SUPERIOR COURT OF NEW JERSEY
LAW DIVISION: BERGEN COUNTY
DOCKET NO. BER-L-7773-12

MICHAEL BARTA,

Plaintiff,

-vs-

INFRASTRUCTURE REPAIR SERVICE, LLC, JOHN DOES 1-5 and ABC CORP 1-5,

Defendants.

ORIGINAL

DEPOSITION OF:

KEITH BENOFF

REVISED

TRANSCRIPT of the stenographic notes of the proceedings in the above-entitled matter, as taken by and before DEBORAH A. GAUGHAN, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, License No. X100687, held at the office of RABIN, FREMED & PRINCE, 700 East Palisade Avenue, Englewood Cliffs, New Jersey, on June 9, 2015, commencing at 1:50 p.m.

Job No. NJ2077027

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KEITH BENOFF, 700 East Palisade Avenue, Englewood Cliffs, New Jersey, having been duly sworn by the Notary Public, testified as follows:

EXAMINATION BY MR. MURGATROYD:

Q. Doctor Benoff, my name is Anthony Murgatroyd and I represent the Plaintiff, Michael Barta. I'm assuming you had your deposition taken before?

A. Yes.

Q. About how many times?

A. Probably 25 or so, I haven't really kept count.

Q. In the process of having your deposition taken, have you been given instructions before by other attorneys?

A. Yes.

Q. Are you familiar with those instructions?

A. Yes.

Q. Do you need me to go over all the instructions again?

A. Not necessary.

Q. The only instruction I want to make sure to emphasize, if you don't understand something, let me know. I don't want you going out a limb with

something you don't understand. Let me know you didn't understand. I'll be happy to rephrase it so you do understand. If you answer a question, I'm going to assume you did understand it and you answered truthfully and to the best of your ability. Do you understand my instruction?

A. I do.

Q. Have you reviewed your report in advance of today?

A. Yes.

Q. You did an examination, took a history, did some tests. Does the report contain all your opinions as a result of your testing?

A. Yes.

Q. Is there any new information you reviewed prior to today that wasn't available when you prepared your report?

A. I did see a couple of supplemental reports. I'm sorry. Mr. Kelly provided.

Q. Did any of your reports change your opinions in any way?

A. No.

Q. Does the report that you wrote--well, it's dated September 18?

A. Yes.

Q. Is your report dated September 18, 2014 the only report you've written?

A. Yes.

Q. Just a couple of general principles, would it be fair to say as a neuropsychologist you try to report fairly and accurately whenever possible?

A. Yes.

Q. When you administer a test do you administer according to the test manuals and protocols?

A. Yes.

Q. If you don't follow the protocols, would that affect the outcome of the testing?

A. It would depend on why. Obviously it could be to differing degrees depending how you deviated from instructions.

Q. Just for an example, if you're doing a delayed recall test and you do it too long after the protocol, could that affect the test result?

A. Probably not because the delayed recall is assumed to be not what the person will remember at say 30 minutes later, but not 32 minutes later as long as you don't do it too soon. It has no effect, 35 minutes or 40 minutes. It's still a very reliable

measure.

Q. You don't feel that doing it after the standard protocols could affect the outcome?

A. No. It shouldn't. That's why it's viewed as a stable, reliable delayed memory. Once it's committed to memory, it should stay there for an extended period of time. It shouldn't disappear after the next 10 or 15 minutes.

Q. How far from the protocol to the point where it would start to disappear?

A. I would be more concerned if 30 minutes to an hour passed, but under that it's not really a significant concern. In fact, if you look, just to prove this point, if you look at the test, for example, the logical memory test, they say that the delay should be given between--it can be given 20 to 30 minutes after logical memory.

One, the understanding being that there's no difference between 20 minutes and 30 minutes. There's latitude in terms of something like memory in particular.

Q. So to go back to my question. Try to stay within the protocols when they address a range like --

A. Yes. Sometimes there's reasons why you

can't, if the individual requires a break or individual takes longer than anticipated working on another task, it will conflict with exactly time of the delayed recall, but the understanding are these are approximates. They're not meant to be--something is administered at the second it's supposed to be administered. It's usually invalid. That's not the case at all.

Q. Going to the logical memory, are you aware of any written source, whether it be textbooks, articles or literature from of the manufacturer that says it's acceptable to go beyond 30 minutes?

A. I don't know of any specific citation, but that doesn't necessarily mean it doesn't exist.

Q. When you interpret a test do you try to remain consistent with the recommendation that the company that produced the testing manual or user manual?

A. Sometimes there are additional sources of information that are relevant. For example, the original normative data will come out, particular test will come out with updated information. They update the data. It will be to compare the person's test.

Q. Did you do any of the testing with

Mr. Barta? Did you go beyond what the test manual permitted? Did you do that with any of the testing you performed on Mr. Barta? In other words, did you go beyond any of the interpretation recommendations by the company that produced the testing manual?

A. Well, for example, on for the control oral Word Association Test and Boston Naming Test there is a group known as Mitroshina. They published a book a number of years back. I don't remember the exact date of publication. They did meda-analytic studies of a collection of a whole host of researchers who have administered and published today.

They sent the scientists together in one larger scale, one larger data set so to speak which also allows for adjustments in terms of age and education and perhaps according to many a more accurate read on a person's level of performance. I tend to use the Mitroshina data in terms of evaluating someone's performance rather than the Bototan data which came out many, many years ago.

Q. Is there any other test where you went beyond what was in the testing manual to arrive at an interpretation?

A. Well, let's say for the Ray Complex

Figure Test. There's some newer data that's come out that I used, not the original from the 1940's. I don't remember when the original rate figure originally came out. I've used the Perdue Peg Board. That's been updated, the data for the Perdue Peg Board test, the Trailmaking test and I think that's it.

Q. What's the updated data on the Ray Complex Figure test?

A. I forget the name of the authors. It's a man and a woman. I forget their name, but they also much more recently published normative data. Again, the idea to get cognition can change with time. The idea is to get an accurate representation based on currently available data, not based on old data. It's doesn't mean the test was administered differently. It just means the scores and interpretation changed slightly with regard to the population as a whole.

Q. Did you use that data in interpreting Mr. Barta's testing scores?

A. Yes.

Q. As well as I should refer to the Trailmaking for that?

A. Mitroshina for -- -

Q. For Ray Complex Figure test?
A. I forget the authors of the book. I can locate it if you want to get it on to the attorney later.
Q. For the Boston Naming Test?
A. Also from the Mitroshina.
Q. And control test?
A. Controlled Oral Word Association Test, yes.
Q. I think that is what you first mentioned?
A. Yes. That's in the Mitroshina book.
Q. Is there any other testing you did where the scoring or interpretation was done not with reference to the manual but with reference to some other source?
A. No.
Q. Have you offered any opinions that are in conflict with any of the test manuals?
A. No.
Q. I want to ask you a question about your opinions which are on the bottom of page 14 on to page 15. You say "People with MTBI" I guess for purposes of being shorter, mild traumatic brain injury?

A. Concussion.
Q. For purposes of people with that, they typically recover within six to nine months?
A. Yes.
Q. So in that statement can we assume some people do and some people don't?
A. There is a small minority of people who either on testing or by report do not present as having fully recovered.
Q. Do you know what that minority percentage is?
A. It varies study to study.
Q. What's the range?
A. I've heard estimates as low as 5% and estimates that go as high as 14%.
Q. You have no way as a neuropsychologist to predict who's going to fall in that minority; do you?
A. Ahead of time you mean?
Q. Yes.
A. No. There would be no way of knowing.
Q. Are you familiar with the statistical analysis done on any of studies? For example, what the age groups are, what the sexes are, what part of the brain was injured, anything like that?

A. It varies study to study. The adult population, both male and female has been widely studied.

Q. But as you sit here you're not cognizant of any particular test of what the group consisted of?

A. I'm not citing any opinions based on individual studies.

Q. Your other opinion, you gave objective measure performance validity scores were consistent both with exaggeration and non-exaggeration of cognitive deficits. What objective testing are you referring to?

A. Green's Word Memory Test.

Q. Anything else?

A. That's the objective test. There are multiple scores that come out of the word memory test.

Q. When you say exaggeration, are you saying Mr. Barta was dishonest with you?

A. No. I'm not saying that at all.

Q. Did you ever feel he was trying to mislead you in some way?

A. It not my impression he was intentionally misleading me.

Q. Or engaging in symptom magnification or malingering?

A. I wouldn't say any evidence of malingering. His performance on the word memory test was consistent with sort of inconsistent degree of effort over the span of the evaluation. Times he was better able to apply himself, sometimes and he applied himself less.

Q. The Green Test is not a malingering test per se or is it an effort test?

A. It measures effort.

Q. Are you aware of any journal articles that are critical of the Green's Word Memory Test?

A. There are journal articles that are critical of every psychological test.

Q. I'm asking about that one.

A. Along with every other test that I administered, yes.

Q. Have you read any?

A. Yes.

Q. What is the general criticism?

A. One of criticisms that I've heard lodged at it is that there are select researchers who have felt that it identifies more people as exaggerating than it should.

Q. High false-positive rate?
A. That is a criticism that a number of people have lodged, yes.
Q. Do you know what the false-positive rate is for the Green's Word Memory Test?
A. Not off the top of my head.
Q. What would you consider a high false-positive rate?
A. It's occurring more than about six or seven times out of a hundred. That's a little too high.
Q. Were you aware that the Green Word Memory Test is a self-published test?
A. Yes. I'm aware of it.
Q. When you did the Green Word Memory Test did you require Mr. Barta to use a computer?
A. That's the standard administration of the test.
Q. Do you know what his level of experience is with a computer?
A. It requires no expertise with the use of a computer. It's successfully used with people of any age or background. It requires no computer skills or knowledge whatsoever.
Q. In whose opinion is that?

A. It's, first of all, it's the opinion in the manual and the literature. It's also based upon the fact that when the test is administered the examiner is present during the beginning to ascertain that the directions are clearly understood and the initial responses are being responded to with an understanding of the directions.

Q. What directions did you give Mr. Barta at the beginning of that test?

A. Well, at the beginning there are two phases where you're looking at the words on the screen so he was instructed to sit and observe the screen and do his best to remember the pairs of words as they presented on the screen, self-pace test.

Then the words appear a second time, then for a third time. I either offer, if the person requested, I offer to click on the response for them. I can manipulate the mouse and click on whatever they verbalize or point to as the response or if they feel comfortable, they themselves can use the mouse or touch pad and click on the target responses.

Q. Did you give him any instructions other than what you just indicated?

A. Only for the latter portion where you're not doing the forced choice recognition, where the

multiple choice recognition where you're supposed to choose from a list of options and the same response format in which as you're clicking on a word, but instead of choosing between two options, you're choosing between a list of options.

Q. Is there a standard procedure for the delayed time between the immediate recall which I'll call IR and the delayed recall which I'll call DR?

A. The standard is about 30 minutes.

Q. What would be the reason for having a standard delay time?

A. Again, we're looking ultimately at one's memory ability after a period of time has elapsed. It's the same basic principle as the memory test we discussed earlier.

Q. When you do a test maybe for this or just any test in general, are you keeping any records of the time sequences when you're starting a test and beginning a test?

A. I don't record.

Q. Recording starting and ending?

A. I don't record.

Q. Do you record any of the delay times?

A. No. I don't record the times.

Q. Now, is it acceptable to administer

other kinds of tests between the WMT, IR and DR portions?

A. As long as you're not administering anything that would provide inappropriate interference such as vocabulary test, it should be fine.

Q. Is it acceptable to administer a verbal memory test between those two portions?

A. Not a list learning test, but a story recall test would be fine.

Q. What would be the reason not to do a list test between the IR and DR portions?

A. Because the word memory test itself is a list task. You would have interferences of two different lists that someone would be keeping track of. A story is different type of psychological construct.

Q. For example, you shouldn't be doing logical memory test if you --

A. No. Actually, you're hundred percent wrong in misconstruing what I said. You wouldn't do a list. If you read through the list of tests I administered or if you looked into logical memory. You would know that the logical memory is not a lists learning task whereas the California Verbal Test is a

list learning task.

Q. Are the California Memory Test and the Logical Memory Test both forms of a verbal memory test?

A. They are very different visual memory tests. As I said, the logical memory test is a contextural story recall test that does not recall list learning in any capacity. The California Learning is much more analogous to the Williams Memory test where information is provided to recall, very different constructs and there's no interference.

Q. What parts of the Green Word Memory Test did Mr. Barta pass?

A. The delayed recognition he failed on the immediate recognition and consistency measure. It's cautionary scores meaning they were on the threshold. They're sort of in between passing and failing.

Q. That was going to be my next question. Did he fail any parts?

A. There's no frank failure. We're seeing a fluctuation in effort over the course. I didn't say that he failed on any particular items in my report.

Q. Are you saying there is no failing score

for the Green Word Memory Test?

A. I didn't say that. I said he did not obtain a failing score. He obtained some scores with it being on the threshold which would be classified as less than optimal effort.

Q. What is a failing score?

A. 83 and a 1/2% which would be one more item wrong for both immediate recognition and consistency scores.

Q. And Mr. Barta's memory sub test profiles the MC,PC and FR are all consistent with somebody making a good effort?

A. They're reasonable, yes.

Q. Now, you used the word in your report exaggeration of cognitive efforts?

A. I said exaggeration of cognitive deficits.

Q. Are you aware of any written source, whether it be a textbook, journal, article or even a user manual that would allow you to use the word exaggeration of cognitive deficits given that he had not actually failed any portion of this test?

A. No. What I'm saying is that when there is fluctuation over the span of the administration of a test like this, particularly when it's a

consistency type measure from before and after where he did better after than before. What that is consistent with is at suboptimal. He did not consistently produce scores that were within the fully passing range. I don't know of a specific citation for that, but most opinions do not have a specific citation nor would I consider it appropriate to state a psychological opinion based upon one particular citation.

Q. Would Green in his manual permit the use of the phrase exaggeration of cognitive deficits for this type of score?

A. You would have to ask him.

Q. Have you read the manual?

A. I read the manual. You have to ask him. I'm not going to speak on his behalf, on the manual's behalf.

Q. Does he say anything in the manual about how you should report scores?

A. There is a discussion on reporting scores, but it's not limited to using exactly the manual's terminal. The user of the test is encouraged to interpret performance based upon the individual in front of you.

Q. Are you aware Green has recommended

terminology for interpreting scores in his manual?

A. There is recommendation in there, but that doesn't mean I have to quote him verbatim in my reports.

Q. The recommendation applies to someone who failed the tests?

A. There are recommendations in all directions to my knowledge.

Q. Are you aware a recommendation in a situation where somebody passes and has two scores that are cautionary?

A. Off the top of my head I do not know exactly what he phrases for each individual situation.

Q. I want to talk to you about the MMPI 2. Now, on page 13 of your report, the bottom paragraph you talk about how the MMPI 2 RF showed over-recording of physical and cognitive symptoms?

A. Yes.

Q. Direct me to specifically where you draw that opinion from on the MMPI 2 RF test.

A. The manual that comes with it.

Q. Well, I'm asking specifically what test results elevated scores on the FBS, but most specifically the RBS validity scores.

A. I said F as in Frank, RBS, but it's more the RBS than the FBS.

Q. What's wrong with the FBS?

A. It's just that the RBS is more elevated than F, that's more consistent with the exaggeration.

Q. So is anything inconsistent other than the RBS?

A. I didn't say it was inconsistent.

Q. What is it?

A. I said it's elevated score and elevated score on the RBS is consistent to that degree is consistent with over-report.

Q. What is elevated level for the RBS?

A. I would want to consult the test manual before specifically identifying the criteria because it varies a little bit scale to scale. When I author a report, I like to check to make sure I'm getting the interpretation right.

Q. Do you have something you where you can check that?

A. I have the manual in the record room.

Q. For now let me assume you're right and it is elevated. I think elevated 80% raw score?

A. There are gradations. It's not a binary interpretation of yes-no. There are gradations of

elevation.

Q. I'll give to you for now that's an elevated score. Aren't you overlooking all the other over-reporting scales?

A. No. I'm saying I'm reporting by definition. I'm reporting one thing that is elevated. I also stated in my report if you read it carefully that Mr. Barta's profile is valid and reliable in the main. The obvious conclusion to be drawn from that, he did not produce a report that a profile that is unreliable or invalid as a consequence of other validity concerns.

Q. The RBS is a scale that people use to determine cognitive memory, correct?

A. It is one of the uses, yes.

Q. And all the other scales, FR and FPR, FS and FBS is all tests of over-reporting of emotional, psychological and cognitive measures, correct?

A. Yes.

Q. Where in the manual are you permitted to draw the inference that somebody is over-reporting physical and cognitive measures based on that, this one, RBS?

A. RBS is more than memory, more broadly used. Most of these have validity is a little more

broad than you're making them out to be.

Q. I don't think that's an answer, Doctor.

A. What I'm saying, RBS is not exclusively limited to memories. You asserted a moment ago the question that is tapped moves beyond memory. They also speak to psychological state.

Q. Are you aware of any written source, whether it be any treatises, textbooks or the user manual itself that would permit you to draw the conclusion that someone is over-reporting physical and cognitive symptoms based solely on an elevated RBS score?

A. The RBS is a newer measure that is not in the manual. A lot of literature is coming out on it now. Basically it's not in the manual so I can't reference it from there. In particular, I'm not going to give a specific citation for the RBS. I do not have that on my fingertips.

Q. Well, when you wrote that opinion other than your personal opinion, what are you relying on?

A. As I said, I'm aware of the literature. I don't have the specific author and date of publication. One can be aware of a concept without knowing exactly when a concept was published.

MR. MURGATROYD: I'd like you to produce

that literature for Mr. Kelly.

THE WITNESS: Feel free to get the motion in.

MR. MURGATROYD: I'd like to know where you're getting that.

THE WITNESS: Feel free to get the motion.

MR. KELLY: Make a request.

MR. MURGATROYD: I'll write a request.

Q. Now, the RBS scale, do you know what the testing population for that was when they released that scale?

A. It looks at a variety of people not limited to one specific little sub-group.

Q. Did they test people with head injuries?

A. I believe they tested some people with head injuries, but there were some other studies that looked at people without head injury, also, people with general medical conditions. There were probably some people that were just in the healthy population as a whole.

Q. Do you know if the predominant group of testees were not head injured?

A. It varies article to article. There isn't one article on it is what I'm trying to say.

Q. Are you aware of any articles where the majority of the population tested were people with head injuries?

A. Again, I'm not going to be able to give you the name of a specific author who commented on a particular sub population with the RBS. That's something I have to research and produce a citation.

Q. Are you aware of any other possibilities for elevated RBS score?

A. Well, certainly if someone is exaggerating cognitive deficits, that's one common explanation. It's possible that there could be inconsistent response. It's possible that someone is just being non-compliant in a general sense, but I don't believe that was the case with Mr. Barta.

Q. Is it also possible the person could have a substantial emotional dysfunction?

A. Sure. As I said earlier, someone with psychological symptoms or features may have elevated score which is why I referred to that in my report.

Q. Somebody with substantial emotional problems that are credible?

A. It's a possibility.

Q. Would that possibility be strengthened by Mr. Barta's score on the cognitive scale?

MR. KELLY: Note my objection to the question with standards and possibility.

Q. The cognitive scale on the somatic cognitive.

A. You're trying to boot strap a validity scale with cognitive scale. That would be inappropriate double dipping. I would want corroboration from something secondary to this.

Q. Like, for example, the user manual?

A. No. An entirely different test information in medical records, someone's daily functioning, variety of things. I wouldn't want confirmation from a clinical scale. That's not how we do with things. We don't use a clinical scale to bolster a validity scale. That's not how it's interpreted.

Q. Isn't a cognitive scale a measure of somebody's cognitive impairment?

A. Many of the items that fall on the RBS fall on the cognitive scale. They're not separate. Each item on the MMPI is not used only once. That's not how the test is used. You can't double dip and use one to prove the other. That's not appropriate.

Q. You never saw those two scales drawn together by any literature?

A. The proper way to use the scales is to use the validity for interpreting clinical scale, not backward as you're suggesting.

Q. And on the validity scale all the measures of over-reporting physical symptoms, psychological symptoms, emotional symptoms through the F scales are all appropriate, correct?

A. Well, as I just said a moment ago, the RBS also has a degree of psychological overlay. It is true that elevated scores were not found on other scales such as F, FP and FS. That doesn't mean there wasn't an elevated score on the RBS which can represent an over-report of cognitive and to a degree psychological symptoms and complaints. That's the proper interpretation of the scale.

Q. Aren't there also a consistency portion of the scale, correct?

A. Which scale are you referring to?

Q. Actually, this test doesn't have CNT.

A. Actually, you're wrong. The VRIN and TRIN are consistent.

Q. He did fine on those?

A. Correct. Which is why I didn't assert he was inconsistent in his response.

Q. Well, what draws you to the conclusion

that Mr. Barta over-reported his cognitive and physical symptoms?

A. The RBS score as we talked about.

Q. I was not finished. If you don't look at it in conjunction with what he actually reports as his cognitive symptoms --

A. The RBS was not meant in terms of perfectly healthy individuals. The RBS is with the understanding that there were people incorporated who not only had no major medical conditions, but it also considers those with genuine medical conditions which could include something along the lines of what he's experienced, his headaches, pain and concussive type symptoms.

Q. What are the somatic cognitive internalizing scales? What does that display for us?

A. The somatic and cognitive, it's a constellation of symptoms that are reported by a person referring to as you can see from the bottom malaise, gastrointestinal complaints, head pain, neurological complaints, cognitive complaints. Basically it's a constellation of symptoms that are reported by a person.

Q. Fair to say Mr. Barta scored pretty high on all those scores?

A. That's not correct. His gastrointestinal was very low.

Q. Except gastrointestinal, I was talking about the cognitive issues, malaise, suicidal, helplessness.

A. No. It's not very high. Those are elevated scores.

Q. They're elevated?

A. Elevated does not mean very high.

Q. You selected elevated RBS to arrive at an opinion, Doctor?

A. Correct.

Q. Why aren't they important?

A. Because what the elevated RBS tells you is that there is an over-report of a variety of the symptoms and complaints such as this. What I did not say in my report is that they are to be ignored. I just said you have to interpret the scales with caution, given a tendency to over-report symptoms and complaints.

Q. You chose to override the F scales in arriving -- -

A. I did not override anything. In fact, I referred to his profile as reliable and if he had validity on the F scales, I would have to report it.

Q. When you use the word over-reporting, are you trying to say that they're not real to Mr. Barta?

A. No. I didn't say that at all. I just said he's endorsing an exception. The high number of these symptoms and complaints, that's what over-report is. I'm not speaking to his truthfulness. I'm not speaking to the genuineness of the complaint. That would be for a physician to comment on.

Q. What's the Ray Computer Test?

A. There is no Ray Computer Test.

Q. The Ray Complex Figure Test?

A. Visual memory test.

Q. Does that test also measure cognitive memory?

A. I don't know what non-cognitive memory.

Q. What does the Ray test?

A. It measures visual memory. That's why it's a figure.

Q. Give me an example or explanation.

A. Well, the Ray Figure, the first phase of the Ray Figure is where you copy a complex figure and then several moments later you're asked to draw from memory whatever you recall and then after a delay you draw whatever you recall. There are three phases to

the Ray Complex Figure Test.

Q. Is that test used as a test to detect effort and truthfulness?

A. No, not generally. There's the Ray 15 Item Test. That is a totally different test.

Q. What is that test used to measure?

A. That is one of the tests that are available for effort.

Q. Did you administer that test?

A. I choose not to because the data is not very good on it.

Q. What are the parts of the Ray test that you administered?

A. As I said, you're confusing two different things. The Ray 15 Item test is one effort test. The Ray Complex Figure test is an entirely different test. That has nothing to do with the Ray 15.

Q. You did the Ray Complex Figure test?

A. That's correct.

Q. Break that down for me. What do you do there?

A. The first phase is the copy where the individual is asked to copy the figure on the page in front of them. Then the second phase is immediate

recall where after a delay of several minutes, they're asked to draw from memory whatever they can, then later after a delay they're asked to draw from memory whatever they recall.

Q. A copy and IR and DR?

A. Yes.

Q. What's the standard delay time between each of those tests?

A. About 30 minutes, 30.

Q. Between the copy and IR and DR?

A. No. There's no 30 minute delay between the copy and IR.

Q. It goes right to the IR?

A. No. Usually there's a delay of a few minutes in between.

Q. Do you know what that delay should be?

A. A few minutes, several minutes.

Q. Can you give me an estimate?

A. Three or four.

Q. And between the IR and DR portions?

A. About 30 minutes.

Q. Again, I guess the reason you want to adhere to that, what we've been discussing in general delays between IR and DR portions?

A. Again, the--again it is not with it

being too long afterward unless you truly have blown away past the 30 minute time frame. The idea would be not to give it too soon, then it's not really a measure of delayed memory.

Q. Do you know what the delay time was when you tested?

A. As I said earlier, I don't record the times.

Q. You don't remember?

A. Not offhand. If I didn't record it, I don't have a specific memory.

Q. We talked a little bit about the logical memory wherein you're testing. Do you generally put that particular test--there's two parts. Where in your testing would you normally put the last part of that? Do you do that whole one and two together?

A. Sometimes yes, sometimes no. It really depends on the individual, depends on how rapport is developing, depends on how the evaluation is moving along.

Often I give the logical memory in the same general time frame as the Ray because there is that delay of between 20 and 30 minutes for logical memory and there's a delay of about 30 minutes for the Ray Figure. I often use that as a way of doing

before and after so I can roughly time them to the same time frame.

Q. Do you know whether you did them together for Mr. Barta or whether you broke them up?

A. I don't record exactly what degree they were together. Usually they're in minutes of each other, but I don't recall exactly for Mr. Barta.

Q. Do you typically do the test?

A. Again, it fluctuates a little bit based on the needs of the individual and how rapport is unfolding. Usually the logical memory and Ray Figure are earlier in the evaluation. That's the best I can tell you.

Q. We're not talking about the Ray test, talking about the logical memory.

A. Both the Ray and logical memory are administered. The first portions of it are usually administered within the first 20 minutes or so of the testing. The delay is after the delay.

Q. Anything wrong with doing all or part of it at the end of the testing?

A. As long as someone is getting appropriate breaks they're offered and they're maintaining their ability, it shouldn't really matter when it's given.

Q. I'm going to go now to your last point which is the reduced performance relative to previous testing not characteristic of MTBI?

A. Yes.

Q. What tests are you referring to in particular when you refer to previous tests?

A. Well, I refer when Doctor Mack tested Mr. Barta during November of 2013, he had higher levels of performance. They were low average scores for the immediate and delayed recall of contextural memory which is the logical memory test and he had a low average score on confrontational naming and average score on a verbal fluency test relative to my evaluation.

Also, the issues when comparing Doctor Tennyson's evaluation to mine. Doctor Tennyson, she elevated Mr. Barta during January of 2012 and she found low average to average scores for timed phonemic fluency and a low average score for confrontational naming. Whereas I had lower scores at this point in time.

Q. What would the test be for phonemic fluency?

A. That's controlled oral word association test. They may have used different, but they work

basically the same way. You give a letter and you ask someone to generate as many words as they can think of. Again, the letter aside from pronouns.

Q. Did you note in your report there are areas where Mr. Barta improved?

A. No. Because that wasn't relevant to the point. It was a discussion. The point I was addressing, not typically for someone to decline from one point in time after a mild traumatic brain injury or concussion to some later point after a concussion. That pattern of decline is much more consistent neurodegenerative process. Whether it was a neurological disorder such as multiple sclerosis or Parkinson's or some dementia type condition. That's not typical for a concussion.

Q. Is that the only reason?

A. Yes. That was the point of that bullet point.

Q. Can someone's depression account for reduced test results?

A. It's one possible explanation. It is my understanding the levels of depression were comparable.

Q. You did note several times in your report to diagnose Mr. Barta with depression?

A. I didn't say he had no depression. What I'm saying, he had depression earlier on too. It's not as if he spontaneously expressed depression right before I evaluated him. He was depressed when Doctor Tennyson evaluated and he was depressed when Mr. Mack evaluated him.

Q. He scored elevated on some of the symptoms that would indicate depression when you tested him; didn't he?

A. When I tested him, his score on indices of the MMPI that measured stress and worry was not elevated. A score for anxiety, anger, pronice, behavior, restricting fears, multiple specific fears, inefficacy, all of which can be tied into depression and those were not elevated.

He also didn't elevate on measures of social avoidance, passivity, shyness, dysafeltiveness. Again, those are all sensitive to depression. He did not elevate on those scales. It is possible that he is experiencing a degree of depression, but it's not as if this man is profoundly depressed and completely incapable of functioning on his own report on MMPI.

Q. He did elevate on suicidal death ideation, helplessness, hopelessness, self-doubt and

stress and worry?

A. He elevated. His score on the suicidal ideation was based on one item response. Any psychologist will tell you who is knowledgeable of uses you cannot make a diagnostic impression based on one item. The suicidal ideation scale is intent on finding anyone who is endorsing a symptom like that. We have a very low threshold for elevation on that.

With respect to the self-doubt scale, his score was exactly on the margin where many people would not consider that. An elevated T score of 65 would be consistent with about 15% of the population reporting that. That's not an off the chart elevated score.

Q. Doesn't the test create or consider 65 elevated?

A. The test creators may, but that does not mean it's uniformly accepted among psychologists. Anything over a T score of 65 is considered elevated. One would be inappropriate to treat a T score of 65 the same as 75 or 85. One is far more elevated than the other.

Thirdly, elevate does not mean the person is more depressed whereas the higher you get on the T score the more depressed. That's not the

proper interpretation of the T score. What it means is their response pattern is consistent with a depressed profile so a T score of 90 does not mean someone is more depressed than someone with a T score of 60 or 65 I should say. That's a misinterpretation of the T score.

Q. When you take together the history and I can go through your report and identify all the doctors who diagnosed him with depression, you combine that with the scores he got with you on the validity test, would it be fair to say Mr. Barta exhibited signs of depression?

A. I think it's fair to say he exhibits signs of depression. It would probably be classified as adjustment related response to the physical symptoms he's experiencing. I didn't say he has major depressive disorder. What I'm saying, he probably experiences some symptoms of depression. There's a big difference between them.

Q. How does depression affect somebody's test scores?

A. It can. It doesn't necessarily affect someone's test scores. It might have the net effect of reducing some scores. It's not automatic or inappropriate to conclude just someone is

experiencing signs of depression automatically. It means they're going to under-perform on cognitive. There's a big, very big leap of logic.

Q. Let me ask you this question, isn't depression you said can come from the pain, from physical pain from a trauma. Couldn't it also be part of the normal sequella of mild traumatic brain injury?

A. I'm not sure what you mean. There are no normal long term sequella of concussion. That's what I'm trying to say. The large majority of people return to baseline levels of functioning.

Q. I'm talking about the people that don't. Can they develop depression?

A. They can.

MR. KELLY: Objection.

A. It has multiple etiology. There are a variety of things that can go on, changes in someone's life, maybe someone is having trouble with family members inter-personally, maybe a couple is divorcing, maybe someone has a complicated relationship with their children, maybe someone isn't sleeping well. There are a number of factors that could account for it.

Q. Sleep as well, correct?

A. Certainly sleep could contribute to depression. Absolutely.

Q. Did Mr. Barta share any personal tragedies with you other than the grinder hitting him on the head on the construction site?

MR. KELLY: Objection.

A. What do you mean by a personal tragedy?

Q. You said sometimes depression can come from personal tragedies?

A. Did I say say tragedies? I don't think I said tragedies.

Q. Circumstances?

A. What did I say? I'd like to know what I said.

(Reporter reads back.)

A. I didn't say anything about a tragedy.

Q. Can we agree on the word personal circumstances? I'm trying to sum it up.

A. I don't like being misquoted.

Q. I wasn't trying to misquote you, Doctor.

A. I believe you.

Q. I was trying to put an adjective on the list of things you mentioned.

A. It's a rather extreme one.

Q. Personal circumstances?

A. Tragedy.

Q. I'm going to go with personal circumstances.

A. Much better. Clearly, Mr. Barta reported that he has been experiencing a fair amount of pain in terms of his upbringing. He clearly struggled in school. He said he had trouble, "school was not for me" were his words so that could not have been simple for him. He reported that he and his wife divorced sometime between 2009 and 2013.

He reported having contact with his children most days, at least the sons most days, but he doesn't see his daughter more than once a week. He reported difficulty sleeping. Sure. It's entirely possible that someone could experience some symptoms of depression when they're having certain difficulties such as that, especially the pain.

Q. Well, you reviewed his medical records; didn't you?

A. Yes.

Q. Did anyone diagnose him with depression because of personal circumstances?

A. I don't know that anyone specifically--quite frankly, I don't think anyone specifically should have attributed it to one

specific source of origin. I'm saying it's a leap of logic to say that someone's depression is specifically attributed to a concussion. That's a very big leap in logic.

I would be comfortable saying that the pain and after effects of a concussion can certainly contribute to depression, but it would be inappropriate in this case to say it's specifically attributed exclusively to the concussion.

Q. You also mention sleep. Sleep can affect someone's test performance; is that correct?

A. It can. Mr. Barta reported that most nights he sleeps between eight and nine hours. He said occasionally he sleeps a few hours less, but most nights between eight and nine hours which is more than sufficient for someone to perform well on cognitive testing.

Q. You said in your report nights he sleeps three to four hours?

A. Correct.

Q. Did you note anywhere what he slept the night before your exam?

A. He didn't specifically say.

Q. Did you ask him?

A. I don't remember if I specifically

asked.

Q. You also mention pain from physical injury. Can we assume the pain from physical injury can also affect someone's test results?

A. If one is tested appropriately it should not directly have a major impact on their performance. That I mean if someone is particularly in pain, we frequently offer breaks throughout an evaluation.

We tell the person at the beginning of the evaluation to let us know when they can so we can properly set breaks or just offer spur of the moment. If feasible, the idea is to minimize the contribution. Can we say definitely it plays no role, but we do minimize the contribution.

Q. If somebody is having a bad headache, can that affect their test results?

A. It certainly can.

Q. Mr. Barta, did he report to that, he was having intense headaches?

A. He said he has intense, constant headaches.

Q. What do you do when you're testing someone in the middle of the testing or at some point in the middle of the testing they tell you they're

having bad headaches?

A. Well, it depends where you are. If you're in the middle of something that can't be interrupted, the idea would be to encourage the person, can we try to get to a point when a break is an option. Some tests can't be interrupted in the middle. It's the nature of the beast.

If it's possible to take a break, we take a break at that point. If not, we try to take a break as soon as possible. On the other hand, if somebody responds they're always having headaches, then it would never be possible to do an evaluation. Then we express our--how upset we are on their behalf. They have a headaches, but we're sorry, we need to proceed with the evaluation as best we can.

Q. Do you recall that Mr. Barta reported to you having any headaches during the testing and if so, what did you do about it?

A. I can't tell you what specifically I did. I can tell you customarily.

Q. We covered another way which is how the test is administered can also affect the results? We're beating a dead horse?

A. I would agree.

Q. Do you have an opinion one way or

another as to whether Mr. Barta suffered a mild traumatic brain injury as a result of his accident on July 29, 2011?

A. He meets the diagnostic criteria for having sustained a concussion, meets the criteria.

Q. Can you tell me how do you define traumatic brain injury?

A. There is no unitary traumatic brain injury. There are different gradations. Mild traumatic brain injury otherwise known as concussion, typically there are three different gradations. Even within that level, one to three, level one, there's no loss of consciousness whatever.

Concussive symptoms, they typically resolve within 15 minutes or less. With grade two there's no frank loss of consciousness, but the symptoms resolve later than 15 minutes. With a grade three concussion, we're talking about an actual loss of consciousness that is typically reported.

Q. When we talk about traumatic brain injury versus mild traumatic brain injury, mild doesn't refer to the consequences of the injury, it refers to the degree of consciousness that's lost?

A. It refers to the degree of consciousness, post traumatic amnesia, mental status

afterward. That's what it refers to.

Q. Are you familiar with the American Congress' definition of a mild traumatic brain injury?

A. Yes.

Q. Do you agree with it?

A. I don't have issue with it.

Q. Fair to say you don't have to hit your head? You can hit your head very mildly and still have a concussion?

A. Yes. As I said, something as simple as period of post concussive symptoms, feeling dazed or dizzy or disoriented for a brief or longer period of time. There need not be a frank loss of consciousness. There need not be open head injury so to speak. It does not have to be overly dramatic.

Q. There doesn't have to be amnesia?

A. No. There does not have to be.

Q. I used the word concussion before. Is concussion the same thing as mild traumatic in brain injury?

A. They're used interchangeably.

Q. And also with a mild traumatic brain injury you can have diagnostic studies like MRI's and CT's that are normal?

A. Yes. That would typically be the case for a concussion.

Q. In fact, it's more commonly true than not true?

A. If there's positive image or focal deficits on neurological examination, it's moderately TBI, not mild TBI.

Q. Normal Glasgow Scale and still have a mild traumatic brain injury?

A. One of the diagnostic criteria most of us use is 2 GS to 15 which is normal.

Q. Can you get your curriculum vitae? You are an adjunct professor at Rutgers?

A. Yes. I'm clinical assistant professor. That's a clinical appointment I have at Rutgers from UMDNJ through my work that I do at Kessler.

Q. Explain the relationship to me between everyone. UMDNJ or actually, Rutgers and Kessler because you made a connection that I didn't quite understand.

Kessler, the rehab facilities, particularly the inpatient facilities are training centers. They place students. Rutgers places their medical students from the medical and physical therapy from Kessler.

I'm a neuropsychologist at Kessler on per diem basis. I was appointed to clinical assistant professorship as a consequence of the work that I do at Kessler. I work with residents or fellows in the PMR department.

Q. So that means that you don't have to go to Rutgers on a regular basis?

A. No, I don't. My work is done. At Kessler occasionally I'll do a grand rounds or some sort of lecture. I can consult on occasion if the residents or fellows choose to consult me.

Q. Unlike a professor, you don't have a publication requirement?

A. No.

Q. How often do you go to the campus?

A. Kessler?

Q. Rutgers.

A. Not often. Usually the residents and fellows themselves come to Kessler. It's not usually the other way around.

Q. You're not teaching any classes?

A. It's a clinical professorship.

Q. With Yeshiva, you're adjunct professor at the University in New York?

A. Yes.

Q. Do you still do that?

A. I haven't been teaching this year. They're reorganizing a little bit. I haven't been teaching this year, but the appointment is technically still there. When I'm asked to come back, I'll happily come back and teach.

Q. Yeshiva or is that the Ferkau campus?

A. I teach at the Yeshiva campus in upper Manhattan.

Q. If you're not doing that anymore?

A. Not currently.

Q. When is the last time you were adjunct professor there?

A. The spring of 2014.

Q. I'm just looking at your publications. Your publications seem to all be related to visual impairments; would that be fair to say?

A. Well, with the exception of the duchenne muscular dystrophy, yes.

Q. So you don't have any publications on cognitive disorders or traumatic brain injuries?

A. Well, my publication such as compendium looks at the evaluation of various cognitive functions in people with low vision or multiple.

In other words, I was working with

people at Lighthouse to publish a manual how to go about the psychological and cognitive assessment of children with low vision.

Q. Have you published anything on the neuropsychological assessment of traumatic brain injuries?

A. No, I haven't.

Q. You have a hospital appointment with UMDNJ. Is that still --

A. UMDNJ became Rutgers. There was some degree of a merger where I think Rutgers took over. It's technically not UMDNJ anymore. It's Rutgers University now.

Q. Is that the position you have that is affiliated with Kessler?

A. Yes, it is.

Q. We talked about that already?

A. Yes, we have.

Q. So you're not making hospital rounds --

A. No.

Q. --at UMDNJ?

A. No, I'm not.

Q. Do you subscribe to any professional journals?

A. Yes, I do.

Q. What do you subscribe to?

A. I get the Journal of International Neuropsychological Society. I get Archives of Clinical Neuropsychology. I through a colleague I look at just because I'm not actively subscribing to it, but I look at issues of the Clinical Neuropsychologist and then there is American Psychologist from the American Psychological Association.

Q. Last one was Clinical Psychologist?

A. No. American Psychologist, it's from APA, American Psychological Association.

Q. You're a member of that organization?

A. Yes.

Q. I think the Archives of Clinical Neuropsychology is also a journal of a particular professional organization. Do you know which one it is?

A. National Academy of Neuropsychology.

Q. You're a member of that?

A. Yes, I am.

Q. You read when you get the journal articles from those publications we just discussed? Do you keep up on it?

A. I try my best.

Q. You consider them reliable?

A. I do.

Q. Do you hold a board certification in any area of neuropsychology?

A. That's a process under way. It's become much more common in the current generation of graduates to get boards as soon as possible. When I completed school back in 2000, it was a relative rarity. We get schooled in as practitioner first. I'm in the age cohort going through the process of getting the boards in place.

Q. You're working on the numbers?

A. The hard part at this point, I'm trying to dig up information on my education from 15 to 20 years ago, what professors I had on a course 20 years ago.

Q. What are the board requirements to get certified in both?

A. One has to complete a doctoral program in clinical psychology. It also depends when you graduated. The criteria have changed over time.

At least for the American Academy of Clinical Neuropsychology the criteria has changed over time. The general consensus course work in the relevant area, particularly doctoral and post

doctoral experience usually in the realm of neuropsychology. They're looking for someone either licensed or licensed eligible as psychologist.

Q. You're also not a diplomate in clinical neuropsychology?

A. That's what it means to be board certified diplomate.

Q. Isn't there a board certification separate from the diplomate in clinical neuropsychology?

A. Basic board certification diplomate status, sometimes people achieve fellow status.

Q. Doctor Mazur has that?

A. He's a diplomate.

Q. Have you ever been sued for malpractice?

A. No, not to my knowledge. If you know better, please.

A. Do you still belong to all the professional organizations you listed in your C.V.?

A. I believe my memberships are current. They haven't notified me about them not being current.

Q. Are there any organizations that you were a member of that you decided to become discontinued with?

A. No, not that I can think of.

Q. I understand you're presently--are you an employee, I don't know if I'm getting the organization Rabin, Fremed and Prince?

A. I am an employee, yes.

Q. How often are you at this office for that organization?

A. I'm here. It varies somewhat week to week, but I'm generally seeing patients for Rabin, Fremed and Prince three to four days a week.

Q. What are the hours those three to four days?

A. It fluctuates a lot depending on patients scheduling.

Q. Do you have typical day or day that's more common than others?

A. The more common day would be come in see patient in the morning, see a patient in the afternoon and try to take home and dictate as best I can overnight.

Q. Neuropsychology exams take a long time?

A. They can.

Q. How many hours do you typically spend?

A. Most examinations run three to four hours.

Q. Can you ever get in three in one day?
A. I wouldn't try to do that. It wouldn't be fair to anyone.
Q. Are you here, not to minimize, only to do the testing and the evaluation or do you come in for office work?
A. I'm here to do the clinical interview, the evaluation, the testing. I should say the scoring, but often I take the work home with me to dictate and review the records to dictate.
Q. Most of the time when you're here it's to do an evaluation of someone?
A. That's correct.
Q. Now, when do you work at Kessler?
A. Friday and sometimes sporadically throughout the week, but mostly Fridays.
Q. Is it a full day on Friday?
A. Again, it varies a little bit by time of year and case load, but usually most of the day, not a whole day.
Q. Are you an employee of Kessler?
A. Per diem employee, yes.
Q. 1099 or W-2?
A. W-2 per diem arrangement, not full time or part time.

Q. What do they pay you on a Friday?
A. Hourly wage.
Q. What do they pay you per hour?
A. I believe per diem. I haven't checked the pay stub, 60 per hour.
Q. Five hours or seven hours?
A. Usually closer to seven, eight hour day depending on time of the year.
Q. You also have on your C.V. neuropsychologist at Montefiore?
A. Yes.
Q. Is that accurate, sir?
A. I typically as neuropsychologist on behalf of another psychologist. I administer tests, but I'm not actually seeing patients in the Bronx per se.
Q. What do you do?
A. I did my pre-doctoral and post doctoral training there as a courtesy to someone I still help out with testing, but I'm not treating anyone per se.
Q. You're not on the list of neuropsychologists at the hospital?
A. No.
Q. Are you being paid by Montefiore?
A. No, I'm not. It's just helping out a

colleague.

Q. How often do you do that?

A. It averages out to two mornings a month.

Q. So if it's one day a week at Kessler and once or twice a month at Montefiore, would it be fair to say the majority of your time is spent here?

A. Either in his office or our other office, yes.

Q. How many offices do you have?

A. Two.

Q. Didn't there used to be three?

A. We haven't really been seeing people in the third office for a while.

Q. When you're at Kessler, are you seeing patients for cognitive evaluations?

A. Yes.

Q. Those are people who need treatment?

A. That's the assumption. It doesn't always materialize that way.

Q. Allegedly?

A. They're presently with cognitive symptoms.

Q. Are you prescribing cognitive therapy for them?

A. If indicated.

Q. When you prescribe cognitive therapy, is there a standard protocol for the amount of time you would prescribe that person for mild traumatic brain injury?

A. For mild traumatic brain injury we usually recommend a trial of several months.

Q. Six months?

A. No, several, three to four months.

Q. I take it you're not doing forensic evaluations at Kessler?

A. No, I'm not.

Q. Are you testifying for people who are patients at Kessler?

A. It hasn't happened. Doesn't mean it can't happen, but it hasn't happened.

Q. All the expert work you're doing then with Fremed, Rabin and Prince? I messed up the word order?

A. Yes.

Q. What would you say the percentage of forensic work is versus clinical work?

A. About 50/50.

Q. And of the forensic work, how much is done on behalf or at the request of the defendant?

A. Most.

Q. 99%?

A. I haven't really tabulated, but it's certainly well in the 90's. I don't have an exact number.

Q. Did you do any forensic reports on behalf of a plaintiff last year?

A. I wish I could answer, but I don't really remember case specific to a particular year. It's possible. I can't really say for sure.

Q. How about in 2015?

A. I don't recall doing one for a plaintiff this year.

Q. Have you ever testified on behalf of a plaintiff in court?

A. No.

Q. Have you ever written a report in 2014 or 2015 where you recommended further neuropsychological treatment on a forensic exam?

A. I don't know if I specifically recommended neuropsychological treatment. I know I certainly recommended psychological evaluation treatment and then I don't know if I recommended it. I'm usually being asked to evaluate and comment on the person's currently functioning, not treatment.

Q. And the person you recommended

psychological treatment for, was that because you felt they had some degree of psychological overlay to their injuries?

A. It's because I felt they were in need of treatment, very importantly they receive treatment at that time.

Q. As related to their accident?

A. Not specific to the accident, just in terms of their presentation when I evaluated them.

Q. In the past three years have you written a report where you found permanent neuropsychological sequella on behalf of a plaintiff?

A. I don't know if I found permanent on. Yes, I did. I do remember. I don't remember the person's name, but I do remember authoring a report that found some permanent sequella of a brain injury.

Q. Who was that person?

A. Again, I don't remember the name of the person who presented for evaluation.

Q. What year was that?

A. It was either last year or the year before. I do not remember. I apologize for not having the name on my fingertips.

Q. What percentage of work would you say you do forensically for defendants? I forgot what

you said.

A. It was somewhere in the mid to high 90's.

Q. If you did a report like that, it would stick out in your head; wouldn't it?

A. Not necessarily. The name, the report would stick out in my head, but not the name.

Q. You remember one report last year or the year before. That would probably be a matter that somebody could find in your office; would that be correct?

A. We don't cross reference things like that.

Q. Have you ever asked by a court to make that?

A. I've never been asked for something so broad. People have made requests, but it's never gone beyond somebody making a request that I do a fishing expedition on every case. That's a very large scale fishing expedition we don't have the resources or ability to entertain.

Q. Do you recall being deposed in a case called Kim versus Matawan-Aberdeen Regional School?

A. I know I was deposed in the case. I don't recall the specifics of the deposition.

MR. KELLY: What is the plaintiff's name?

MR. MURGATROYD: Kim versus Matawan.

Q. Were you aware the court ordered you to produce a copy of any reports in 2012 and 2013 where you found residual cognitive impairment as a result of the head injury?

A. I was aware of a court ordering that. I'm also aware of the fact I spoke to defense counsel and advised him that would be a fishing expedition. We don't have the resources to be able to entertain.

Q. You're aware defense counsel submitted a response to the Notice to Produce indicating you had no such reports?

A. I'm not aware of that.

(Reporter marks exhibit Benoff-1 for identification.)

Q. Do you need to look at?

A. I can't see why it would help me.

Q. Is it fair to say that you can make that determination?

A. What I told you is I do not have the ability to go searching through a year and a half to two years worth of charts looking for a specific report when I don't know a name I'm looking for. I'm telling you it is too time consuming, too burdensome

on my practice and I do not have the ability to shut down for months at a time to go scanning through everything.

Q. You have no idea why the attorney would represent you had no reports when you're telling me you never looked?

A. I have no idea why the attorney said what he said.

MR. MURGATROYD: I'm going to make the request just for the year and a half. I'm not going --

THE WITNESS: I'm telling you I'm not going to be able to produce that kind of--I'm not going to be able to search a year and a half of reports.

MR. MURGATROYD: The attorneys can talk about that. I'm going to make the request any way.

MR. KELLY: Any request, transcript requests follow up with a letter.

MR. MURGATROYD: Sure.

Q. What's your charge for depositions?

A. We have a two hour minimum and it is 590 an hour.

Q. How much of that do you get to keep?

A. The arrangement that I have in terms of

my compensation is that it's not specific to a deposition or a case, whatever the month's collections are minus expenses. I keep 35%.

Q. Mr. Kelly was asked to pay a 7,000 dollar retainer. Is he going to be refunded a portion of that? Do you know?

A. Again, I don't handle the billing on these things, but after whatever is utilized, be it with evaluation, review the of records, testimony, et cetera, then the balance is refunded.

Q. I believe you said you were deposed about 25 times in the beginning of the deposition.

A. It's a guesstimate. I don't tabulate how many times I've been deposed in a year.

Q. Can you tell me how many times you've been deposed in the past five years?

A. About that, about 25, I don't keep a count of exactly how many times I've been deposed.

Q. Have they all been at the request of a defendant?

A. Being deposed at the request of a defendant?

Q. I'm sorry. It wasn't artfully phrased. Were you being deposed as an expert at the request of a defendant?

MR. KELLY: You mean was he a defense expert?

MR. MURGATROYD: Yes. I'm sorry, maybe it's the legal lingo, sounded like the opposite.

MR. KELLY: It wasn't the legal lingo.

Q. Maybe somewhat confusing. What do you charge for a report?

A. The evaluation, we don't charge for the report. We charge for the evaluation.

Q. That includes the report?

A. Yes.

Q. What's the charge for evaluation?

A. I'd have to check with the fee schedule. I don't do the billing. I'm not sure, 3,300 or 3,500 for the evaluation.

Q. I would assume then if you're doing approximately two evaluations three to four times a week, probably do the math on how many reports.

A. That's a very big assumption. There's no show contingency to be dealt with. We do not have one hundred percent compliance with people showing up a week like that is exceedingly rare.

Q. Can you tell me how many actual people that show up you see a week?

MR. KELLY: Talking about for forensic

exams?

MR. MURGATROYD: Yes, forensic exams.

A. It's typically one to two a week.

Q. In the three to four days?

A. Yes. A lot of people do not show, a lot of people reschedule, a lot of people move things around and there isn't always a complete schedule. There's gaps that occur in a practitioner's schedule.

Q. How many times have you testified at trial in the last five years?

A. In court, I'm going to guess about 10 times. Again, I don't know exactly how many times I've testified in court.

Q. What's your charge for trial? When I say your charge, I don't mean you, person in the group.

A. It's 3,500 for a half day.

Q. You get to keep how much of that?

A. It goes into the monthly collections and I keep 35% of whatever my colleagues are charging.

MR. MURGATROYD: Thank you, Doctor.

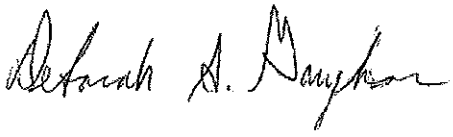
(Whereupon deposition is concluded at 3:20 p.m.)

C E R T I F I C A T E

I, DEBORAH A. GAUGHAN, a Notary Public and Certified Shorthand Reporter of the State of New Jersey, do hereby certify that prior to the commencing of the examination KEITH BENOFF PhD duly affirmed to testify the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.



Notary Public of the State of New Jersey

My Commission Expires: 4/18/18

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VERITEXT LEGAL SOLUTIONS
800-227-8440

ASSIGNMENT NO. NJ2077027
CASE NAME: Barta, Michael v. Infrastructure Repair Service
DATE OF DEPOSITION: 6/9/2015
WITNESS' NAME: Keith Benoff

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Keith Benoff

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New Jersey Rules Governing Civil Practice

Part IV, Rule 4:14

Depositions Upon Oral Examination

4:14-5. Submission to Witness; Changes; Signing

If the officer at the taking of the deposition is a certified shorthand reporter, the witness shall not sign the deposition. If the officer is not a certified shorthand reporter, then unless reading and signing of the deposition are waived by stipulation of the parties, the officer shall request the deponent to appear at a stated time for the purpose of reading and signing it. At that time or at such later time as the officer and witness agree upon, the deposition shall be submitted to the witness for examination and shall be read to or by the witness, and any changes in form or substance which the witness desires to make shall be entered upon the deposition by the officer with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness. If the witness fails to appear at the time stated or if the deposition is not signed by the witness, the officer shall sign it and state on the record the fact of the witness' failure or

refusal to sign, together with the reason, if any, given therefor; and the deposition may then be used as fully as though signed, unless on a motion to suppress under R. 4:16-4(d) the court holds that the reasons given for the refusal to sign require rejection of the deposition in whole or in part.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2014. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.