked with the

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closest. She picks up the phone when I call. Mary Clyde Pierce is a colleague of mine at the University of Chicago, has some people that work with her. I don't recall their names. And it would be more sideline, meaning we'd be discussing, and they'd be there too.

Q I want to make sure I understand what you can and cannot do as a child abuse doctor in Mississippi. Can you sign a death certificate?

A Yes.

Q When was the last time that you signed a death certificate?

A I've never signed a death certificate in the state of Mississippi. The last time I signed one was in Louisiana.

Q Have you ever certified a death in a case of nonnatural causes?

A No.

Q Have you ever performed an autopsy?

A No.

Q Have you ever removed a brain?

A I've assisted, but I can't say that I was the one doing it. I was just helping.

Q Have you ever examined tissues microscopically?

A Yes, but not for official purposes. I am not a histopathologist.

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Q Do you teach in the teaching aspect of your job determining cause and manner of death?

A Yes.

Q And in what courses? Is that in all the courses? Do you teach the dental students that?

A No. So that would be just to the medical students, and that is part of the curriculum. They all have to learn that, because in -- for natural deaths, any that are non-sudden or unexpected they're required to give a cause and manner of death on the death certificate.

Q Have you ever testified on behalf of a criminal defendant that was alleged to have killed a child?

A No.

Q Have you ever testified in the case where an allegation of shaken baby syndrome was the cause of death and you testified that you didn't believe that was what occurred in the specific case?

A No.

Q So what was the original cause and manner of death in the Jeffrey Havard case?

A I would have to look at that report, but I believe the cause was shaken baby syndrome and the manner was homicide.

Q In the autopsy report -- and we can pull it up

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for you --

A Actually, I did put it in here.

Q Okay. So the causes of death in pathological findings, the immediate cause of death were changes consistent with shaken baby syndrome and closed head injuries. Is that correct?

A The order that he put it was closed head injuries consistent with shaken baby syndrome, and the manner was homicide.

Q As we sit here, is it your opinion that the immediate cause of death in this case, changes consistent with shaken baby syndrome and closed head injuries?

A I actually agreed with his modification in his subsequent deposition where he said shaken baby syndrome with impact or blunt force trauma. I believe this baby died of blunt force head trauma.

Q And from your review, what was the blunt force? What caused the blunt force head trauma?

A Don't know. I don't think that's adequately explained by anything that we have seen so far.

Q So did you review the testimony of -- you said that you reviewed the testimony of Dr. Hayne in this trial regarding the cause and manner of death. Correct?

A I did.

Q Let's take a look at that. I'm going to mark

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

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

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

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

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

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

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

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

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Q Do you think that the American Academy of Pediatricians is a fringe group?
A Is the American Academy of Pediatrics? No, I don't think it's a fringe group.
Q And thank you for that correction.
American Medical Association, is that a fringe group?
A I'm not aware of -- I mean, I used to be a member of the American Medical Association. I'm not aware of them -- I mean, if we say fringe group within the realm of child abuse, I don't know that they have any major positions, although they do have a section that deals with pediatric issues. They're not very big in abuse issues.
Q Would you agree that child abuse doctors are also advocates for a position?
A Sure. I think we're all advocates for a position.
Q Did Chloe Britt suffer injuries from shaking in this case that you're aware of?
A I think it's possible. I think she definitely sustained some severe acceleration/deceleration injuries, of which shaking is one possible mechanism of that.
Q What is your -- what are the findings that are consistent with what you just said?

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A Predominantly the bilateral subdural hemorrhages that are whole hemispheric to both sides of her head. The bilateral retinal hemorrhages, which include retinal folds, and they are multilayered and severe. We just don't see those in accidents.
Q Just so your testimony is clear, you're not believing that shaking alone killed Chloe Britt.
A No. There's plenty of evidence she had impact trauma to her head and in multiple planes.
Q Are there other conditions that can cause subdural hemorrhages?
A Yes.
Q Such as?
A In my report I list them all. But in my experience the most common causes are trauma, and that can come in three forms: inflicted trauma is definitely the most common; accidental trauma, the next most common; and birth trauma if we're dealing with kids under three months of age, as we frequently will find subdural hemorrhages.
Then we go down the list. And those are broad sweep. So we see them in genetic and metabolic disorders. We see it with coagulopathies, or bleeding disorders. And there's a list of different things. We can see tumors. We can see anything that affects those

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systems indirectly, like leukemia, neuroblastoma. I could look at my list and flesh it out for you, but there's a list of things that can cause subdurals.
Q Dr. Benton, did you make a diagnosis of cause of death that was separate from Dr. Hayne's findings in this case?
A I don't think so. I think I just reaffirmed his latest position. I agreed with it. I don't think I set -- let me just double-check. I don't think I advanced a separate position. And as I sit here now, I agree.
Q Do you believe it's your role to determine manner of death? Is that a child abuse doctor's role?
A So within the confines of state statutes as far as for the initial first official determination, that is relegated to the coroner in the state of Mississippi, so I have no role. I can advocate for what I believe, but it's not my official role.
Same thing post-determination, we do this, we meet and review every death as to cause and manner of death for every sudden, unexpected death. I may disagree what's there, but once it's on the final death certificate, we have no authority to change it or even to pursue a change in it. That's just how the statutes are set up.

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Q And I know we have your list of cases here, at least at the time and you're going to give us an updated one, but other than the Chloe Britt case, have you given opinions in a case, either whether it's the habeas level or in post-conviction --
A I don't know what habeas means.
Q Okay. So let me strike that. And thank you for slowing me down because I was going to just say a bunch of legal stuff and you wouldn't know any of it maybe.
A I may or may not. I've heard habeas corpus, but I don't really know what it means.
Q Okay. Other than the Chloe Britt case, have you given reports or opinions in a forensic situation after the trial has already taken place?
A No, I think this is the first.
Q Are you aware of other cases that the State has asked you to get involved in, for example, regarding other people that were convicted of shaken baby syndrome?
A This is the first.
Q Do you believe that Chloe Britt was the victim of abuse?
A Yes.
Q Do you have an opinion that the abuse caused this death?

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A Yes.
Q And do you have an opinion as to what that abuse was?
A I mean, we can speculate as to the exact mechanisms, but I do think it involved blunt trauma to the head that had a severe acceleration/deceleration force to the head. There's also evidence of other injuries to parts of the body that in a six month old are equated with abuse.
Q Would a fall cause blunt trauma to a child's head?
A It can, yes.
Q And what other areas were you talking -- are you talking about as it relates to Chloe Britt?
A The child's got a torn frenum. The child has two bruises to the anterior thigh and also had something happen to the anal area with blood in the diaper and bruising to the rectum.
Q Have you reviewed or do you have any opinions regarding whether Chloe Britt suffered from any sexual assault in this case?
MR. SMITH: I'm going to object, and I'd like to give a basis. The sexual battery injuries to the sexual battery are beyond the scope of this remand, and it's irrelevant.

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BY MR. JICKA:
Q You can go ahead and answer.
A I don't have a firm opinion only because I don't think we -- I don't think all the evidence was thoroughly evaluated to come to that conclusion. I think it is possible she was sexually abused. I think it's also possible we could come to a different determination if we had the ability to go back and look at things.
Q What would be the type of information that you would like to see to make that determination?
MR. SMITH: Objection.
MR. JICKA: And I understand it's the same. You can -- we'll just note the objection.
A With what he objected, I did not make any special effort to look at this, but if you go back through the whole record, I would like to see what instrumentation was done to the child's rectum. And again, I did not take note or make note of that because I was told that wasn't an area of interest.
But it's clear there was a contusion. Even your own experts have seen that on the histopathologic slide. I don't necessarily agree with Dr. Ophoven when she says there has to be a break in the skin. That actually doesn't make any sense. I've done thousands of rape exams, and I don't think that's a true

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statement.
The biggest concern for me it that there's blood in the infant's diaper that is seen in the crime lab, in the crime lab reports but wasn't pursued any further. And yes, there's no sex-specific findings of semen or sperm, but the blood in the diaper indicates something has happened before there was any medical instrumentation or, as advanced by Havard, that perhaps there was -- well, there had to have been some penetration to get into the rectum.
BY MR. JICKA:
Q The frenulum.
A Yes.
Q Just my understanding, that's the inside of your upper lip. Is that correct?
A It's the piece of fibrous tissue that connects the upper lip to the gums.
Q Did you read the trial testimony where the State decided that it was not going to pursue that as abuse or as -- or as abuse in this case?
A I read it. I don't recall it as we sit here right now.
MR. JICKA: How are you doing? This is not a marathon. I don't want to -- if you need a break -- are you good to keep on trucking?

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THE WITNESS: I'm fine.
BY MR. JICKA:
Q Dr. Benton, did you personally review the videotaped interview of Jeffrey Havard where he describes the accidental fall?
A No.
Q Where did you get your information about the fall?
A Transcript.
Q Would you agree that history is important when you're evaluating a case such as Chloe Britt's?
A Yes.
Q And why is that?
A Because it sets the context and perhaps other peripheral details that can modify your opinion of the factual details or objective details.
Q What is your understanding of the dynamics of the accidental fall as described by Jeffrey Havard?
A The child was in a infant tub inside of an adult tub, was removed by Havard. And I've seen the photographs of the scene, so there's a commode just to -- if you're facing the tub, there's a commode just to the right of the tub that he was -- there was a towel lying over the seat of the commode. And that he had the child in hand, that apparently was trying to get to the towel,

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that the child's legs hit the lid of the toilet, and he was -- he used the word definitely sure that the body or torso hit the tank, was not as sure whether the head hit the tank or not.

After that interaction or somewhere in that interaction he said he possibly may -- that may have been one instance where he could have penetrated the child's rectum. That the child was wiggling and he dropped the child. Actually uses the word slide and/or drop in different circumstances in the record. The floor in that area is a red carpet kind of shag, '70ish carpet. And that the child gasped, that he picks the child up, he says that the child was altered mentally, my words, I don't recall his exact words, and that he shook the child to revive the child, and subsequently grabbed the towel, brought the baby to the bedroom, and I think the child deteriorated from there. That's my understanding.

Q Thank you. Did you read or view the video statement of Rebecca Britt?

A I did not.

Q Were you provided any information regarding that?

A I definitely was not provided any video.

Q Do you recall seeing a transcript of her pretrial interview?

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A I don't think so. As I sit here, I'm trying to recall what she would've said, and since I can't, I don't think I saw that.

Q Dr. Benton, what I'd like to do is go through your table of Findings of Injury on page 5 of your report, sir. Are you with me, sir?

A I am.

Q On the top it says Pediatric Forensic Medicine Consultation Report. Is this a chart that Dr. Benton has come up with or is this one that you have received from some other -- used from some other source?

A No, I created it.

Q And what I'd like to do is just kind of go through how it's set up. Okay, sir?

A Sure.

Q All right. So it says Findings of Injury. Is that correct?

A Correct.

Q And then the first column says Type. Is that correct?

A Yes, sir.

Q And so are you trying to identify all of the findings of injury from the evidence available?

A Yes, sir.

Q And then you have Location next, which would be

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where that injury is located. Correct?

A Yes, sir.

Q And then Pattern, what do you mean by pattern?

A Does it have a pattern. So in our field, patterns mean a lot, so such as belt buckle pattern or parallel linear patterns that would indicate contact with an object or things like that.

Q Okay. And so in your field as a child abuse doctor, if there's a pattern, that could be evidence that there has been some systemic child abuse.

A It doesn't necessarily imply abuse, but it does imply contact with a specific object that we then want to hear a history to explain that, and the absence of an explanation may lend towards abuse as opposed to an accident. But it's not always that simple. Some patterns are very specific. I mean, belt buckles, I mean, when you see them, particularly in repetition, you have to come up with a really good explanation why that's on a child's body.

Q Have you ever worked on cases where you had cigarette burns in a pattern on children?

A Yes.

Q Would that be the type of pattern that would also be included?

A Same thing. So we have to still listen to the

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history to it because we do see -- we don't see it as much anymore; people are smoking less. But certainly --

Q That's another benefit.

A Children would run past a cigarette and sustain a cigarette burn, and I wouldn't call that necessarily abusive. So yes, we do look at certain patterns, and there are certain -- I mean, I've definitely had some cases where you see their abdomens burned and their faces burned, and these aren't typically accidental areas.

Q All right. So when you use the word "amorphous" on the pattern, what does that mean?

A Without pattern or without shape.

Q And I see --

A Or it's not described.

Q As you go down, it has "multifocal." What does that mean as a pattern?

A I put that in quotes because that's the pattern as it was described in the autopsy report. It wasn't more specific than that.

Q Does autopsy use the term "pattern"?

A They should.

Q Well, I'm asking did this one use the term pattern in it?

A I would have to look at the report to see if he used the term pattern. But the word used relative to the

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

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

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

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

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Dr. Benton?
A Like I said, it was based off of -- oh, this chart?
Q Yes.
A Contemporaneously with reviewing the records.
Q I'm sorry, the format for this chart, when did you come up with it?
A Oh, somewhere in the late 1990s. Dr. Adams came out -- Dr. Adams -- and it's in the article "It's Normal to be Normal," that's the title of the article. It was a sex abuse article. But I was taken by how she framed each of the injuries in isolation of the history, because that's what forensics is about. And that's something that was drilled into me when I was in San Diego is that if the history determines the finding, then you're not evaluating the finding; you're just taking the history for it.

So we have to communicate to you guys or whoever is interested what does the finding mean in isolation as well as put it in the context, but do them separately. And that's the third application of any evaluation of injury.
Q Have you trademarked or copyrighted or --
A No.
Q -- anything in this chart? Is it in any

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textbooks that you're aware of?
A Sure, it's in -- I wrote the chapter in the textbook, so, I mean, I published this. It's a shame I can't remember the title of the book.
Q We'll get your --
A It's Forensic Pathology of Infancy and Childhood is the textbook. And it would be in my CV. I didn't even think to look there. It's Forensic Pathology of Infancy and Childhood. I wish they would page number them so I --
Q That's okay. So as we look on your CV in the publication list, it's Book Chapter -- is it the "Sexual Abuse of the Young"?
A It is.
Q And that was published in 2014. Is that correct?
A That is correct.
Q So prior to 2014, are you aware of this chart ever being published in any textbook?
A So there are charts and -- the answer is yes, but maybe not exactly the way I -- so there are numerous people. Dr. Adams is probably the foremost person who has evolved guidelines for how to classify things. She strictly limits herself to sexual abuse. She's never gone into the physical abuse realm. I thought it had

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applicability, and so I've extended it there. So you will see various versions of this concept in the child abuse literature and textbooks, but most of it is going to be towards sexual abuse.
Q And that's why I meant this, you know, the Benton chart as I want to call it now.
A No, don't call it that.
Q Doesn't that sound good? So the Benton chart, before 2014 are you aware of it ever being published in any textbook?
A No.
Q Did you publish it other than in -- the "Sexual Abuse of the Young," has it been published in any other textbooks or other chapters?
A Again, there are other people that have published in reliability scales, but not what I have characterized a five-point scale. I mean, there are other five-point scales. Again, I'm leveraging off of other people's works. And actually, if you look at that chapter, I cite the evolution of these scales, so all the literature that describes previous people's works on how this evolved.
Q Who is using that textbook now, the sex abuse --
A Predominantly pathologists, forensic

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pathologists. I mean, it's one of the -- one of the...
Q One of the good ones?
A Yes. I mean, those are two leading authors. And I'm very sad to say Kim Collins is the pathologist I forgot to say before out of the University of South Carolina.
Q Then the final category is Consistent with History.
A So that's the third application. So you start first with what does it mean in isolation, and then the third factor is to apply the history to it, is the history consistent.
Q All right. When you do your chart, do you always have an asterisk after the yes or a no?
A No. So this is definitely -- so it's a good question. So originally --
Q I'm going to have like three more the rest of the afternoon, so count them up.
A Originally if you take any one of these in isolation, the consistent with history could be true if it was just that one finding, or maybe two of the findings. But once you start adding up all of these and we only have maybe hit the head on the lid, maybe hit the head on the floor, that's not even definitive. We just know the kid slid, dropped to the floor, not sure what

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body part actually hit the floor. And now we have all of these. So I went back and I put the asterisk next to those saying the trouble is, we don't have enough history to cover all of these findings. And that's why I put no.

Q Looks like you have a maybe for edema on the face.

A Uh-huh.

Q So that might be consistent with the history that was given?

A Well, when people start dying and things alter pretty quickly, you can get edema to the face or other places. So maybe that's included in the process. It was not significant to me.

Q The chart, the Benton chart on finding consistent with history, what are -- you gave me the range as it related to specificity. Is there also a range -- and I'm guessing it might be yes, no, maybe, but what are all the different findings you could have under consistent with history?

A It's a dichotomy. I mean, it's either yes, no, or I guess unsure. That part of it I purposely do not offer a specific opinion because that's now invading the province of the chart artifact.

Q And you agreed that child abuse doctors should not do that.

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A Correct. Any of us should not do that.

Q When you consider the history here, are you considering the full history or only the fall history that was described?

A So all history that I took into account is summarized ahead of time, so that goes from birth to present that was available to me.

Q So that would include Jeffrey Havard's history regarding the fall. Correct?

A Yes.

Q Would it include what happened at the ER with --

A Yes.

Q -- the ER nurses and so forth?

A Oh, yes.

Q Okay. Is it important when you're trying to do this to determine the timing of these entries, in other words, when did certain things occur?

A Where able, yes.

Q Did you make an attempt in the Jeffrey Havard case to make a determination as to the timing of these?

A I did not only in the sense that all of the injuries that we see here are of an acute timing that our current medical understanding of the time frame is too big to be of any significance in discerning a who. So

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the only time I will make timing statements is if it can discern the who. So, I mean, you can go down the list, but most of those our -- the limits of our ability to time are on the order of a week or more, nothing that would be of help, so I did not do anything further.

Q Did you make a determination as to the possible etiologies of each of these injury findings?

A I mean, I certainly considered it in each, and the ones that are labeled non-specific I didn't come up with anything. The ones that are labeled concerning I certainly leaned towards this has some predilection that something non-accidental happened to the child. The ones that are labeled suggestive, as I previously stated, are seen fairly frequently, almost to the exclusion, but it's not definitive, meaning that there are some circumstances where if you have the right history you can see these findings.

Q Did you request or perform a biomechanical analysis?

A No.

Q Are you able to do that?

A Yes. Well, with the Attorney General's money but --

Q Assuming they would cut the check?

A We've done that in other cases, but no.

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Q What is your understanding of Jeffrey Havard's description of Chloe's symptoms right after the impact?

A So after he dropped her, as I previously said -- and I assume this is when she hits the floor she kind of gasped for air is his words. He then picks her up, says that he shook her side to side, and he said that she started crying again. The next recording of her behavior was that she spit up some more in the bedroom and that she had blood which he attributed to coming from her nose. And that he laid her down on her stomach but doesn't describe any other behaviors after that.

Q Dr. Benton, is it fair to say that that's a pretty normal description of a concussion with an acute subdural hematoma, what he described there? Take a look.

A No, I wouldn't say that that's a typical description, unh-unh.

Q If someone had an acute subdural hematoma from a concussion, would these be symptoms that you would -- you could expect to see someone describe, a layman describe?

A No. So a layman describe. I mean, did he use the word "concussion"?

Q No, I'm using the word concussion.

A Okay. So restate the question, please.

Q Sure. What you just read, the description of

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Chloe's symptoms right after impact, is that a pretty fair description of a concussion with an acute subdural hematoma?

A No.

Q And why not?

A I mean, for multiple reasons. First off, the gasp for air implies impact either to the abdomen or chest typically, if I had to ascribe anything to it. The crying doesn't fit. I mean, I would say in the thousands of cases that we look at where kids fall out of bed and stuff, they pick them up and they're crying. So that could fit a fall, I don't have any problems with that, but that's not a concussion.

So in our world a concussion is an altered state of mentation. We don't typically think of concussions in an infant, or at least we don't use that word. We think of it more in sports-related injuries. I'm not saying that you can't have a concussion.

Now, to the second part of your question, when I see a subdural like this, bi-hemispheric, whole hemispheric, I use that as a marker of what else is going on. So we see plenty of kids who have subdurals, and they have no effect on the child whatsoever. I mean, so it's not blood in the subdural space that's the problem; it's the underlying pathology of the brain. And

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generally when we do see this degree of subdural, there's usually unconsciousness on the brain, and it is in almost all descriptions, including invention descriptions where people confess to injuring the kid, it's instantaneous, and the lights are out.

Q If Chloe had had a preexisting injury to her head, would that make her more vulnerable to concussion and injury from a second event?

A Restate the question one more time.

Q If Chloe had a preexisting injury to her head, would that make her more vulnerable to concussion and injury from a second event?

A The short answer is we don't think so. So there is a body of literature called second-impact syndrome, which is under heavy scrutiny in a lot of -- so it was published, I believe, about in the mid 1990s, et cetera, and involved high-impact injuries among footballers, et cetera. I think it came out of Australia.

And we considered that. Is there a priming, so to speak, of particularly the sodium or other channels in the brain that might lead one to have a more severe injury than one would expect. Except we just don't see that in other accidental injuries. Now, we certainly give that advice to families, but so far we

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have not seen sudden death in a kid who's previously had a known accidental head injury.

Q And you're probably watching a lot of television lately, but we see football players who have repeated concussions and the fact that it may -- the first concussion or the second concussion may make you more vulnerable as you continue to receive concussions. Is that a fair statement?

A Yes, I think it's fair to say that severe head injuries that happen repetitiously is not a good thing for the brain.

Q And not only not a good thing, but it continues to get -- you become more vulnerable after each event.

A If you're using vulnerability in the way I think of it with the literature on second-impact syndrome, I think the jury is out on that. If you're using it in terms of -- and I've not seen the movie, but the guy in Los Angeles that helped to establish that there was pathology to the brain with repetitious injury, I agree with that. So I'm not sure what to say about vulnerability other than our concussion guidelines were predicated off of the second-impact syndrome, whether you're talking about professional football players or high school or what have you.

And I think they're constantly under

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evaluation. Do we want to risk anyone's life about that? Well, the professional people do. I mean, they try to hide their concussions because they're paid to play. But in high school, you know, we'll cut it short. In soccer -- I was a soccer referee -- we take no chances. If you have a slight dizziness or something, we call it a concussion, and you sit out and you got to sit out until a significant time has passed, which we don't know what that is. Is there a true vulnerability? We don't know.

Q In your job as a treating physician, do you actually treat patients in your job?

A We do. Well, I mean --

Q Does Dr. Benton see people as a doctor?

A We see living patients, and if they have problems that fall within the realm of general pediatrics, we will treat them for it as we're evaluating the reason that they're there.

Q Okay. And when you say "we," that's the only thing --

A I'm sorry about the royal we. I do that.

Q Okay. Do you treat, have you treated people who have had -- children who have had concussions?

A Not in a long time. So in my past I also did hospitalist work and did some ER work, I guess for the first five to six years I was starting out. As I got

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

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

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

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

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pediatric imaging or child abuse specifically, and you will see that that is the No. 1 etiology of subdural hemorrhages.
Q Can you give me specifics, please? What textbook are you talking about that I can pick up and --
A I mean, so --
Q If you want to cite your own work, you can, I guess.
A No, I'm not -- so if you look at the body of literature textbook-wise, Lori Frasier is the editor of Abusive Head Trauma. I think it's in its second edition. The -- gosh, who's the -- we use it all the time, and I'm trying to think of the guy's name. You're hitting me with all these -- I should know the names. He's a professor of radiology at Harvard, and it's the bible that we look at in terms of radiologic imaging or neuro imaging in children. I can get it to you later, but it's sitting on my desk at the office.
Q Is it, you think, reasonable to rely upon, for example, those two textbooks that you have just testified about?
A I think on that particular issue, yes. I mean, generally speaking there's also many articles and review articles that look at subdurals that will list or publish some of these same lists. I did not create this list.

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It's an amalgamation of textbooks and articles.
Q I think you testified earlier that, for example, birth trauma can cause subdural hematoma -- hemorrhages. Correct?
A Yes.
Q Do you know what the incidence of subdural hemorrhages, what that -- what the rate is, what the incidence rate is?
A Depends on what group you're talking about. So the group I think we're interested in, if I can add to your question, is normal term, asymptomatic infants. And the incident rate in that group is close to 30, 40 percent.
Q What causes I'm going to call it SDH in birth, subdural hemorrhages?
A So the prevailing theory is that it's a rent in the tentorium, because most of the bleeding of that type is in the posterior fossa of the brain. So as the head conforms either to the vaginal canal or if there is -- particularly if there's forceps or a vacuum that are used, there's a lot of forces on the head. And the tentorium is a membrane that separates the upper cerebrum from the cerebellum, and the prevailing thought is that there's forces that causes it to actually injure the blood vessels and bleed into that area.

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The same thing is true in C-sections, so C-sections aren't immune. Being a pediatrician, that's the types of deliveries we would go to, and they're not as benign as you would think. It's not just cutting the baby out. It does take a lot of force to still get them out, particularly since ladies like those small bikini cuts. Just saying there's a lot of force even in C-sections.
And I cite the literature in my report. And those are the three -- there's actually four now, but those are the three main studies that look at that.
Q Are you an engineer?
A No.
Q Are you a biomechanic?
A No.
Q Do you know what acceleration or deceleration forces are?
A Generally speaking, yes.
Q Do you know the units that they're measured in?
A I probably could think about it. At one point I wanted to be a physics major. I read these articles all the time. I would have to think about it to tell you. So, I mean, you can either have linear translational units or you can have angular translation units. So meters per second or I can't remember what the

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angular velocity terms are.
Q Do you have -- you used the word "severe." Do you have a magnitude at which measurement or unit that acceleration or deceleration is severe?
A No. I mean, I have no doubt they exist, but I don't even play the numbers game.
Q Can this acceleration/deceleration occur in a fall? Can you have forces in a fall?
A Yes.
Q And how far of a fall, if you know, would be a severe fall?
A Generally in the literature severe fall is more than two stories. You can talk about all injuries and say 4 feet is about a number that is often cited. And I put the general survey of all of that literature at the end of my report.
Q So just, if you don't mind, what is the basis of that opinion that you've just given? What is the literature that you're relying on?
A So Chadwick, David Chadwick who, again, was an intern of mine at San Diego, has spent his career looking at falls and fall studies and how can we put that. His summary -- and I can't remember how many studies that it was an amalgamation of -- looked at all the possible ways of heights, falls, and correlations with injuries. And I

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believe the common correlator that comes out of that is that we don't expect any life-threatening injury under 4-foot falls.

Q Would you agree that falls also have a rotational force?

A Some do.

Q A fall as described in the history by Jeffrey Havard, would that have a rotational force?

A No.

Q And why not?

A This is a baby who is being held. I mean, so we've got a man who is five-foot-nine holding an infant who is reaching for this towel we're talking about inches before that child -- if the child's head even hit the tank of the toilet. He then is very clear to describe that he's grasping this child. That's also slowing this child down. And the child is sliding. And even if the child fell, we're talking about less than 2-foot fall onto a carpeted surface. Every day I deal with people that have much more significant falls, and there's no significant injuries.

Q And I believe you just testified to this, but does it matter the surface upon which the child hits?

A To some degree, yes. Overall in this low thing, no. So most of the studies that we look at that

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are witnessed fall studies have linoleum over concrete, so you can't get much harder surface than that.

Q Taking everything as equal, would you rather drop a child on the shag rug or on a toilet, on a porcelain toilet?

A Obviously the shag rug.

Q What is your understanding of the Hall study that's referenced on page 7 of your report?

A Hall was an attempt to characterize fatal falls. It was published in 1989 or so. I didn't cite it. I was just merely responding to one of your pathologists who cited it. It's often cited as evidence that short falls can kill children. Unfortunately, the histories were not validated in any of those cases.

In fact, that was the predicate of my mentor, David Chadwick, for saying, hey, let's do this study -- and I cite that also in mine -- let's take everything, let's not do any validation whatsoever on the history that's given, and let's see what's the incidence of short-fall deaths. Very interesting, it came up to be seven times that of a high-fall death, which you can draw either two logical conclusions: one is that there are some extraordinary forces in short falls, which I think no mechanical engineer would ever agree with; or someone is lying to us.

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So when we look at old studies like that where they don't do validation or some other mechanism to test the veracity of the fall and we're saying the kid died from a short fall, that's an injustice. That's a misuse of the literature.

Q So you're critical of that and their lack of investigation.

A I am. And so -- I mean, you can pick up any reputable review article on falls, and they'll be critical of that study.

Q What do you believe the researcher should have done to verify the stories?

A Well, first off, you don't publish unverified things. That's one of the biggest pet peeves we have is people that will publish what somebody says without any independent way of verifying it, and that leads to potential erroneous conclusions. I mean, it litters the literature. Particularly if our biomechanical engineers are to apply their research to real world, then you've got to mimic real-world data. And if that real-world data is corrupt, then your numbers are going to be corrupt also.

So how can you do it? So the proposal of my mentor was let's use scenarios where we know that kids fall all the time: daycares. Let's put in cameras.

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Let's only publish cases that have the highest fidelity of knowing what happened.

And I'm not saying we can't consider and look at and certainly there are cited other cases of a short fall, but for example, the case where this child is sitting down and falls backwards dead, there's something wrong with that case, and we're going to publish that simply on the word of a five year old. And that was one of the cases that was also cited by one of your pathologists to support that short falls kill. That's one isolated case.

And yet, we look at Chadwick's work that shows that, I mean, we look at thousands, millions of falls. And you can even use one of the cases that you cited of Plunkett, although not totally applicable to the infant age group, short falls are rare causes of death when you have a witness structure to it. So that's the critique of that particular literature.

Q And if you were going to submit this literature in a report, is that what you --

A Design a study?

Q Is that what you would do?

A If I would design a study?

Q Yes.

A Well, then you use your criteria to -- I mean,

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if we want to inform -- and that's what research is supposed to be about, what is the real world -- then you're going to design a study that has fidelity on those things which you have the least control over, and that's the history. How can we do that? Well, if you look at the history of fall literature, let's put it in context, such as hospitals where there are witnesses that are not familial, not related. And there's a whole body of that literature which shows that almost no injuries really occur, and some of these are very significant falls onto linoleum over concrete. Use of cameras, again, as a way of doing that to help understand those types of things.

And I think that if you -- and that was cited in your case, and I don't disagree. So Case No. 5 in Plunkett was a video of a child falling off of a playground, you know, 4, 5 feet, hitting the head, and having a large subdural. No relevance to this case, but that informs us, that tells us what types of things can happen and what we need to be careful about. Believe it or not, we do try to get it right.

Q Dr. Benton, do you have an opinion about what specifically happened to Chloe Britt?

A I believe that she was abused. I don't know if there was intent behind it. Probably not. In most of my experience, there was probably some frustration. As I

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analyzed this case in light of -- I take histories from all these families. I mean, I've been doing this for 20 something years. I don't understand a man that, as I read in these descriptions, who's got an infant who is tucked into a swing, why does he respond? I mean, he says in his own statement, "I'm going to leave this baby alone for five minutes," and then does some fairly invasive things that he's never done before and admits to never having done before.

Somehow that child, in my opinion, irritated him, and the injuries occurred. And the injuries are multifocal to the head, the face, the anterior thighs, and the chest. I typically don't think we see CPR causing bruising to the chest, but I'll even allow that one away. Then we have the rectal mucosa hematoma. I mean, all of this is too much.

Q Any more specific than that?

A I'm not sure what that means.

Q Do you know what --

A Oh, exact --

Q -- he hit -- yeah, the instrument or --

A No --

Q -- the anything?

A -- because the pattern is not there. I mean, sometimes we will see -- for example, let's say that this

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was so severe he hit that toilet lid on the head. There's no linear pattern or a corner pattern or anything that I can say, okay, I can match that to that. So all the bruises did not have a pattern to it.

MR. JICKA: Are you doing okay?

THE WITNESS: I'm fine.

MR. JICKA: Okay. I'm not sure I am. I may take a break in just a second.

Are you okay?

THE REPORTER: (Nods head affirmatively.)

MR. SMITH: Before we proceed, can we go on the record and just identify everyone who's in the room? And I'll begin. Brad Smith, Special Assistant Attorney General. And?

MR. WHITE: Marvin White, Special Assistant Attorney General.

MS. IVANOV: Caroline Ivanov, attorney at Watkins & Eager.

MR. VAN EE: Chris Van Ee, engineer at Design Research Engineering.

MR. CARNER: Graham Carner, attorney for Mr. Havard.

MR. JICKA: And I'm Mark Jicka at Watkins & Eager for Jeffrey Havard.

MR. SMITH: Good. Thank you.

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BY MR. JICKA:

Q All right. On page 6 of your report, Dr. Benton, you said that the physical findings indicate two patterns, one of which is severe acceleration/deceleration trauma. Do you see that, that you later describe as whiplash motion?

A Yes.

Q With bilateral intracranial findings and absence of skull fracture and cerebral contusion.

A Yes.

Q What is the evidence of severe acceleration/deceleration injury?

A The subdural and the retinal hemorrhages. Well, to some degree even the subarachnoid bleeding.

Q Are you aware of national and international peer-reviewed literature that does not support the diagnosis that those are caused by severe acceleration and deceleration?

A Tell me who you're referring to. No.

Q What's the most common cause of traumatic brain injury in children Chloe's age, if you know?

A Six months old? Most common?

Q Most common cause of traumatic brain injury.

A Traumatic brain injury. Probably motor vehicle crash.

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Q How about falls, where would they --
A Way down the list. Unfortunately, motor vehicle crashes probably lead almost every list. We get all of them. That's how -- I see every unrestrained motor vehicle crash.
Q What do you do with those? Are they --
A We surveil them to make sure that we're not missing anything. I hate to tell you, but sometimes people do stupid things: They injure their kid, then they go get in a crash so they can cover up the injury.
Q I see.
A So we look for other signs that we may have a history that is wrong.
Q So every car wreck --
A We get involved.
Q You get involved with that comes to UMMC.
A We don't get as involved as the ones where they suspect abuse upfront, but we do double-check. We make sure was there a wreck, was there a crime scene report. So we call the police and make sure that it was notified. If that's true, then we back off.
The next thing is unrestrained. As you know, it's an illegal act in the state of Mississippi, although it's a misdemeanor.
Q So have you been involved in testifying in the

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prosecution of cases where a child was unrestrained?
A No, nobody to my knowledge has ever prosecuted a parent for an unrestrained death or morbidity in a motor vehicle crash.
Q Do you have an opinion on whether those parents should be prosecuted?
A No, I don't think they should be prosecuted. I don't know what the answer is there. I mean, to some degree prosecution sets a standard of -- we want to believe that by prosecuting someone we're creating a public health benefit, that people might alter their behavior. I don't really believe that.
Q You've given opinions about your skepticism about the history of the fall as described by Jeffrey Havard. Correct?
A I mean, my skepticism is based on the incompatibility of the totality of the findings and what he said happened. That's the basis.
Q Your opinion is not based on physics or biomechanics, though. Correct?
A No. Well, I mean, indirectly they are, but am I using mathematical formulas to arrive at that? No.
Q You haven't applied the science of physics or biomechanics to the Jeffrey Havard case. Correct?
A Physics obviously undermines everything -- or

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underlies, excuse me, everything that happens in life. I mean, that's the purest of the sciences. Well, mathematics is, and then physics is based on math. So I think that what we're saying is consistent with the science of physics, but no, we're not doing measurements or things like that.
Q Have you visited the scene of this incident?
A I have not.
Q So you've mentioned Chadwick many times today, and you cite his paper from 2008. And you describe it as an excellent meta-analysis of false studies. Is that --
A I cited two studies by him. So 1991 and 2008, and yes, I do think it's an excellent meta-analysis.
Q Are you aware of the serious statistical criticisms of his conclusions?
A I have heard that there are criticisms, but I have not actually seen them.
Q Do you make a diagnosis on the basis of probabilities?
A Sure.
Q Couldn't Chloe have suffered a fall in this situation, in this incident?
A Yes.
Q Are you aware of the AAP 2009 -- I'm going to get this wrong, the American Academy of Pediatrics?

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A Correct.
Q I will learn someday. Of its 2009 position that changed the term shaken baby to abusive head trauma?
A Yes.
Q Would you agree that that is a substantial change that took place by the AAP?
A It's a change in words, yes.
Q Are you aware of a recent Swedish publication verifying the lack of correlation between the typical triad and shaking?
A I am aware of the Swedish publication, the Swedish study. I would not agree with your conclusion that it verifies a lack of a triad.
Q Have you reviewed that study?
A To my knowledge, that study hasn't been published in English, but we have disseminated on our list a Google translate version of it. There also was a preliminary publication that just happened in January that was in English, and that has been reviewed, yes.
Q When you say we have disseminated on --
A It's the royal we, but it's the Helfer listserv. These are all these individuals that I told you that we're all vested in looking at children who are suspected of being abused and neglected.
Q Are you aware of multiple court cases where

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judicial action has precluded the use of the traditional triad diagnosis for shaken baby syndrome? Are you made aware of court findings throughout the country that have occurred recently?

A I know of no specific court things. I have heard that there is a defense that is being promulgated to both preclude that sort of testimony and use it as defense if there is an argument that certain findings reflect abuse.

Q Do you know what it means for a report to be peer reviewed?

A Yes.

Q Does anyone review your opinions? For example, did anyone peer review your opinions for purposes of quality of work or your findings in the Jeffrey Havard matter?

A How can I say this? So we have quality review, which is not subject to discovery or discussion, and I can't answer yes or no with respect to this report or any other report.

Q There's a secret review of this?

A Again, under the state statutes, quality review is permitted, and it's done without discovery. And yes, there is a quality improvement project. I can't speak to a specific case, and I won't use it to bolster my

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statements nor -- suffice it to say, if someone is critical of me, then I'm going to change what I write, if that helps you.

Q Do you know the statute number?

A No, but I'm pretty -- Mark Ray at our University can cite it for you. That's true of every place I've ever been.

Q And let me --

A That's the only way to improve the medical process.

Q And that's -- because I asked you earlier if anybody else had done work on this case, you know --

A And I said no.

Q You said no. You said some people had proofread it.

A Correct. No one else provided substantive input into my thoughts.

Q Okay. But if someone with expert qualifications had reviewed this report, you're saying you can't tell me about it.

A That's correct. I'm saying I take ownership of this, and every institution you're ever going to deal with medically had a peer-review quality assurance process.

Q Who is on -- this is a general question. Who

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is on the peer review quality of reports at UMMC for the type of work you do?

A One of them is the Trauma in Morbidity and Mortality Committee, the other one is the General Morbidity and Mortality Committee, in addition to which, because there's no one else that does what I do, we're a party to a collection of individuals from California, Tennessee, New York -- I'd have to look at the list to tell you all the different places. These are coordinated out of New Orleans where they're stripped of all identifiers and submitted and it's discussed type of thing. So that's the external peer review.

Q Did this report go through an external peer review?

A I cannot -- I can't -- I'm prohibited from saying that any one thing did or did not go through that.

Q And I'm certainly not trying to fight with you. I just want to make sure I'm not missing the right question.

A No, and I'm not trying to mislead you. And I know what you're after, but I cannot.

Q Okay. The external peer review bunch from either New Orleans or California, are they other child abuse doctors?

A Yes. In my -- they're all child abuse -- all

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board-certified child abuse pediatricians.

Q Do you work at an advocacy center?

A No. I work with them, but I don't work at them.

Q Which advocacy centers do you work with?

A All of them.

Q And will you please give me the list of advocacy centers you work with?

A So there are 10 currently, 11 forming in the state of Mississippi. So going from the north to the south, we have one in Southaven, I don't recall its exact name; we have one in Lafayette County, that's in Oxford; we have one in Tupelo; West Point; none in the Delta; Pearl, Mississippi; Natchez; McComb; Meridian; newly developing in Biloxi, they don't have accreditation yet; and Gulfport. Does that add up to ten?

Q I didn't count, but it sounds like about ten.

What are the -- what's the purpose of these advocacy centers?

A So the Children's Advocacy Center was a movement that started out of Huntsville, Alabama, by a then U.S. Senator who recognized that there was not a uniform process in dealing particularly with sexual abuse. So it started off with sexual abuse, and it's still mostly dealing with sexual abuse of children. And

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this sort of arose out of some gross injustices or perceived injustices -- we can hash that one later, like the Martin Preschool trial -- and that people who had no training were interviewing kids. We weren't recognizing the developmental vulnerabilities of kids, et cetera.

So it started with that Senator who created a process is Huntsville and then spread throughout the country saying that we need to handle child abuse issues in a coordinated or multidisciplinary fashion. Mississippi was a little bit later to that movement. You'd have to look at the statutes, but it was put into the statutes I believe in the early 2000s that all youth court jurisdictions must develop a multidisciplinary team approach.

They decided to adopt the child advocacy model. The first one was in Hinds County, which has subsequently moved to Pearl, but it was in Jackson. And I'm not sure the order that -- I could guess, but I think the one in Tupelo was second and then Lafayette County. And I know the rest came later because I helped them to get their accreditation. So the others were before me.

So it is a nongovernmental entity that helps to coordinate CPS, law enforcement, prosecution, mental health, pediatrics, with the intent of providing best practices for evaluation.

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Q Is part of the responsibility of these advocacy centers to assist in the prosecution of child abuse cases?

A Since the DA is often involved on the multidisciplinary team, I would say yes. Since law enforcement is involved, I assume that they have probable cause that eventually could lead to a criminal action. CPS, no. The predominant there is to get to youth court and decide protection or custody issues. I can speak for mental health and myself, we are not vested one way or the other where the case goes.

Q Do you have any expertise in ophthalmology or the examination of eyes?

A Yes.

Q What is your expertise?

A So at Children's Hospital in New Orleans we had two pediatric ophthalmologists who did -- they're phenomenal. George Ellis was the president of American Academy of Ophthalmology, and they did not have time to see every single kid that we wanted them to see. So I asked them to train me in indirect ophthalmoscopy as well as I became their photographer.

So the entire stint in New Orleans I did all the ophthalmic photography. And because much like here, we didn't want to just see the ones that we knew or

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reasonably suspected had retinal hemorrhages, we wanted to see the cases where we weren't sure. Like all falls, we looked at everyone and photographed everyone's retina. They would come behind us and do their exam. But photography is tedious. I mean, it can take about an hour or two to get good photographs of a child.

Q Are you a pediatric ophthalmologist?

A No.

Q Did you rely on the eye findings in this case?

A Yes.

Q What were the findings?

A Bilateral severe multilayered retinal hemorrhages with folds.

Q What does that mean?

A So the retina is made up of ten layers, and to be simplistic, they are the rods and cones that we see with. And then there's the nerve layers that connect that back to the optic nerve. The retina is predominantly attached -- or the vitreous is predominantly attached to the retina at the optic nerve, which is what comes from the brain to the eye. The macula, which is the part of the eye that we see best with, which is usually just to the side of the optic nerve, and to the ora serrata, or the front most attachment of the retina.

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And depending where you are, it takes certain -- certain layers appear differently. So if you're in the rod and cone layer, you're going to look and it looks like dots and blots. It's funny because I just testified yesterday, that really is the medical term for it. I mean, the poor judge, I was giving him so many medical terms, I said here's an easy one: dots and blots.

There's also flame hemorrhages, so these are in the neurofibrillary layer, or in those layers that connect back to the optic nerve. So each different layer has different thresholds for injury. And then the folds occur where the attachment is to the vitreous to the retina, and it tugs on the retina and it separates the layers of the retina. And that's because of the strength of the vitreous attachment. It's equivalent in the adult world to retina detachment, but we don't -- we typically see what's called retinoschisis, not detachment, in young infants.

Q How did the retinal findings affect your opinions in this case?

A I think they were corroborative of an acceleration/deceleration force. And when you talk about retina folds, there's -- other than Pat Lantz's article which showed that crush injuries -- or at least one case

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in the entire literature crush injuries can also cause retina folds, we have not really found anything other than severe acceleration/deceleration that causes retinal folds.

Q Did you review the laboratory tests that were performed on Chloe in this case?

A Anything that was in the record that was given to me I reviewed, so if that helps.

Q As we sit here, what did you consider important that you reviewed as it related to laboratory tests?

A I don't recall. I did look at every laboratory test. If you have something specific in mind, I can either re-reference or answer the question.

Q Did you look at the slides? Did you look at --

A No.

Q -- any slides?

A No.

Q Have you reviewed any X rays in this case?

A My understanding there was only one X ray, that was a chest X ray, and it was described as normal. And no, I didn't review it.

Q And as we sit here -- and I don't mean to beat a dead horse -- are you aware of any other lab tests that you reviewed as part of your work in the Chloe Britt case? And you're welcome to look at your report.

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A I did write down. So yes, there was a arterial blood gas, a CBC, and a basic metabolic panel that I reviewed and made some notations.

Q Okay. What relevance or impact did that have on your opinions in this case?

A The arterial blood gas is important because the first presenting arterial blood gas is a fairly good predictor of mortality. So in this case the arterial pH was 6.58. Very rare to have anyone survive that presents with that pH. And the other subsequent numbers describe that the kid did not have any issues with the lungs being able to ventilate, but obviously had had a period of anoxia and acidosis.

The complete blood count showed that we're looking at the platelets, so that's an indirect indicator platelet and coagulation issues were normal. There was a slightly elevated white count at 12. Not too significant for a child this age. And a hemoglobin and hematocrit of 10.4 and 29.6, which for a six month old is about right for what we call physiologic nadir, maybe a little bit low.

The basic metabolic panel had multiple electrolyte disturbances, which would be typical for a child who is being resuscitated.

Q What is a differential diagnosis, Dr. Benton?

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A It is, I guess, in best terms the different possible explanations for a given finding.

Q What was your differential diagnosis of what happened or what was wrong with Chloe? Did you use that in this case?

A Well, so we went by finding, and I did list for you all the possible differential diagnoses for subdurals. You can almost use the exact same list for the eye, which is why I didn't make a separate list. Not quite the same list for subarachnoid hemorrhage. But generally when we see subarachnoid blood in concert with subdural, we're not dealing with a different pathology.

Q Are you aware of Dr. Hayne conducting any differential diagnosis of his opinions and work in this case?

A I don't recall.

Q Dr. Benton, in doing your work, in doing your differential diagnosis, did you have to rely on some of Dr. Hayne's findings from the autopsy or his testimony?

A Yes.

Q Does subdural hematoma require rotational forces?

A Mostly yes, not always.

Q And what is your -- do you have a medical reference for that?

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A So there are a lot of articles. I don't have any specific in mind. But so beginning way back in the 1950s we looked at various mechanical means of causing subdurals. Subsequently, there's been looking at various medical things. And that's how medicine evolves. So the differential list that I have here is reflective of the different things that over time have been shown to cause subdurals.

Q Do you think that biomechanics is an unreliable science in the interpretation of this case?

A Loaded question there with Dr. Van Ee in the room. No. I think it has challenges. I think that there is a future for biomechanical analysis. Our big problem is the one that plagues us in general: I can't go shake a living kid. I can't go hit a living kid and see what happens and do it with enough reliability and exactness in terms of forces.

So when we look at our biomechanical literature now, we're roughly stuck in the same thing that I'm critical about certain case reports with the history of people. You, as an attorney, know histories from people are frequently either inexact or unreliable or misinterpreted or flat-out lies. And somewhere all of that is mixed into our basis in which we come up with rules and measurements.

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

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

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

A Yes.

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

A Yes.

Q What is your understanding of that inquiry?

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

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

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

Q When was that inquiry?

A 2007ish, I believe.

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

A I don't think I said that here.

Q Do you agree with that?

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

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

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

A Defer, what does that mean?

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

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

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

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the time that it occurred?

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

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

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

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

A Yes, sir.

Q And when did that protocol come into effect?

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

Q That was my next question. Do you recall when

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

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

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

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

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pushing for this, to come to sort of a conclusion that this is as unscientific, it lacks merit and shouldn't be used to define child abuse. That I have a problem with, and so does the rest of my colleagues.

Q You would agree with me that this Swedish version of the SDU is not a fringe group. Correct?

A I agree.

Q The --

A But the --

Q -- what is your --

A -- I'm sorry, I'm going to add to that.

Q Yeah.

A The Swedish Pediatric Society has roundly condemned what has gone on as being tainted, as not being open, as not being part of the scientific process that we're used to, which suggests why. And I think you're going to hear more about this in the next ensuing months. So it becomes to take on a fringe when there's not an openness to the inquiry.

MR. SMITH: Do you need a break?

THE WITNESS: I'm good.

(Exhibit 5 marked)

BY MR. JICKA:

Q All right. Dr. Benton, let me hand you Exhibit 5, and I've given a copy to Brad. I'll give you

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just a second to look at that.

Maybe just to focus you, Dr. Benton, I'm going to ask you questions on the bottom of 415 beginning with -- you can look at the question on 18, but going from 415, 18 through the top of 416.

A Yes, sir.

Q This is the direct examination of Dr. Dar. Do you know who Dr. Dar is?

A If I'm not mistaken, that was the baby's primary care physician. I mean --

Q Sure --

A -- do you agree or --

Q -- yeah, no, I'm not trying to pop quiz you.

A No, I know, but I also know that you know the answer. There were three physicians in the emergency room. Dr. Dar was the primary care physician of that child.

Q The question was asked, "Why don't you tell us what you observed about the baby." You see that on 415?

A Yes, sir.

Q And it says, "Baby was being intubated." What does that mean?

A It's not very specific, but in my understanding, they're putting a tube into the airway.

Q Was --

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A You can intubate many things, but it's usually the airway they're referring to.

Q "Was blue around the mouth. Pupils were fixed. So I walk onto her...side first, and so I had this luxury of being able to look in her eyes because the rest was being done, and I said -- pupils were fixed which means -- which is a sign of brain dead." Do you agree, Dr. Benton, that fixed pupils is a sign of being brain dead?

A It certainly goes along with brain death, but we don't use it as a criteria for brain death.

Q Going on it says, "Pupils were fixed and dilated. So I look through her pupils and I see hemorrhages in her retina which means -- which is so very specific of this kind of injury." Did I read that correctly?

A Yes.

Q And the next question, "What kind of injury is that?" "Being a shaken baby. Retinal hemorrhages. Nothing else causes that..." Do you agree that retinal hemorrhages are only caused by shaking?

A No.

Q Would you disagree with this testimony from Dr. Dar?

A Yes.

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MR. JICKA: All right. Why don't we go off the record, and I will organize and try to complete your deposition. Okay, sir? Thank you.

(OFF THE RECORD 4:22 p.m.)

(ON THE RECORD 4:40 p.m.)

BY MR. JICKA:

Q Dr. Benton, I have just a few more questions for you, sir.

When you said that you had spoken with Dr. Steven Hayne over a period of time, have you discussed with Steven Hayne the Jeffrey Havard case?

A No, sir.

Q When you said that you reviewed the transcript of Jeffrey Havard regarding the history of the fall, what transcript are you talking about?

A My memory -- and perhaps it's not a transcript, but there are direct quotes, I thought it was a transcript, of his description of what happened. And I thought it was a custodial interrogation.

Q It's not on the stuff that you gave us, and I didn't know -- that we could find.

A Everything I have on that disk is all that I had, so it's somewhere in there.

Q All right.

A And I'm pulling those direct quotes. I might

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

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

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

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

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

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

CERTIFICATE OF REPORTER

I, LORI P. GALLASPY, Registered Professional Reporter and Notary Public in and for the State of Mississippi, do hereby certify that the above and foregoing pages contain a full, true, and correct transcript of the deposition of SCOTT A. BENTON, M.D., taken in the aforenamed case at the time and place indicated, which proceedings were recorded by me to the best of my skill and ability.

I also certify that I placed the witness under oath to tell the truth and that all answers were given under that oath.

I also certify that I have no interest, monetary or otherwise, in the outcome of this case.

This the 22nd day of March, 2017.

LORI P. GALLASPY, RPR, CSR

CERTIFICATE OF DEPONENT

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

_____
SCOTT A. BENTON, M.D.

Subscribed and sworn to before me this the _____ day of_____, 2017.

_____
Notary Public

My Commission Expires:

CORRECTION SHEET

I, SCOTT A. BENTON, M.D., do hereby certify that the following corrections and additions are true and accurate to the best of my knowledge and belief.

CORRECTION	PAGE	LINE	REASON

_____ _____
DATE SCOTT A. BENTON, M.D.

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

_____
Notary Public

My Commission Expires:

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